



High prevalence of depressive symptoms in a national sample of adults in Indonesia: Childhood adversity, sociodemographic factors and health risk behaviour

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ABSTRACT

Background: The aim of this study was to investigate depressive symptoms and their association with socio-demographic factors, stressors and support, including childhood adversity, health status risk and behaviour in Indonesia.

Method: In a cross-sectional national population survey in 2014–15 in Indonesia, 31442 adults (mean age 37.3 years, SD = 14.9, age range 15–101 years) responded to the Centers for Epidemiologic Studies Depression Scale (CES-D-10) and various other measures.

Results: Overall, 15.0% of participants reported moderate and 6.9% severe depressive symptoms, or 21.8% moderate or severe depressive symptoms (21.4% among men and 22.3% among women). In multivariable logistic regression among both men and women, sociodemographic factors (younger age, poor subjective economic background, being unemployed, residing in Java and main island groups), stressors (childhood hunger and poor or fair self-rated health status and having experienced disasters), lack of social trust and religiosity, having one or more chronic conditions, tobacco use and soft drink consumption were positively and obesity negatively associated with moderate or severe depressive symptoms.

Conclusion: High rates (21.8%) of depressive symptoms were found. Several risk factors including socio-demographic factors such as younger age, stressors, lack of social support, health risk status and behaviour variables were identified which can be utilized in guiding interventions.

1. Introduction

Depressive disorders are a leading cause of the global burden of disease globally and in low- and middle-income countries (Ferrari et al., 2013a) and are therefore of utmost public-health importance (Steel et al., 2014). The global prevalence of depression using a symptom scale was 12.1% (17.0% among women and 11.6% among men) (Ferrari et al., 2013a,b). Among adult women in urban Indonesia the prevalence of depressive symptoms was 15% (Christiani et al., 2015) and among a small sample of individuals aged 60 years or older living in Indonesia 33.8% (Wada et al., 2005). In a sample of university students in Jakarta, Indonesia, 24.4% had depressive symptoms (Peltzer and Pengpid, 2015) and among rural dwellers in North Sulawesi, Indonesia, 10% screened positive for psychological distress (anxiety and depressive symptoms) (Kinzie et al., 2016). In countries in the region, the national prevalence of depressive symptoms was 2.4% in China

(Chen et al., 2017), 6.7% and 11% in Korea (Oh et al., 2013; Shin et al., 2017), 4.2% in Nepal (Risal et al., 2016), and the prevalence of diagnosed depression was 2.8% in Vietnam (Vuong et al., 2011). There is lack of recent national data of depressive symptoms prevalence in Indonesia.

With this in mind, the main aim of this study was to estimate the health-care needs by assessing the prevalence of depressive symptoms in a national adult survey. We also wished to establish associations with sociodemographic factors, stressors and support, including childhood adversity, health status risk and behaviour. As a result this could fill important gaps regarding depressive symptoms epidemiology and socio-culturally relevant correlates in the Southeast Asian region, and would help in guiding public mental health policy in Indonesia.

Sociodemographic factors have been linked with the prevalence of depression and depressive symptoms, such as older age in low- and middle-income countries (Adjaye-Gbewonyo et al., 2016; Kessler et al.,

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2010; Risal et al., 2016), female gender (Adjaye-Gbewonyo et al., 2016; Salk et al., 2017), lower socioeconomic status (Adjaye-Gbewonyo et al., 2016; Tampubolon and Hanandita, 2014), lower income (Chen et al., 2017), lower education (Daray et al., 2017), rural residency (Chen et al., 2017), and being unemployed (Skapinakis et al., 2013).

Stressors and lack of social support have been identified as risk factors for depression, such as stressful life events (Chen et al., 2017; Daray et al., 2017), childhood adversity (Fryers and Brugha, 2013), parental separation (Bohman et al., 2017), childhood hunger (Stickley and Leinsalu, 2018), low social capital (trust, participation) (Tampubolon and Hanandita, 2014), and lack of religiosity (Purwono and French, 2016; Tampubolon and Hanandita, 2014).

Health risk status and behaviours have been shown to be risk factors of depression, including having chronic health conditions (Daray et al., 2017; Liew, 2012) and obesity was shown to increase the risk of depression as well as depression was predictive of obesity (Luppino et al., 2010). In a more recent review, Mannan et al. (2016) found that the “strength of the association is greater for the direction leading from depression to obesity and this link was more pronounced for young and middle aged women”. Current smoking (Chen et al., 2017; Daray et al., 2017; Liew and Gardner, 2016), physical inactivity (Schuch et al., 2017), and specific dietary behaviours such as no or low fruit and vegetable consumption (Li et al., 2017) and soft drink consumption (Guo et al., 2014; Yu et al., 2015) have been found to associated with depression.

Several authors (e.g., Bromet et al., 2011; Ferrari et al., 2013a,b) have indicated that sparse national data on depressive symptoms are available from Southeast Asia, including Indonesia. Therefore, the aim of this study was to investigate depressive symptoms and their association with sociodemographic factors, stressors and support, including childhood adversity, health status risk and behaviour in Indonesia.

2. Method

2.1. Study design and participants

Data were analysed from the “Indonesia Family Life Survey (IFLS-5)”, a continuing demographic and health survey that began in 1993 and had since four rounds of data collection, with the fifth wave (IFLS-5) having been completed in 2015 (Strauss et al., 2016). The community surveys collected data on household, individual, and community level using a multistage stratified sampling (Strauss et al., 2016). The sampling frame of the first survey in 1993 was based on households from 321 enumeration areas (EAs) (20 households were randomly selected from each urban EA, and 30 households were selected from each rural EA) in 13 out of 27 Indonesian provinces that were selected representing 83% of the Indonesian population in 1993, more details in (Strauss et al., 2016). At household level, several randomly selected household members were asked to provide detailed individual information. In the IFLS-5, 16,204 households and 31447 15 years and older individuals were interviewed with complete depressive symptoms measurements. In the IFLS-5, “the dynasty recontact rate was 92% and for the individual target households (including split off households as separate) the re-contact rate was 90.5%.” (Strauss et al., 2016). Although the survey is longitudinal, we restricted our analysis to the IFLS-5 cross-sectional survey for persons 15 years and older, being the most recent national survey available assessing depressive symptoms.

2.2. Measures

Depressive symptoms were assessed with the “Centers for Epidemiologic Studies Depression Scale (CES-D-10)” (Andresen et al., 1994). Although the CES-D-10 may not be directly compared to a clinical diagnosis of major depression, the sensitivity and specificity of the CES-D-20-item has been reported to average 80% and 70%, respectively, compared to formal diagnostic interview (Mulrow et al.,

1995). Scoring is classified from 0 to 9 as having a mild level of depressive symptoms, 10 to 14 as moderate depressive symptoms, and ≥ 15 representing severe depressive symptoms (Andresen et al., 1994). In a cross-national study, results support the validity of comparing responses on the CES-D across cultures, including Indonesia (Mackinnon et al., 1998). The Cronbach α reliability coefficient of this 10-item scale was 0.72 in this study.

Socio-demographic factor questions included age, gender, marital status, education, work status, religion, residential status (urban or rural), subjective socioeconomic background, and province. Subjective economic status was assessed the question “Please imagine a six-step ladder where on the bottom (the first step), stand the poorest people, and on the highest step (the sixth step), stand the richest people. On which [economic] step are you today?” The answers ranged from (1) poorest to (6) richest (Strauss et al., 2016). Economic step 1 to 2 was classified as poor, 3 as medium and 4 to 6 as rich economic status. Provinces were grouped in three regions, Sumatra, Java and major island groups.

2.3. Stressors and support variables

Childhood adversity questions included: “Would you say that your health during your childhood was in general excellent, very good, good, fair, or poor?” (Coded as poor or fair); 2) “Did you experience hunger in your childhood (from birth to 15 years)?” (Response option “yes” or “no”) (Coded as yes); 3) “When you were 12, were your biological parents still married?” (Response option “yes” or “no”) (Coded as no); 4) “When you were 12, did any of your parents: smoke, drink heavily, have mental problems or none of the above?” (Strauss et al., 2016) Responses were grouped into a) parents had no substance use and/or mental problem, b) smoked, c) smoked and drank heavily, and d) had a mental problem, drank heavily or combination of any other three issues.

The experience of a natural disasters was assessed with three questions, 1) “In the last 5 years, was there any natural or other disaster (including civil strife) in the area where you live?” And if yes, 2) “Was any of the disasters severe enough to cause death or major injuries of a household member, cause direct financial loss to the household, or cause the household member to relocate?” and if yes, 3) “How many times has this household experienced a natural disaster in the last 5 years?” (Response option number of times) (Strauss et al., 2016) (Coded as 0, 1, 2 or more)

Social trust was assessed with 4 items (e.g., “How safe do you consider this village?”) generated from the first two factors of a factor analysis of 10 trust items. Response options ranged from 1 = strongly disagree to 4 = strongly agree (Strauss et al., 2016). Responses from the four questions were coded into low (4–10), medium (11), and high (12–16).

Religiosity was measured with the question, “How religious are you?” (Response options were, very religious, religious, somewhat religious and not religious) (Strauss et al., 2016). Responses were coded as 1 = not religious or somewhat religious, 2 = religious and 3 = very religious.

2.4. Health status and behaviour risk variables

Chronic medical condition was assessed with the question, “Has a doctor/paramedic/nurse/midwife ever told you that you had...?” “Hypertension, Diabetes or high blood sugar, Tuberculosis, Asthma, Other lung conditions, Heart attack, coronary heart disease, angina or other heart problems, Liver, Stroke, Cancer of malignant tumor, Arthritis or rheumatism, High cholesterol (total or LDL), Kidney diseases (except for tumor or cancer, Stomach or other digestive disease, Emotional, nervous of psychiatric problem, and Memory-related disease”) (Yes, No). Responses were added up and dichotomized into having no and having one or more chronic conditions (Strauss et al.,

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