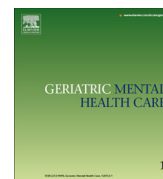




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Association between alcohol consumption and self-reported depression among elderly Australian men



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ABSTRACT

Background: Links between alcohol consumption and depression have been reported; however, associations amongst the elderly remain unclear. We aimed to investigate the relationship between alcohol consumption and self-reported depression in a population-based sample of 514 men aged 65+ (median 76.4yr, IQR 71.2–82.4).

Methods: Alcohol intake over the previous 12 months was estimated from a food frequency questionnaire. Participants were classified as non-drinkers or habitual consumers of ≤ 2 or ≥ 3 standard drinks per day. Symptoms of past and 12-month depression were ascertained by self-report based on DSM-IV criteria. Using logistic regression, we estimated the association between alcohol intake and depression, adjusting for age and lifestyle factors.

Results: There were 91 non-drinkers (17.7%), 249 (48.4%) consuming ≤ 2 drinks/day, and 174 (33.9%) consuming ≥ 3 drinks/day. Forty eight (9.3%) were identified as having lifetime depression and 31 (6.0%) with 12-month depression. With those consuming ≤ 2 drinks/day as the reference, the odds of lifetime depression were greater for non-drinkers (OR=2.50, 95% CI 1.15–5.44) and tended to be greater for those consuming ≥ 3 (OR=1.45 95% CI 0.70–3.00). After excluding those with past depression, the likelihood of 12-month depression tended to be greater for non-drinkers (OR=2.38 95% CI 0.89–6.38) and those consuming ≥ 3 drinks/day (OR=1.68 95% CI 0.70–4.07). These associations were not explained by age, mobility, smoking, BMI, SES or number of medications.

Conclusions: These results suggest a U-shaped relationship between alcohol consumption and depression in this sample of elderly men.

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1. Introduction

Persons aged 65 years and older comprised 13.6% of the total population in Australia in 2010 (Bleicher et al., 2010), and this is projected to rise to 24% by 2051 (McLennan, 1999). In light of increasing life expectancy and the growing proportion of the elderly within the population, maintaining good health for this segment of society is of obvious and profound benefit. Although depression is suggested to be less common among the elderly than in younger adults (Kessler et al., 2010; Williams et al., 2010), it is

estimated that depression takes a chronic or relapsing course amongst half of elderly patients and is often misdiagnosed or untreated (Djernes, 2006), furthermore it is known that suicide rates are high amongst the elderly (WHO, 2002).

Among the elderly, relatively low prevalence rates of depression have previously been reported. For example the 12-month prevalence rate for Major Depressive Disorder (MDD) was reported to be 0.8% for men (75+ years) in the 2007 National Survey of Mental Health and Wellbeing (NSMHWB) survey (Trollor et al., 2007). However, such surveys have been criticised for under-representing the extent of mental illness within this population, and more recent projections have indicated that around 8% of Australians aged over 60 years experience clinically significant depression (Pirkis et al., 2009). A recent review of depression amongst the elderly reported lifetime prevalence to range between 0.9% and 9.4% for individuals

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living in private households and 14–42% amongst those in nursing homes (Djernes, 2006). Another review reported the lifetime prevalence of MDD to range between 4.5% and 6.9% for elderly men (Luppa et al., 2010).

Alcohol use is common within Australian society and has been long recognised as an important part of the Australian way of life, used in a range of situations and for different functions (Dare et al., 2014). While alcohol use in the elderly has not traditionally received much attention, there are a number of reasons to research consumption patterns within this segment of the population. Firstly research will inform public health messages aimed at maintaining health within an ageing population, secondly elderly men are more likely to be daily drinkers than their younger counterparts (AIHW, 2011; Choi and Dinitto, 2011b; Coulson et al., 2010), and finally, they may be particularly vulnerable to harms from alcohol use due changes in metabolism, interactions with medications or existing medical conditions or to risk from falls (NHMRC, 2009; Oslin, 2000).

Considerable research has demonstrated an association between alcohol consumption (or abstinence) and depression (Choi and Dinitto, 2011b; Merrick et al., 2008; Sacco et al., 2009). A number of hypotheses are proposed to account for this link. Firstly, chronic alcohol use may result in direct biological effects that increase the risk of developing depression. Secondly, alcohol may be consumed in an attempt to manage existing depressive symptoms (self-medication hypothesis). Thirdly the association may be bidirectional. Fourthly, that shared factors (including social isolation, stress, adjustment to changing roles and physical limitations, grief/loss and the presence of chronic medical conditions) may contribute to both alcohol consumption and increase vulnerability to depression. Further research is required to elucidate causal pathways however many authors suggest that the association is likely bidirectional (Choi and Dinitto, 2011a; Schutte et al., 1995; van den Berg et al., 2014).

Limited research has been conducted examining the relationship between alcohol consumption and depression specifically within in elderly population. Within existing studies both abstainers and heavy alcohol consumers have been demonstrated to be at increased risk of depression compared to moderate consumers. In one study, elderly individuals who consumed excessive alcohol over a period of five years were found to have a six-fold increased risk of any psychiatric illness, and a four-fold increased risk of depression when compared to healthy peers (Saunders et al., 1991). Men (aged 57–85 years) who consumed 4+ drinks per day were found to have higher depression scores than abstainers in a US study (Choi and Dinitto, 2011b). In another study focusing on elderly European men (aged 70–89 years), moderate baseline alcohol consumption was found to be protective against the development of depression over the following five year follow-up period (OR=0.35) (Bots et al., 2008). Another study comparing depressed with non-depressed older adults (aged 60–90 years), found a high proportion of abstainers amongst the depressed group and that abstainers reported more functional limitations and chronic diseases than moderate drinkers. This study also found that both abstainers and those who drink 4+ drinks per day reported lower social support than moderate drinkers (van den Berg et al., 2014). Within an Australian household survey both abstainers and consumers of more than 2 drinks per day were more likely to report a past or current mental illness and higher levels of psychological distress than moderate alcohol drinker (AIHW, 2011). In a study of US older adults (aged 50+ years), moderate alcohol consumers (2 or less drinks/day) was associated with lower levels of psychological distress in men when compared to abstainers. However, this effect disappeared after controlling for socio-demographic variables and health status (Choi and Dinitto, 2011a).

There is a paucity of research examining the relationship between alcohol consumption and depression specifically for elderly men, and research has largely been conducted in North America or Europe rather than in Australia. Considering the known variability of alcohol consumption across cultures, conducting research within the Australian context is of vital importance. To address the gaps in the literature, this study sought to examine the relationship between different levels of current alcohol consumption and the occurrence of self-reported depression in a random population-based sample of elderly men from the south-eastern region of Australia.

2. Methods

2.1. Participants

This study examined data collected from men enrolled in the Geelong Osteoporosis Study (GOS); detailed descriptions of the study sample and procedures are published elsewhere (Henry et al., 2010; Pasco et al., 2012). Between 2001 and 2006, 1540 men (age range 20–93 years) were randomly selected from the Commonwealth electoral rolls for the Barwon Statistical Division (BSD), a geographical region within south-eastern Australia (67% response). The BSD region is well suited to epidemiological research due to having a comparable age distribution and socio-economic indicators to the broader Australian population (Pasco et al., 2012). Participants attended the study centre for clinical assessments; self-reported depression, alcohol consumption and other lifestyle factors were documented by questionnaire.

For this cross-sectional study, participants over the age of 65 years at time of assessment were eligible for analysis ($n=581$); participants were excluded if they had incomplete alcohol consumption data ($n=27$) or depression data ($n=40$), resulting in a final sample of 514 participants. All participants provided informed written consent. Approval for the study was obtained from the Barwon Health Human Research Ethics Committee.

2.2. Measures

2.2.1. Alcohol consumption

Alcohol intake was ascertained from a validated (Hodge et al., 2000), self-report food frequency questionnaire (FFQ) designed by the Cancer Council (Victoria) (Giles and Ireland, 1996) which documented the total number of standard drinks usually consumed on drinking days within the previous 12 months. Participants were categorised into non-drinkers, and alcohol users who consumed ≤ 2 or ≥ 3 standard drinks on a usual drinking day. Participants were provided with examples in the FFQ of how to convert volumes of alcohol into number of glasses according to Australian standard drink measures. A standard drink was defined as containing 10 g ethanol.

2.2.2. Depression

Symptoms of depression were ascertained by a self-report questionnaire; participants were presented with a list of symptoms corresponding to DSM-IV-TR criteria (DSM-IV, 1994) and asked to indicate if they had experienced each symptom within the same 2-week period in the previous year or within their lifetime. A classification of clinically significant depression was consequently made if the participant had experienced either dysphoria (depressed mood) or anhedonia (inability to take or diminished pleasure in daily activities) consistently over at least a two-week period, together with at least four accompanying symptoms (three if both dysphoria and anhedonia were endorsed). Participants were subsequently divided into depressed and never

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