

Title	Living longer and feeling better: healthy lifestyle, self-rated health, obesity and depression in Ireland
Authors	Harrington, Janas M.;Perry, Ivan J.;Lutomski, Jennifer E.;Fitzgerald, Anthony P.;Shiely, Frances;McGee, Hannah;Barry, Margaret M.;Van Lente, Eric;Morgan, Karen;Shelley, Emer
Publication date	2010-02-01
Original Citation	HARRINGTON, J., PERRY, I. J., LUTOMSKI, J., FITZGERALD, A. P., SHIELY, F., MCGEE, H., BARRY, M. M., VAN LENTE, E., MORGAN, K. & SHELLEY, E. 2010. Living longer and feeling better: healthy lifestyle, self-rated health, obesity and depression in Ireland. The European Journal of Public Health, 20, 91-95. doi: 10.1093/eurpub/ckp102
Type of publication	Article (peer-reviewed)
Link to publisher's version	http://eurpub.oxfordjournals.org/content/20/1/91.abstract - 10.1093/eurpub/ckp102
Rights	© The Author 2009. Published by Oxford University Press on behalf of the European Public Health Association. All rights reserved.. This is a pre-copy-editing, author-produced PDF of an article accepted for publication in The European Journal of Public Health following peer review. The definitive publisher-authenticated version Janas Harrington, Ivan J. Perry, Jennifer Lutomski, Anthony P. Fitzgerald, Frances Shiely, Hannah McGee, Margaret M. Barry, Eric Van Lente, Karen Morgan, and Emer Shelley (2010) Living longer and feeling better: healthy lifestyle, self-rated health, obesity and depression in Ireland. The European Journal of Public Health 20 (1) 91-95 is available online at: http://dx.doi.org/10.1093/eurpub/ckp102
Download date	2024-05-13 21:05:08
Item downloaded from	https://hdl.handle.net/10468/592



University College Cork, Ireland
Coláiste na hOllscoile Corcaigh



LIVING LONGER AND FEELING BETTER: Healthy lifestyle, self-rated health, obesity and depression in Ireland



Journal:	<i>European Journal of Public Health</i>
Manuscript ID:	EJPH-2009-03-OM-0186.R2
Manuscript Type:	Original Manuscript
Date Submitted by the Author:	
Complete List of Authors:	Harrington, Janas; University College Cork, Epidemiology & Public Health Perry, Ivan; Department of Epidemiology and Public Health, University of Cork Lutomski, Jennifer; University College Cork, Epidemiology & Public Health Fitzgerald, Anthony; University College Cork, Epidemiology & Public Health Shiely, Frances; University College Cork, Epidemiology & Public Health McGee, Hannah; RCSI, Psychology Barry, Margaret; NUI, Galway, Health Promotion van Lente, Eric; NUI, Galway, Health Promotion Morgan, Karen; Royal College of Surgeons in Ireland, Division of Population Health Sciences Shelley, Emer; Royal College of Surgeons in Ireland, Division of Population Health Sciences
Keywords:	lifestyle behaviours, self rated health, obesity, depression, protective behaviours



LIVING LONGER AND FEELING BETTER: Healthy lifestyle, self-rated health, obesity and depression in Ireland

Running Title: The impact of four combined protective lifestyle behaviours on general health

Harrington J¹, Perry IJ¹, Lutomski J¹, Fitzgerald AP¹, Sheily F¹, McGee H², Barry MM³, Van Lente E³, Morgan K², Shelley E²

¹Department of Epidemiology and Public Health, University College Cork

² Division of Population Health Sciences, Royal College of Surgeons in Ireland

³ Department of Health Promotion, National University of Ireland, Galway

Harrington J, Researcher, j.harrington@ucc.ie

Perry IJ, Department Head i.perry@ucc.ie

Lutomski J, Researcher, j.lutomski@ucc.ie

Fitzgerald T, Biostatistician t.fitzgerald@ucc.ie

Sheily F, Lecturer f.sheily@ucc.ie

McGee H, Department Head hmcgee@rcsi.ie

Barry M, Department Head margaret.barry@nuigalway.ie

Eric Van Lente, Researcher eric.vanlente@nuigalway.ie

Morgan K, Lecturer, kmorgan@rcsi.ie

Shelley E (Senior Lecturer), emer.shelley@hse.ie

Correspondence to:

Janas Harrington

Dept of Epidemiology & Public Health

University College Cork

Room 2.62

Brookfield Health Sciences Complex

College Road

Cork

Tel: +353-21-4901597

Fax: +353-21-4901604

E-mail: j.harrington@ucc.ie

Word Count: 2047 (excl acknowledgements)

Abstract:232

FUNDING

SLÁN was funded by the Department of Health and Children

Abstract

Background

The combination of four protective lifestyle behaviours (being physically active, a non-smoker, a moderate alcohol consumer and having adequate fruit and vegetable intake) has been estimated to increase life expectancy by 14 years. However, the effect of adopting these lifestyle behaviours on general health, obesity and mental health is less defined. We examined the combined effect of these behaviours on self-rated health, overweight/obesity and depression.

Methods

Using data from the Survey of Lifestyle Attitudes and Nutrition (SLÁN)2007 a protective lifestyle behaviour (PLB) score was constructed for 10,364 men and women (18+ years), and representative of the Republic of Ireland adult population (response rate 62%),. Respondents scored a maximum of four points, one point each for being physically active, consuming 5 or more fruit and vegetable servings daily, a non-smoker, and a moderate drinker.

Results

One fifth of respondents (20%) adopted four PLBs, 35% adopted three, 29% two, 13% one and 2% adopted none. Relative to those with zero PLBs those with four were seven times more likely to rate their general health as

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

excellent/very good (OR 6.8 95% CI [3.64-12.82]); and four times more likely to have better mental health (OR 4.4 95% CI [2.34-8.22]).

Conclusions

Adoption of core protective lifestyle factors known to increase life expectancy is associated with positive self-rated health, healthier weight and better mental health. These lifestyles have the potential to add quality and quantity to life.

Key Words: lifestyle behaviours, self rated health, obesity, depression, protective factors

Introduction

It has been known for some time that adoption of a number of core protective/health promoting lifestyle behaviours at an individual level has a potentially large positive influence on population health. There is increasing recognition of the value of these behaviourally defined protective behaviours for health promotion and population health monitoring ¹⁻⁸ and, advice on smoking cessation, healthy diet, physical exercise and moderation in alcohol consumption has been a pillar of health education for many years. While anecdotally a perception exists that adoption of a healthy lifestyle may impair quality of life as evidenced by the admonition “You won’t live forever, it will just feel like it”, recent evidence suggests that quality as well as quantity can be added to life through the adoption of relatively minor lifestyle changes. ⁵.

Results from the Nurse’s Health Study ⁹, reported the positive effects of a limited number of core protective lifestyle behaviours (BMI<25kg/m²; a diet high in cereal fibre and polyunsaturated fat and low in trans fat and glycaemic load; engagement in moderate-to-vigorous physical activity for at least half an hour per day; no current smoking; and the consumption of an average of at least half a drink of an alcoholic beverage per day) in relation to the decreased risk of type two diabetes. This work has been replicated in a cross-sectional study with markers of cardiovascular risk including hypertension, dyslipidemia and insulin resistance ^{4 5 10}. More recently Khaw

1
2
3
4 *et al*¹, in their work from the European Prospective Investigation into Cancer
5
6 (EPIC) study, focused on behaviourally defined measures. They identified
7
8 four lifestyle behaviours: being physically active, a non-smoker, having a
9
10 moderate alcohol consumption and an adequate fruit and vegetable intake
11
12 and found that the combined effect of these health behaviours predicted a 4-
13
14 fold difference in total mortality in men and women¹, equating to a 14-year
15
16 difference in life expectancy between individuals practising none of these
17
18 behaviours relative to those practising all four of them. In further work from
19
20 the EPIC study, Myint *et al*¹¹ concluded that behavioural factors were
21
22 associated with substantial differences in age-related decline in functional
23
24 health and the prevalence of those in good and poor functional health in the
25
26 community.
27
28
29
30
31
32
33
34
35

36
37 Examining the effects of individual risk factors for chronic disease and poor
38
39 physical and mental health is not a new concept, however, their combined
40
41 effect on general health, obesity and mental health is less well defined. The
42
43 aim of this study was to examine the combined effect of practising four non-
44
45 clinically defined lifestyle behaviours (being a non-smoker, being physically
46
47 active, being a moderate drinker, and consuming five portions of fruit and
48
49 vegetables daily), on self-rated health, overweight/obesity and mental health.
50
51
52
53
54
55
56
57
58

59 **Methods**

60

Based on the work by Khaw et al ¹, we constructed a protective lifestyle behaviour (PLB) score. Participants scored one point for each of the following health behaviours: being a non-smoker, being physically active (moderate/high activity score), being a moderate drinker (1-14 alcohol units per week), and consuming five or more servings of fruit and vegetables daily. Respondents could score from zero to four on protective health behaviours.

General Study Design

The study was the third national Survey of Lifestyle, Attitudes and Nutrition (SLÁN) in Ireland conducted in 2007 ¹²⁻¹⁴, involving a nationally representative sample of 10,364 respondents (62% response rate) to whom a detailed health and lifestyle questionnaire was administered by face-to-face interview. In addition, 9,223 (89%) completed a Willett Food Frequency Questionnaire (FFQ). The FFQ was an adapted version of the EPIC study ¹⁵, validated for use in the Irish population ¹⁶. Participants who did not complete a FFQ were excluded from this analysis.

Sampling

The population for the survey was defined as adults aged 18 years and over living in residential households in Ireland (residents of institutions, nursing homes, hospitals, prisons and homeless hostels were not included). Full details of the sampling frame and weighting can be found elsewhere ¹². In

summary, the sampling frame used for the survey was the GeoDirectory, a list of all addresses in the Republic of Ireland, which distinguishes between residential and commercial establishments. The sample was a multi-stage probability sample, where each dwelling has a known probability of selection. The sample was weighted to closely approximate the Census 2006 figures for gender, age, marital status, education, occupation, region, household size and ethnicity.

Health and Lifestyle Questionnaire

A single question was included on self-rated health, respondents were asked to rate their health on a 5-point scale ranging from 'excellent' to 'poor'. Being a current smoker was defined as smoking either 'every day' or 'some days'. Non smokers were classified as those had never smoked; former smokers were those who had smoked 'at least 1000 cigarettes in their lifetime' but do not currently smoke. For the purposes of this paper, current smokers are compared to non-smokers. Average alcohol consumption was estimated as the units of alcohol consumed per week. For the purpose of this paper, a moderate drinker was defined as someone who consumed between 1 and 14 units a week. A unit is defined as either 'a half pint of beer; a single measure of spirits; or a single glass of wine, sherry or port'. Respondents were also asked if they had experienced any chronic illness from a pre-defined list in the previous 12 months.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

International Physical Activity Questionnaire (IPAQ)

Respondents were asked a series of questions relating to the time they spent being physically active. The responses were used to calculate a physical activity score (IPAQ-Score) for each respondent. These scores were classified as high (over 10,000 steps per day), moderate (5,000-10,000 steps per day) or low (less than 5,000 steps per day). For this analysis a binary variable was created; 'low' or 'moderate/high', 'low' was defined as being physically inactive.

Composite International Diagnostic Interview (CIDI)

Respondents were asked a series of questions pertaining to their mental health status. The CIDI-SF (short form) Version1.1 health interview survey part of which was incorporated in the main SLÁN interview, provides a probable diagnosis* of major depressive disorder¹⁷. Full details of the mental health measures have been reported elsewhere¹⁸.

Food Frequency Questionnaire

The dietary habits of respondents who completed a FFQ were analysed in relation to food groups. Full details of the FFQ have been documented elsewhere¹⁹. For this analysis fruit and vegetable intake was collapsed to a

* CIDI-SF yields a likelihood of having a major depression rather than a full diagnosis hence the term 'probable Major Depressive Disorder' is used throughout this paper

1
2
3 binary variable with participants categorised as consuming '5 or more servings
4
5
6 daily' or 'less than 5 servings daily'.
7
8
9

10 11 Body Mass Index 12

13
14 SLÁN 2007 respondents were also asked to self-report their own height and
15
16 weight. BMI was calculated based on the standard formula (height
17
18 (m)/weight (kg) X weight (kg)), they were classified as overweight or obese
19
20 based on a BMI score of $\geq 25\text{kg/m}^2$ or 30kg/m^2 respectively.
21
22
23
24

25 Statistical Analysis 26

27
28 Data were analysed using SPSS™ (Version 15.0). Logistic regression was
29
30 used to examine the relationship between PLB score, self-rated health,
31
32 probable depressive disorder and obesity levels after adjusting for age, sex,
33
34 education and social class. Additionally we examined the relationship
35
36 between PLB score and past diagnoses of medically-diagnosed chronic illness.
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Results

Demography

Table 1 shows a breakdown of the relevant participant characteristics differentiated by gender. Higher proportions of women were normal weight and consumed 5 or more daily servings of fruit and vegetables compared to men. Men were more likely to be smokers, to consume more alcohol and to be physically active compared to women. Women were more likely to have adopted more of the protective lifestyle behaviours. Table 2 shows the age, gender, social demographic profile and the distribution of key outcome variables in five groups of study participants defined on the basis of number of protective lifestyle behaviours. Clear and highly significant trends were seen for age, gender, education and social classification status. Those with three and four protective lifestyle behaviours were more likely to be female, in the younger/middle age group to have tertiary education and to be in the 'large employers/professional/manager' socioeconomic classification group. Respondents with a lower PLB score were significantly more likely to have a depressive disorder ($P<0.01$).

Associations between protective lifestyle behaviours and feeling healthy

The association between PLB score, self rated health, healthy weight and better mental health adjusted for age, sex, education and social class is shown in table 3. For self rated health and depressive state, clear and highly

significant trends in odds ratios were observed across the five groups of study participants. These trends were not as obvious for body weight. Relative to those with zero PLBs those with four were eight almost 7 times more likely to rate their general health as excellent/very good (6.8 95% CI [3.64-12.82]). These trends persisted even when the model was adjusted for depressive disorders. Those with 4 PLBs were also four times more likely to have better mental health (OR 4.4 95% CI [2.34-8.22]) indicating a better overall general health and well being. While similar trends were not as obvious in relation to BMI status, those with four PLBs had an elevated likelihood of being normal weight (BMI<25kg/m²) than overweight/obese (BMI >25kg/m²) compared to those with fewer PLBs.

Discussion

We know from longitudinal studies that protective lifestyle behaviours increase longevity ¹; this paper also shows that they are also associated with better self-rated health, better mental health and healthier body weight; conversely those who had fewer protective lifestyle behaviours, were ‘not only’ leading unhealthier lifestyles, they also perceived their overall health to be poorer, had a higher likelihood of having depression and were heavier than those with higher numbers of protective lifestyle behaviours. Higher scores were also less likely to be associated with being diagnosed with a cardiovascular event and being diagnosed with any illness by a doctor in the last twelve months. While our results are congruent with the work by Khaw *et al* ¹ and Myint *et al* ¹¹ who examined the relationship between protective lifestyle behaviours and mortality ¹ and protective lifestyle behaviours and functional health ¹¹, this is one of the first studies to look at self-rated health, depression and overweight/obesity in relation to protective lifestyle behaviours.

Limitations of the study include the cross sectional design, and the relatively low response rate (62%). However this is similar to response rates seen in other major National Health and Lifestyle Surveys ^{13 14}. It is increasingly difficult to get high response rates from national general population surveys due to the sociodemographic trends in modern society including, longer

1
2
3 working days and the phenomenon of gated communities, particularly in
4
5 urban areas. Unfortunately data on non-participation are not available.
6
7
8 However, sample weights were used derived from the most recent Census ²⁰.
9
10 Interpretation of the data must be cautious; since exposure and outcome were
11
12 measured at the same time it is not possible to ascertain which the cause is
13
14 and which is the effect. It can be argued that persons with better than average
15
16 self-rated health and better mental health are more likely to engage in health
17
18 seeking behaviour. The issue of reverse causation cannot be resolved in this
19
20 study, however it is likely that the causal effects of these health seeking
21
22 behaviours flow in both directions and are mutually beneficial: better mental
23
24 health and better self-rated health leading to increased health seeking
25
26 behaviours and vice versa. What is clear is that there is no evidence to
27
28 suggest that the presence of health seeking behaviours is associated with
29
30 poorer mental health and well being.
31
32
33
34
35
36
37
38
39
40
41
42
43
44

45 Our findings add to the evidence that we can achieve progress to address the
46
47 'causes of the causes' of all-cause mortality, mental ill-health and
48
49 cardiovascular disease through small achievable lifestyle behaviour
50
51 modifications. A key challenge for future research is to better understand the
52
53 individual and societal determinants of health seeking behaviour. For
54
55 instance, there is emerging data highlighting the importance of adverse
56
57 childhood experiences as a determinant of health related behavior in adult
58
59
60

life²¹. Data from the US ²²⁻²⁴ show that children with low rates of childhood adversity not only have better mental health in adult life but better physical health with lower rates of high risk behaviours and conditions e.g. obesity.

Conclusion

Given the association between self-rated health, better mental health and higher numbers of protective lifestyle behaviours, we propose that the four lifestyle behaviours detailed in this paper be used as outcome measures from which effectiveness of public health policy can be gauged.

ACKNOWLEDGEMENTS

“We thank other SLÁN 2007 Consortium members for their contribution to this research. Consortium members: Professor Hannah McGee (Project Director)(RCSI), Professor Ivan Perry (PI)(UCC), Professor Margaret Barry (PI)(NUIG), Dr. Dorothy Watson (PI)(ESRI), Dr Karen Morgan (Research Manager, RCSI), Dr. Emer Shelley (RCSI), Professor Ronan Conroy (RCSI), Professor Ruairí Brugha (RCSI), Dr. Michal Molcho (NUIG), Ms. Janas Harrington (UCC) and Professor Richard Layte (ESRI), Ms Nuala Tully (RCSI), Ms Jennifer Lutomski (UCC), Mr Mark Ward (RCSI) and Mr Eric Van Lente (NUIG).” Also Jan van den Broeck for his helpful comments during the drafting of the paper.

COMPETING INTERESTS

None declared

ETHICAL APPROVAL

SLÁN 2007 was approved by the Ethics committee of the Royal College of Surgeons of Ireland.

KEY POINTS

- ☞ Being a non smoker, being physically active, having a moderate alcohol intake and consuming 5 portions of fruit and vegetables daily are associated with better self rated health, better mental health and a healthier weight.
- ☞ We would propose that the 4 lifestyle behaviours detailed in this paper be used as outcome measures from which effectiveness of public policy can be gauged.

References

1. Khaw KT, Wareham N, Bingham S, Welch A, Luben R, Day N. Combined impact of health behaviours and mortality in men and women: the EPIC-Norfolk prospective population study. *PLoS Med* 2008;5(1):e12.
2. Stamler J, Neaton JD. The Multiple Risk Factor Intervention Trial (MRFIT)--Importance then and now. *JAMA* 2008;300(11):1343-1345.
3. Stamler J, Wentworth D, Neaton JD. Is relationship between serum cholesterol and risk of premature death from coronary heart disease continuous and graded? Findings in 356,222 primary screenees of the Multiple Risk Factor Intervention Trial (MRFIT). *JAMA* 1986;256(20):2823-2828.
4. Villegas R, Creagh D, Hinchion R, O'Halloran D, Perry IJ. Prevalence and lifestyle determinants of the metabolic syndrome. *Ir Med J* 2004;97(10):300-3.
5. Villegas R, Kearney PM, Perry IJ. The cumulative effect of core lifestyle behaviours on the prevalence of hypertension and dyslipidemia. *BMC Public Health* 2008;8:210.
6. Culic V. Moderate drinking, psychological factors, and cardiovascular protection. *Eur Heart J* 2009;30(3):381-.
7. Janszky I, Ljung R, Ahnve S, Hallqvist J, Bennet AM, Mukamal KJ. Alcohol and long-term prognosis after a first acute myocardial infarction: the SHEEP study. *Eur Heart J* 2008;29(1):45-53.
8. Pedersen JO, Heitmann BL, Schnohr P, Gronbaek M. The combined influence of leisure-time physical activity and weekly alcohol intake on fatal ischaemic heart disease and all-cause mortality. *Eur Heart J* 2008;29(2):204-212.

- 1
2
3 9. Hu FB, Manson JE, Stampfer MJ, Colditz G, Liu S, Solomon CG, et al. Diet,
4
5 Lifestyle, and the Risk of Type 2 Diabetes Mellitus in Women. *N Engl J Med*
6
7 2001;345(11):790-797.
8
9
- 10 10. Villegas R, Salim A, Flynn A, Perry IJ. Prudent diet and the risk of insulin
11
12 resistance. *Nutr Metab Cardiovasc Dis* 2004;14(6):334-43.
13
14
- 15 11. Myint PK, Surtees PG, Wainwright NW, Wareham NJ, Bingham SA, Luben RN,
16
17 et al. Modifiable lifestyle behaviors and functional health in the European
18
19 Prospective Investigation into Cancer (EPIC)-Norfolk population study. *Prev*
20
21 *Med* 2007;44(2):109-16.
22
23
- 24 12. Morgan K, McGee H, Watson D, Perry I, Barry M, Shelley E, et al. SLÁN 2007:
25
26 Survey of Lifestyles, Attitudes and Nutrition in Ireland. Main Report. Dublin:
27
28 Department of Health and Children, 2008.
29
30
- 31 13. Friel S, Nic Gabhainn S, Kelleher C. The National Lifestyle Surveys: Survey of
32
33 Lifestyle, Attitudes and Nutrition (SLÁN) and the Irish Health Behaviour in
34
35 School-Aged children survey (HBSC). Dublin: Department of Health and
36
37 Children, 1999.
38
39
- 40 14. Kelleher C, Nic Gabhainn S, Friel S, Corrigan H, Nolan G, Sixsmith J, et al. The
41
42 National Health and Lifestyle Surveys: Survey of Lifestyle, Attitudes and
43
44 Nutrition (SLÁN 2002) and The Irish Health Behaviour in School-Aged
45
46 Children (HBSC): Centre for Health Promotion Studies NUI, Galway and the
47
48 Department of Public Health Medicine and Epidemiology, UCD, , 2003.
49
50
- 51 15. Riboli E, Kaaks R. The EPIC Project: Rationale and study design. *International*
52
53 *Journal of Epidemiology* 1997;26(1 Supplement):S6-S13.
54
55
- 56 16. Harrington J. Validation of a Food Frequency Questionnaire as a Tool for
57
58 Assessing Nutrient Intake. NUI, Galway, 1997.
59
60

17. Kessler RC, Andrews, G., Mroczek, D., Ustun, B. and Wittchen, H.U. . he World Health Organization Composite International Diagnostic Interview Short-Form (CIDI-SF). *International Journal of Methods in Psychiatric Research* 1998;7:171-85.
18. Barry MM, Van Lente, E., Molcho, M., Morgan, K., McGee, H., Conroy, R., Watson, D., Shelley, E. and Perry, I. SLÁN 2007:Survey of Lifestyle, Attitudes and Nutrition in Ireland. Mental Health and Social Well-being Report: Department of Health and Children. Dublin: The Stationery Office, 2009.
19. Harrington J, Perry IJ, Lutomski J, Morgan K, McGee H, Shelley E, et al. SLAN 2007: Surevy of Lifestyles, Attitudes and Nutrition in Ireland. Dietary Habits of the Irish Population. In: Department of Health and Children, editor. Dublin: The Stationery Office, 2008.
20. Central Statistics Office. Census 2006. Volume 8: Occupations. Dublin: The Stationery Office, 2007.
21. Chapman DP, Whitfield CL, Felitti VJ, Dube SR, Edwards VJ, RF A. Adverse childhood experiences and the risk of depressive disorders in adulthood. *J Affect Disord* 2004;82(2):217-25.
22. Felitti VJ. The Relation Between Adverse Childhood Experiences and Adult Health: Turning Gold into Lead. *The Permanente Journal:Focus on Pediatrics* 2002;Winter 6(1):44-47.
23. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine* 1998;14(4):245-258.

- 1
2
3
4 24. Foege W. Adverse childhood experiences: A public health perspective. *Am J Prev*
5
6 *Med* 1998;14(4):354-5.
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

For Review Only

Table 1: Distribution of variables for SLÁN 2007 participants included in this analysis²

Variable	Category	Men	Women	Total
		(N=4511)	(N=4661)	(N=9172)
		Mean (std dev)	Mean (std dev)	
Age (years)	-	43.4 (16.9)	44.3 (17.8)	43.8 (17.4)*
		N (%)	N (%)	N (%)
Body Mass Index Kg/m ²	Underweight (15-18.5)	60 (1.4)	128 (3.0)	188 (2.2)*
	Normal weight (18.5-24.9)	(1745) 40.4	2397 (55.8)	4142 (48.1)
	Overweight (25-29.9)	1831 (42.4)	1217 (28.3)	3048 (35.4)
	Obese (>=30)	684 (15.8)	557 (13.0)	1241 (14.4)
European Socio-Economic Classification	Large employers, professional, managers	1541 (34.2)	1482 (31.8)	3023 (33.0)*
	Intermediate, lower supervisory occupations and technicians	593 (13.1)	758 (16.3)	1351 (14.7)
	Self-employed and small employers	800 (17.7)	561 (12.0)	1361 (14.8)
	Lower sales/service, lower technical and	1379 (30.6)	1344 (28.8)	2723 (29.7)

² Participants who did not complete a FFQ were excluded from the analysis

	routine occupations			
	Unknown/unclassified	198 (4.4)	516 (11.1)	714 (7.8)
Education	Primary	1712 (38.0)	1594 (34.2)	3306 (36.6)*
	Secondary	1217 (27.0)	1289 (27.7)	2506 (27.3)
	Tertiary	1582 (35.1)	1778 (38.1)	3360 (36.6)
Smoking Status	Former	1023 (22.9)	720 (15.6)	1743 (19.2)
	Never	2110 (47.2)	2672 (57.9)	4782 (52.6)
	Current ³	1335 (29.9)	1224 (26.5)	2559 (28.2)
Physical Activity	Low	913 (24.3)	1266 (32.7)	2179 (28.6)*
	Moderate/high	2844 (75.7)	2606 (67.3)	5450 (71.4)
Alcohol drinking	Above weekly recommended units	1975 (52.21)	2214 (62.2)	4189 (57.0)*
Fruit and Vegetable consumption	>5 servings per day	2691 (59.6)	3318 (71.2)	6009 (65.5)*
No. of Protective Lifestyle Behaviours	0	54 (2.4)	40 (1.6)	97 (2.0)
	1	388 (16.2)	259 (10.4)	647 (13.3)
	2	727 (30.4)	675 (27.2)	1402 (28.8)
	3	802 (33.5)	920 (37.1)	1722 (35.3)
	4	419 (17.5)	589 (23.7)	1008 (20.7)

³ Smoker was classified as someone who smokes either everyday or some days

Self Reported General Health	Excellent/very good/good	3955 (87.8)	4100 (88.3)	8055 (88.0)
Probable major depressive disorder		210 (4.7)	349 (7.5)	559 (6.1)*
Any chronic illness in the previous 12 months excl CVD events		1517 (33.7)	1832 (39.4)	3349 (36.6)*

*Significant gender difference P<0.01; ***Significant gender difference P<0.05

Table 2: Demographic breakdown by number of protective lifestyle behaviours practised

		Number of protective behaviours					
		0	1	2	3	4	P-
		N=153	N=919	N=1954	N=2159	N=1008	value
		% (N)	% (N)	% (N)	% (N)	% (N)	trend
Gender	Male	85 (55.9)	566 (61.6)	1063 (54.4)	1025 (47.5)	419 (41.6)	0.000
	Female	67 (44.1)	353 (38.4)	891 (45.6)	1134 (52.5)	589 (58.4)	
Age Group	18-29	35 (23.2)	242 (26.3)	574 (29.4)	598 (27.7)	324 (32.1)	0.000
	30-44	46 (30.5)	307 (33.4)	661 (33.8)	733 (33.9)	321 (31.8)	
	45-64	38 (25.2)	271 (29.5)	554 (28.3)	644 (29.8)	287 (28.5)	
	65+	32 (21.2)	100 (10.9)	166 (8.5)	185 (8.6)	76 (7.5)	
Education	Primary	84 (54.9)	349 (38.0)	624 (31.9)	543 (25.2)	193 (19.1)	0.000
	Secondary	36 (23.5)	265 (28.8)	580 (29.7)	628 (29.1)	277 (27.5)	
	Tertiary	33	305	751	988	538	

		(21.6)	(33.2)	(38.4)	(45.8)	(53.4)	
European	Large Employers,	37	280	694	863	438	0.000
Socio-	professional,	(24.2)	(30.4)	(35.5)	(40.0)	(43.5)	
Economic	managers						
Classification	Intermediate, lower	23	143	299	356	149	
	supervisory	(15.0)	(15.5)	(15.3)	(16.5)	(14.8)	
	occupations &						
	technicians						
	Self employed and	22	153	279	270	138	0.000
	small employers	(14.4)	(16.6)	(14.3)	(12.5)	(13.7)	
	Lower sales/service,	59	298	600	556	221	
	lower technical &	(38.6)	(32.4)	(30.7)	(25.7)	(21.9)	
	routine occupations						0.000
	Unknown/unclassified	12	46	83	115	62	
		(7.8)	(5.0)	(4.2)	(5.3)	(6.2)	
Self-rated	Excellent/very	122	796	1780	2112	971	0.000
health	good/Good	(79.7)	(86.9)	(91.0)	(93.3)	(96.7)	
	Fair/Poor	31	120	175	144	33	0.000
		(20.3)	(13.1)	(9.0)	(6.7)	(3.3)	
BMI	>=25 kg/m ²	86	484	952	983	411	0.000
		(61.9)	(55.2)	(51.5)	(47.9)	(42.7)	
Probable major depressive disorder		19	66	116	117	47	0.001
		(12.5)	(7.2)	(6.0)	(5.4)	(4.7)	

Any chronic illness in the previous 12 months	74 (48.7)	366 (39.9)	685 (35.1)	694 (32.2)	310 (30.8)	0.000
---	--------------	---------------	---------------	---------------	---------------	-------

For Review Only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Table 3: Respondent’s likelihood of self-rated general health being excellent/very good/good; likelihood of BMI<25 kg/m² and the likelihood of not having depressive disorder compared to having depressive disorder by number of protective lifestyle behaviours adjusted for age, gender, education and social class

	Excellent/very good/good self rated health vs fair/poor *			BMI<25 kg/m ² vs BMI>25kg/m ² *			Not having depressive disorder vs depressive disorder *		
	Odds Ratio	95% CI	P-value	Odds Ratio	95% CI	P-value	Odds Ratio	95% CI	P-value
0	1	-	-	1	-	-	1	-	-
1	1.7	0.95-2.95	0.07	0.85	0.52-1.38	0.52	2.0	1.12-3.77	0.02
2	2.8	1.60-4.82	0.00	0.95	0.59-1.51	0.83	3.2	1.75-5.69	0.00

3	3.3	1.89-5.70	0.00	1.07	0.68-1.69	0.77	3.6	1.98-6.40	0.00
4	6.8	3.64- 12.82	0.00	1.18	0.74-1.89	0.49	4.4	2.34-8.22	0.00

*P-value for trend significant P<0.01

CONTRIBUTORS

JH worked as a senior researcher on the SLÁN 2007 study, she is an author on the main SLÁN 2007 report and had a major role in the data analysis and interpretation. She worked on the statistical analysis and drafted the paper. She is guarantor. IJP was a PI on SLÁN 2007 and was a contributor to the study design, data analysis and interpretation for the study. He made revisions to the paper. JL is an author on the main SLÁN 2007 report and had a major role in the data analysis and interpretation. She made revisions to the paper. APF was the statistical consultant for this paper. FS worked as a senior researcher on the 1998 and 2002 SLÁN data. She made revisions to the paper. HMG was a principal investigator on SLÁN 2007 and a significant contributor to the main report. She made revisions to the paper. MMB was a principal investigator on SLÁN 2007 and is the main author of the SLAN-2007 Mental Health report. She made revisions to the paper. KM was the project manager of the SLÁN 2007 study and is the principal author of the SLAN 2007 main report she had a major role in the data analysis and interpretation. She made revisions to the paper. EvL is an author on the SLÁN 2007 Mental Health resport. He made revisions to the paper. ES was was a PI on SLÁN 2007. She made revisions to the paper. All authors approved the final version of the paper for publication.

For Review Only