Depression in carers of elderly people living at home

Alcohol misuse could be a factor

EDITOR,—In their study of the prevalence of depression in carers of elderly people living at home, Gill Livingston and colleagues used diagnoses according to ICD-10.¹ However, there was no mention of the ICD-10 category F10-F19, disorders due to psychoactive substance use. I suppose this was due to it not being sought rather than it not existing, as excessive drinking is widespread—28% of men and 11% of women in the general population drink more than the recommended "safe" levels.² My clinical experience suggests that this population of carers may be at increased risk.

About 15% of men and 5% of women over the age of 65 drink more than the recommended weekly safe drinking levels. In community based studies of elderly people, harmful drinking has been found in 3-27% of men and 0-9% of women.³ The misuse of alcohol may present non-specifically, with self neglect, confusion, malnutrition, or it may cause exacerbation of pre-existing conditions such as dementia.⁴

Increased psychiatric morbidity in the spouses of problem drinkers is well documented, and this may apply in caring for elderly people with alcohol related problems. The Centre for Research on Drugs and Health Behaviour is currently conducting a study on home carers and the identification of substance misuse and mental health problems in elderly people. Previous studies indicate that a proportion of elderly clients of home carers consume significant amounts of alcohol and also that carers are asked by their clients to buy alcohol.⁵ Alcohol and drug

problems in elderly people are easily overlooked. Unless there is a high level of awareness to look for substance misuse, opportunities for therapeutic gains will be missed. Livingston and colleagues' results suggest that caring for people with mental illness predisposes carers to depression; I should like to know whether this population also has an increased risk of substance misuse.

R H BIRD

Senior registrar in substance misuse

Community Alcohol Team,
Leicestershire Community Drug and Alcohol Services,
Narborough,
Leicester LE9 5DF

- Livingston G, Manela M, Katona C. Depression and other psychiatric morbidity in carers of elderly people living at home. *BMJ* 1996;312:153-6. (20 January.)
- Department of Health. *The health of the nation: a strategy for health in England*. London: HMSO, 1992.
- Herring R. Alcohol, the elderly and their carers. London: Centre for Research on Drugs and Health Behaviour, 1995. (Executive summary No 43.)
- Dunne FJ. Misuse of alcohol or drugs by elderly people. *BMJ* 1995;308:608-9.

Other studies were misrepresented

EDITOR,—Gill Livingston and colleagues reach the conclusion that being the coresident carer of an elderly person with a psychiatric disorder predisposes towards suffering from depression.¹ Their conclusion may be valid, but their consideration of the issue is rather lacking in care and in depth.

Their review of similar studies refers to one paper I coauthored² and describes the findings of another as: "no significant relation was found between being a carer and cognitive impairment in the spouse. Psychological distress was, surprisingly, slightly greater in those married to the subjects with cognitive impairment."³ The first statement is meaningless. For the record, we found a weak (but statistically significant) correlation between cognitive impairment in a wife and depression in her husband. Presumably, the second statement quoted above should read "not surprisingly" Our other study² found that coresident carers of elderly people with dementia had higher stress levels but did not have higher levels of psychiatric morbidity than coresident carers of the elderly people without dementia.

The authors overlook another of our papers⁴ when they maintain that other studies have not addressed the issue of coresident carers and functional psychiatric disorder in elderly people. We found statistically significant concordance between spouses for depression and anxiety among 274 elderly married couples. As discussed in that paper, it is simplistic to view this finding as straightforward cause and effect. It ignores findings on assortative mating, whereby neurotic or psychiatrically ill members of the opposite sex are more likely to marry one another. Furthermore, Livingston and colleagues studied a sizeable proportion of coresident children, to whom psychological disorder could have been transmitted genetically rather than through the stresses of caregiving.

Finally, the authors do acknowledge that their subjects derive from a deprived urban population. Our studies were based in a small town and the surrounding rural and semirural areas.^{2,3} It seems quite possible that community cohesiveness and the availability of other relatives and

friends to share the burden of caring may contribute to some of the differences between the findings of Livingston and colleagues' study and our own.

J M EAGLES
Consultant psychiatrist

Royal Cornhill Hospital,
Aberdeen AB9 2ZH

- Livingston G, Manela M, Katona C. Depression and other psychiatric morbidity in carers of elderly people living at home. *BMJ* 1996;312:153-6. (20 January.)
- Eagles JM, Craig A, Rawlinson F, Restall DB, Beattie JAG, Besson JAO. The psychological well-being of supporters of the demented elderly. *Br J Psychiatry* 1987;150:293-8.
- Eagles JM, Beattie JAG, Blackwood GW, Restall DB, Ashcroft GW. The mental health of elderly couples. I. The effects of a cognitively impaired spouse. *Br J Psychiatry* 1987;150:299-303.
- Eagles JM, Walker LG, Blackwood GW, Beattie JAG, Restall DB. The mental health of elderly couples. II. Concordance for psychiatric morbidity in spouses. *Br J Psychiatry* 1987;150:303-8.
- Merikangas KR. Assortative mating for psychiatric disorders and psychological traits. *Arch Gen Psychiatry* 1982;39:1173-80.

Carers' characteristics could be risk factors

EDITOR,—Gill Livingston and colleagues suggest that caring for people with psychiatric illness predisposes to depression, and that this may be mediated by lack of a confiding relationship.¹ Our study of carers of people with dementia suggests that pre-existing characteristics of carers determine their likelihood of becoming depressed.

We evaluated the association of carer's depression, measured by Beck's depression inventory,¹ with perceived health (number of physical symptoms and quality of sleep¹) and with sociodemographic and clinical characteristics of patients and carers (n=125). Patients' mean score on Folstein's mini-mental state examination was 14.2 (SD 6.7). Carers' mean age was 53.9 (13.9) years; 90 were women. Depression was absent (Beck's depression inventory scores <10) in 39 (31%) carers, mild (scores from 10 to 18) in 50

Table 1—Relation of patients' behavioural disturbance to carers' depression, stratified by number of physical symptoms and quality of sleep of carer

Characteristics of carers	No of carers	Mean (SD) behavioural disturbance of patient*
Carer not depressed (n=39)†		
Physical symptoms:		
≤3	24	67.6 (20.2)
>4	12	89.8 (23.7)
Quality of sleep:		
Good	29	66.5 (20.6)
Poor	10	94.2 (20.5)
Carer depressed (n=86)‡		
Physical symptoms:		
≤3	37	83.3 (23.6)
>4	49	89.5 (21.4)
Quality of sleep:		
Good	28	85.0 (27.1)
Poor	58	88.2 (20.4)

*Determined by the behaviour and mood disturbance scale; scores range from 0 to 160, higher scores indicating greater behavioural disturbance.

†Beck depression inventory score below 10 (out of 63).

‡Beck depression inventory score 10 or higher.

Advice to authors

We receive more letters than we can publish: we can currently accept only about one third. We prefer short letters that relate to articles published within the past four weeks. Letters received after this deadline stand less chance of acceptance. We also publish some "out of the blue" letters, which usually relate to matters of public policy.

When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Wit, passion, and personal experience also have their place.

Letters should have fewer than 400 words and no more than five references (including one to the *BMJ* article to which they relate); references should be in the Vancouver style. We welcome pictures.

Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

Please enclose a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

Letters will be edited and may be shortened.