

# **Combined effects of depressive symptoms and resting heart rate on mortality: the Whitehall II prospective cohort study**

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## **Abstract Objective**

**To examine the combined effects of depressive symptoms and resting heart rate (RHR) on mortality.**

## **Methods**

**Data come from 5936 participants, aged 61 ±6 years, from the Whitehall II study. Depressive symptoms were assessed in 2002–2004 using the center-for-epidemiologic-studies-depression-scale (score ≥16). RHR was measured at the same study phase via electrocardiogram. Participants were assigned to 1 of 6 risk-factor-groups based on depression status (yes/no) and RHR categories (<60, 60–80, >80 bpm). Mean follow-up for mortality was 5.6 years.**

## **Results**

**In mutually adjusted Cox regression models, depression (hazard ratio = 1.93 p <0.001) and RHR>80 bpm (hazard ratio = 1.67, p <0.001) were independent predictors of mortality. After adjustment for potential confounding and mediating variables, participants with both depression and high RHR had a 3.0-fold higher (p <0.001) risk of death compared to depression-free participants with RHR ranging from 60 to 80 bpm. This risk is particularly marked in participants with prevalent CHD.**

## **Conclusions**

**This study provides evidence that the coexistence of depressive symptoms and elevated RHR is associated with substantially increased risk of death compared to those without these two factors. This finding raises the possibility that treatments that improve both depression and RHR might improve survival.**

**Author Keywords** depression ; resting heart rate and mortality

## **INTRODUCTION**

Depression is a major public health issue worldwide <sup>1</sup>. Projections of the Global Burden of Disease by the WHO suggest that depression will account for 10% of the total disease burden in high-income countries by 2030 <sup>2</sup>. There is fairly consistent evidence that depression is independently associated with increased risk of mortality <sup>3–7</sup>. For example, a recent meta-analysis of 25 community studies on a total of 106,628 individuals found a 1.8-fold increased risk for all-cause mortality in depressive compared to non-depressive subjects <sup>8</sup>.

Resting heart rate (RHR), an indicator of the autonomic nervous system activity, has also been found to be an independent predictor of mortality <sup>9–11</sup>. In a recent study of working men without clinically detectable cardiovascular diseases (CVD) at baseline followed up for 23 years, the risk for sudden and non-sudden death from acute myocardial infarction and all-cause mortality increased in a dose-response manner with increasing RHR, after adjustment for biobehavioral risk factors <sup>12</sup>. Another recent study involving a large sample of men and women found elevated RHR to be a long-term predictor for mortality independent of other risk factors in patients with suspected or proven coronary artery disease <sup>13</sup>.

Despite the large amount of evidence showing depression and RHR to be predictors of mortality, previous studies have not examined the combined impact of depression and RHR. However, in many individuals depression and elevated RHR are co-morbid 14–16 and it is possible that they exert a combined effect on mortality. Indeed, several studies found clinically depressed psychiatric patients and CHD patients with depression, as compared with their non-depressed counterparts, to have elevated levels of plasma catecholamines and other markers of altered autonomic nervous system (ANS) activity, including elevated heart rate, low heart rate variability, exaggerated heart rate responses to physical stressors 14–20. All these indicators of altered ANS function have been found to be associated with increased risks of mortality and cardiac morbidity in patients with CHD 14.

We are aware of no published study that examined mortality risk as a function of both depression status and RHR level. To address this issue, the present study examines the combined effect of depressive symptoms and RHR on mortality in a large cohort of middle-aged British adults.

## **MATERIAL & METHODS**

Data are drawn from the Whitehall II study, established in 1985 as a longitudinal cohort study to examine the socioeconomic gradient in health and disease among 10,308 civil servants (6,895 men and 3,413 women). All civil servants aged 35–55 years in 20 London based departments were invited to participate by letter, and 73% agreed. Baseline screening (Phase 1) took place during 1985–1988, and involved a clinical examination and a self-administered questionnaire. Subsequent phases of data collection have alternated between postal questionnaire alone [Phases 2 (1989–1990), 4 (1995–1996), 6 (2001) and 8 (2006)] and postal questionnaire accompanied by a clinical examination [Phases 3 (1991–1993), 5 (1997–1999) and 7 (2002–2004)]. The University College London ethics committee approved the study.

### **Measures**

#### ***Depressive symptoms***

Depressive symptoms were assessed using the Center for Epidemiologic Studies Depression Scale (CES-D, Cronbach's alpha = 0.83) at phase 7 of the Whitehall II study (2002–2004). The CES-D, a widely used and validated instrument, is a 20-item self-report questionnaire designed to measure depressive symptomatology in community studies 21. A score  $\geq 16$  from a total possible score of 60 has been used extensively to distinguish depressed from nondepressed subjects 21.

#### ***Resting Heart Rate***

RHR was measured at the phase 7 screening clinic via electrocardiogram (ECG) on participants in the supine position following a standard protocol. The following classification was used to categorize RHR:  $RHR < 60$ ,  $60 \leq RHR < 80$ , and  $RHR \geq 80$  beats/minute (bpm), based on current guidelines that have defined adequate rate control as a ventricular response between 60 and 80 bpm at rest 22.

#### ***Vital status***

Mortality follow-up was available through the British National Health Services Central Registry until 30<sup>th</sup> April 2009. Death certificates were coded using the 10<sup>th</sup> revision of the International Classification of Disease (ICD). All-cause mortality was the main outcome in our analysis.

### ***Covariates***

#### ***Sociodemographic measures***

Sociodemographic measures included age, sex, ethnicity, and socioeconomic position (SEP) assessed by British civil service grade of employment taken from the phase 7 questionnaire.

#### ***Biobehavioral risk factors***

Behavioral risk factors were assessed using response to the phase 7 questionnaire and were categorized as follows: smoking status (never, ex, and current), physical activity ( $\geq 1.5$  or  $< 1.5$  hours of moderate or vigorous exercise/week), alcohol consumption in the previous week was categorized as abstention, moderate (1–14 units for women/1–21 units for men), and high consumption (14+ units for women/21+ units for men). A unit is 10 ml or 8 grams of pure alcohol. The following biological CVD risk factors were measured at phase 7 clinical examination: hypertension (systolic blood pressure  $> 140$  mm/Hg or diastolic blood pressure  $> 90$  mm/Hg or antihypertensive medications), high total blood cholesterol ( $\geq 6.2$  mmol/l), body mass index (BMI) ( $< 20$ , 20–24.9, 25–29.9, or  $\geq 30$  kg/m<sup>2</sup>) and diabetes, assessed via glucose tolerance test at the medical screening or self-report of doctor diagnosis.

### ***Medications***

Data on antidepressant medications was drawn from the phase 7 questionnaire where participants were asked whether in the last 14 days they had taken antidepressants drugs prescribed by a doctor (yes/no). CVD medications at phase 7 were also drawn from questions on whether in the last 14 days the participant had taken CVD drugs, including diuretics, beta blockers, ACE inhibitors, calcium channel blockers, nitrates, antiplatelets prescribed by a doctor (yes/no). The same question was used to assess whether participants had taken lipid-lowering medications.

### ***Prevalent Coronary heart disease (CHD)***

CHD status at phase 7 was defined as non-fatal myocardial infarction (MI) or 'definite' angina and was based on clinical examinations at phases 1, 3, 5, and 7 and records obtained from general practitioners and hospitals. Potential non-fatal myocardial infarction was ascertained by questionnaire items on chest pain (the World Health Organisation Rose questionnaire 23) and the physician's diagnosis of heart attack. Confirmation of myocardial infarction according to MONICA24 criteria (Multinational Monitoring of Trends and Determinants in Cardiovascular Disease) was based on electrocardiograms, markers of myocardial necrosis, and chest pain history from medical records. Angina was assessed based on participant's reports of symptoms with corroboration in medical records or abnormalities on a resting electrocardiogram, an exercise electrocardiogram, or a coronary angiogram.

### **Statistical analysis**

Differences in depression status and RHR categories as a function of the sample characteristics were assessed using a chi-square test. The associations of depression and RHR with mortality were examined separately using Cox regressions in 4 serially adjusted models. A resting heart rate between 60–80 bpm was used as the reference category so that the hazard ratios (HRs) of lower RHR (< 60 bpm) and higher RHR (above 80 bpm) were estimated. In model 1, HRs were adjusted for the following socio-demographic characteristics: sex, age, ethnicity and SEP. Model 2 additionally adjusted the hazard of mortality for smoking, BMI, alcohol consumption, physical activity, hypertension, total blood cholesterol and diabetes. Model 3 was model 1 additionally adjusted for CVD medication (diuretics, beta blockers, ACE inhibitors, calcium channel blockers, nitrates, antiplatelets), antidepressant medication, lipid lowering medication, and history of CHD. Model 4 included all aforementioned variables, depression and RHR categories, in order to estimate their independent effect on mortality.

To examine the combined effect of depression and RHR on mortality, we divided the study sample into six groups based on the cross classification of depression status (depression, CES-D  $\geq 16$  vs. no depression, CES-D < 16) and RHR categories (<60, 60–80, >80 bpm) with non-depressive participants with RHR between 60 and 80 bpm taken as the reference group.

Cox regressions models were used to calculate multivariable-adjusted risk of death for each group compared with the reference group using the adjustment specified in models 1 and 2 above. The proportional hazards assumption was checked graphically by plotting the log of the negative log of the survival function. These curves were essentially parallel, suggesting therefore that the proportional hazard was not violated.

We also examined the additive interaction between depressive symptoms and elevated RHR as defined by Rothman 25 by calculating the relative excess risk due to interaction (RERI) 26 using the methods outlined by Andersson et al. 27. For example, a RERI of 4.0 would mean that the relative risk of death from all-causes in depressive participants with elevated RHR is increased by 4.0 compared to the relative risk that one would expect if there were no interaction between these two factors. In the absence of an interaction between depressive symptoms and RHR, the RERI will be 0. Probability values and 95% CIs for the RERI were computed by the delta method 28.

## **RESULTS**

A total of 5936 participants were included in the analyses. Of them, 170 died during the mean follow-up period of 5.6 years (SD 0.7, range 0.03–6.6). The mean age of the participants at phase 7, the start of the follow-up for our analysis, was 61 years (SD 6.0). The prevalence of depression (CES-D  $\geq 16$ ) was 14.9%. 24% of participants had RHR < 60 bpm, 61% were in the normal range with RHR between 60 and 80 bpm and 15% had RHR > 80 bpm. Compared to participants included in this study, those who did not respond to the CES-D questionnaire or did not have data on RHR were more likely to be: women (39.8% vs. 29.1%,  $p < 0.001$ ), non-white (15.2% vs. 8.4%,  $p < 0.001$ ), older (19.5% vs. 9.3%,  $p < 0.001$ ), and from lower SEP (34.1% vs. 15.9%,  $p < 0.001$ ).

Table 1 shows the sample characteristics as a function of depression status and RHR categories at phase 7. Participants with depressive symptoms were more likely to be female, younger, from lower SEP, non-white, on medication (antidepressants, nitrates and antiplatelets), current smokers, less physically active, and to have lower BMI and higher prevalence of diabetes and CHD (all  $p \leq 0.04$ ). Men were more likely to have low RHR (<60 bpm,  $p < 0.001$ ). Participants with higher RHR (>80 bpm) were more likely to be from lower SEP, less physically active, hypertensive, obese, diabetic, on CVD medication (beta blockers, nitrates, antiplatelets) and lipid-lowering medication, and to have depressive symptoms (all  $p \leq 0.032$ ).

Table 2 presents estimates from Cox regression models for the associations between depressive symptoms, RHR and mortality. In model 1 adjusted for socio-demographic characteristics, depressive participants (CES-D  $\geq$  16) were at increased risk of death (HR = 2.46, 95% CI 1.74–3.48), when compared to nondepressive participants (CES-D < 16). Using the same adjustments, but with RHR as the predictor, participants with RHR >80 bpm were at increased risk of death from any cause (HR = 1.70, 95% CI 1.18–2.44) compared to those with RHR between 60 and 80 bpm. In model 2 adjusted for CVD biobehavioral risk, the magnitude of the associations was reduced, but participants with depressive symptoms remained at greater risk of mortality. Participants with RHR > 80 bpm were also at greater risk of mortality. In model 3, adjustments for CVD, antidepressant and lipids lowering medication and prevalent CHD did not alter the associations observed in model 1. Inclusion of all of these variables and both depression and RHR in model 4 did not substantially affect these associations; both depressive symptoms (HR=1.93, 95% CI 1.35–2.76) and high RHR (HR=1.67, 95% CI 1.14–2.45) remained independently associated with an increased risk of mortality.

Table 3 shows the associations of combinations of depression status and RHR categories with mortality as the outcome. Model 1, adjusted for sociodemographic characteristics, shows that compared with the reference group (participants without depression and with RHR between 60 and 80 bpm), the hazard of death was higher for depressive participants with RHR between 60 and 80 bpm (2.71, 95% CI 1.73–4.23), for those without depression but with RHR >80 bpm (1.80, 95% CI 1.17–2.76), and for those with both depression and RHR >80 bpm (3.85, 95% CI 2.03–7.31). After further multivariate adjustment for biobehavioral risk factors in model 2, the magnitude of the associations was reduced, but the associations persisted. In model 3, adjustment for CVD, antidepressant and lipid lowering medications, and prevalent CHD did not substantially alter the associations observed in model 1. Finally, after inclusion of all these variables in model 4, the hazard for death was 2.1-fold ( $p < 0.001$ ) higher for participants with depression but with RHR between 60 and 80 bpm, 1.8-fold ( $p < 0.001$ ) higher for those without depression but with RHR >80 bpm, and 3-fold ( $p < 0.001$ ) higher for those with both depression and RHR >80 bpm. The RERI between depressive symptoms and elevated RHR was 0.20 (95% CI, -2.17–2.5).

### Sensitivity analyses

In order to assess the robustness of the present findings, we repeated the analyses excluding participants with a personal history of CHD. The number of deaths was reduced by 22% (n deaths=133). In fully mutually-adjusted model, depressive symptoms (HR=1.82,  $p = 0.005$ ) and elevated RHR (>80 bpm, HR= 1.63,  $p = 0.03$ ) remained independent predictors of death. The corresponding fully adjusted risk of death was 2.5-fold ( $p = 0.04$ ) higher for participants with both depressive symptoms and RHR > 80 bpm when compared to those without depressive symptoms and with RHR between 60 and 80 bpm. The corresponding RERI was -0.60 (95% CI, -2.90–1.71). Similar patterns of association were observed when the analyses were restricted to participants with prevalent CHD (n deaths = 37). The corresponding fully mutually adjusted HRs were 2.97 ( $p = 0.006$ ) for depressive symptoms and 2.00 ( $p = 0.17$ ) for those with RHR > 80 bpm. Finally, participants with both depressive symptoms and RHR >80 bpm had a 7.5-fold ( $p = 0.005$ ) higher risk of death relative to those without depressive symptoms and with RHR between 60 and 80 bpm. The corresponding RERI was 2.39 (95% CI, -4.13–8.90).

In addition, we repeated the analysis in subgroups of beta blockers users and non-users. In fully mutually-adjusted model, depressive symptoms (HR=2.14,  $p < 0.001$ ) and elevated RHR (>80 bpm, HR= 1.57,  $p = 0.025$ ) remained independent predictors of death (n=142) among non beta blockers users. The corresponding fully adjusted risk of death was 3.22-fold ( $p \leq 0.001$ ) higher for participants with both depressive symptoms and RHR > 80 bpm when compared to those without depressive symptoms and with RHR between 60 and 80 bpm. Among beta blockers users (n deaths= 28) the corresponding HRs were 0.99 ( $p = 0.99$ ) for depressive symptoms and 2.48 ( $p = 0.26$ ) for elevated RHR. Only two beta blocker users had depressive symptoms and RHR > 80 bpm thus preventing further analysis of this group. Although the risk of death seems to be lower among beta blocker users, the small number of deaths among this group precludes any definite conclusions regarding these observations.

## DISCUSSION

In this study we sought to examine the combined effect of depressive symptoms and RHR on mortality in a large cohort of British adults. We found that depressive symptoms and elevated RHR were independent predictors for death from all-causes over 5 years of follow up. Concurrently, the study also shows that the coexistence of depression and higher RHR is associated with substantially elevated risk of death from all-causes beyond the effect of having either depression or elevated RHR alone. For instance, after adjustment for relevant biobehavioral risk factors, participants with both depression and RHR >80 bpm were at a 3-fold higher risk of death when compared to those without depression and with RHR ranging from 60 to 80 bpm. This risk is particularly marked in participants with prevalent CHD where there was some evidence of an additive interaction between depressive symptoms and elevated RHR.

### Findings in context of the literature and possible mechanisms

To our knowledge, this is the first prospective cohort study to compare the effects of depressive symptoms on mortality in individuals as a function of their RHR. Our findings are based on a large well-characterized cohort with depression symptomatology assessed by a validated scale and biological risk factors assessed by clinical examination. We found that both depression and RHR were strong predictors of death independently of biobehavioral risk factors and of each other. This is consistent with previous studies 3–5, 9–11,

even though these studies usually considered depression and RHR as individual predictors and rarely showed mutually adjusted analyses. In comparisons across the six exposure categories, we also found that participants with co-existing depression and elevated RHR (>80 bpm) were more likely to die than were participants in any of the other five combinations. Moreover, participants with depression but with RHR ranging from 60 to 80 bpm were at increased risk of mortality compared to those without depression and RHR > 80 bpm, RHR considered to be elevated. These results suggest that the effect of depression on mortality is strong and it is perhaps a stronger predictor of death than RHR in this cohort of middle-aged men and women.

Although this study did not aim to examine the mechanisms that could explain the current observations, several hypotheses seem possible. The finding showing depression to be associated with increased risk of all-cause mortality suggests that depression may act as an exacerbating factor in the progression of other medical illnesses 29 . Although depression is thought to be implicated in the development of certain physical illnesses such as CVD 30 , secondary depression, where a diagnosed or undiagnosed medical illness precedes depression, is also possible. In this case, depression may appear to be a marker of the severity of physical illnesses 31 , 32 . The coexistence of depression with other medical illnesses may impair recovery and increase the risk of mortality by impeding treatment seeking, adherence to pharmacological and behavioral regimens, and adoption of healthy life-styles 33 . The association between RHR and mortality is plausible because RHR is a marker of both autonomic nervous system and cardiorespiratory fitness, both of which, when impaired, are associated with the risk of death 34 , 35 . Although an elevated RHR might be the reflection of poor underlying health status 10 , it is primarily an indicator of cardiorespiratory fitness which is related to physical fitness 34 . Indeed, exercise capacity is a powerful predictor of mortality 34 and RHR is lower in individuals who undertake vigorous physical activity 36 . Depression has been shown to be associated with decreased cardiorespiratory fitness 37 which may be the consequence of a lower engagement of individuals in physical activity. Data from the Established Populations Epidemiologic Studies of the Elderly cohort provide some evidence that physical activity is one of the mechanisms underlying the link between depression and physical decline, as those who were depressed undertook less walking, gardening, and vigorous physical activities 33 . This may explain why depression has been found to be associated with high RHR, although depression itself could also affect physical fitness and subsequently RHR levels by directly modulating central nervous system pathways 14 , 38 . Furthermore, despite the independent effects observed in this study, high RHR and depression may be associated due to partially shared biological processes. Increased RHR in depressive participants could reflect deficits in cardiac vagal control. It is known that cardiac vagal activity when unaltered decreases cardiac activity by reducing RHR and contractility.<sup>39</sup> However, there is also some evidence showing an increased RHR in the absence of reduced vagal tone in depressed patients 40 . Recent studies have shown depression to be associated with low heart rate variability 41 , 42 , an index of reduced cardiac vagal activity, which has been found to be a risk factor for all cause and cardiac mortality 43 , 44 .

Considering the plausibility of the influence of depression on RHR via behavioral and pathophysiological mechanisms and their independent link with mortality, it is highly possible that they exert a combined effect on mortality risk. However, the underlying mechanisms, including the vagal mechanism, behind this association need to be examined in future studies.

### **Study limitations**

In interpreting the present results, it is important to note some limitations. First, this cohort of civil servants did not include blue collar workers, unemployed or younger adults; thus it is not representative of the general population of working age, which may limit the generalisability of our findings. Second, we assessed depressive symptoms rather than clinical depression. However, it has been suggested that significant depressive symptomatology could be a risk factor for clinical depression 21 . Finally, we did not have the power to examine cause specific mortality but the results for all cause mortality are robust. The lack of power may also explain why the confidence interval around the RERI estimating the interaction between depressive symptoms and elevated RHR was large among participants with CHD, but did not reach statistical significance. Although this finding is consistent with the idea that depression and RHR are general rather than specific risk factors of any disease, 10 , 45 further studies should examine whether depression and elevated RHR exert a combined effect on CVD, cancer, and non CVD mortality.

### **Conclusions and implications of this finding**

Despite these potential limitations, depression is increasingly recognized to have an important predictive and prognostic value and this study provides additional evidence that the coexistence of depressive symptoms and elevated RHR is associated with substantially increased risk of death. Our findings raise the possibility that treatments that improve both depression and RHR might improve survival.

### **Acknowledgements:**

The Whitehall II study is supported by grants from the Medical Research Council; British Heart Foundation; Health and Safety Executive; Department of Health; National Heart Lung and Blood Institute (R01HL036310), US, NIH: National Institute on Aging (R01AG013196 and R01AG034454), US, NIH; Agency for Health Care Policy Research (HS06516); and the John D and Catherine T MacArthur Foundation Research Networks on Successful Midlife Development and Socio-economic Status and Health. JV and MK are supported by the Academy of Finland (projects 124271, 124322, 129262 and 132944) and MK is additionally supported by the BUPA Foundation, UK, the National Heart,

Lung, and Blood Institute and the National Institute on Aging, USA. MJS and AB are supported by a grant from the British Heart Foundation and MGM by a Medical Research Council research professorship. AS-M is supported by a "European Young Investigator Award" from the European Science Foundation.

## Footnotes:

**CONFLICT OF INTEREST:** none declared

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## Depression, Resting Heart Rate and Mortality

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**Table 1**

Sample characteristics as a function of Depression and Resting Heart Rate at phase 7

Variables	Depressive symptoms (CES-D score $\geq 16$ )			Resting Heart Rate categories			
	N total	N (%)	p value	< 60 bpm N (%)	60–80 bpm N (%)	>80 bpm N (%)	p value
<b>Sex</b>			< 0.001				< 0.001
Male	4268	559 (13.1)		1124 (79.2)	2498 (68.8)	646 (73.0)	
Female	1668	326 (19.5)		296 (20.8)	1133 (31.2)	239 (27.0)	
<b>Age in years</b>			< 0.001				0.703
< 54	1110	212 (19.1)		250 (17.6)	721 (19.9)	139 (15.7)	
54–59	1822	272 (14.9)		421 (29.6)	1139 (31.4)	262 (29.6)	
60–64	1259	163 (12.9)		321 (22.6)	746 (20.5)	192 (21.7)	
65–69	1196	163 (13.6)		275 (19.4)	717 (19.7)	204 (23.1)	
70–74	549	75 (13.7)		153 (10.8)	308 (8.5)	88 (9.9)	
<b>SEP</b>			< 0.001				< 0.001
High	2040	201 (9.9)		546 (38.5)	1221 (33.6)	273 (30.8)	
Middle	3032	469 (15.5)		717 (50.5)	1831 (50.4)	484 (54.7)	
Low	864	215 (24.9)		157 (11.1)	579 (15.9)	128 (14.5)	
<b>Ethnicity</b>			< 0.001				0.543
White	5485	743 (13.5)		1320 (93.0)	3347 (92.2)	818 (92.4)	
Other	451	142 (31.5)		100 (7.0)	284 (7.8)	67 (7.6)	
<b>Smoking status</b>			< 0.001				0.479
Never smoker	2678	377 (14.1)		639 (45.0)	1637 (45.1)	402 (45.4)	
Ex smoker	2282	297 (13.0)		556 (39.2)	1364 (37.6)	362 (40.9)	
Current smoker	680	145 (21.3)		157 (11.1)	437 (12.0)	86 (9.7)	
Missing	296	66 (22.3)		68 (4.8)	193 (5.3)	35 (4.0)	
<b>Alcohol consumption</b>			0.514				0.755
Abstainers	973	220 (22.9)		206 (14.5)	604 (16.6)	163 (18.4)	
Moderate	3725	484 (13.0)		9439 (66.1)	2286 (63.0)	500 (56.5)	
High	1158	153 (13.2)		254 (17.9)	691 (19)	213 (24.1)	
Missing	80	28 (35.0)		21 (1.5)	50 (1.5)	9 (1.0)	
<b>Exercise</b>			< 0.001				< 0.001
$\geq 1.5$ h/week	5152	699 (13.6)		1277 (89.9)	3134 (86.3)	741 (83.7)	
< 1.5 h/week	784	186 (23.7)		143 (10.1)	497 (13.7)	144 (16.3)	
<b>Hypertension</b>			0.315				0.032
No	3585	521 (14.5)		811 (57.1)	2336 (64.3)	438 (49.5)	
Yes	2351	364 (15.5)		609 (42.9)	1295 (35.7)	447 (50.5)	
<b>BMI (kg/m<sup>2</sup>)</b>			0.002				< 0.001
< 20	179	38 (21.2)		53 (3.7)	108 (3.0)	18 (2.0)	



Depression, Resting Heart Rate and Mortality

20–24.9	2028	263 (13.0)		570 (40.1)	1242 (34.2)	216 (24.4)	
25–29.9	2606	365 (14.0)		588 (41.4)	1627 (44.8)	391 (44.2)	
≥ 30	1099	214 (19.5)		206 (14.5)	638 (17.6)	255 (28.8)	
Missing	24	5 (20.8)		3 (0.2)	16 (0.4)	5 (0.6)	
<b>Diabetes</b>			< 0.001				< 0.001
No	5656	816 (14.4)		1371 (96.5)	3470 (95.5)	815 (92.1)	
Yes	281	69 (24.6)		49 (3.5)	162 (4.5)	70 (7.9)	
<b>High blood cholesterol</b>			0.266				< 0.174
No	3940	599 (15.2)		991 (69.2)	2401 (66.1)	548 (61.9)	
Yes	1886	263 (13.9)		396 (27.9)	1174 (32.2)	316 (35.7)	
Missing	110	23 (20.9)		33 (2.3)	56 (1.5)	21 (2.4)	
<b>Antidepressant drugs</b>			< 0.001				0.842
No	5728	786 (13.7)		1366 (96.2)	3514 (96.8)	848 (95.8)	
Yes	208	99 (47.9)		54 (3.8)	117 (3.2)	37 (4.2)	
<b>CVD medications (Yes)</b>							
Diuretics	494	76 (15.4)	0.757	135 (9.5)	277 (7.6)	82 (9.3)	0.518
Beta Blockers	584	91 (15.6)	0.631	345 (24.3)	223 (6.1)	16 (1.8)	< 0.001
ACE Inhibitors	649	110 (16.9)	0.122	164 (11.5)	356 (9.8)	129 (14.6)	0.113
Calcium Channel Blockers	420	67 (16.0)	0.533	118 (8.3)	228 (6.3)	74 (8.4)	0.614
Nitrates	62	18 (29.0)	0.002	27 (1.9)	33 (0.9)	2 (0.2)	< 0.001
Antiplatelets	584	104 (17.8)	0.038	199 (14.0)	310 (8.5)	75 (8.5)	< 0.001
<b>Lipid lowering medications</b>			0.242				0.001
No	5247	772 (14.7)		1207 (85.0)	3253 (89.6)	787 (88.9)	
Yes	689	113 (16.4)		213 (15.0)	378 (10.4)	98 (11.1)	
<b>History of CHD</b>			0.001				< 0.001
No	5385	777 (14.4)		1229 (86.5)	3348 (92.2)	808 (91.3)	
Yes	551	108 (19.7)		191 (13.5)	283 (7.8)	77 (8.7)	
<b>Depressive symptoms (CES-D ≥16)</b>							0.007
No	5051			1239 (87.3)	3074 (84.7)	738 (83.4)	
Yes	885			181 (12.7)	557 (15.3)	147 (16.6)	

**Table 2**  
Associations between Depression, Resting Heart Rate and Mortality

Predictors	Mortality risk		
	n events/n participants	HR	95% CI
<b>Model 1</b>			
<b>Depressive symptoms</b>	170/5936		
Score ≤ 15	123/5051	1	reference
Score ≥16	47/885	2.46	(1.74–3.48) <sup>‡</sup>

<b>Resting Heart Rate</b>	170/5936		
< 60 bpm	33/1420	0.85	(0.57–1.26)
60 bpm ≥ HR ≤ 80 bpm	95/3631	1	reference
> 80 bpm	42/885	1.70	(1.18–2.44) <sup>†</sup>
<b>Model 2</b>			
<b>Depressive symptoms</b>			
Score ≤ 15		1	reference
Score ≥ 16		1.98	(1.39–2.82) <sup>‡</sup>
<b>Resting Heart Rate</b>			
< 60 bpm		0.85	(0.57–1.27)
60 bpm ≥ HR ≤ 80 bpm		1	reference
> 80 bpm		1.54	(1.06–2.23) <sup>*</sup>
<b>Model 3</b>			
<b>Depressive symptoms</b>			
Score ≤ 15		1	reference
Score ≥ 16		2.42	(1.70–3.45) <sup>‡</sup>
<b>Resting Heart Rate</b>			
< 60 bpm		0.69	(0.45–1.06)
60 bpm ≥ HR ≤ 80 bpm		1	reference
> 80 bpm		1.74	(1.21–2.52) <sup>†</sup>
<b>Model 4</b>			
<b>Depressive symptoms</b>			
Score ≤ 15		1	reference
Score ≥ 16		1.93	(1.35–2.76) <sup>‡</sup>
<b>Resting Heart Rate</b>			
< 60 bpm		0.75	(0.49–1.15)
60 bpm ≥ HR ≤ 80 bpm		1	reference
> 80 bpm		1.67	(1.14–2.45) <sup>†</sup>

\* p<0.05,

† p<0.01,

‡ p<0.001

Model 1: adjusted for sex, age, ethnicity and SEP

Model 2: model 1 additionally adjusted for BMI, alcohol consumption, smoking status, exercise, hypertension, antihypertensive drugs, total blood cholesterol, and diabetes.

Model 3: model 1 additionally adjusted for: CVD medication (diuretics, beta blockers, ACE inhibitors, calcium channel blockers, nitrates, antiplatelets), antidepressant medication, lipid lowering medication and history of CHD

Model 4: adjusted for all aforementioned variables and depression for the association between resting heart rate and mortality or resting heart rate for the association between depression and mortality.

\*\* n events/n total is the same in all models.

**Table 3**

Hazard ratios for mortality as a function of combinations of depression and resting heart rate.

		RHR < 60 bpm	60≥ RHR ≤ 80 bpm	RHR > 80 bpm
<b>Model 1</b>				
<b>Depressive symptoms</b>				
<b>No</b>	n events/n total	26/1239	66/3074	29/738
	HR (95% CI)	0.92 (0.58–1.45)	1 (reference)	1.80 (1.17–2.76) <sup>†</sup>
<b>Yes</b>	n events/n total	7/181	29/557	11/147
	HR (95% CI)	1.88 (0.86–4.13)	2.71 (1.73–4.23) <sup>‡</sup>	3.85 (2.03–7.31) <sup>‡</sup>
<b>Model 2</b>				
<b>Depressive symptoms</b>				
<b>No</b>	HR (95% CI)	0.92 (0.58–1.46)	1 (reference)	1.66 (1.08–2.56) <sup>*</sup>
<b>Yes</b>	HR (95% CI)	1.55 (0.70–3.42)	2.21 (1.41–3.49) <sup>‡</sup>	2.81 (1.46–5.56) <sup>‡</sup>
<b>Model 3</b>				
<b>Depressive symptoms</b>				
<b>No</b>	HR (95% CI)	0.75 (0.46–1.21)	1 (reference)	1.84 (1.20–2.83) <sup>†</sup>
<b>Yes</b>	HR (95% CI)	1.67 (0.76–3.70)	2.55 (1.62–4.04) <sup>‡</sup>	3.67 (1.92–7.02) <sup>‡</sup>
<b>Model 4</b>				
<b>Depressive symptoms</b>				
<b>No</b>	HR (95% CI)	0.79 (0.48–1.28)	1 (reference)	1.77 (1.14–2.75) <sup>†</sup>
<b>Yes</b>	HR (95% CI)	1.40 (0.63–3.13)	2.10 (1.32–3.32) <sup>‡</sup>	2.99 (1.53–5.81) <sup>‡</sup>

\* p<0.05,

† p<0.01,

‡ p<0.001

Model 1: hazard ratios (HR) adjusted for sex, age, ethnicity and SEP

Model 2: model 1 additionally adjusted for BMI, alcohol consumption, smoking status, exercise, hypertension, antihypertensive drugs, total blood cholesterol, and diabetes.

Model 3: model 1 additionally adjusted for: CVD medication (diuretics, beta blockers, ACE inhibitors, calcium channel blockers, nitrates, antiplatelets), antidepressant medication, lipid lowering medication and history of CHD

Model 4: HRs adjusted for all aforementioned variables

\*\* n events/n total is the same in all models.