



Divorce and changes in the prevalence of psychotropic medication use: A register-based longitudinal study among middle-aged Finns



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ABSTRACT

The annual prevalence of psychotropic medication use exceeds 10 percent in Europe and the United States, the prevalence being higher among the divorced than the married. We analysed changes in the three-month prevalence of psychotropic medication use (psycholeptics and psychoanaleptics excluding medication for dementia) by proximity to divorce, sex, medication type and socio-demographic characteristics, using register-data on 304,111 Finns between 25 and 64 years of age, of whom 23,956 divorced between 1995 and 2003 and 142,093 were continuously married from 1995 to 2004. Five years before divorce, men and women already displayed about one percentage point higher prevalence of psychotropic medication use than those who continued their marriage. The excess prevalence increased with approaching divorce and peaked six to nine months before divorce, reaching 7.3 percent (95% CI 6.8–8.0) among divorcing men and 8.1 percent (95% CI 7.5–8.8) among divorcing women. The peak was followed by an 18-month decline, after which the excess compared to the continuously married settled at nearly three percentage points. The excess was not due to being socio-economically disadvantaged, and socio-demographic factors also seemed to have few modifying effects. The changes in prevalence were largest for antidepressants and almost non-existent for antipsychotics. Our results suggest that the high prevalence of psychotropic medication use among the divorced results both from selective factors already present five years before divorce and the acute and long-term causal effects of becoming and being divorced. Counselling is needed for individuals in the process of divorce, rather than economic support for divorced individuals.

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Introduction

Psychotropic medicines are among the most widely prescribed medicines (Mojtabai & Olfson, 2008; Paulose-Ram, Jonas, Orwig & Safran, 2004), with annual prevalence of use exceeding 10 percent both in Europe and the United States (ESEMeD/MHEDEA 2000 Investigators, 2004a; Paulose-Ram, Safran, Jonas, Gu & Orwig, 2007). The annual prevalence of mental disorders is lower – although nearly 10 percent in Europe (ESEMeD/MHEDEA 2000 Investigators, 2004b) – but patients with serious mental disorders are still largely untreated, even in developed countries (WHO World Mental Health Survey Consortium, 2004). The majority of treatment is received by patients with minor or mild disorders (Bijl et al., 2003) or no diagnosed psychiatric morbidity (Kessler et al., 2005). Furthermore, the rate of treatment has increased more among individuals with less severe mental disorders (Mojtabai,

2008), which accounts for a large part of the overall increase and cost of psychotropic medication (Brugha et al., 2004).

A specific case in the optimal allocation of resources is the treatment for adverse life events such as divorce (Mechanic, 2003). The prevalence of psychotropic medication is higher among the previously married than the currently married (Beck et al., 2005; ESEMeD/MHEDEA 2000 Investigators, 2004a; Kessler et al., 2005; Sihvo et al., 2008), but this might partly result from selective effects, as mental disorders increase the probability of future divorce (Hope, Rodgers & Power, 1999; Kessler, Walters & Forthofer, 1998). However, previous longitudinal research has consistently shown that divorce increases psychological distress (Blekesaune, 2008; Bulloch, Williams, Lavorato & Patten, 2009; Meadows, McLanahan & Brooks-Gunn, 2008; Simon, 2002; Strohschein, McDonough, Monette & Shao, 2005; Wade & Pevalin, 2004; Waite, Luo & Lewin, 2009; Williams & Dunne-Bryant, 2006; Wu & Hart, 2002), suggesting that divorce could also have causal effects on the use of psychotropic medication.

We studied changes in the prevalence of psychotropic medication use before and after the date of divorce. Based on the observed

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changes, we further estimated how important selective and causal effects were in producing increased psychotropic medication use among the divorced. An increase in the prevalence of psychotropic medication during the process of divorce would imply that divorce has causal effects on medication use. In contrast, there would be support for the selection argument if the probability of psychotropic medication use is already elevated before the process of divorce.

Background

Divorce and mental health

Mental disorders are more common among the previously married than the currently married (ESEMeD/MHEDEA 2000 Investigators, 2004b). It has been suggested that this difference in mental health is due to a combination of selective and causal effects (Bulloch et al., 2009; Johnson & Wu, 2002; Liu & Chen, 2006; Meadows et al., 2008; Williams & Dunne-Bryant, 2006). According to the selection argument, either initial poor mental health might directly increase the risk of future divorce, or prior individual characteristics, such as poor socio-economic resources, could increase both the risk of divorce and poor mental health. Consistent with the selection explanation, increased psychological distress and the increased probability of mental disorders have been shown to precede divorce, even after controlling for social and economic resources such as education, income, employment and parenting (Hope et al., 1999; Johnson & Wu 2002; Kessler et al., 1998; Simon, 2002; Wade & Pevalin, 2004). In the United States, levels of psychological distress were elevated up to five years before divorce (Johnson & Wu, 2002; Simon & Marcussen, 1999) — either as a result of selection or the strains of chronic marital conflict and anticipation of future divorce. However, in the United Kingdom, higher pre-divorce distress levels were mainly limited to the period directly prior to divorce (Hope et al., 1999).

Most studies agree that in addition to potential selective effects, divorce has a causal effect on mental health (Bulloch et al., 2009; Liu & Chen, 2006; Marks & Lambert, 1998; Wade & Pevalin, 2004; Williams, 2003). The effects of being divorced could be related to disadvantages in economic and social resources, although previous research has shown limited support for such mediating effects (Hope et al., 1999; Johnson & Wu 2002; Marks & Lambert, 1998; Shapiro, 1996; Waite et al., 2009; Williams & Dunne-Bryant, 2006). According to the so-called stress-adjustment perspective (Amato, 2000), divorce is also a stress factor to which individuals adjust over time. The negative effects of divorce may either be short-lived, in accordance with the so-called crisis model, or more long-standing, in line with the model of chronic strain (e.g., maladjustment to changed circumstances).

The causal effect of divorce on mental health is suggested to be strongest during the period of separation or the months immediately after divorce (Blekesaune, 2008; Wade & Pevalin, 2004; Waite et al., 2009; Willitts, Benzeval & Stansfeld, 2004). Accordingly, most studies report stronger short-term effects and weaker long-term effects (Blekesaune, 2008; Hope et al., 1999; Johnson & Wu, 2002; Meadows et al., 2008; Wade & Pevalin, 2004; Willitts et al., 2004), although some observe increased psychological distress for extended periods after divorce (Johnson & Wu, 2002; Shapiro, 1996; Waite et al., 2009). The most precise view of distress trajectories is provided by studies using annual observations of the same individuals. Wade and Pevalin (2004) measured psychological distress with the General Health Questionnaire using British survey data and reported a clear increase 12 months prior to divorce. However, using more waves from the same data, Blekesaune (2008) identified the time of sharpest increase to be 18 months prior to divorce, followed by a decline during the next 18 months.

Unfortunately, these studies have not been replicated in other countries, nor have other measures of mental health been used.

It has been suggested that socio-demographic factors modify the effect that divorce has on mental health. Studies commonly report that increases in psychological distress after divorce are larger among women (Hope et al., 1999; Kalmijn & Monden, 2006; Simon, 2002; Williams & Dunne-Bryant, 2006), although some find no difference between men and women (Strohschein et al., 2005; Waite et al., 2009). Williams (2003) argues that studies are likely to find stronger effects for divorce on women's mental health because women are more likely to express distress with depression. A low level of education (Mandemakers, Monden & Kalmijn, 2010), financial difficulties (Kalmijn & Monden, 2006; Liu & Chen, 2006; Mandemakers et al., 2010; Shapiro, 1996), non-employment (Kalmijn & Monden, 2006), poor housing, and parenting responsibilities (Hope et al., 1999) could all increase vulnerability to the negative effects of divorce, but on the other hand they could also form barriers to leaving troubled marriages (Williams, 2003). Parenting and childcare might also increase distress due to financial strain, cause conflicts over custody, and prevent remarriage (Liu & Chen, 2006).

Mental health and psychotropic medication

High levels of psychological distress should not be confused with the presence of mental disorders (Horwitz, 2007); furthermore, not all mental disorders need medical treatment (Mechanic, 2003; Regier et al., 1998). Less severe mental disorders — particularly if associated with adverse life events — often are self-limiting and are resolved spontaneously with no need for professional intervention (Anderson et al., 2008; Beck et al., 2005; Mechanic, 2003; WHO World Mental Health Survey Consortium, 2004). According to evidence-based care guidelines, the medical treatment of short-term mild or sub-threshold disorders is not recommended (Anderson et al., 2008; Baldwin et al., 2005). However, a large proportion of people receiving medical treatment for mental health problems, including the prescription of psychotropic medication, have no diagnosis for a mental disorder (Kessler et al., 2005; Olfson & Marcus, 2009; Sihvo et al., 2008), while at the same time under-treatment of people with mental disorders is common (ESEMeD/MHEDEA 2000 Investigators, 2004a; Kessler, 2007; Kessler et al., 2005).

Overall, the annual prevalence of psychotropic medication exceeds 10 percent in the adult populations of both Europe and the United States (ESEMeD/MHEDEA 2000 Investigators, 2004a; Paulose-Ram et al., 2007). However, in Europe less than a third of individuals with a mental disorder had used psychotropic medication within the last 12 months (ESEMeD/MHEDEA 2000 Investigators, 2004a). In Finland the majority of depressed patients do not receive antidepressants (Laukkala et al., 2001; Sihvo et al., 2008). In the past 25 years the rate of treatment has increased more among the less severely ill (Brugha et al., 2004; Mojtabai, 2008). Accordingly, the use of new antidepressants has increased several fold from the 1990s (Mojtabai, 2008; Olfson & Marcus, 2009; Paulose-Ram et al., 2007; Zuvekas, 2005), while the use of anxiolytics, hypnotics and sedatives, and medications such as antipsychotics that are mainly used to treat more severe disorders has remained relatively constant (Paulose-Ram et al., 2007).

Psychotropic medication use is more common among women than men (ESEMeD/MHEDEA 2000 Investigators, 2004a; Kessler et al., 2005; Paulose-Ram et al., 2004; Sihvo et al., 2008), reflecting differences in psychiatric morbidity (ESEMeD/MHEDEA 2000 Investigators, 2004b; Middleton, Gunnell, Whitley, Dorling & Frankel, 2001; Simon, 2002; Wang, Berglund & Kessler, 2000; WHO International Consortium in Psychiatric Epidemiology, 2000). Medication use is also more common in older age-groups (ESEMeD/MHEDEA 2000 Investigators, 2004a; Kessler et al., 2005;

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