

ABSTRACT

Objective: Our aim was to evaluate the relationship between adherence to different Dietary Approaches to Stop Hypertension (DASH)-diet indices and the risk of depression.

Design: This is a prospective study. We assessed 14,051 participants of a dynamic (permanently on-going recruitment) prospective cohort [the Seguimiento Universidad de Navarra (SUN) Project], initially free of depression. At baseline, a validated food-frequency questionnaire was used to assess the adherence to four previously proposed DASH indices (Dixon, Mellen, Fung, and Günther). To define the outcome we applied two definitions of depression: a less conservative definition including only self-reported physician-diagnosed depression (410 incident cases), and a more conservative definition that required both clinical diagnosis of depression and use of antidepressants (113 incident cases). Cox regression and restricted cubic splines analyses were performed.

Results: After a median follow-up period of 8 years, the multiple-adjusted model showed an inverse association with the Fung DASH score (Hazard Ratio (HR):0.76; 95% Confidence Interval (CI):0.61-0.94) when we used the less conservative definition of depression, and also under the more conservative definition (HR:0.63; 95% CI:0.41-0.95). We observed a weak inverse association with the Mellen DASH score, but no statistically significant association was found for the other definitions. The restricted cubic splines analyses suggested that these associations were non-linear (U-shaped).

Conclusions: Moderate adherence to DASH diet as operationalized by Fung and Mellen was related to lower depression risk. Since these associations were non-linear, additional prospective studies are required before the results can be generalised and clinical recommendations can be given.

INTRODUCTION

The burden of depression is on the rise and it is predicted to be one of the main causes of Disability Adjusted Life Years (DALYs) by 2020 worldwide ⁽¹⁾. Hence, the identification of preventive dietary factors for depression has become a public health priority, as it may contribute to provide prevention opportunities to stop this alarming increase ⁽²⁾.

The impact of diet on depression has received considerable attention over the past five years ^(2; 3). In this sense, the intake of single dietary nutrients such as B vitamins, folate, zinc, magnesium, or long-chain omega-3 fatty acids have been reported to be inversely related to the risk of depression ⁽²⁾. However, it should be acknowledged that nutrients may interact with each other, and thus, it might be difficult to attribute an effect to a specific nutrient or food ⁽⁴⁾. Therefore, research examining the role of whole dietary patterns on depression has emerged as a better suited approach to identify the association between dietary habits and depression. In this regard, healthy dietary patterns such as the Mediterranean dietary pattern (MDP) have been shown to decrease the risk of depressive symptoms and depression diagnosis, while Western-type diets have been proposed to do the opposite ^(2; 5). Moreover, it is likely that better adherence to other known healthy overall dietary patterns, including high intakes of fruit, vegetables, fish, low-fat dairy and whole grains, but low intakes of meat/meat products, saturated fat, sugar and sodium may also contribute to lower the risk of depression ⁽²⁾.

There is a growing body of evidence suggesting an association between depression and hypertension ⁽⁶⁾. Unhealthy lifestyle habits, like the intake of hypercaloric and poor diets, smoking and alcohol consumption and lack of physical activity are risk factors for both depression and hypertension. Moreover, depression and high blood pressure (BP) are associated with dysregulated redox activity signalling and elevated immuno-inflammatory response ^(3; 7). These disorders may produce hyperactivation of the hypothalamic-pituitary-adrenal (HPA) axis, which results in an increased secretion of corticotrophin-releasing factor, adrenocorticotrophic hormone, and cortisol, known risk factors for the elevation of both BP and depressive symptomatology ⁽⁸⁾. Oxidative stress and low-grade inflammation may also cause dysfunction of the autonomic nervous system, including both increased sympathetic and decreased parasympathetic activities, promoting hypertension and depression ^(9; 10). Moreover, endothelial dysfunction has been proposed as a risk factor for depression due to the role of endothelial cells in the

production of brain-derived neurotrophic factor. Endothelial dysfunction is also a risk factor for hypertension since it may contribute to the elevation of BP and because the vascular endothelium may acquire pro-inflammatory properties ⁽¹¹⁾.

The Dietary Approaches to Stop Hypertension (DASH) eating plan, consisting of following a diet rich in fruits, vegetables and low-fat dairy foods and low in saturated fatty acids (SFA) and red meats, has proved to be effective in reducing inflammatory markers and cardiovascular risk factors, including BP and blood lipids ⁽¹²⁾. Also inverse associations between adherence to the DASH diet and diabetes or cardiovascular disease have been reported ⁽¹²⁾. Since both hypertension and depression share numerous risk factors, and due to the potential benefits of the DASH diet on diabetes, cardiovascular diseases and low-grade inflammation, it is of interest to determine whether the dietary treatment for hypertension may be associated with depression risk. In this sense, the MDP has been associated with reduced prevalence and incidence of both hypertension and depressive symptoms ^(2; 13). However, epidemiological data on the association between adherence to the DASH diet and the development of depression have not been reported yet. Therefore, the aim of the present study was to evaluate the relationship between four previously published DASH diet indices and the risk of depression in a prospective cohort of Spanish university graduates.

METHODS

Participants

The “Seguimiento Universidad de Navarra” (SUN) Project is a prospective dynamic cohort composed of alumni of the University of Navarra, registered professionals from some Spanish provinces, and other university graduates ⁽¹⁴⁾.

The recruitment of participants started in December 1999 and it is permanently ongoing as this is a dynamic cohort study (**Supplemental figure 1**). The baseline questionnaire collected information about lifestyle factors [including a detailed food-frequency questionnaire (FFQ)], and sociodemographic and clinical variables ⁽¹⁵⁾. Information with regard to exposure and outcome is collected through self-administered questionnaires sent by mail or responded by internet every 2 years. Up to December 2011, 21,187 subjects were recruited. Of these, 19,270 were successfully followed-up (at least one follow-up questionnaire), achieving an in-person retention rate of 90·95%.

Participants who reported energy intakes out of predefined limits (<800 Kcal/day or >4,000 Kcal/day in men and <500 Kcal/day or >3,500 Kcal/day in women) were excluded from analyses (n = 1,807). Subjects with cancer, diabetes or cardiovascular disease at the beginning of the study were also excluded (n = 1,214), as were those who reported physician-diagnosed depression or users of antidepressant medication at baseline (n = 1,822). Subjects with missing data in any covariate (n = 40) were also excluded. Finally, data from 14,341 participants were used in the statistical analyses.

The Institutional Review Board of the University of Navarra approved this study. Informed consent was implied by the voluntary completion of the first questionnaire.

Exposure assessment

The dietary exposure was determined at baseline by using a self-administered 136-item semi-quantitative FFQ, which has previously been validated in Spain ⁽¹⁵⁾. Each item in the FFQ included a typical portion size. Daily food consumption was calculated by multiplying the portion size by the consumption frequency for each food item (nine options ranging from never or almost never to six or more times per day). The nutrient composition of the dietary intake items was derived from Spanish food composition tables ⁽¹⁵⁾.

We tested 4 previously published scores, namely Dixon, Mellen, Fung and Günter, to operationally assess the adherence to the DASH dietary pattern. Four different DASH indices were analysed since a previous study found that differences in how the DASH dietary pattern was operationalized affected the ability of the DASH indices to predict disease risk ⁽¹⁶⁾. Briefly, these indices give higher values to adequate adherence and lower to inadequate adherence, giving slightly different scores to the food groups or nutrients included in each of the four scores. The Dixon's DASH index is composed of 8 food groups and 1 nutrient component, and it ranges from 0 to 8. The Mellen's DASH index is comprised of 9 nutrients and its total scores ranges from 0 to 9. The Fung's DASH index is composed of 8 components (7 food groups and 1 nutrient), which are subsequently divided into quintiles and gives higher points to the fifth quintile (higher consumption) for the healthy items, and higher points to the first quintile (lower consumption) for the unhealthy items, and the total score ranges from a minimum of 8 to a maximum of 40 points. Finally, the Günter's DASH index is composed by 10 components, given a maximum score of 10 when the recommendations were achieved,

while lower intakes were scored proportionately. The total score ranges from 0 to 80. Detailed information about how these DASH indices were calculated can be found in **Supplemental table 1**.

Supplemental table 2 shows the pairwise correlation matrix between each DASH diet index. Further information on their composition and how to calculate these DASH diet indices can be found elsewhere ^(17; 18; 19; 20).

Outcome assessment

The follow-up questionnaires were used to obtain the outcome (4, 6, and 8 years of follow-up, respectively: Q_4, Q_6, or Q_8) (**Supplemental figure 1**). If incident depression was missing in any of the follow-up questionnaires (Q_4, Q_6 or Q_8) we used the participants' answers to a brief questionnaire (a shorter version of the follow-up questionnaires only used when participants, after several reminders, do not answer to the full-length follow up questionnaires). Participants reporting depression at baseline as well as early cases of depression (physician-diagnosis or antidepressant use reported within the first 2 years of follow-up) were excluded from the analysis to avoid reverse causation bias. Two definitions of Major Depressive Disorder, both of them self-reported, were used: a less conservative (broad) definition that included a positive answer to the question 'Have you ever been diagnosed of depression by a medical doctor?', and a more conservative (strict) definition that required both self-reported physician-diagnosed depression and use of antidepressant medication by participants in any of the follow-up questionnaires (Q_4, Q_6 or Q_8, or the short questionnaire). A psychiatrist used a sub-sample of our cohort using the Structured Clinical Interview for DSM-IV (SCID-I) as a gold standard in order to validate the broader definition of incident depression (first definition). The percentage of confirmed cases of depression was 74.2% (95% CI, 63.3%-85.1%), while the percentage of confirmed cases of non-depression was 81.1% (95% CI, 69.1%-92.9%) ⁽²¹⁾.

Covariate assessment

The baseline questionnaire was used to obtain most of the covariates. Information regarding socio-demographic characteristics (age, sex, marital and employment status), anthropometric (weight, height and body mass index (BMI)) variables, and lifestyle and health-related habits (smoking status, or leisure-time physical activity) were collected.

In the baseline questionnaire participants also answered questions about personality and behaviour features using Likert-type scales with values in the range 0–10, including the level of competitiveness (higher scores, more competitive), level of anxiety (higher scores, more anxious) and level of dependence (higher scores, more dependant). Body weight was collected in the follow-up questionnaires (every 2 years), and the “weight change” variable was created by resting the body weight until depression incidence appears or end to follow-up to the weight at baseline. Physical activity was evaluated using a validated questionnaire ^(5; 22). Moreover, the prevalence of hypertension at baseline (self-reported) was also ascertained, to assess potential interactions, since the DASH diet was specifically designed to combat hypertension, and can be especially suited for hypertensive patients.

Statistical analysis

Baseline characteristics of participants stratified by the higher and lower categories of each of the four DASH diet indices were described using relative frequencies, means and standard deviations. The four indices were divided into quintiles except for Dixon’s DASH index, which was divided into four categories due to its low resolution. Chi squared tests for trend (categorical variables) and ordinary least squares linear regression analyses (continuous variables) across quintiles of DASH diet indices were used for the comparisons of baseline characteristics.

Time-to-event methods with Cox regression models were used to assess the relationship between the different categories of the adherence to the DASH diet indices and the incidence of depression during follow-up. Each of the four DASH diet indices was divided into quintiles except for the Dixon’s DASH diet which was divided into quartiles due the small number of subjects in the extreme categories. Hazard ratios (HR) and their 95% confidence intervals (CI) were calculated using the lowest quintile or quartile of each DASH diet index as the reference category. The Cox model included age at baseline (when the FFQ was completed) as the entry time variable. Birth date was used as the origin variable (i.e. age was the underlying time variable in Cox models). Exit time was defined as the date when completing the last follow-up questionnaire, death or for participants who developed depression their date of diagnosis. Analyses were stratified by date of recruitment (2-year periods) and deciles of age. To check for proportional hazard assumption, we used time-varying covariates and the Schoenfeld residuals.

In all analyses, we applied multiple-adjusted models where the following potential confounders were included as covariates: age, sex, smoking (never, current, former), physical activity (quartiles), total energy intake (Kcal/day), living alone (yes/no), marital status (married or not), employment status (unemployed or no), baseline hypertension (yes/no), weight change (until depression incidence appears or end to follow-up, quartiles), and the personality traits of competitiveness (higher scores, more competitive), relaxation/stress (lower scores, more relaxed) and dependency (higher scores, more dependant) ranging from 0 to 10. We evaluated the interaction between each of the 4 DASH diet indices and baseline hypertension, age categories (deciles of age) and sex by introducing interaction terms in separate models, and then comparing the models with and without the interaction term with likelihood ratio tests. Tests of linear trend across increasing categories of adherence to the DASH diet were conducted by assigning medians to each category and treating this variable as continuous in the Cox regression model. Moreover, Pearson's correlation coefficients were calculated to identify the relationship between each DASH diet index.

Finally, the possible non-linear relation between adherence to the DASH diet indices and incident depression was further examined with restricted cubic splines analyses with four knots. To test for non-linearity, we used the likelihood ratio test, comparing the model with only the linear term to the model with the linear and the cubic spline terms. The models were adjusted for the same potential confounders as the main Cox regression analyses previously explained. All *P*-values were two-tailed and $P < 0.05$ was considered significant. Analyses were performed using STATA/SE version 12.1 (StataCorp, College Station, TX, USA).

RESULTS

The main characteristics of the 14,051 participants categorized according to their adherence to the different DASH diet indices are presented in **Table 1**. Participants with higher adherence to the four DASH diet indices were more likely to be married, women and physically more active. According to the less conservative definition of depression, after a median follow up of 8 years, a total of 410 new cases of depression during the follow-up period were identified, which accrued 100,434 person-years, while for the more conservative definition 113 new cases were documented (83,627 person-years).

The association between baseline adherence to the DASH diet indices and the risk of depression considering the less conservative definition of depression is presented in **Table 2**. The Cox regression analysis using baseline adherence to the DASH diet indices as exposure showed a positive association between adherence to the Dixon index of the DASH diet and the incidence of depression [HR in the highest versus the lowest category of adherence = 1.44 (95% CI: 1.05-1.99)]. A non-linear, U-shaped relationship between depression risk and adherence to the Mellen, the Fung and the Günther DASH diet indices was found. In the multiple-adjusted models, we observed that the HR for developing depression significantly decreased in the second and third quintiles of adherence to the Mellen DASH diet [HR: 0.68 (95% CI: 0.51-0.91)] for the second, and HR: 0.55 (95% CI: 0.37-0.83) for the third quintile], in the second and fourth quintiles of adherence to the Fung DASH diet [HR: 0.62 (95% CI: 0.46-0.84)] for the second, and HR: 0.68 (95% CI: 0.51-0.92) for the fourth quintile], and in the third quintile of adherence to the Günther DASH diet index [HR: 0.72 (95% CI: 0.52-0.99)]. However, this association was stronger in the Fung DASH index. When the more conservative definition of depression was used (diagnosis of depression plus antidepressant use) the apparent inverse association between incidence of depression and adherence to the Mellen and the Fung DASH diet indices was maintained (**Supplemental table 3**). No statistically significant interactions between sex, age or hypertension and adherence to any of the analysed DASH diet indices were found (data not shown).

Another Cox regression analysis was conducted after merging all participants belonging to the upper categories (3-9 points or Q2–Q5) of adherence to the DASH diet indices in a single group. We compared them with those participants in the lowest category of adherence (**Table 3**). The rationale for using this cut-off point is supported by the possibility that only a clearly suboptimal nutrient intake (e.g. of some micronutrients such as magnesium, potassium and calcium and also vitamin B6, folate, and vitamin B12, which are needed for the synthesis of active bioamines) might be related to a higher risk of depression, and it may be present only in the lowest category of adherence to a healthy dietary pattern, such as the DASH diet. We repeated these analyses using both the less conservative and the more conservative definitions of incident depression. No significant differences were found for the indices proposed by Dixon and Günther. However, the upper categories of adherence to the Fung DASH diet

exhibited lower depression risk in both definitions of depression. Moreover, a lower risk of depression was also observed in the upper categories of adherence to the Mellen DASH diet only for the less conservative definition of depression.

To account for non-linear associations, models with restricted cubic spline analysis adjusted for the same potential confounding factors were used (**Figure 1**). We found a nonlinear association between adherence to the Mellen's (P for nonlinearity = 0.008) and the Fung's (P for nonlinearity = 0.003) DASH diet indices and the incidence of depression; for Dixon and Günter DASH indices, P for nonlinearity was > 0.100.

DISCUSSION

The results from this prospective study suggest that adherence to the Mellen and the Fund DASH diet indices, but especially to the Fung DASH diet index, were inversely associated with depression risk. There was evidence of nonlinear associations between adherence to the Mellen and the Fung DASH diet indices with risk of depression. We also found a weak positive association between the Dixon DASH index and incident depression. To our knowledge, this is the first epidemiological study that has assessed the association between adherence to four established DASH diet indices and the incidence of depression.

Only the Mellen and the Fung DASH indices showed significant inverse associations with the incidence of depression. An important difference between the four studied DASH indices is the scoring system. Also, some indices are composed by specific food choices, whereas others reflect nutrient intakes. While the Mellen DASH index is more focused on nutrient intake, the Fung DASH index reflects food choices ⁽¹⁶⁾. Surprisingly, the Dixon DASH index was positively associated with incident depression when the index was stratified into four categories. However, this association was not significant after merging all participants belonging to the upper categories (3-9 points) in a single group and comparing it with those participants in the lowest category of adherence, nor when the more conservative definition of depression was used, nor in the spline regression model. Therefore, we suggest that the isolated significant positive association might be due to multiple testing or residual confounding, since it was not significant in the rest of our analyses.

Among the components of the Mellen and the Fung DASH diet indices there are several food groups and nutrients that have been related with lower risk of developing

depression. The Mellen's DASH index considers several minerals that have previously been related to lower depression risk, such as calcium and potassium ⁽²³⁾, and maybe these components make the difference. Specifically, magnesium, potassium and calcium have been proposed as having a protective effect against psychiatric disorders ⁽²³⁾, while high sodium intake has been associated with increased urinary cortisol and its metabolites, insulin resistance and MetS, known risk factors for depression ^(24; 25). The Mellen's DASH index takes fibre content into account, however, the possible involvement of fibre in mood disorders has so far not been investigated much, although a negative association has been observed ⁽²⁶⁾. On the other hand, the Fung's DASH index takes food groups into account. High SFAs as well as total dietary fat consumption have been related to higher depression risk, although this effect has not been much studied ^(2; 26). Moreover, fruits and vegetables are good sources of B vitamins and antioxidants, which appear to be important in reducing depressive symptomatology ^(2; 27). Although legumes have not been independently associated with depression, these food groups are good sources of fibre, B vitamins and minerals, nutrients that appear to be important in reducing depressive symptoms ^(26; 27). Also, the possible beneficial effects of the Fung diet compared to the others may reside in that it is the only index that takes into account the consumption of sugar-sweetened beverages. High sugar-sweetened beverages consumption might produce an increased HPA axis activity ⁽²⁸⁾, which may increase cortisol levels and hence, depression risk ⁽²⁹⁾. Additionally, the degree of non-differential misclassification was lower in the Fung index than in the other indices (**Supplemental table 4**), and this ability of the Fung index to better capture the actual DASH diet was a likely explanation of the stronger association found with this index.

In some of our analyses we separated the lowest category of adherence from the rest of categories. The rationale was related to exploring the possibility that only a clearly suboptimal nutrient intake (including their interactions) is related to a higher risk of depression, and it may be present only in the lowest category of adherence to a healthy dietary pattern, such as the DASH diet. Once a sufficient level of nutrient intake is reached no further benefit is obtained. In this line of thought, not only magnesium, potassium and calcium, but also a widely accepted etiological hypothesis of depression is related to the availability of serotonergic or noradrenergic monoamines in the central nervous system and their availability in the synapse ⁽³⁰⁾. It may be speculated

that some micronutrients or a set of metabolically relevant cofactors related to the synthesis of these monoamines may present suboptimal intakes mainly in the group with the lowest adherence to the DASH pattern.

Several dietary patterns have been recently related to depression, however, most of these studies had a cross-sectional design ⁽²⁾, whereas also longitudinal studies have found similar results ^(5; 31). To follow a healthy dietary pattern has been inversely associated with depressive symptoms ^(2; 32). Similarly, the MDP might prevent the development of future depression ^(5; 31), while unhealthy dietary habits like fast-food, processed food and trans-unsaturated fat consumption were related to an increased risk of suffering depression ^(2; 32). Importantly, the MDP includes healthy fats such as olive oil and oily fish among its components, however, the DASH diet considers total fat intake a harmful component of the diet. An increased consumption of oily fish and olive oil has been related with reduced depressive symptoms ⁽³³⁾. This may explain why a clear inverse association between MDP and depression was previously found in this cohort ⁽⁵⁾, but not a very strong association between the DASH diet and incidence of the depression has been detected in the present study. As previously proposed ⁽³⁴⁾, the threshold effect of moderate adherence, but not higher adherence, to Fung and Mellen DASH indices might be due to some baseline psychological elements, such as neurotic or obsessive traits, present in some participants classified in the highest category of adherence to Fung and Mellen DASH indices. Although this might explain the attenuated effect of the Fung and Mellen DASH indices on depression risk in the highest category, this hypothesis could not be confirmed.

In order to verify that the definition of incident cases of depression (diagnosis of depression, and diagnosis of depression and antidepressant treatment) did not affect the observed association in this study, our analyses were repeated for both cases. Since both definitions of incident cases of depression showed similar results, the possibility of an important information bias due to depression misclassification does not seem very likely to affect our results. In any case, the potential misclassification of disease should be nondifferential with respect to exposure in our prospective study, and it is well known that independent nondifferential disease misclassification with very high specificity and low sensitivity did not bias the risk estimate ⁽³⁵⁾.

To our knowledge, only one previous randomised controlled trial has analysed the effect of a DASH diet on mood ⁽³⁶⁾. In this study, almost one hundred postmenopausal women

were assigned to follow a healthy diet or a DASH diet for 14 week, and mood was measured by the Profile of Mood States. The authors found that the DASH diet appeared to improve mood to a greater extent than the healthy diet. However, this study reflects a short-term dietary intervention focussed on postmenopausal women and the overall mood state, not depression.

The prospective design, data collection, data analysis and the inclusion of a large number of participants are notable strengths of our study. This study also presented a high retention rate, the existence of published validation studies for our methods^(15; 21), and a sufficiently large induction period, which reduces reverse causation bias. Moreover, we have used validated diagnoses of depression, adjusted for a wide array of potential confounders including personality traits, and excluded participants with other important diseases (such as diabetes and cardiovascular diseases) that may share some common pathophysiological mechanisms with depression. Moreover, it is not likely that reverse causality could have biased our results since cases reported in the first follow-up questionnaire were also excluded from the analyses.

Some limitations of our study should be acknowledged. Firstly, a self-reported clinical diagnosis of depression was used and different subtypes or levels of depression were not taken into consideration. Secondly, the DASH diet indices were derived from a self-reported 136-item FFQ at baseline; however, previously published validation studies support the appropriateness of this methodology⁽¹⁵⁾. Changes in dietary intake during the follow-up period were not updated. Moreover, to date, there is not a perfect DASH index and the four indices used in this study may present potential limitations previously mentioned in the discussion. These limitations may have introduced a non-differential misclassification bias, that will lead to driving the crude estimate towards the null. However, previously published validation studies support the appropriateness of this methodology^(15; 21).

CONCLUSIONS

In summary, the results obtained in the present study suggest that moderate adherence, but not higher adherence, to the Mellen and the Fung DASH diet index might be associated to lower depression risk. Since these associations were non-linear, additional

378 prospective studies are required to confirm these findings before the results can be
379 generalised and clinical recommendations can be given.

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FIGURE LEGENDS

Figure 1. Relationship between each DASH diet index (A, Dixon; B, Mellen; C, Fung; D, Günter) with depression risk in the SUN study population (HR and 95% CI) using the less conservative definition of depression (diagnosis of depression). Restricted cubic spline model. The black line represents the HR and the pointed-lines represent the 95% confidence interval. The multiple-adjusted model was stratified by date of recruitment (2-year periods) and deciles of age. Adjusted by sex, age, smoking (never, current, former), physical activity (quartiles), energy intake (quartiles), living alone (yes/no), unemployment (unemployed or no), marital status (married or not), baseline hypertension (yes/no), weight change (quartiles), and for the personality traits competitive, relaxed and dependant (from 0 to 10). Abbreviation: DASH, Dietary Approaches to Stop Hypertension. The SUN (*Seguimiento Universidad de Navarra, University of Navarra Follow-up*) Project 1999–2011.

488 **Table 1.** Baseline characteristics of SUN study population according to extreme quintiles of DASH diet index scores (SUN Project, 1999–2011)

		Dixon's DASH index		Mellen's DASH index		Fung's DASH index		Günther's DASH index	
	All participants	≤ 2 point	≥ 5 points	Quintile 1	Quintile 5	Quintile 1	Quintile 5	Quintile 1	Quintile 5
N		4598	1752	3747	2678	3581	2372	3041	2402
Sex, % <i>female</i>	59.1	44.8	87.9	47.5	71.3	57.9	60.4	46.3	73.7
Age, years	37.5 (11.5)	38.5 (11.6)	37.4 (11.9)	34.8 (10.4)	40.7 (12.3)	33.3 (9.6)	42.1 (12.4)	35.4 (10.8)	39.5 (12.3)
BMI, kg/m ²	23.5 (3.4)	24.0 (3.5)	22.5 (3.2)	23.4 (3.4)	23.4 (3.4) ^a	23.0 (3.3)	23.5 (3.3)	23.6 (3.5)	23.0 (3.1)
Leisure time physical activity, MET- h/week	21.7 (23.0)	20.1 (20.4)	25.4 (27.6)	19.4 (20.5)	25.2 (27.1)	18.2 (20.3)	27.7 (28.4)	18.8 (21.5)	26.9 (27.3)
Unemployed, %	4.0	3.5	5.0	4.3	3.4 ^a	4.9	2.8	4.5	4.0
Smoking status, %									
Never smoker	48.1	41.8	52.7	47.4	48.8 ^a	48.9	49.0 ^a	44.7	51.8
Former smoker	28.1	30.0	28.0 ^a	23.8	31.8	21.1	34.9	24.4	31.1
Current smoker	21.3	25.7	16.5	26.4	18.9	27.4	13.6	28.1	15.0
Marital status, % <i>married</i>	50.7	54.2	45.1	44.2	54.0	39.8	58.2	46.4	50.0

Living alone, %	6.4	5.3	8.5	5.2	8.5	5.0	8.5	4.7	9.4
Total energy intake, Kcal/day	2357 (615)	2280 (578)	2485 (618)	2579 (611)	2132 (596)	2452 (608)	2313 (571)	2410 (649)	2379 (570)
Hypertension, %		7.7	5.1	5.4	8.6	4.0	9.7	5.9	7.3
Weight change, kg	1.5 (6.1)	1.5 (6.1)	1.1 (6.1)	1.8 (6.3)	1.1 (6.7)	1.9 (6.1)	0.9 (5.9)	1.5 (6.1)	1.5 (6.1)
Personality traits									
Competitive	7.0 (1.7)	7.0 (1.7)	7.0 (1.7)	6.9 (1.7)	7.1 (1.7)	7.0 (1.7)	7.0 (1.7)	6.9 (1.8)	7.0 (1.7)
Relaxed	5.9 (2.2)	5.9 (2.2)	5.9 (2.2)	5.9 (2.2)	5.9 (2.2)	5.9 (2.2)	5.8 (2.2)	5.9 (2.2)	5.9 (2.2)
Dependant	3.6 (2.8)	3.6 (2.9)	3.5 (2.9)	3.6 (2.7)	3.5 (3.0)	3.7 (2.7)	3.4 (2.9)	3.7 (2.8)	3.5 (2.9)

Data expressed as mean and Standard Deviations, or %. ^a Indicates P>0.05 for chi square test for trend (categorical variables) and lineal regression analysis (continuous variables) across quintiles of DASH diet indices. Abbreviations: DASH, Dietary Approaches to Stop Hypertension, BMI, body mass index; MET, metabolic equivalent of task.

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Table 2. Hazard ratios and 95% CIs for incident depression (diagnosis of depression) according to baseline categories of adherence to the DASH diet indices in adults (SUN Project, 1999–2011)

Dixon's DASH index	-	≤ 2 points	3 points	4 points	≥ 5 points	<i>P</i> trend
No. of cases per person-year	-	116/32964	147/36787	81/18416	66/12266	
Multiple-adjusted model	-	1.00 (ref.)	1.14 (0.89 to 1.46)	1.21 (0.90 to 1.63)	1.44 (1.05 to 1.99)	0.108
Mellen's DASH index	Q1	Q2	Q3	Q4	Q5	<i>P</i> trend
No. of cases per person-year	128/27224	72/22755	31/11787	88/19925	91/18742	
Multiple-adjusted model	1.00 (ref.)	0.68 (0.51 to 0.91)	0.55 (0.37 to 0.83)	0.93 (0.70 to 1.24)	1.02 (0.76 to 1.37)	0.430
Fung's DASH index	Q1	Q2	Q3	Q4	Q5	<i>P</i> trend
No. of cases per person-year	133/26197	66/21307	56/14390	74/22150	81/16389	
Multiple-adjusted model	1.00 (ref.)	0.62 (0.46 to 0.84)	0.79 (0.58 to 1.09)	0.68 (0.51 to 0.92)	1.09 (0.81 to 1.45)	0.553
Günther's DASH index	Q1	Q2	Q3	Q4	Q5	<i>P</i> trend
No. of cases per person-year	97/22271	76/20054	67/21076	82/20384	88/16647	
Multiple-adjusted model	1.00 (ref.)	0.84 (0.62 to 1.13)	0.72 (0.52 to 0.99)	0.87 (0.64 to 1.18)	1.22 (0.90 to 1.65)	0.235

HR estimated with Cox regression and 95% CI. If the CI includes 1.00, the results are not significant (2-tailed $P > 0.05$). Multiple-adjusted model: sex, smoking (never, current, former), physical activity (quartiles), energy intake (quartiles), living alone (yes/no), unemployment (unemployed or no), marital status (married or not), baseline

498 hypertension (yes/no), weight change (quartiles), and for the personality traits competitive, relaxed and dependant (from 0 to 10). All models were stratified by date of
499 recruitment (2-year periods) and deciles of age. Abbreviation: DASH, Dietary Approaches to Stop Hypertension.
500 The SUN (*Seguimiento Universidad de Navarra, University of Navarra Follow-up*) Project 1999–2011.
501

502 **Table 3.** Hazard ratios and 95% CIs for incident depression according to baseline categories of adherence to the DASH diet indices in adults
 503 (SUN Project, 1999–2011)

	Less conservative definition (diagnosis of depression)		More conservative definition (diagnosis of depression and antidepressant use)	
Dixon's DASH index	≤ 2 points	3-9 points	≤ 2 points	3-9 points
No. of cases per person-year	119/32964	294/67469	28/27362	85/56265
Multiple-adjusted model	1.00 (ref.)	1.21 (0.97 to 1.51)	1.00 (ref.)	1.47 (0.95 to 2.30)
Mellen's DASH index	Q1	Q2-Q5	Q1	Q2-Q5
No. of cases per person-year	128/27224	282/73209	37/22390	76/61237
Multiple-adjusted model	1.00 (ref.)	0.80 (0.64 to 1.00)	1.00 (ref.)	0.68 (0.45 to 1.04)
Fung's DASH index	Q1	Q2-Q5	Q1	Q2-Q5
No. of cases per person-year	133/26197	277/74237	37/21595	76/62032
Multiple-adjusted model	1.00 (ref.)	0.76 (0.61 to 0.94)	1.00 (ref.)	0.63 (0.41 to 0.95)
Günther's DASH index	Q1	Q2-Q5	Q1	Q2-Q5
No. of cases per person-year	97/22271	313/78162	23/18276	90/65351

Multiple-adjusted model	1·00 (ref.)	0·88 (0·69 to 1·11)	1·00 (ref.)	1·01 (0·63 to 1·62)
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504 HR estimated with Cox regression and 95% CI. If the CI includes 1·00, the results are not significant (2-tailed $P > 0·05$). Multiple-adjusted model: sex, smoking (never,
505 current, former), physical activity (quartiles), energy intake (quartiles), living alone (yes/no), unemployment (unemployed or no), marital status (married or not), baseline
506 hypertension (yes/no), weight change (quartiles), and for the personality traits competitive, relaxed and dependant (from 0 to 10). All models were stratified by date of
507 recruitment (2-year periods) and deciles of age. Abbreviation: DASH, Dietary Approaches to Stop Hypertension.
508 The SUN (*Seguimiento Universidad de Navarra, University of Navarra Follow-up*) Project 1999–2011.