Review Article

Social Protective Factors in Depression among the Elderly: The Role of Family, Social and Community Supports

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Abstract

Introduction: Geriatric depression is common in Thailand, occurring in between 9.6% and 41.4% of the elderly depending on their living situation and other factors. It is associated with gender (women) and educational level, as well as pre-existing mental and physical health problems, chronic pain and illness and other factors. There are also some known protective factors for geriatric depression.

Objectives: The objective of this article is to provide a review of social protective factors in geriatric depression. The review focuses on family relationships, social connections and community supports, drawing on studies from Thailand and elsewhere.

Key Issues: Family relationships are the strongest social protective factor against geriatric depression. Elderly people with strong affective and instrumental family relationships and high levels of interaction also have a lowered risk of depression. Social connections with family and friends and social interaction outside the family also protect against depression, with elderly people with diverse social relationships and interactions including both family and friends having the lowest risk of depression. Community supports, including both integrated community healthcare programs and community social programs, can also protect against depression.

Conclusions: Although depression is common in the elderly, social relationships and connections with family members, friends and the broader community can be a significant protection against depression. There are still some areas which are poorly understood, especially in Thailand, which could be investigated further.

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Implications: Nursing professionals caring for the elderly should be aware both of the occurrence of depression in the elderly and the possible protective effect of family, social, and community interactions and relationships.

Keywords: Geriatric depression; Social protective factors, Family supports; Social supports; Community supports

Introduction

Depression, signified by lowered mood and energy and anhedonia (inability to feel happiness) is one of the most common mental challenges faced by the elderly.[1] Geriatric depression, or depression in the elderly, can be early-onset, or in other words something the patient had experienced throughout their lifespan. It can also be late-onset, meaning that it occurs for the first time after age 65.[2] Geriatric depression is more common in some sociodemographic groups than others, for example women[3] and people with lower educational levels.[4–7] Depression is also known to frequently occur among elderly people with pre-existing chronic health challenges, such as physical injury or chronic disease, chronic pain, general frailty, and poor health habits such as smoking or a sedentary lifestyle.[1,5–11]

Depression is a major concern for the elderly. It has been shown to both lower the quality of life for the elderly[5,9] and have an impact on cardiovascular disease and hypertension.[12,13] Furthermore, late-onset depression is a possible early warning sign of developing age-related dementia.[14] Therefore, because of both the physical and mental impacts of depression in the elderly, it is important to recognize it as soon as possible and mitigate the factors that influence it.

Depression is of concerns not only in health sectors but also for the whole population in general. In Thailand, there have been several studies conducted that estimated occurrence of depression in the elderly ranging from 9.6% to as high as 41.4%. [4,5,8,15] These rates vary widely in part because of the setting. While the lowest figures come from studies where the elderly were situated in the community (living on their own or with family members), much higher rates of depression were found for those in care homes. This raises the question of whether the social environment of the elderly person provides a protective effect against depression. Despite the importance of geriatric depression and its frequency in Thailand, there has been little systematic effort to investigate how this could be mitigated. This is a critically important issue for practitioners of elderly medical and social care. The reason for conducting this research is to evaluate

these factors and how they protect against geriatric depression, offering empirical evidence for practitioners.

The objective of this article is to review the literature on social protective factors that can help mitigate the impact of depression on the elderly, by reducing its occurrence, increasing the potential for spotting the development of depression, and if possible, minimizing its impact on the individual's functioning. There are three social protective factors that are identified: family relationships, social supports, and broader community supports. These relationships can be understood to represent micro, meso and macro levels of social support for the elderly. Family relationships are micro-level relationships, often involving direct interaction or caregiving. The difference between social support and community support is the degree of personalization. Social support, a meso-level support, includes friends and social acquaintances, who provide personal interaction and engagement but may not provide personal care. Community supports, on the other hand, are less personal but may include care; for example, institutional and group supports and activities, care homes and medical systems. Below, the academic literature of the past 10 years (2010-2020) is reviewed to examine how these factors influence geriatric depression. The literature, which focuses on Thailand (though it includes other countries) illustrates how family, social, and community support can be used at multiple levels to reduce the frequency and/or mitigate the effects of geriatric depression. At the same time, it also illustrates the limits of the literature and of the role of social protective factors in geriatric depression.

The Role of Family Relationships in Geriatric Depression

One commonly identified source of social supports for the elderly is that of family relationships and family supports. Family relationships have been defined in multiple ways in the studies reviewed, including affective (emotional) relationships, instrumental (practical), relationships, and the frequency of interaction, along with the denseness of family connections and negative indicators such as family conflict and abandonment. Thus, these studies do not always reflect the same underlying measure of family relationships, but they are consistent in their finding that this is the most important protective social relationship.

Several studies have been conducted in Thai elderly populations in Thailand which point to the importance of family relationships and supports. One study investigated the incidence and factors of geriatric depression in Chainat province.[16] The authors found that participants with poor family relationships, for example those with few interactions with

their families and no familial supports, were significantly more likely to be depressed than those with good family relationships. Another study in Thailand focused on elderly living in care homes.[17] As these authors noted, elderly in care homes in Thailand often have very poor family relationships, and lack of family or broken family relationships were the primary cause for many of the participants being in the care home. This study found that social supports had a significant protective effect against depression, which included supports from both family and friends. A third study, this time focusing on adults living in rural communities, once more reinforced the importance of family relationships.[10] The authors in this study surveyed elderly in communities in Chachaoengsao province. Their study showed that imbalanced family types, including those with low attachment between family members, low cooperation between family members, and poor alignment between family members, were one of the highest risk factors relating to depression (OR 4.52). The only other risk that was close was current smoking. Therefore, this study indicates that poor family relationships (or no family relationships) may be one of the biggest risk factors for depression among the elderly in Thailand. Taken together, these studies strongly support the idea that for Thai elderly, familial relationships are one of the most important factors in protecting against depression.

Studies outside Thailand have confirmed that family relationships and family supports are important factors in geriatric depression. One of these studies investigated depression in elderly members of Chinese migrant families.[18] The authors found that close family relationships, especially filial piety and emotional closeness, had a significant protective effect against depression both for elderly migrants and elderly Chinese residents with transnational families. Thus, regardless of the distribution of family members, closeness with family members was an important aspect. Another study also investigated depression among the Chinese elderly, this time in the context of those at home.[19] The authors showed that intergenerational relationships with younger family members and family supports had a negative effect on incidence of depression. These relationships included not just practical and instrumental supports (for example, help with shopping or transportation), but also affective and emotional connections. A study in India has also shown that familial relationships, both instrumental and affective, protect against depression in the elderly.[20] These authors found that poor relationships with family members, lack of social interaction and activities with family members, and not being cared for during illnesses by family members, all had a positive association with depression. These studies support the idea that family relationships – both instrumental and affective – have a protective effect against depression in the elderly.

Despite the evidence for the positive effects of family relationships and supports, they are not enough on their own to fully protect against depression. A systematic review of 51 studies found that a high level of family inclusion in a diverse social network (accounting for perhaps 25% to 50% of social connections) appeared to have a protective effect against depression in the elderly.[21] However, the exact extent of this effect did vary, and in fact some studies showed that being entirely dependent on family (having no or few friends or other social contacts) was detrimental to well-being and increased the risk of depression. This is consistent with the findings from a review of studies on Chinese elders, which found that both social and family relationships were important, though family relationships had a stronger protective effect.[22] Furthermore, the effects of family relationships may be more positive for men than for women, who may experience more stress associated with family relationships.[21] These findings show that there are limitations to how effective family relationships and support can be in meeting the needs of those patients with geriatric depression. Simply, while not being in contact may exacerbate geriatric depression, being cared for by family does not guarantee its absence. Furthermore, there are many reasons why elderly patients may not have family support which cannot be mitigated. This includes cases where the individual has outlived their family, their family is unsuitable for caregiving (for example, requiring care of their own, cases of elder abuse and so on) or where it is economically infeasible to provide adequate care for elders. Thus, there is a need to consider the social environment and connections outside the family environment, both for social enrichment of elders with family support and for support of those without. It is the need for diversity of social connections that also encourages investigation of the role of communities in geriatric depression.

The Role of Social Connections in Geriatric Depression

Social connections are people who are neither family relationships nor have a formal caring role – friends, acquaintances and those who engage in the same activities as the elderly person. There have been multiple studies, both inside and outside Thailand, which have shown that social connections and social interaction have a protective effect against depression.

Within Thailand, one recent study has taken a novel approach of looking at a social network index to represent relationships.[23] This index, which measures the diversity and frequency of social contacts, was calculated for very elderly people (aged 80 and over) who lived in their own homes in Chiang Mai Province. The authors found that those with a limited social network were at high risk of depression, while those with a medium or diverse

social network were at reduced risk. This study does not strictly represent only the effect of social non-family contacts, as family contacts were also included in the social network index, but does demonstrate the importance of social connections in mitigating the effects of depression. Another study, using a more traditional approach, investigated social supports from both family and friends for elderly living in care homes.[17] The authors showed that those with low social supports were more likely to suffer from depression, although they did not break this out into friends and family. Thus, evidence from Thailand does supports the idea that social connections are an important protective factor against depression, but does not distinguish well between family and non-family connections.

Studies outside Thailand have frequently distinguished between social connections and supports from family and from other sources, and these studies do support the role of non-family social connections in geriatric depression. One of these studies was conducted in a sample of Nigerian elders.[24] These authors showed that loneliness and social isolation were related to feelings of depression, although their main target for the investigation was that of loneliness rather than depression. Another study, which took place in India, found risk factors associated with lack of social contacts, including not participating in social activities with others and not regularly meeting with family and friends.[20] Although the risk of these factors was not as high as for poor family relationships, it still represented a significant risk. A study conducted in Portugal also used the social network index approach.[25] The authors showed, like Aung, et al.,[23] that elderly people with more extensive social networks are less likely to suffer depression than those with sparser networks. A study in China further elaborated the role of social supports in depression.[26] Their study tested the interrelationships of loneliness, social supports and depression. Their findings showed that social supports had a mediating role between loneliness and depression, with a dense network of social connections reducing the effect of loneliness on depression. Since many elderly people do experience loneliness due to general social isolation, loss of spouses and separation from family, this could be a particularly important mitigating effect. This was also found in a study on loneliness and depression in an Irish population of elderly [27]. These findings are consistent with Santini, et al.'s[21] international review, which showed that social connectedness and the density and diversity of social networks was consistently found to have a negative effect on incidence of depression. Some international studies have also added more information about these relationships. Liu, et al.'s[18] study on depression among elderly in transnational Chinese families found that the number of friends the individual had and their participation in social activities outside the home had a significant effect on depression. In fact, having many friends and

participating in social activities outside the home were one of the strongest protective factors against depression, although strong family effects did have more of an effect.

In summary, strong social connections – friends, social activities and so on – are one of the factors that reduce the occurrence of depression among the elderly. Although its effect is not as strong as that of family relationships, in some ways it is easier to consider, because it does not appear to be dependent on gender, age or other factors. However, neither family nor friends can offer some elements of supports. Thus, supports from the broader community is also considered as a possible protective factor.

The Role of Community Supports and Care in Geriatric Depression

Community supports, for example senior social groups and community centers, churches, and mutual aid groups (among others), may be an important form of social protection against depression for the elderly, although the evidence for the effect of broader community supports is less consistent than that of family relationships and social connections. At the same time, the studies that have been conducted point to a diverse set of possible community supports that can protect against depression in the elderly.

Collaborative mental and physical healthcare for the elderly is one of the ways in which depression can be mitigated through early detection and effective holistic treatment.[28] Thota, et al.'s paper offers a review of a Community Preventative Services Task Force, which was set up to offer integrated care for the elderly. They showed that integrating mental and physical healthcare in community settings resulted in improvement of depression symptoms, better adherence to and response to treatment, and eventually remission and recovery from depression symptoms. This resulted in a significant improvement in perceived quality of life. Another study also investigated community-based mental and physical healthcare interventions, this time in South Korea.[29] In this intervention, care monitoring was provided not just by medical professionals, but also by members of the community, who checked in with elderly participants and monitored them for signs of depression. This was effective at identifying cases of geriatric depression early, allowing for early treatment and mitigation of impact. Thus, the integration of community services to provide effective medical treatment for depression can significantly reduce the effect of depression on the elderly when it does occur. Furthermore, such healthcare services can include not just healthcare providers, but also other community members who are trained to identify problems such as depression and act appropriately.

Medical treatment is not the only way that community supports can be provided – instead, the community can serve as a social framework for building relationships and

engaging the elderly mentally and physically. A senior center, which offers activities aimed at seniors including health activities, physical activities, hobbies and crafts, and general social activities, is one of the classical community supports for the elderly.[30] These centers are a social hub for seniors, as well as engaging their physical and mental interest. Fulbright, et al. [30] showed that seniors who participated in activities at a senior center were more likely to build close relationships and much less likely to suffer from depression. Thus, simply providing a social space within the community can mitigate the chances of depression. There are also less traditional programs that have been tried in the community to improve social connections and ties between seniors and others. One example is an intergenerational playgroup, which brings together the elderly and parents and their children to engage in play activities.[31] This type of group includes at least three generations, and can include related groups or unrelated groups. Skropeta, et al.[31] reported on one group in Germany which was used as a case study to investigate its effects on the elderly. They found using a pre-test/post-test design that the intergenerational social interaction and play did reduce the apparent incidence of depression. Perhaps more importantly, the playgroup also established long-term relationships between older and younger people, which had positive benefits for all three generations involved. Therefore, such a group is beneficial not just to the elderly, but also to those that interact with them. Overall, these studies show that there are strong positive benefits to structured community-based activities that do not require existing social connections such as friends and family, allowing seniors to make friends and develop new social ties.

Conclusions

Depression is a significant threat to the mental and physical health, well-being and quality of life of the elderly. However, its effects are not inevitable. As this review has shown, there are some protective factors that either reduce the chances of the elderly suffering from depression in the first place or mitigate its effects. Furthermore, there are multiple levels of such protective factors. Family interactions and relationships can be viewed as a first line of protection, with positive emotional and affective relationships having a strong negative effect on the chances of developing depression. Social connections with non-family members, such as friends and acquaintances, also protect the elderly against depression. Finally, community resources and connections, ranging from community healthcare services to community centers and playgroups, provide more social connections and allow for monitoring for development of depression.

There are limitations to this study. By focusing only on the social protective factors in depression, the study did not address physical health and disability, pre-existing mental health problems, or other factors that are known to affect the chances of depression, or on genetic and biological risk factors for depression. It also did not investigate the question using primary research, instead relying on the many studies that have been conducted previously on the social aspects of geriatric depression. These limitations were chosen deliberately to control the scope of the article and focus on one aspect that is particularly helpful for nurses working with the elderly and in communities. They also offer some opportunities to investigate geriatric depression further, particularly in Thailand and other Southeast Asian countries where there has been limited exploration of depression in the elderly. In particular, the studies on geriatric depression in Thailand have focused on sociodemographic and social causes of geriatric depression and have not addressed physical and biological causes as much. This was one topic that fell outside the scope of the study, but it would be particularly helpful for understanding geriatric depression in Thailand better. Thus, this is an opportunity for future research.

Implications for Practice

The key implication for nursing practice is that when providing care for the elderly, it is important to be aware of their social context and connections. Patients with strong family relationships, for example, may be at less risk of depression than those with weak family relationships. Weak family relationships (which some authors have termed imbalanced family relationships) may be signified by lack of existing family, family abandonment, lack of family interaction and visits, or family conflict. These patients may need to be monitored carefully for signs of depression to enable rapid action should it begin to develop. This may be particularly true in care home or rural settings, where the elderly may be even more isolated.

Family relationships do not act on their own. In fact, elderly people with a diverse mixture of family and non-family social connections and interactions are even less likely to develop depression than those with a lot of family social connections but few external connections. Thus, patients who have few or no external social connections, such as friends and acquaintances, may need to be monitored for depression as well.

It is incorrect to assume that seniors without family or close friends have no social resources. Community social resources, like community centers, playgroups and others, can provide seniors with the opportunity to engage in social activities and build social relationships. Therefore, it should not be assumed that the elderly cannot form these

relationships – instead, if they are not already present, and even if elderly patients do have existing family and social relationships, it may be appropriate to encourage them to take part in community social activities.

Ultimately, a community or care home nurse is not charged solely with caring for or monitoring elderly patients for depression. The community care model can and should be extended, including physical and mental health caregivers and community members who can monitor the elderly for signs of depression. This is an important issue both for the physical and mental quality of life experienced by the elderly and for early detection of cognitive deterioration and possible onset of problems such as Alzheimer's disease. Thus, this type of community-based integrated monitoring should be part of routine community-based care for the elderly, as a first line of detection and prevention of geriatric depression. For administration, there is an additional implication, which is that care plans and policies need to consider and incorporate the social needs of elders, both individually and as a group. These needs cannot be treated as optional, but should be considered alongside the medical and physical safety needs when preparing for care. This should also be taken more seriously by academics, through consideration of the social needs of elders in the care process.

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