Archives of Gerontology and Geriatrics 61 (2015) 240–246

Contents lists available at ScienceDirect

Archives of Gerontology and Geriatrics

journal homepage: www.elsevier.com/locate/archger

Late-life depression: Burden, severity and relationship with social support dimensions in a West African community

Andrew Toyin Olagunju [a,b,*], Michael Olasunkanmi Olutoki [c,d], Oluseun Peter Ogunnubi [b], Joseph Dada Adeyemi [a,b]

[a] Department of Psychiatry, College of Medicine, University of Lagos, PMB 12003, Lagos, Nigeria
[b] Department of Psychiatry, Lagos University Teaching Hospital, PMB 12003, Lagos, Nigeria
[c] Federal Neuropsychiatric Hospital, Yaba, PMB 2008, Lagos, Nigeria
[d] Federal Neuropsychiatric Hospital, Calabar, PMB 1052, Calabar, Cross River State, Nigeria

ARTICLE INFO

Article history:
Received 8 December 2013
Received in revised form 4 May 2015
Accepted 5 May 2015
Available online 14 May 2015

Keywords:
Africa
Depression
Geriatrics
Late-life
Prevalence
Social support

ABSTRACT

Objectives: The occurrence of depression in old age is often linked with grave consequences. The purpose of this study is to investigate the burden of depression and its relationship with perceived social support among the elderly in a West African community setting.
Methods: In this cross-sectional study, participants made up of 350 elders aged 60 years and above were selected through multi-stage random sampling technique. All participants were interviewed with designed questionnaire, multidimensional scale of perceived social support (MSPSS) and Geriatric Depression Scale (GDS) to elicit socio-demographic profile, social support and depressive psychopathology respectively.
Results: The participants were largely females (52.9%) and their mean age was 68.8 ± 7.3 years. A little above one-quarter (26.4%) had depressive episode, and mild severity was preponderant. Low level of social support was associated with depression ($\chi^2 = 8.418$, $p = 0.004$); especially low social supports from significant others ($\chi^2 = 3.989$, $p = 0.046$) and family members ($\chi^2 = 4.434$, $p = 0.035$). Similarly, severity of depression in the elderly correlated negatively with availability of social support from significant others ($\chi^2 = 5.495$, $p = 0.019$) and family members ($\chi^2 = 5.149$, $p = 0.023$).
Conclusion: Considering the burden of depression in this elderly population and the influential roles of social support especially from family and significant others on depression; strengthening of informal social support and formal social support for the elders is advocated. In addition, design of community based geriatric mental health with social services and articulation of public policy to address old age needs are implied.

1. Introduction

The rapid increase in the global population of the elderly is becoming of considerable concern, especially as the proportion of people aged 60 years and above is growing faster than any other group. Demographic estimations projected that between 1970 and 2025; the elderly population is expected to grow by approximately 694 million (223%). Such that by 2025, there will be about 1.2 billion people over the age of 60; and of which 80% will be living in developing countries. Specifically, it was projected that the proportion of young people will decline to19.6%, while the proportion of the elderly will progressively increase to 17.1% and 21.1% in 2005 and 2050 respectively; and the proportion of the oldest old (70 and over) will increase from 1.7% to 5.5% in that same period across developing countries like Nigeria in West Africa (Kanchanakijsakul et al., 2002; Kinsella & Velkoff, 2002; WHO, 2002).

Late-life period is associated with many challenges including physical and mental disorders. Although different types of mental disorders are found among the elderly, studies have shown that depression is very common (Ritchie et al., 2004; Sokoya & Baiyewu, 2003). While depression is a global public health problem affecting all age groups (Cole, Bellavance, & Mansour, 1999; Kouzis, Eaton, & Leaf, 1995), the elderly population has been reported to be disproportionately affected in previous studies, although findings have been largely inconsistent across contexts (Andrade et al., 2003; Beekman, Copeland, & Prince, 1999; Cole et al., 1999; Haller,

* Corresponding author at: Department of Psychiatry, College of Medicine, University of Lagos, PMB 12003, Lagos, Nigeria. Tel.: +234 8058841643.
E-mail address: aolagunju@unilag.edu.ng (A.T. Olagunju).

http://dx.doi.org/10.1016/j.archger.2015.05.002
0167-4943/

Weggemans, Ferry, & Guigoz, 1996; Lai, 2003; McCabe et al., 2006; Ritchie et al., 2004; Sokoya & Baiyewu, 2003). In terms of epidemiological burden, rates of depressive symptoms are much higher with studies showing prevalence rates between 30% and 45% among the elderly in the community in comparison to prevalence rates of major depression (Alexopoulos et al., 2001; Fountoulakis et al., 2003; Gureje, Kola, & Afolabi, 2007; Harman, Schulberg, Mulsant, & Reynolds, 2001). Furthermore, depression in late-life has been associated with adverse consequences such as increased health care costs, decline in physical abilities and increased mortality (Cronin-Stubbs et al., 2000; De Jonge et al., 2004). It also carries worse prognosis than earlier in life in terms of persistence, recurrence, increased mortality and higher risk of suicide (Cattel & Jolley, 1995; Murphy, Smith, Lindesay, & Slattery, 1988).

Closely linked to the aforementioned is that depression has been shown to have proximal relationship with constriction in social support in the elderly (Hatfield, Hirsch, & Lyness, 2013; Koizumi et al., 2005; Olutoki, Olagunju, & Adeyemi, 2014). In relation to mental health issues, recent evidence suggests that lower perceived social support is significantly associated with suicidal ideation (Rowe, Conwell, Schulberg, & Bruce, 2006) and in public health parlance; lack of social support is associated with increased morbidity and mortality (Penninx et al., 1997; Temkin-Greener et al., 2004; Wilkins, 2003). The significant role of social support in mental health, especially depression may better be understood from its description by Sarason, Levine, Basham, and Sarason (1983) as the existence of people on whom one can rely, resulting in the knowledge as well as feeling that one is cared about, valued, and loved. Again, it refers to support systems that provide assistance and encouragement to individuals to better cope with their physical or emotional disabilities (Berkman, Leo-Summers, & Horwitz, 1992). While, informal social support is usually provided by friends, relatives, or peers, whereas formal assistance is provided by churches, groups, and government among others.

It is therefore potentially detrimental to the wellbeing of the elderly that the rapidly increasing population of old people based on contemporary global demographic transition seems to parallel the dismantling of traditional social support system built around multigenerational extended family system in Africa, and Nigeria in particular. More so because this informal type of social support, prevalently imbibed across the West African region has been viewed to compensate for the poorly developed formal social support system from government, as obtainable in the developed world. Some of the reasons for weakening family social support in Africa include reduction in family size, westernization, economic issues, and physical separation among family members due to urban migration among others (Ezewu, 1986; Ogunniyi et al., 2005; Okumagba, 2011).

Review of literature indicates that depression, perceived social support among the elderly seems to have been studied in many populations around the world, although with western preponderance. However, there is wide range of differences in terms of outcome, which may be attributed to study design, cultural differences, and variations in accessibility and utilization of medical facilities among others. For instance, studies done among elderly population in the West African region are not only very few but inconsistent in their findings (Baiyewu, 2003). One of the earliest studies in West Africa listed late life depression as one of the common psychiatric disorders seen in the elderly and suggested no significant difference in the pattern of psychiatric disorders in the aged from those seen in the developed countries (Lambo, 1966). While a number of recent studies among the elderly have noted similar findings of common occurrence of late-life depression (Baiyewu et al., 2007; Gureje et al., 2007; Uwakwe, 2000a, 2000b), however, others have reported contrary findings (Makanjuola, 1985). Previous studies from the elderly in the West Africa region have documented 10.4% incident rate and 17.9% prevalence rate for late life depression, and both social isolation as well as poverty as significant correlates (Gureje, Oladeji, & Abiona, 2011; Yusuf, Isa, Amedu, Nuhu, & Garko, 2013).

There is need for sustained research to address the growing mental health needs of elderly people in West Africa; especially as traditional family support is changing from what it was in the past due to dwindling resources globally and reduction in the capability of the younger people to take care of the elderly. This cross sectional study among the elderly in Nigerian community cohorts was set to investigate the burden with severity of late-life depression and its relationship to perceived social support. The adoption of 60 years in describing late-life, resulting in inclusion of a wider population of old people in a mixed urban community setting seems novel to better improve the paucity of literature on emotional issues among the elderly in West Africa region. It is postulated that the elderly would experience varied severity of depressive symptoms and perceived social support would be associated with the experience of depressive symptoms in late-life.

2. Methods

2.1. Study location and participants

The study was carried out in wards across Mushin Local Government Area (LGA) of Lagos State in Nigeria. Mushin LGA is located in central Lagos. It is one of Lagos's 20 LGAs and one of Nigeria's 774 LGAs, with wards being the smallest representative electoral units in LGA across the country. It is populated by people of all age groups with good representation of the elderly population. Official permission was obtained from Mushin LGA officials with the aim of liaising with key leaders and groups in the community. The study population consisted of individuals who were 60 years of age and above, and 350 respondents were interviewed based on the sample size calculated using the formula by Kish (1965). Multi-stage random sampling technique was used to select participants. In the first stage, a total of eleven political wards in Mushin LGA were selected. In the second stage, household survey was done using address list, it involved a list of streets in the wards, followed by a list of houses (or blocks), and then a list of households in each house was obtained, from which thirty-two households were selected. At the final stage, a participant was selected from each household. The Kish grid was used to select the sample if there was more than one participant who met the inclusion criteria in any household, since homogeneity within sample clusters increases estimation variances, and these can be easily reduced by selecting only one member per household (Kish, 1965). Thirty-two participants were selected from each of the selected wards.

The elderly persons, 60 years and above, in selected households were interviewed if they met the inclusion criteria. Each household with an elderly occupant was visited at least three times in order to interview the elderly living there. Participants who were 60 years old and above and residing in Mushin LGA were included in the study, while those who refused to give consent were excluded. Approval to carry out the study was obtained from the ethical and research committee of the Federal Neuropsychiatry Hospital. Informed consent was obtained from all the participants after explaining the aims and procedure of the study to them. They were also required to sign or thumb-print the consent form before commencing the interview. Participants were assured of the freedom to decline consent to continue participation at any time