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EDITORIAL

Depression and social support in late life: A clear but not obvious relationship

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In this issue of *Aging & Mental Health*, four articles confirm the intuitive. Social factors, specifically social support, are important buffers to the stressors of late life that can lead to depression. Social support may also independently protect older adults from the risk of depression (Cappeliez, O'Rourke, & Chaudhury, 2005; Jang, Kim, & Chriboga, 2005; McCrae et al., 2005; Pirjo & Heikkinen, 2005; VanDerHorst & McLaren, 2005). A fifth article encourages social intervention to correct the impaired social support experienced by elders in the community through social care practitioners (McCrae et al., 2005). To most readers of our journal, the findings will be informative but not surprising. Yet investigators in the past as well as the present have either explicitly challenged or implicitly ignored this critical association of social risk and protective factors with late life depression.

As the field of gerontology was emerging, a hypothesis was expounded by social scientists. Cumming and Henry (1961) suggested that the natural transition to be expected of older adults would be from social engagement to disengagement. Society and the elderly would mutually agree to 'disengage' from one another in late life. The older person would not only accept but actually welcome society's decreased involvement. This withdrawal was believed to have both developmental as well as adaptive qualities. The elder would become increasingly preoccupied with the self and decrease emotional investment in persons and objects in the environment. The image of the elder happily being placed on an iceberg and cut loose from the tribe to float into oblivion emerges.

George Maddox (1964) challenged this received wisdom. He believed that activity, not disengagement, was the secret to successful aging. A physically and socially active lifestyle was the most adaptable means for achieving life satisfaction in the later years. Empirical studies over the past 20 years have proved Maddox correct. Older adults are healthier and they live longer when they are socially engaged (Blazer, 1982). Social isolation and impaired social support have also been found to be associated with both moderate and severe depressive symptoms in the elderly (Bruce, 2002; Chi & Chou, 2001; George et al., 1989). Social scientists are now convinced that social engagement and support are critical for the physical and mental health of older adults.

Now the challenge to the social engagement/social support argument comes implicitly from a different source. Biological psychiatry is in the ascendance, especially in the USA, and therefore social factors (either as risks or protective factors) have faded to the background. For example, in a recent edited textbook on late life depression (Roose & Sackeim, 2004; for which this writer contributed a chapter on epidemiology) social support was only mentioned as a 'moderator' of treatment response to antidepressant therapies. Even the psychotherapies that are most widely studied in North America for combination with antidepressant therapy focus on changing the individual, not the social environment—therapies such as cognitive-behavioral therapies (Reynolds et al., 1999).

We cannot ignore the findings from biological psychiatry. The empirical evidence is mounting that many older adults are biologically vulnerable to the onset of depression (Alexopoulos et al., 2000; Krishnan, 2002). Even so, epidemiological studies document that depression is less frequent among the elderly until one reaches the oldest old (Blazer, 2002a). If one 'connects the dots', it would appear that older adults are more biologically vulnerable to depression, yet psychological and social factors are more protective in late life compared to mid-life

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when cognitive dysfunction and physical illness are held constant (Blazer, 2002a; Blazer & Hybels, in press).

We have made dramatic gains in our ability to treat depression in older adults with medications as well as psychotherapies (Gallagher & Thompson, 1982; Reynolds et al., 1999). These gains, paradoxically, have led to a focus upon the individual rather than the social environment when considering prevention and intervention for late life depression. Psychosocial interventions that address the environment as well as the individual, interventions which attempt to prevent depression onset as well as identify and treat depression early, have been dramatically understudied (Blazer, 2002b). Therefore the articles in this issue are a welcomed balance to the predominant focus upon the biological origins of depression in the elderly and treatments that focus upon changing the individual, not the social environment.

Tiikkainen and Heikkinen (2005) explore the association between loneliness and depressive symptoms. As noted by these authors, feelings of sadness and loneliness are ubiquitous (Hybels, Blazer, & Pieper, 2001). Feelings of loneliness are potential targets for intervention, yet investigators must understand the nuances of loneliness, for loneliness has multiple dimensions. Too often clinicians may simply incorporate loneliness into their construct of depression, yet the constructs are not identical. According to Tiikkainen and Heikkinen, the absence of a sense of not being integrated into the social environment is a critical correlate of loneliness. In contrast, depressive symptoms are associated with a lack of guidance. Both share a lower level of perceived emotional togetherness in social interaction. Those who are lonely will often appear depressed but many who feel depressed are not lonely. In my view, these findings are especially applicable to older adults in long-term care facilities. Some of these elders will be severely depressed and the origin of that depression will be biological, either through comorbidity with physical illness or dementing disorders. These elders will not be lonely. In contrast, others will feel a profound loneliness, even in the midst of many others, yet free of the overt signs of depression. This latter group especially may be a target for social intervention to prevent the onset of depression.

Jang and colleagues (2005) approach social isolation from a complementary perspective. They found Korean-American older adults who were not acculturated to American culture less likely to endorse positive affect items on typical symptoms scales, such as 'feel happy'. They hypothesized that, given the emphasis on modesty and self-effacement in traditional Korean society, those elders less acculturated would be more likely to inhibit positive affects in depressive symptom reports. And that is what they found. These findings are most important as they alert us to cultural differences even in the midst of apparent cultural homogeneity. Older adults can feel disconnected from those around them, thus placing them at more risk for depression, even when they appear to be firmly situated in a social network. If we consider older persons in long-term care facilities, we need not look too far to recognize that some 'just don't fit' and subsequently are less happy and lonelier. Both can be risks for depression. Yet as this article suggests, one must be careful not to over interpret such findings. Older Korean-Americans who do not endorse more positive affect may be reflecting their culture as much as their life satisfaction.

VanDerHorst and McLaren (2005) address the serious consequences of ignoring social support among the depressed elderly. They found that fewer social resources were associated with higher levels of depression and suicidal ideation. Of interest, the sense of belonging to the community was not an additional predictor of mental well-being but rather a sense of poor (and perhaps more immediate) social resources were the important factors. More attention has been paid to 'neighborhood' effects in recent years (and the fit of the individual within the community) (Sampson, Raudenbush, & Earls, 1997; Silver, Mulvay, & Swanson, 2002) and therefore studies of the neighborhoods of older people who are aging 'in place' through time will be important to pursue. These investigators, however, remind us of the importance of immediate social resources.

Cappeliez and colleagues (2005) provide us with some indirect evidence for how we may provide social intervention more effectively. A natural and relatively straightforward means for intervention to enhance social support is simply to spend time with older adults and to listen to them tell their stories. Unfortunately, just telling one's story or reminiscing is not enough. If elders only review old problems or simply fill a void of other social stimulation, then such reminiscing is associated with lower life satisfaction and greater psychiatric distress. In addition, reminiscences that attempt to maintain connection with a departed person cause psychiatric distress. On the other hand, reminiscences in the service of preparation for death (such as talking through plans) and in the service of conversation (sharing stories) were linked to higher life satisfaction. These findings suggest that reminiscences can be in part guided toward topics that are beneficial to the psychic well-being of the older adult.

Finally, McCrae and colleagues (2005) surveyed social health care practitioners in Great Britain to determine both their perceptions of the depression experienced by their clients and their suggestions for intervention. Depression was perceived to be remarkably common, a significant part attributed to social isolation. These practitioners encouraged social interventions for social causes. To put it another way, the 'troops on the ground', those professionals

who were in most immediate contact with older adults in their homes, emphasized the importance of social, recreational, and psychological interventions. One must assume that they would not recommend such interventions if they did not envision practical ways by which such interventions could be employed.

Social support is a most important factor in preventing both the onset and progression of depression in later life. Recent advances in our understanding of the biological underpinnings of these depressive states must not blind us to the importance of social factors. Effective social interventions can be initiated by social and health care workers as well as by family and friends.

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