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Research Article

Relationship Between Depression and Social Support Among the Elderly in A Community in South South Nigeria.

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Abstract

Depression in the elderly is an important public health problem because of its devastating consequences. Depression is a serious medical illness that can cause suffering for individuals and has negative effects on their family and the community they live in. The impact of depression on the physical and mental wellbeing of elderly cannot be overemphasized.
Despite this growing burden of mental illnesses such as depression and the resultant level of suffering for individuals and society, efforts to address it are unsatisfactory. Depression in the elderly has been linked to risk factors such as poor social support and chronic diseases. Social support is a resource that has significant effect on health outcome in the face of stress. The lack of social security, institutional framework for the care of the old and the support from extended family fading out, has resulted in some elderly being physically and emotionally abused. The mental health of the elderly has been investigated in various parts of Nigeria, mainly in the urban areas and only a few has been done in the rural areas and we do not have sufficient local data in Eku Baptist Hospital to establish this fact.

The aim of this study is to determine the relationship between depression and social support among elderly patients attending Eku Baptist Hospital. This study was a hospital based descriptive cross-sectional study. The study instruments were Questionnaires which included socio-demographic variable, two validated tools (Geriatric Depression Scale SF-15 and Multidimensional Scale of Perceived Social Support), medical history and physical examination.

Data was collated and analyzed using the Statistical Package for Social Sciences (SPSS-21). Test of association was done using Pearson's chi square (or Fisher's exact test). The level of significance was set at 5% ($p<0.05$).

The majority were in the age range 60 to 69 years with the mean (SD) age of respondents as 69.7 ± 6.7 years. Majority of the respondents ninety-six (46.6%) had moderate social support, seventy-nine (38.4%) had high social support while thirty-one (15.0%) respondents had low social support. The association between social support and depression status was statistically significant ($p<0.0001$).

This study showed that social support is one of the factors which influence symptoms of depression in the elderly. As one ages, social support should be encouraged in any form.

Keywords: Aging, depression, elderly, social support, social isolation

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INTRODUCTION

Social isolation is becoming an issue now, especially among the elderly people. Family structure and traditional care for the elderly in Nigeria are also collapsing. Most times, the elderly live alone in their apartments and their children have their own apartments.[1]Social support is a resource that has significant effect on health outcome in the face of stress.[2] The lack of social security, institutional framework for the care of the old and the support from extended family is fading out and has resulted in some elderly being physically and emotionally abused. Social support (SS) refers to the degree of affection, care, esteem or assistance a person gets from other people or groups.[2]
Screening and institution of appropriate intervention plays a crucial role in the reduction of morbidity and mortality especially associated with depression in the elderly.

Depression in the elderly is of immense public health concern because of its grave consequences on the family and their community. Yet, not much attention is paid to this psychological aspect of the elderly. Depression impairs independence in the older population and overtime worsens functional outcomes among the multi-morbid group.[3] The decline in functional status may make them more dependent and vulnerable to mistreatment.[3]
Many elderly prefer to receive their depression treatment in primary care, where providers can address not only mental health problems but also acute and chronic medical conditions that are common in this age group and often co-morbid with depression.[4,5] Primary care providers who provide continuity of care also have an important opportunity to track depression over time because depression in older adults is often chronic or recurrent.[4]

Research Questions

1. What proportion of elderly, attending the General Out-patient Clinic (GOPC) of Eku Baptist Hospital (EBH) has depression?
2. What is the level of social support in the respondent?
3. Is there any relationship between depression and social support in the respondent?

Hypothesis

Null Hypothesis
There is no association between social support and depression.
Alternate Hypothesis
There is an association between social support and depression.

LITERATURE REVIEW

Depression in elderly or Late-life depression is depressive disorder occurring in a patient older than 60 years, although the onset and cut-off may vary.[6,7] Depression in elderly is associated with disabilities, co-morbidities and significant effects on quality of life of those affected and it leads to higher care burdens for family members and caregivers.[8] The most common mental health problem in the elderly, depression exerts a profoundly deleterious effect on patients, their families, and their communities.[9] Elderly persons often suffer from depression without anyone around them noticing. Depression among aged may often go undiagnosed, especially in rural areas where symptoms of mental illnesses are entangled with myths, superstitions, taboos and ignorance. Moreover psychiatric illness causes considerable stigma that strip them off their dignity and results in isolation and hopelessness.[10]
Depression affects approximately 7% of the elderly globally.[11] The World Health Organization estimates that the overall prevalence of depressive symptoms among the elderly varies between 10-20% depending on the cultural situation. The largest community-based international research conducted on elderly sample taken from six countries in India, China, Ghana, Mexico, South

Africa, and Russian Federation revealed that prevalence of depression was highest in India (27.1%) followed by Mexico (23.7%), Russia (15.6%), Ghana (11%), South Africa (6.4%) and China (2.6).[12]An epidemiological data on prevalence of geriatric depression from around the world are, in Europe it is 11.9-18.3% and Asia it is 12-34%.[12]Another study in Saudi Arabia reported a prevalence of 49.9%.[13] Data on depression in Africa are limited.[14,15] Studies suggested that depression was more prevalent in elderly inmates of old-age homes in comparison with other settings like home, community, hospitals etc.[16,17]

In Africa, some studies done revealed prevalence of 4% in South Africa.[18] Studies in Ethiopia reported a prevalence of 9.1- 41.8%.[19,20] Olagunju et al in a study in a community in west Africa revealed that 26.4% of the elderly had depressive episodes.[21]

As the number of aged in our population is increasing, many of their traditional life sustaining and fostering influences have been eroding. Changes in society seem to leave them no meaningful social role either within the family or in the community.[22]

To this end, the need for early detection, proper diagnosis and management of any form of mental ill health at every level of health care delivery in elderly, cannot be overemphasized as this population is increasing globally.

The WHO International classification of Diseases, 10th edition (ICD-10), described depression as the persistent presence for at least two weeks of a sad mood, loss of interest in activities usually experienced as pleasurable (anhedonia), reduced energy and at least, two of the other common symptoms which include reduced concentration, reduced self- confidence, idea of guilt, a bleak and pessimistic view of the future, idea of self harm or suicide, disturbed sleep and diminished appetite.[23]

Notably, the prevalence of depression or depressive symptoms is higher in patients with chronic medical condition than in the general public.[3] The underlying reasons include the illness itself and the heavy medical cost, unsatisfactory medical care service and poor doctor–patient relationship.[3]

The risk factors for depression include low income and socio-economic status, chronic illness, certain drugs, poor family functioning, female gender, introvert personality, loss of a loved one and lack of social support to mention but a few.[24-26]

The population-based World Mental Health Survey Initiative (WMHS) carried out in Nigeria reported lifetime and 12 month major depression at 3.1% and 1.1%.[27] A hospital based study done in Port Harcourt reported a prevalence of 28%.[28,29] In a recent hospital based study done in the primary care arm of a tertiary hospital in Calabar, by Okonkon and colleagues a prevalence of 58.1% depression in elderly was reported.[30] Another hospital based study done in Uyo found that 45.2% of the elderly patients visiting the general out-patient clinics had depressive symptoms.[31.] A community based study done in some rural communities in Delta state, reported a prevalence of 44.7%.[8] It is well established that depression is more common among women than in men.[32,33]

Protective factors include social support, social and religious activities such as volunteering and physical activity. Depression is less likely if the patient retains a sense of humour, responds warmly to affection from family and caregivers, shows an interest in life and pleasurable activities, looks forward to family visits, readily accepts assistance, actively participates in treatment, and points to reasonable causes for pain.[4]

Various clinical interview-based instruments are available for screening people of different age groups for depression. For adults, available but not exhaustive instruments include the Geriatric Depression scale, The Patient Health Questionnaire, Hamilton depression inventory HDI), Becks depression inventory (BDI), second edition; BDI-primary care; Epidemiology Studies Depression Scale, Zung Self-Rated Depression Scale and Cornell Scale for Depression in Dementia. They help elicit some depressive symptoms but cannot be used alone for diagnosis.

Social support (SS) is often used in a broad sense, referring to any process through which social relations might promote health and well-being; it refers to the social resources that persons perceive

to be available or that are actually provided to them by non-professionals in the context of both formal support groups and informal helping relations.[34] Social support can also be defined as any information leading the subject to believe that he is cared for, loved and is an esteemed member of a network of mutual obligation.[34] It is one of the important factors that plays a major role in maintaining well-being in the aged because it is a moderator of stressful life events.[34] Social support is actually extremely important for our physical and mental health. Research shows that social support and contact may help to reduce stress, depression, anxiety and isolation, as well as promote our self-esteem, normality, well-being and quality of life, while a lack of social support has the opposite effect.[35] It appears to play a significant role in explaining differences in subjective functioning.[36]

Sources of Social Support.

People are dependent on having social support and contact with their immediate family, friends, colleagues, neighbours and the people they meet through various interests and leisure activities. The family is most often the major source of social support and primary caregiver of patients, especially those with chronic illnesses and not the health care providers.[36] Social support from friends and significant others are necessary, but are largely inadequate. A more recently emerging literature explained that online social network could be a source of social support and explored the ways in which computer-mediated communication and online social networks relate to social support.[37]

Tools for Measuring Social Support.

Various tools have been used to measure SS which includes multidimensional scale of perceived social support scale, Duke-UNC functional social support questionnaire; Medical outcomes study social support survey, Norbeck social support questionnaire, perceived social support scale and the social support questionnaire.[38]

This study explored social support in the elderly using the multidimensional scale of perceived social support

Social Support and the Elderly.

Social support is critical for the elderly because of the peculiarity of their physical and emotional challenges. Age-related factors, such as widowhood and chronic illness, put them at further risk of decreased social interaction with others.[39] Elders could be faced with greater losses in the context of fewer social resources and a lower adequacy of social support, both in subjectively perceived support and frequency of contacts.[40]

Study findings shows that social interactions and closeness with others decline in the elderly.[41] In another study done on sources of social support associated with health and quality of life among Canadian and Latin American older adults, it was found that support from children was more salient in socially and materially deprived areas than in more affluent environments.[42]

In Africa, the care of the elderly by children and relatives was well appreciated in the past but the recent rural-urban drift of children for greener pastures has promoted nuclear family system and has resulted in lack of care and social support for many elderly.[43] In Nigeria, poverty is widespread and elderly persons are at high risk, the economic situation of most children makes it difficult for them to cater for their parents.

Social Support and Mental Health.

The different facets of social support often have distinct implications for psychological well-being and physical health. For example, perceived social support (PSS) is more persistent and more powerfully related to mental wellbeing than are received social support (RSS).[33] The rationale for this is that, the resources of support can only be utilized if perceived by an individual. It is PSS that has been most closely associated with mental wellbeing and it is critical for the elderly.[44]

Not all support is beneficial; links between received support and health are fraught with complex moderators, such that received support that is beneficial in one circumstance may be ineffective or even detrimental under other conditions.[45] Recent research, has examined the factors that determine the direction and magnitude of the effects of received social support. Some evidence suggests support may be most beneficial when it is unobtrusive and matches the receiver's needs. In contrast,

unhelpful or unsolicited received support, which may feel controlling, frustrate receivers, or lower self-esteem and self-efficacy.[45] There are two proposed mechanisms, by which social support influences mental health.[46]

i. The direct effects model: This holds that social support can be beneficial in the absence of stressors. The direct effect implies that social relationships have a beneficial effect on health, regardless of life situation. It has impact on health and wellbeing because it provides us with feelings of predictability, belonging, purpose and security.[40]

ii. The stress buffering (indirect) model, which contends that support protects against the negative impacts of stressors. This implies that social relationships only have a beneficial effect for persons exposed to stressors, such as negative life events and hardships over time. In this instance, social support is thought to buffer the effects of stress by enhancing personal coping abilities such as self-esteem and self efficacy. Through a strengthening of the coping mechanism, the negative emotional reaction to a stressful event will either be reduced, or the physiological responses on health via the immune system will be dampened.[40]

Relationship between Depression and Social Support.

Social support has a very close relationship with development, control and prevention of depression.[47,48] A large body of research identified an important relationship between depression and social support, while further stating that depressive symptoms decrease as social support increases.[40,44,48] These findings support the notion that social support is a crucial factor in the development and maintenance of psychosocial wellness in the elderly.

Another study also found that receipt of Social support reduces depressive symptoms among older individuals but at the same time made them feel they had lost control which in turn increases their depressive symptoms thereby counteracting the positive effect of received social support.[49]

In another Study no significant correlation was found between depressions and received social support. This may be that in depression, the cognitive impairment leads to poor perception of actual received social support and this may lead to persistence of depression.[50]

In Africa generally and West Africa in particular, people are shielded from untoward effects of circumstances by supports from families, friends and significant others.[51] Studies have shown an increased likelihood of depression among elderly in African setting that live alone, compared to those that live with their families.[51,52] Poor social support and loneliness could be implicated in geriatric depression since the family plays a vital role in the care the elderly receives.[53]

Afolabi and colleagues found a significant association between level of family support and depression among patients attending the Family Practice Clinic in Wesley Guild Hospital, Ilesa, Nigeria. They found that majority of patients with weak or no family support had depression.[51]

Okhakhume and colleague in Oyo State found depression was associated with lower level of perceived social support from family and friends among 200 elderly participants in a cross-sectional study.[50]

In view of the above, the prevalence of depression in elderly is high. It is often under diagnosed and undertreated in primary care because it co-exists with co-morbidities and psychosocial problems. It is therefore, important to assess SS in elderly in whom depression is suspected. Thus this study chose to focus on perceived social support which reflects an individual's feeling that he/she is accepted, loved, and valued by other members of their social network and its relationship with depression. Considering the burden of depression in this elderly population and the influential roles of social support; 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 is pertinent.

METHODOLOGY

Background to Study Area

The study was conducted at Eku Baptist Hospital (EBH), Eku, Delta state. EBH is a secondary health facility that is strategically located in Ethiope East Local Government Area (LGA) of Delta state.

Eku town is an hour and half drive from the state capital, Asaba, forty five minutes drive from Warri, thirty minutes drive from Sapele and fifteen minutes drive from Abraka. Delta state is located in the Niger Delta region, the South-South geopolitical zone of Nigeria Nigeria is located between latitude 4^0 and 14^0 north of the equator and longitudes 3^0 and 14^0 East of Greenwich meridian. Thus, it is entirely within the tropical zone and has alternate dry and rainy seasons.

The hospital serves the people of Eku, nearby towns in the state and neighbouring states. The community is inhabited by the Urhobo ethnic group mainly and people from other ethnic groups are a minority. The people engage mostly in subsistence farming, fishing and trading.

The hospital is a renowned centre for family medicine training and practice; it was managed by the Baptist Mission but currently managed by the Delta State Government, under the Hospitals Management Board after taking over the hospital from the Baptist Mission on 2nd November, 2009. The hospital has a capacity of 142 beds. Patients are seen both on out-patient and in-patient basis. Outpatient clinics are open from 9am-4pm Mondays to Fridays except on public holidays. Emergency services are rendered 24 hours.

The Family Medicine clinic/ General Outpatients Clinic represent the primary care unit of the hospital. All patients except in emergencies are expected to pass through it for evaluation and assessment. Most of these patients are managed while others are appropriately referred to other units of the hospital.

Study Population

The elderly patients aged 60 years and above attending the General Out-patient Clinic (GOPC) of EBH, who met the inclusion criteria.

Inclusion Criteria:

All consenting elderly patients (60 years and above) attending the GOPC of EBH.

Exclusion Criteria:

A. Patient with other psychiatric conditions, that are violent or on medications that could affect their mood.

A. Patient who had any form of language impairment

B. Severely ill patient.

Study Duration

The study was conducted for a period of three months (August, 2019 to October 2019).

Study Design

The study was a descriptive cross sectional study.

Sample Size Determination

The Leslie Kish's formula was used to determine the sample size:

$n=Z^2pq/d^2$

Where

n=minimum sample size

z=standard deviation of 1.96 corresponding to 95% confidence interval (CI).[54]

P= local prevalence of elderly with depression in Nigeria was 28%[28-29]

q=1.0 – p i.e1.0 – 0.28 = 0.72

d = significance level, 0.05 (since the degree of accuracy was set at 95%)

Therefore

$n = 1.96^2 \times 0.28 \times 0.72/0.05^2$
309.786624 =310
The desired sample size when population is less than 10,000 was given as
$nf=n/ \{1 + (n-1/N) \}$[55,56]
Where N is = the number of elderly patient that attended the GOPC in 3month in 2017 which was 609
nf= 310/ {1 + (310-1/609)}
=205.6535948479
Calculated sample size was therefore=206
Sampling Method
Information from the records unit of the hospital showed that 2,441 elderly was seen in GOPC in the year preceding the study (2017), which made it an average of 203 per month (about 609 in 3 months).
A systematic random sampling method was used in this study for selection of respondents using a sampling interval of 3. This was derived from dividing the average total number (609) of elderly seen over the study period of 3 months by the sample size (206). The index subject was chosen by simple balloting daily, subsequent subjects were picked using the sampling interval of 3. Patients' folders were labeled and a research register was kept to avoid double sampling. This was done daily until the sample size of 206 was realised.
A pre-test of the questionnaire was conducted at the General Hospital, Abraka to explore the weakness, misconceptions and ambiguity of the questionnaire.
Questionnaire
A structured interviewer administered questionnaire was used. It comprised of socio-demographic variable, two validated tools (Geriatric Depression Scale SF-15 and Multidimensional Scale of Perceived Social Support), medical history and physical examination.
The first part of the questionnaires the socio-demographic section consisted of information such as age, sex, ethnic group, marital status, family type and living situation.
The second part was the Geriatric Depression Scale (GDS-15) developed by Yesavage et al, which is a screening instrument for depression in the elderly.[57] It is a fifteen-item validated screening instrument for depression in the elderly. The GDS-15 yields a sensitivity of 92% and a specificity of 81% using a cut off of 5.[57,58] The GDS-15-item was used in this study to screen for depression and respondents answered each question in a yes and no format, one point for each of "yes" answers and zero for " no". It was scored from 0 to 15. The severity was divided into the following categories: 0-5 no depression (normal), 6-10 (moderate depression) and 11-15 (severe depression).
The third part is the Multidimensional Perceived Social Support Scale (MPSS) which was developed by zimmet et al. It is a 12-item scale measurement tool with three subscales: Family, friends and significant support.[59] Each item was rated on 7-point likert-type response format. . To calculate mean scores: Total Sum across all 12 items, then divide by 12.[59]
A mean scale score ranging from 1 to 2.9 could be considered low support; a score of 3 to 5 could be considered moderate support; a score from 5.1 to 7 could be considered high support.

Data Analysis
The collected data was sorted, coded and entered into the computer for analysis using the Version 21 software packages of the Statistical Package for Social Sciences (SPSS-21). Data was calculated in means and percentages and chi square for categorical variables. Bivariate analysis was performed to determine associations, while multivariate logistic regression was used to identify factors that significantly predict depression in the subjects at 5% level of significance (P –value = 0.05). Descriptive data was presented using frequency tables, graphs and charts.

Ethical Considerations

Permission to undertake the study was sought from the Head of Department of Family Medicine, EBH. The approval to undertake the study was obtained from Ethical Review Committee of Eku Baptist Hospital, Eku and Faculty of Family Medicine, West African College of Physicians.

Informed consent was obtained from eligible subjects before administration of questionnaire and examination. Privacy and confidentiality of the respondents were guaranteed by anonymity of respondents.

RESULTS

Socio-Demographic Characteristic of the Subjects

Table 1 showed the socio-demographic characteristics of the study subjects. The majority were in the age range 60 to 69 years. Almost three-fifth, one hundred and nineteen (57.8%) respondents were between the ages 60-69 years while nine (4.4%) respondents were 90 years and above. The mean (SD) age of respondents was 69.7 ± 6.7 years. The male to female ratio of the study subjects was 1:1.8. One hundred and five (51.5%) respondents were currently married while eight (3.9%) respondents were never married. A total of one hundred and ninety eight were ever married and of these one hundred and fourteen (57.6%) respondents were polygamous while eighty four (42.4%) respondents were monogamous. One hundred and fifty nine (77.2%) respondents were Urhobo while forty seven (22.8%) respondents were other ethnic groups. One hundred and sixty-five (80.1%) respondent were living with someone while forty-one (19.9%) were living alone. Eighteen (8.7%) respondents had no children while one hundred and forty two (69.0%) respondents had above four children.

Table 1: Socio-demographic characteristics of study subject

Variable	Frequency (n =206)	Percentage (%)
Age group (years)		
60 – 69	119	57.8
70 – 79	59	28.6
80 – 89	19	9.2
>90	9	4.4
Mean ± sd age (years)	69.7 ± 6.7	
Sex		
Female	132	64.1
Male	74	35.9
Marital status		
Currently married	106	51.5
Widowed	52	25.3
Separated/divorced	40	19.4
Never married	8	3.8
Marriage type *(n=198)		
Polygamous	114	57.6
Monogamous	84	42.4
Ethnicity		
Urhobo	159	77.2
Ukwani/Ika	18	8.7
Ijaw/Itsekiri/Isoko	11	5.3
Benin	8	3.9
Others	10	4.9
Living situation		

Living with someone	165	80.1
Living Alone	41	19.9
Number of children		
None	18	8.7
1-4	46	22.3
>4	142	69.0

*only married respondents (n=198)

Perceived Social Support of Study Subjects

The pie chart in figure 1 showed that majority of the respondents ninety-six (46.6%) had moderate social support, seventy-nine (38.4%) had high social support and thirty-one (15.0%) respondents had low social support.

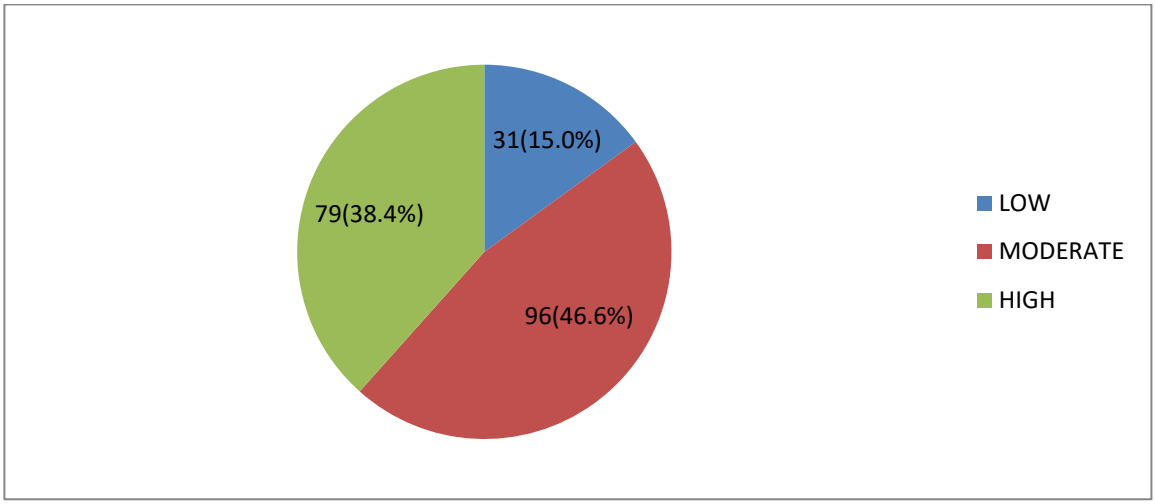

Figure1: Pie chart showing the perceived social support of study subjects

2: Pattern of Sources of Perceived Social Support in the Study Subjects

Figure:2. showed the pattern of perceived social support from different sources (family, friends and significant others). For social support from family, 47.6% reported high social support, 41.7% moderate and 10.7% low support. For support from friends 7.8% had high social support, 70.9% had moderate social support and 21.4% had low social support. For support from significant others 14.1% reported high support, 51.0% have moderate support, while 34.9% have low social support.

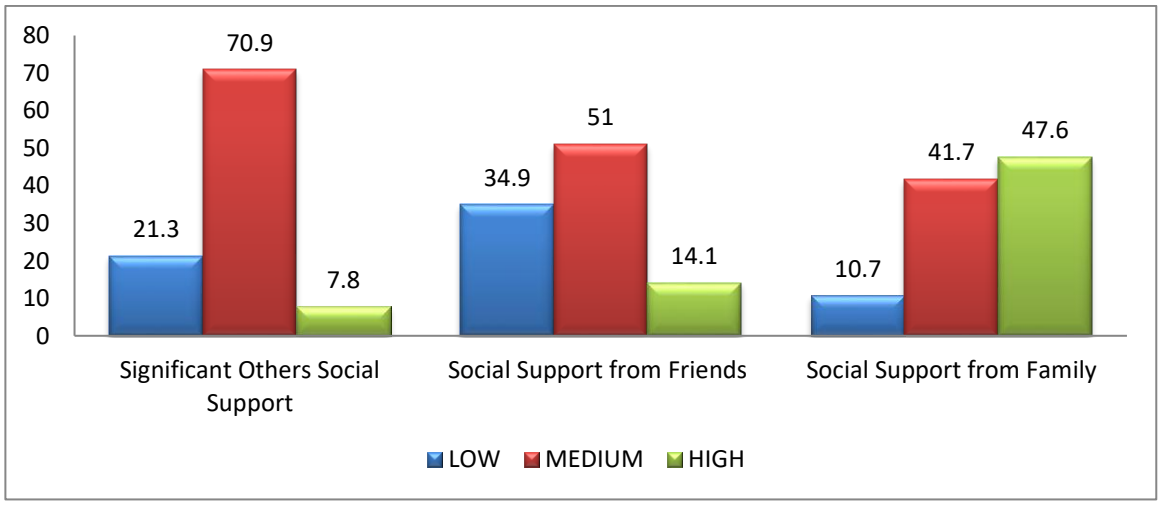

Fig 2: Pattern of perceived social support from the different sources of social support in the study subjects

Proportion of Study Subjects with Depression

Table 2: showed that approximately half of the subjects, one hundred and two (49.5%) had depressive symptoms while one hundred and four (50.5%) had no depressive symptoms.

Table 2: Proportion of study subjects with depression

Variables	Frequency (n=206)	Percentage (%)
Presence of depression		
Depression	102	49.5
No depression	104	50.5

Relationship between Social Support and Depression

Table 3 is a contingency showing the relationship between level of social support and presence of depression. The table showed proportionally more respondents thirty (96.8%) with low social support had depression and only one (3.2%) had no depression. On the other hand, the respondents with high social support twenty five (31.6%) had depression and fifty-four (68.4) had no depression. The association between social support and depression status was statistically significant ($p<0.0001$).

Table 3: Relationship between level of overall social support and depression among study population

Level of Social support	Depression n=102	No depression n=104	Test statistics	p-value
Low	30 (96.8)	1 (3.2)	$\chi^2=37.800$	$<0.0001^{\dagger}$
Moderate	47 (49.0)	49 (51.0)		
High	25 (31.6)	54 (68.4)		

†Statistically Significant

Association between Depression and the Different Sources of Social Support

Table 4: is a contingency table showing the relationship between the different sources of social support and depression. The data showed that proportionally more respondents 20(90.9%) with low social support from family had depression and 2(9.1) had no depression compared to respondents with high social support from family 34(34.7%) had depression and 64(65.3) had no depression. The association between social support from family and depression status was statistically significant ($p<0.0001$).

For social support from friends a higher proportion 51(70.8%) of respondents with low social support had depression and 21(29.2%) had no depression compared to respondents with high social support from friends 7(24.1%) and 22(75.9%) had no depression. The association between social support from friends and depression status was statistically significant ($p<0.0001$).

For social support from significant others a higher proportion 37(84.1%) of respondents with low social support had depression and 7(15.9%) had no depression compared to respondents with high social support 5(31.3%) had depression and 11(68.8%) had no depression. The association between social support from significant others and depression status was statistically significant ($p<0.0001$).

Table 4: Association between depression and the different sources of social support in the study subjects

	Depression n=102	No depression n=104	Total n=206	χ^2	P
Family support					
Low	20(90.9)	2(9.1)	22(100)	25.057	0.000†
Medium	48(55.8)	38(44.2)	86(100)		
High	34(34.7)	64(65.3)	98(100)		
Significant others support					
Low	37(84.1)	7(15.9)	44(100)	27.318	0.000†
Medium	60(41.1)	86(58.9)	146(100)		
High	5(31.3)	11(68.7)	16(100)		
Friend support					
Low	51(70.8)	21(29.2)	72(100)	22.994	0.000†
Medium	44(41.9)	61(58.1)	105(100)		
High	7(24.1)	22(75.9)	29(100)		

†Statistically Significant

DISCUSSION

The findings of this study showed that depression is common in the elderly this is not surprising as it has been shown that depression is common in primary care settings. Their aetiology and predisposing factors also cut across all races and ages as well as socio-economic classes.
In this study the prevalence of depression was found to be 49.5% which implies that almost half of the respondents had depressive symptoms. A different scale for assessing depression in the elderly was used by Awunor et al and the report showed a prevalence of 44.7%.[25] This finding is also not surprising as the study area was in the same locality as the study area of this current study. A cross sectional study conducted at three large primary care centres in Riyadh, Saudi Arabia showed a prevalence of 49.9%,[60] The finding of high prevalence of depression in this report may be predicated on the report being the product of a clinic-based data analysis.

Level of Social Support

The findings of this study revealed varying level of perceived social support across the three sources of social support (family, friends and significant others) in the study participants. The overall social support was as follows fifteen (15.0%) study subjects had low social support, ninety-six (46.6%) study subjects had moderate social support and seventy-nine (38.4%) had high social support. This result showed that majority of the respondents reported moderate social support. A plausible explanation for the widespread moderate perceived social support instead of high social support among majority of study participants may be as result of economic situation and also physical separation of parents and children due to increase in urbanization and migration from rural to urban centres.[18] This urbanization and migration has implications for the care of the elderly in Africa and in Nigeria in particular.[18] This study further revealed the pattern of social support from the three sources (family, friends and significant other). It showed that family support was the main source of support for the study subjects, followed by social support from friends. The higher level of family support found in this current study may typify the Nigeria situation. Despite the decline in the traditional family system and cultural norms, family members are still a principal support for the elderly in our environment.[18] Furthermore Odedeji et al revealed that children were the main providers of financial and emotional forms of support.[33] In Nigeria family members play a significant role in the care for the elderly and provide home care.[60] The finding in this current study is almost similar to the finding by Tariq et al in their work that reported that family support was the main source of social support for the study subjects.[61] Okumagbe in his work also reported that social support from most especially children and family members was the main source of social support for elderly in his study[18]. Tambag et al. in Turkey investigated the relationship between

perceived social support and depression in the elderly who reside in nursing homes, despite measuring perceived social support with the multi-dimensional scale for perceived social support (MSPSS) tool as used in the current study it revealed that the elderly were lacking family support, instead Friends were the main source of social support.[17] A possible explanation for this difference may be because the study design and study area were different. Family is still the main system that provides emotional and social support for the elderly in Nigeria. Elderly care seen in the form of institutionalized centres or private home care in some industrialized countries, is rarely seen in Nigeria.[62] Furthermore, moral and cultural influences continue to pressure children to care for their parents.[62] At the moments the Nigeria government does not provide social security for elderly. Even their work benefits and pension are not regularly paid by the government to the retiree; hence these elderly rely on their savings and family.[1]

Social Support and Depression in the Study Subjects

Social support is recognised as a potential protective factor against the risk of developing depressive symptoms. Social support was found to be the only independent predictor of depression in this study. Findings from this study revealed an inverse relationship between social support and depression in the respondents, which means the lower the perceived social support the higher the depressive symptoms. Finding from this current study showed that 96.8% of the respondents who reported overall low social support, were found to have more depressive symptoms. The three sources of perceived social support (family, friends and significant others) showed a strong significant relationship with development of depressive symptoms. They were found to be inversely associated with depression. An inverse relationship of social support with depression is well established in literatures.[63,64] The finding from the current study showed that the study subjects with low social support from family were more likely to develop depressive symptoms when compared to low social support from friends and significant orders. Nevertheless, from the current study elderly with poor social support from other sources also experiences increased depressive symptoms. In this regard, the result of this study was similar to the finding by Tariq et al that demonstrated that higher perceived social support predicted lower level of depression and those elders with low social support from family were more likely to have depressive symptoms.[61]

Social support provides mutual commitment which may provide the feeling of being loved, self esteem and being worthy.[60] It is one of the factors which influence symptoms of depression in the elderly. [34] This effect is important in regions like Nigeria where the elderly predominantly have chronic medical condition, dwindling financial resources and absence of social welfare services.[65] To create the feeling of prosperity and welfare among the elderly, there should be a person whom the elder can trust, share his/her sadness and happiness with and refer to him/her in facing problems.

CONCLUSION

Family physicians as primary care providers must be aware of the high prevalence of depression in the elderly and be ready to screen all elderly patients so as to provide holistic care, thereby improving the overall health of the patients and by extension, the entire nation.

It is important to assess SOCIAL support in elderly in whom depression is suspected. Thus this study focused on perceived social support and its relationship with depression. Considering the burden of depression in this elderly population and the influential roles of social support; 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 is pertinent.

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