International Psychogeriatrics (2022), 34:8, 671–673 © International Psychogeriatric Association 2022
doi:10.1017/S1041610222000576

COMMENTARY

Social capital and geriatric depression in the Asian context

Depression affects 4.5% to 37.4% of older people across different countries (Luppa *et al.*, 2012). It is a leading cause of disability worldwide and significantly contributes to the global burden of diseases (James *et al.*, 2018). Older people with depression have an elevated risk for frailty, cognitive impairment, and mortality (Chang *et al.*, 2021; Hill *et al.*, 2020; Wei *et al.*, 2019). Late-life depression creates tremendous pressure among Asian societies as their populations are aging fast (United Nations, 2019) and most do not have a well-established mental health care system. For example, in China, mental health resources have been concentrated in large specialist hospitals (Xiang *et al.*, 2018). Although China has committed to integrating its mental health care into the primary health care system, much of the efforts have been directed to people with severe mental disorders due to a lack of resources, including a severe shortage of mental healthcare specialists (Liang *et al.*, 2018). Treating depression and other common mental disorders is usually not a priority for the mental health system. Therefore, mobilizing community resources to promote mental well-being, prevent mental disorders, and support those living with common mental disorders could be an integral part of China's primary mental health care strategy.

Social capital refers to resources embedded in social relationships that individuals and groups can use to generate productive outcomes that benefit themselves or society. The contemporary study of social capital started in the 1980s as sociology and political sciences concept (e.g., Bourdieu, 1986; Coleman, 1988; Putnam, 2000). Empirically, researchers have developed different ways to categorize social capital: Bonding social capital refers to the intragroup ties between members sharing common demographic characteristics; bridging social capital refers to relations between heterogeneous groups; and linking social capital refers to ties between individuals and groups that possess unequal wealth, power, and status (Putnam, 2000; Woolcock, 2001). In addition, some researchers categorized social capital into structural and cognitive social capital. Structural social capital refers to externally observable social structures or organizations, while cognitive social capital refers to unobservable norms, values, and beliefs that affect their behaviors (Agampodi *et al.*, 2015). It is beyond this commentary to give a detailed account of the evolution and the measurement of social capital over time.

The earliest study of the association between social capital and mental health can be dated back to 1897, when Émile Durkheim, a French Sociologist, published his seminal work on suicide (Durkheim, 1951). In recent two decades, the number of studies on social capital and mental health has grown enormously, and many, in fact, came from Asia. Evidence suggests that social capital has an inverse relationship with common mental disorders and the effect of cognitive social capital is more robust than that of structural social capital (De Silva *et al.*, 2005; Ehsan and De Silva, 2015; Han *et al.*, 2018; Burnette *et al.*, 2020). However, most of these studies were observational and could not establish a causal relationship between social capital and mental health.

Growing attention has been put on studying social capital and depression among older people with inconsistent results, likely depending on how social capital was measured (Bai *et al.*, 2020; Cao *et al.*, 2015; Nyqvist *et al.*, 2013; Lu *et al.*, 2022). Some studies found that both structural and cognitive social capital were associated with depression (e.g., Forsman *et al.*, 2012). Others found that only cognitive social capital was associated with major depression and structural social capital was not (e.g., Fujiwara and Kawachi, 2008). Recent studies that investigated different structural and cognitive social capital components in association with depression among older people also produced different results. For example, a study in China found that a higher level of social participation, social support, connection, cohesion, and reciprocity was associated with fewer depressive symptoms (Bai *et al.*, 2020). However, another Chinese study found that only social networks, reciprocity, and trust were associated with depression but not social participation (Cao *et al.*, 2015). More recently, Lu *et al.* (2022) found that higher structural social capital, but not cognitive social capital, was associated with fewer depressive symptoms among older people in China. The inconsistent findings were likely due to different measurement tools being used and the mixing between individual and ecological social capital.

The community and cultural context also play an essential role in studying social capital and

https://doi.org/10.1017/S1041610222000576 Published online by Cambridge University Press

depression among older people. For example, Bai *et al*. (2020) found that different dimensions of social capital were associated with depression in cities with different economic levels, which implied that economic levels moderate the association between social capital and geriatric depression. Moreover, as social capital is a culturally sensitive concept, the cultural background of the study population could affect the association between social capital and depression. For example, Kim *et al*. (2013) found that depression for older Chinese immigrants was only associated with political participation. However, the level of depression for older Korean immigrants was only associated with norms and information sharing.

Even with two decades of intensive research on social capital and mental health, we are still far from knowing the exact relationship between them: Does low social capital cause poor mental health or vice versa? Or is social capital only a mediator or a moderator? We are also far from knowing how to use social capital as an intervention to promote mental wellness or prevent mental disorders. To move the field forward, researchers need to be more specific on how social capital be classified and measured (e.g., structural vs. cognitive and individual vs. ecological), adopt longitudinal design or random clinical trial to establish a causal relationship, and pay more attention to the community and cultural contexts of the study population.

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