CHAPTER 1

INTRODUCTION

This chapter presents the background and significance of the research problem, objectives of the study, hypotheses, scope of the study, and definition of terms.

Background and Significance of Research Problem

Depression is one of the biggest human mental health problems of the late twentieth century and a leading cause of human suffering and disability. The World Health Organization (WHO, 2002) reported that 121 million people suffer from depression and the burden of depressive disorders has been increasing. The same report predicted that depression would be the condition with the second greatest disease burden worldwide by 2020. A substantial number of epidemiological studies have consistently found the female to male prevalence ratio of depression to be around 2:1 (Kessler, 2001, Kuehner, 2003). WHO (2002) estimate 9.5% of women and 5.8% of men have a depressive episode in any given year. A prospective 6-year study of a community-dwelling older population found that older women were more prone to depression and more likely to remain depressed than older men (Barry, Allore, Guo, Bruce, & Gill, 2008). The number of women experiencing depression continues to increase at an alarming rate (Palsson, Ostling, & Skoog, 2001). Nowadays women are more prone to depression due to the stressors that are associated with managing

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multiple roles, the demands (family, social, and cultural) and emotional attachments placed on them (Maynard, 1993).

The increase in life expectancy in the 20th century has resulted in a major increase in the prevalence of age-dependent diseases and conditions, such as depression, Alzheimer's disease and other dementias (Gareri, Fazio, & Sarro, 2002). The National Institute of Mental Health considers depression in the elderly to be a major public health problem and the most common psychiatric disease in the elderly (Barry et al., 2008; Casey, 1994). In 1998, the NIH published a consensus statement on late-life depression. The highlights of their findings added to a growing body of evidence indicating that many people older than 65 suffer additional levels of depression that do not meet the standard criteria for defining major depression but are nevertheless associated with greater risk of major depression, physical disability, medical illness, and increased use of health services (National Institutes of Health, 1998). The prevalence of the elderly with mild and moderate level of depression ranges from 13% to 27% among community-dwelling older people, to as high as 50% among ill elderly and nursing home residents (Koenig, & Blazer, 1996). Furthermore, depressive symptoms affect 8% to 20% of community-dwelling older people, with more women than men affected (Barry et al., 2008). Major depression may affect from 10% to 35% of hospitalized elderly, in addition, 10% to 34.5% of older persons in the community may have depressive symptoms if mild or moderate levels of depression are included (Gareri et al., 2002). Sidik, Zulkefli, and Shah (2003) reported the prevalence of depression in the elderly in various countries. The prevalence showed 4.8% in Spain, 18% in Malaysia, and 35% in Turkey and Hong Kong. The study also highlighted the risk factors, which included being female, being

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single, not having formal education, low total family income and being an urban resident (Sidik et al., 2003).

In Thailand, depression has been found both in rural and urban areas. Data from the Department of Mental Health reported that 116,847 people suffered from depression in 2006 (Department of Mental Health, 2006). The prevalence rate of depression in Thailand was 185.98 per 100,000 of the population in 2006. In Chiang Mai, according to the report from the Department of Mental Health, there are 3,430 people diagnosed with depression (Department of Mental Health, 2006). In 2006, the prevalence rate of depression in Chiang Mai was 206.84 per 100,000 of the population. The annual report of Suan Prung Psychiatric hospital, which is a public psychiatric hospital in Chiang Mai city, shows that out of total in-patients, the number of people with depression requiring treatment in the year 2005, 2006 and 2007 were 6,832 (11.89 %), 7,483 (12.77 %) and 8,553 (14.21 %), respectively and the number of outpatients with depression in the year 2007 increased 14.29% from the year 2006 (Suan Prung Psychiatric Hospital, 2007). The prevalence rate of major depression in Thai elderly women was 20.9% whereas it was13.8% in Thai men (Siriwanarungsun et al., 2003). The same study reported that the elderly with depression in the northern part of Thailand was 18.1% (Siriwanarungsun et al., 2003), while the prevalence rate of major depression in elderly in Roi-Et province was 2.4% (Chantamoon, 1996). Linsuwanont (2001) found that 22% of the elderly in Rongmuang Sub-district, Pratumwan, Bangkok suffered from depression. This is similar to the study of Foongpaisarn (1996), which showed that the prevalence of depression among the elderly in Municipal Area of Kamphaeng Phet province was 39.7%, in which 20.3% was mild depression, 11.5% was moderate depression and 7.9% was severe

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depression. Similar to Sidik and colleagues (2003) depression in the elderly was found to relate to gender, marital status, education and income (Chantamoon, 1996; Foongpaisarn, 1996; Linsuwanont, 2001).

Depression in the elderly is a chronic illness that often reoccurs throughout an individual's life. The study showed that rates of recurrence are greater in those age 65 to 79 than in middle-aged patients. Thus, depression in elderly patients is more of a recurring problem (Katz, 2004). The symptoms of depression in old age are similar to those found in youth such as fatigue, appetite loss, insomnia, difficulty concentrating, loss of interest in life or the ability to enjoy it, feelings of emptiness, guilt, sadness, and hopelessness, wishing for death, which may lead to suicide (Harvard Mental Health Letter, 2003). Depression in the elderly is caused by psychosocial stress or physiological effects of disease and can lead to disability, cognitive impairment, suffering, family disruption, increased symptoms from a medical illness, increased utilization of health care services and increased rates of suicide and non-suicide mortality (Alexopoulos, 2005, Gareri et al., 2002). A study by Keller also noted that depression is associated with significant functional impairments including a high rate of mortality (Keller, 2003). Suicide, which is a fatal complication of depression, is increasingly becoming more common in all age groups and particularly in the elderly (Barker, 1999; WHO, 2003). Jeste (2003) reported that the single most significant risk factor for suicide in American elderly is depression. The elderly with depression are less likely to report suicidal ideas than their younger counterparts, although the rate of suicide is alarmingly high (Moutier, Wetherell, Zisook, 2003). Inskip, Harris, and Barraclough (1998) found an estimated 6% suicide mortality in individuals with an affective disorder. The study of 80 people who committed suicide at an average age

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of 68 found that 50% of them had a known history of major depression (Harvard Mental Health Letter, 2003). In patients with severe depression Bradvik and Berglund (2001) reported a mortality ratio of 1.3 when compared to non depressed patients. The suicide rate in elderly women is higher in Asian countries (57-95 per million) than in English speaking countries (40-56 per million) (Pritchard & Baldwin, 2002). In Chiang Mai, according to the report from Department of Mental Health, there are high prevalence rates of both suicide (15.02%) and attempt suicide (46.61%) (Department of Mental Health, 2006). The increase in the rate of suicide due to depression is an alarming trend especially in the elderly (Barker, 1999; WHO, 2003).

The costs of care for depressive patients are rising. This trend is particularly evident with the depressed elderly where inpatient costs are 47% to 51% higher when compared to non depressed elderly patients after adjustments for chronic medical illness are made. Regarding mean cost of care, depressed elderly patients average an increase of $1,045-1,700 in ambulatory and inpatient costs (Katon, Lin, Russo, & Unutzer, 2003). Depression in women contributed to the escalating costs of health care in terms of increased higher rates of chemical dependency and high admission rates to psychiatric hospitals (Maynard, 1993).

Depression in the elderly can be diminished in severity by a number of intervention strategies such as medication, psychotherapy, behavioral interventions including cognitive therapy (Arean & Cook, 2002; Walker & Clarke, 2001). Although antidepressant drugs work well in the elderly, they usually absorb and eliminate drugs more slowly and are more sensitive to side effects. They are often taking several medications, which raises the risk of dangerous interactions (National Institute of Mental Health, 2007). The National Institute of Mental Health (2007)

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reported that 40% of the elderly taking antidepressants quit or repeatedly miss doses because of side effects, memory problems, or difficulty keeping track of complicated drug regimens. The Division of Clinical Psychology of the American Psychological Association has indicated that interpersonal, psychodynamic, and cognitive therapies may be efficacious for late-life depression, especially if people are under severe stress, lack social support, or will not or cannot take medications regularly. Meta-analyses of a number of studies show that cognitive therapy (cognitive-behavioral therapy) is one of the most effective interventions for elderly with mild and moderate depression (Arean & Cook, 2002; Butler, & Beck, 2000; Casacalenda, Perry, & Looper, 2002; Thomson, Coon, Gallagher-Thomson, Sommer, & Koin, 2001; Walker & Clarke, 2001; Wilson, Scott, Abou-Salch, Burns, & Copeland, 1995). In comparison with other psychotherapies, cognitive therapy (CT) is both more cost-effective and shorter in duration than psychoanalysis (Spinelli, 1994, as cited in Landreville & Gervais, 1997). Given the untoward side effects often associated with medication, the cost of anti-depressant drugs, lack of new effective programs and also lack of skills for mental health therapy, particularly in a developing country such as Thailand, new feasible innovative approaches are needed.

According to Beck's Cognitive Theory of Depression, negative cognitive interpretation of experiences lead to negative views of self, experiences and future that are called the "cognitive triad". The automatic negative thoughts (repetitive, unintended, and not readily controllable) affect feelings and behavior which can lead to depression (Sacco & Beck, 1995). Depressed persons view themselves as unworthy, undesirable, and unlovable. Cognitive therapy helps people alleviate depressive symptoms by identifying automatic negative thoughts and changing the

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patient's thinking to bring about enduring emotional and behavioral change (Beck, 1995; Varcarolis, 2002). The strengths of CT make it the most effective treatment for the elderly with moderate level of depression (Thomson et al., 2001). The elderly treated by CT recover more quickly than younger individuals. This recovery is thought to be due in part to a higher attendance rate at the therapy sessions (Walker & Clarke, 2001). Although there are a number of studies indicating the effectiveness of CT treatment for depression in the elderly, the generalizability of these results are still questioned. Effectiveness of CT treatment for depression in elderly Thai women has not been demonstrated. From reviews of CT for depression in the elderly, Koder, Brodaty, and Anstey (1996) reported that the elderly failed to acknowledge their depressive symptoms and automatic negative thoughts. So, the treatment for depression in the elderly requires adaptation associated with aging and culture.

The population of Thailand is predominately Buddhist, therefore Thais have a meaningful connection with a religion that is presented through their faith in religion, have religious principles as guidance in life, and practice religious activities (Kunsongkeit, 2004). The central teaching of Buddhism is the purification of the mind. Lord Buddha indicated that mindfulness is the only path to purification, freedom from suffering, and thus to Nirvana (Pra Rajaprommajarn, 2004). The practice of mindfulness is well known among the population. Mindfulness, the English translation of the Pali, Sati, is an activity reflecting only what is presently happening with non-judgmental observation (Buddhadasa Bhikkhu, 1991; Gunaratana Mahathera, 2007).

The Four Foundations of Mindfulness are the main principles of mindfulness practice, which lead the person to be fully present in each moment,

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continuously and consciously aware of what is happening to the body, feelings, mind and mind- objects. The five purposes for mindfulness practice are to purify the mind, to free the mind of sorrows and lamentation, to get rid of physical and mental sufferings, to understand the truth of life and to extinguish suffering and gain Nirvana (Nyanatiloka Thera, 2000; Phra Rajaprommajarn, 2004). When one is mindful, the mind responds to the unique pattern of experience in each moment instead of reacting mindlessly to fragments of a total experience with old, stereotyped, habitual patterns of mind. Increased mindfulness can help people with depression by allowing early detection of relapse-related patterns of negative thinking, feelings, and bodily sensations (Teasdale et al., 2000). Thus, combining cognitive therapy and mindfulness practice enable people to increase their awareness of what happens to the body, feelings, mind and mind-objects when they are about to undergo dangerous mood swings, decrease misinterpretation and unrealistic thinking, make it easier to identify the automatic negative thoughts. At that point, techniques from cognitive therapy could allow people to deal with the automatic negative thoughts that any sad mood might reactivate, to change in the patient's thinking and alleviate depressive symptoms.

There are few studies that examine the effectiveness of the cognitive therapy and mindfulness practice in depressed patients. Recent evidence shows that Mindfulness-Based Cognitive Therapy (MBCT), a promising cost-efficient psychological approach, could be used to prevent relapse/recurrence in recovered recurrently depressed patients with three or more previous episodes but it did not work for patients who were depressed. Unlike CBT, there is little emphasis in MBCT on changing the content of thoughts. The focus of MBCT is to teach people to become

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more aware of thoughts and change the relationship of thought. The cultivation of detached, decentered relationship to depression-related thoughts and feelings is central in providing skills to prevent the escalation of negative thinking patterns at time of potential recurrence (Teasdale et al., 2000). For persons with depression, the researchers still recommend that they need cognitive therapy to help them change the automatic negative thoughts (Ma &Teasdale, 2004; Teasdale et al., 2000). Unfortunately, no index of scientific literature could be found on the effectiveness of cognitive therapy and mindfulness approaches for depressed patients or people with high risk of depression, especially the elderly.

Depression is a common condition amongst elderly women. Research has shown that Thai elderly suffer from depression and the majority of them are female with mild and moderate degrees of depression (Chantamoon, 1996; Foongpaisarn, 1996; Linsuwanont, 2001). It is hypothesized that Cognitive-Mindfulness Practice Program based on mindfulness and cognitive theory potentially can be used as a treatment option for elderly. This innovation consists of mindfulness practice based on the Four Foundations of Mindfulness, recognition of automatic thoughts, logical analysis of automatic thoughts, and generating a rational response. The purpose of this study is to investigate the effectiveness of a Cognitive-Mindfulness Practice Program as a nursing intervention to reduce depression in elderly Thai women with mild to moderate depression.

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Objectives of the Study

The objectives of this study were to examine the effect of Cognitive-Mindfulness Practice Program on Depression in Thai Elderly Women.

Two specific objectives were:

1. To compare the depression level at one month and four months of Thai elderly women between those receiving Cognitive-Mindfulness Practice Program and those receiving usual care.

2. To compare the depression level of Thai elderly women before and after receiving the Cognitive-Mindfulness Practice Program.

Hypothesis

1. Thai elderly women who receive a Cognitive-Mindfulness Practice Program will show a lower depression level than those who receive usual care, at one month and four months.

2. After receiving a Cognitive-Mindfulness Practice Program, at one month and four months, Thai elderly women who received a Cognitive-Mindfulness Practice Program will show a lower depression level than before receiving the program.

Scope of the Study

This study was conducted with Thai elderly women, aged between 60 to 80 years old, with mild or moderate levels of depression, and residents of Chiang Mai municipality, Thailand over eight months from October, 2006 to May, 2007.

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Definition of Terms

Depression is a complex pattern of deviation of cognitive feelings and behavior that presents with a loss of interest or pleasure, depressed mood, feelings of guilt or low self-esteem, sleep or appetite disturbance, low energy and poor concentration. The intensity of depression is measured by Beck Depression Inventory (BDI-IA) (Beck & Steer, 1993), which was translated into the Thai language by Sriyoung (1979).

Cognitive-Mindfulness Practice Program is developed by the researcher to reduce depression in Thai elderly women. The program is based on mindfulness practice centered on the Four Foundations of Mindfulness to improve individuals' ability to be aware of body, feelings, mind and mind-objects and cognitive theory designed to consciously identify automatic negative thoughts and their problems and to develop alternative thinking patterns and problem solving. The program consists of 2 steps: Step 1: Mindfulness practice (the Four Foundations of Mindfulness) leads the person to be fully present in each moment, continuously and consciously aware of what happens to their body, feelings, mind and mind-objects. Step 2: Cognitive therapy, which consists of recognition of automatic thoughts, logical analysis of automatic thoughts, generating a rational response and problem solving.

Elderly Thai women are Thai women aged 60 to 80.

Usual care means community support and nursing care from the community nurses.

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