CHAPTER 1

Introduction

Background and Significance of the Research Problem

Depression affects approximately 300 million people worldwide (World Health Organization [WHO], 2013b). The percentage of depression with severe impairment in the past year was rise during 2005 and 2014 among adolescents between the ages of 12 and 17. (Substance Abuse and Mental Health Services Administration [SAMHSA], 1014). In Thailand, the Department of Mental Health [DMH], Ministry of Public Health [MPH], (2016) points out that depression cases increased between 2012 and 2013, respectively rated 118.97 and 952.46 per 100,000 of the population with the increasing incidence rate of adolescent depression. Specifically, an undertaking this study in Lamphun Province, Thailand, the incidence rate of depression was ranked first in 2008, 2009, 2011, ranked second in 2010, and ranked fifth in 2013 per 100,000 of the population.

The occurrence of depression is on the rise from early adolescents (Maughan, Collishaw, & Stringaris, 2013). The prevalence of adolescent depression is high and the present studies found that the prevalence rate of Thai adolescent depression in 2012 ranged from 14% to 19%, which occurred mainly in urban areas (Chaveepojnkamjorn, Pichainarong, Adthasangsri, Sativipawee & Prasertsong, 2016; Trangkasombata & Rujiradarpornb, 2012). While in Northern Thailand the prevalence of depression among adolescents in rural areas is 8% (DiMiceli1, Sherman, Aramrattana, Sirirojn & Celentano, 2016). The onset of depression often occurs in childhood and adolescence (Maughan, DPhil, & Stringaris, 2013), increases sharply the age 15 (Thapar, Collishaw, Pine, &Thapar, 2012); and early onset depression is associated with recurrent episodes and chronic course of illness (Tak et al., 2012).

Adolescent depression is a mental disorder affecting people who are between 11 to 18 years old (Eccles, 2010; WHO, 2013a), have the manifestation of either depressed, a lack of favored activities, low self-esteem, social isolation, hopelessness, changes in sleep and appetite, difficulty of concentration, may display psychotic symptoms, and or have attempted suicide (Maughan et al., 2013). Depression leads to a lifelong vulnerability, a loss in a person's competency and can cause detrimental impact to educational achievement, unemployment, increase the rate of suicide (DMH, MPH, 2013), family suffering, and socioeconomic burden (Gladstone, Beardslee, & O'Connor, 2011; Leahy, 2010). Particularly, adolescent onset depression is strongly associated with recurrent and increased probability of a depressive episode in adulthood almost fourfold (Rohde, Lewinsohn, Klien, Seeley, & Gau, 2013). Several preventive depression interventions seems to be focused primarily on treatment rather than onset depression prevention. The development of depression prevention model for Thai adolescents should focus on the onset depression prevention.

Based on literature review, the effective depression prevention interventions aim at reducing the depression risk, such as stressful life event, negative self-evaluation, and inability to cope (Gladstone et al., 2011), the interventions also strengthened protective factors, such as enhancing self-esteem, resilience, (Nauta et al., 2012), the problem solving skill (Hoek, Schuurmans, Koot, & Cuijpers, 2009; Stice, Shaw, Bohon, Marti, & Rohde, 2009) for immunology to prevent depression. The greatest theories applying to depression prevention in adolescent based cognitive learning theory, that provided specifically to modify adolescent's thinking into a realistic way and change behaviors accordingly. Particularly, the use of Cognitive Behavior Therapy (CBT) (Callahan, Liu, Purcell, Parker, & Hetrick, 2012; Schmied, & Tully, 2009), which provided the ability to enhance the positive consequences of depression prevention (Kindt, Van Zundert, & Engels, 2012; Tak et al., 2012). In addition, the intervention can combine into mindfulness-based cognitive behavior therapy (MBCBT) (Stallard, 2013), combining motivation interviewing (MI) with CBT (Hernández, Méndez Carrillo, & Garber, 2014; Hoek et al., 2011; Van Voorhees et al., 2008). Application of all these theories to depression prevention interventions focused on enhancing the protective factors and aimed at reducing risk factors that lead to sufficiency of self-esteem, resiliency, and problem solving skills for prevent depression (Richardson, 2010; Stice et al., 2009).

Nevertheless, a limitation of the interventions is the majority of work in a western context but there has been little work in trying to apply to others context. Therefore, depression prevention interventions should consider cultural sensitivity.

The overall of depression prevention interventions in adolescent are delivered at individual, family, school or community based universal preventive interventions. Several studies have indicated that the intervention based cognitive theory (Callahan et al., 2012; Manicavasgar, Parker, & Perich, 2011; Schmied, & Tully, 2009). The intervention at an individual level are conducted in order to develop meaningful self-perception and personality, such as positive thinking, self-esteem, and enhancing the individual's well-being (Nauta et al., 2012). Furthermore, applying the depression preventive interventions to family approach demonstrates one of the greatest outcomes (Adelaide Health Technology Assessment [AHTA], 2010; Kindt et al., 2012; Tak et al., 2012). It focuses on strengthening families including enhancing parenting attachment, developing healthy parents and children relationships, educate positive parental techniques, and building resilience to support children encountering stress. Interesting, the community or school-based intervention aims to offer cognitive training, to support children encountering serious stress, develop students' problem solving, increase self-awareness, improve motivation, enhance curiosity, and improve social abilities (Min, Lee, & Lee, 2013; Van Voorhees, Ellis, Stuart, Fogel, & Ford, 2005).

In spite of preventive approaches at individual, family, and community or school based may provide a valuable way to prevent depression in high risk children (Nauta et al., 2012). However, several studies points out the limitation of family approach to depression preventions are difficult to get parents to attend the program. The participant may be susceptible to stigmatization when they have to partake in the intervention thus they may lack the motivation to attend (Van Voorhees et al., 2009). Furthermore, taking a long period of time to implement in the community or at a whole-school level, leads to difficulty engaging young adolescents to join with an intervention and also teachers need to undertake intensive training by professional interventionists. As a result, they are not able to devote as much time to providing interventions. Therefore, recent implementation of only family or school-based interventions approaches may be limited or some difficulties may be faced; particularly adherence to

intervention or even well-designed programs can fail to show effectiveness in the real world (Hernández et al., 2014). Similarly in Thailand, the evidence of depression preventions are also delivered at individual, family, community based interventions. Furthermore, majority of depression prevention based on cognitive behavioral theory with others concepts, which were developed in a western culture, has not been consider in Thai culture and context (Prukkanone, Vos, Bertram, & Lim, 2012), therefore did not specifically meet the needs for Thai adolescents. For instance, a randomized controlled trial to evaluate the effectiveness of the self-help intervention program using cognitive behavior therapy (CBT) incorporated in bibliotherapy, could promote resilience, reduce depression levels, and enhance recovery in Thai people aged between 15 and 60, which is not specific application for adolescents (Songprakun, 2010). There are only a few depression prevention programs specific for adolescent (Kongsuk et al., 2010), such as a study researching the effectiveness of a school-based CBT program for Thai adolescents with depressive symptoms indicated that the program improved depressive symptoms, negative automatic thoughts, and adaptive functioning (Vuthiarpa, Sethabouppha, Soivong, & Reg, 2013).

Even though this study indicated that the effectiveness of a school-based cognitive behavior therapy, but a program requires nurses with cognitive behavior therapy knowledge and experience. Additionally, this intervention has its limitations due to the number of adolescent participants may not have been interested in joining activities; comfortable being in a cognitive behavior therapy based group; and /or allowed by their parents to participate. Moreover, the participants expressed a need for their parents to better understand their depression and the CBT program (Vuthiarpa et al., 2013). According to youth departments that primarily work on the youth and parental psychopathology suggest that preventive intervention should consider the interventions should be conducted with parental involvement or family should have more cooperation between the adolescents and their family (Nauta et al., 2012; Stice et al., 2009). That may provide a valuable ways to prevent depression in adolescents who are at high risk.

In Thailand, adolescent depression is at an increasing rate (DMH, MPH, 2013) that may be a predisposition to full depressive episodes in adulthood. Whereas, the existing intervention designs on depression prevention, it still does not emphasize

towards early prevention for depression onset. It may not be specific for Thai adolescents, underserved Thai context. In spite of Thai culture which can affect an individual's thinking that is unable to express in order to distinguish from social context, especially those who were raised very close to their parents during the upbringing (Charoenthaweesub, 2011). The current studies suggest that depression preventive intervention should consider conducting with parental involvement, in order to enhance supportive parenting, healthy relationships, and educating positive parental techniques which will reduce the risk of depression.

Moreover, almost of the depression prevention program had limitations in health system that the health care professional such as psychiatrists and psychiatric nurses who are expert in the CBT program and other interventions required training (Min et al., 2013; Vuthiarpa et al., 2013). Consequently, the limitation of these preventive interventions resulted in poor practice in sustainability depression prevention. The first priority towards prevention of depression will be to practice and continue boosting adolescent on their own and close relationship with significant people in their lives, such as with their peers, parents, and teachers. Therefore, prevention intervention will need to add more elements in order to achieve and sustain the required outcomes. The development of effective prevention is needed in order to listen to adolescent and parent views with the implicit goal of the emancipatory function of depression prevention knowledge towards the understanding of social needs and Thai sociocultural of continual learning within the context and the resources available. It is important that there must be an undertaking prevention application in Lamphun province as the rate of depression was the highest in Thailand.

Participatory action research is a genuine, non-coercive process whereby liberating and acknowledging people's equality of worth and providing freedom from the conditions (Kemmis & McTaggart, 2007). The PAR approach is deliberately and systematically reflexive, that researchers embarked on a process of transforming themselves and their research practices to change community development practices through collaborative processes of communication and learning. It can create people's networks of openly rational debate communication and acting in the ways, which are guided by participant perspectives to shared particular goals, reached the consensus and

framed their thinking. This method may encourage adolescent, parents and teachers participation to develop the depression prevention model for Thai adolescents on their own. Eventually, the model could be practical and can be applied suitably with adolescent's way of thinking, learning, taking into consideration the life style and Thai culturally specific for adolescents and their significant person. It may be sustainability to prevent adolescent become depression.

Objectives of the Study

The purpose of research study was to develop a participatory depression prevention model for Thai adolescents. The specific objectives were:

1. To identify the critical components of depression prevention model for Thai adolescents.

2. To examine the feasibility of depression prevention model implementation for Thai adolescents.

Research Questions

The research questions that direct this study were to:

1. What are the critical components of depression prevention model for Thai adolescents?

2. What is the feasibility of participatory depression prevention model implementation for Thai adolescents?

Definition of Terms

Thai adolescent refers to people aged 10 to14 years old, in the adolescent transition and who live with their parents in selected district, Lamphun province.

Depression prevention model refers to the guiding principles and the knowledge package was developed for protection the adolescent from depression through a principle and a process of participatory action research among Thai adolescents, their parents and teachers.

Critical components of depression prevention model refer to the significant elements that contribute to the design and development of the participatory depression prevention model for Thai adolescents.

Feasibility of depression prevention model refers to expediency of the model demonstrate by adolescents who are able to use emotional balancing prior to the onset of a clinically diagnosable depressive disorder, which evaluated throughout 4 self-reports including The Children's Depression Inventory (CDI), Rosenberg Self-esteem Scale, The Resilience Inventory, and the Problem Solving Inventory.