Solution-Focused Therapy Program on Self-Esteem and Depression in Thai Older Adults with Major Depressive Disorder: A Quasi-Experimental Study

Paijit Phuttharod, Wipawan Chaoum Pensuksan, Jaruwan Suppasri*

Abstract: Major depressive disorder is one of the most prevalent mental health disorders globally. Older adults represent a particularly vulnerable group, with various factors significantly increasing their risk of developing depression. Thus, they need effective intervention to mitigate this problem. This study employed a quasi-experimental, pretest-posttest control group design to evaluate the effectiveness of the Solution-Focused Therapy Program in enhancing self-esteem and reducing depression among older adults with depression in Southern Thailand. This Program emphasizes solutions rather than problems and focuses on helping individuals identify and utilize their strengths and resources to overcome challenges. Fifty participants were purposively selected and matched based on their depression levels. They were then systematically assigned to either the experimental group (n = 25), receiving the Program, or the control group (n = 25), receiving only usual care. Self-esteem and depression were measured before and after the intervention using the Self-Esteem Scale and the Thai Geriatric Depression Scale, respectively. Data were analyzed using multivariate analysis of covariance.

Results indicated that participants in the experimental group exhibited significantly higher median scores on self-esteem and lower depression than those in the control group at one week post-intervention. These findings indicated the Program's effectiveness in enhancing self-esteem and reducing depression among older adults with depression. Trained nurses can implement this Program to meet the unique needs of this population in clinical practice. However, future multi-site, longitudinal studies are recommended to assess changes in self-esteem and depression over time and evaluate the Program's long-term impact before widespread implementation in practice.

Keywords: Major depressive disorder, Older adults, Self-esteem, Solution-Focused Therapy

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Paijit Phuttharod, *RN, PhD, Head, Division of Psychiatric and Mental Health Nursing, Boromarajonani College of Nursing, Trang, Faculty of Nursing, Praboromarajchanok Institute, 92000, Thailand. E-mail: paijit@bcnt.ac.th*

Correspondence to: Wipawan Chaoum Pensuksan, *RN, PhD, SFHEA, Associate Professor, Division of Psychiatric and Mental Health Nursing, Faculty of Nursing, Suratthani Rajabhat University, 84100, Thailand. E-mail: wipawan.pen@sru.ac.th*

Jaruwan Suppasri, *RN, MEd, Instructor, Division of Psychiatric and Mental Health Nursing, Boromarajonani College of Nursing, Trang, Faculty of Nursing, Praboromarajchanok Institute, 92000, Thailand. E-mail: Jaruwans@bcnt.ac.th*

Author contributions:

PP: Principal investigator and lead of the SFT program, conceptualization, method and design, tool development and validation, support for data collection and data analysis

WCP: Data analysis and interpretation, drafting the manuscript, revising the manuscript, editing the manuscript, final approval of the submitted version

JS: Support for method and design, tool development and validation, support for data collection

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Introduction

Global demographics reveal a significant rise in the aging population, with projections suggesting that by 2030, one in six people worldwide will be 60 years or older.[1] In Thailand, the population is projected to decline from 66 million to 60 million over the next two decades, while the older adult population is expected to grow from 13 million to 19 million.[2] This demographic shift underscores the urgent need to address the mental health challenges faced by older adults, who are particularly vulnerable to depression due to aging-related factors and challenges.[3] Physically, older adults face neurobiological changes, reduced bodily efficiency, and an increased prevalence of chronic illnesses, limiting their ability to work and care for themselves.[1,3] Socially, in the Thai context, the shift from extended to nuclear family structures has left many older adults isolated, lacking the traditional support of larger households.[2] Psychologically, this isolation can lead to emotional challenges, including stress, anxiety, loneliness, reduced happiness, and low self-esteem. These factors can escalate into depressive symptoms, increasing the risk of depression and other mood disorders.[4,5]

The growing prevalence of depression among older adults highlights major depressive disorder (MDD) as a critical mental health concern, often coexisting with physical and psychological challenges. With a lifetime prevalence of 2% to 21%, MDD represents a significant public health issue, particularly due to its strong association with an elevated risk of suicide.[6] In Thailand, a recent study revealed that traditional treatment for patients with MDD, including those with a history of suicide attempts, primarily focuses on pharmacological interventions supplemented by supportive psychotherapy or cognitive behavioral therapy (CBT). These therapies are typically provided by psychiatric nurses or clinical psychologists, with frequency and duration often dictated by monthly appointment schedules. However, evidence suggests that many patients continue to engage in self-harming behaviors, and depressive symptoms often persist without significant improvement.[7] While medications can be effective for treating depression, they may not always be suitable for older adults due to the risks associated with polypharmacy and managing multiple health conditions.[3,8] Psychotherapeutic approaches offer a safer and more comprehensive alternative to addressing psychological challenges in this vulnerable population.

Solution-Focused Brief Therapy (SFBT), also known as Solution-Focused Therapy (SFT), has proven effective in achieving therapeutic outcomes within a short timeframe. This approach empowers clients by fostering autonomy and self-direction, with strong evidence supporting its effectiveness in adult mental health[9,10] However, SFT remains underexplored as an intervention for older adults with major depressive disorder (OA-WMDD). This population could benefit greatly from accessible and empowering therapeutic approaches. This study addresses this gap by evaluating the effectiveness of SFT in enhancing self-esteem and empowering OA-WMDD.

Review of Literature and Conceptual Framework

This study was based on the SFT approach and a comprehensive literature review. SFT, developed by De Shazer and Berg during the 1970s and 1980s, is grounded in social constructionism, which suggests that reality is subjective and encompasses multiple valid perspectives.[11,12] SFT focuses on the here and now and finding practical solutions rather than exploring causes or interpreting issues. At its core is the belief that clients are the experts in their own lives and are best positioned to identify the solutions to their challenges.[10,11] As a future-focused, goal-oriented approach, SFT emphasizes solutions over problems, encouraging clients to define goals and develop actionable strategies. By utilizing clients' strengths and resources, SFT facilitates meaningful change through clear, personalized goals tailored to individual needs and contexts. Its adaptability and applicability make SFT an effective framework for addressing adult mental health issues, including depression.[9]

Building on the foundational principles and established effectiveness of SFT, this study applies its key methods to address depression in older adults, aiming to empower clients and foster positive change. SFT integrates core techniques into a cohesive framework that emphasizes client empowerment and promotes constructive outcomes.[12,13] For instance, the Miracle Question helps clients envision their challenges resolved, fostering optimism and goal setting, as in, "If a miracle occurred overnight and your depression was resolved, what would be different tomorrow?" Scaling questions encourage self-assessment and action planning by asking, "On a scale from 1 to 10, where 1 means the problem is at its worst and 10 means it is fully resolved, where would you place yourself today?" Similarly, Working with Exceptions focuses on past successes to address current challenges, such as, "Can you recall a time when this problem was less severe? What was different then?" Supporting techniques such as normalizing, reframing, complimenting, coping questions, and metaphors stimulate cognitive shifts and motivate progress, while homework assignments encourage active client participation through practical application outside therapy. Collectively, these methods create a structured and flexible framework that supports solution-building. Randomized controlled trials and comprehensive reviews further validate SFT's effectiveness in reducing depressive symptoms, enhancing self-esteem, and achieving sustainable outcomes, particularly among adults.[14-16]

Numerous studies demonstrate that SFT improves psychological outcomes by helping clients reframe their situations and utilize their strengths, fostering control, self-efficacy, and self-esteem.[9,17,18] Self-esteem, a critical component of mental well-being, often declines among older adults due to life transitions. Meta-analyses indicate that emotion-oriented approaches, such as reminiscence therapy and life review, enhance self-esteem by encouraging reflection on meaningful life events and fostering emotional expression.[19] These interventions align with SFT principles by enabling individuals to construct positive self-narratives and recognize their intrinsic worth, reinforcing their ability to navigate challenges. Various studies also highlight SFT's effectiveness in addressing emotional problems, including depression, anxiety, and self-injurious thoughts and behaviors like suicidal ideation and self-harm.[9,13,20] SFT's flexibility allows it to adapt to client's needs, with sessions tailored in number and duration based on individual preferences, and it has proven effective in short-term formats.[9,10,20]

Recent comparisons of SFT with other therapeutic approaches, such as CBT, highlight differences in focus and methods.[3,21] CBT is particularly effective for mild to moderate depression in older adults by targeting cognitive restructuring and addressing negative thought patterns. In contrast, SFT emphasizes solutions over problems, enabling clients to draw on their internal resources, strengths, and past successes to address challenges.[11,17] While CBT is highly effective for cognitive restructuring, SFT's goal-oriented, collaborative approach is particularly beneficial for OA-WMDD, offering short-term, flexible, and empowering therapy.[11] Studies suggest SFT is more feasible, brief, and cost-effective than longer-term therapies like CBT.[17] Moreover, its effectiveness across diverse cultural and international contexts underscores its flexibility and broad applicability.[13] However, evidence on the application of SFT among Thai OA-WMDD is limited, highlighting the need for further research.

Study Aim

The study aimed to evaluate the effectiveness of the SFT program by comparing self-esteem and depression levels between an experimental group receiving the SFT program and a control group receiving only the hospital's usual care. It was hypothesized that OA-WMDD in the SFT program would demonstrate significantly higher self-esteem and lower depression scores at the post-intervention assessment one week post-intervention compared to those receiving only usual care.

Methods

Design: This study employed a quasi-experimental, pretest-posttest control group design. This report followed the TREND statement checklist for non-randomized controlled trials.

Sample and Setting: The study sample consisted of adults 60 years or older, diagnosed with MDD (ICD-10 code F32) and receiving outpatient care at a provincial hospital in Southern Thailand, a tertiary care center for Health Region 12. Inclusion criteria were: (1) mild to moderate depression (the Thai Geriatric Depression Scale: scores 13-18 mild, 19-24 moderate); (2) low to moderate self-esteem (Thai version of the Rosenberg Self-Esteem Scale: scores 1.00-1.50 low, 1.51-2.50 moderate); (3) no cognitive impairment (Mini-Mental State Examination-Thai); (4) Thai language proficiency; (5) no visual or hearing impairments; and (6) willingness to participate. Exclusion criteria included severe depression with significant functional limitations and inability to complete all program activities.

Participants were excluded from the study if they missed any SFT program sessions, withdrew consent, experienced significant health issues that impeded participation, or became ineligible due to a change in diagnosis. These criteria ensured the study's integrity and the validity of the results. Discontinued participants were not replaced; the final analysis included only those who completed the intervention assessments.

The sample size for this study was calculated using the effect size from a similar study on older adults with depression. The reference study by Sripeng examined the effects of supportive psychotherapy on depressive symptoms in this population.[22] Based on Cohen's formula, the effect size was determined to be 0.82.[23] Using this effect size, the sample size calculation followed the power analysis table by Polit and Beck, with an alpha level of 0.05 and a power of 0.80.[24] This indicated that each group required 20 participants. To account for potential attrition, the sample size was increased by 20%, resulting in 25 participants per group and a total of 50 participants.

Research Assistant 1 (RA 1) screened 55 older adults for eligibility, excluding five who did not meet the inclusion criteria, resulting in 50 participants. They were purposively sampled and matched in pairs based on depression levels (mild to mild or moderate to moderate) to minimize confounding variables. RA 1 systematically assigned one individual from each pair to the experimental group and the other to the control group (**Figure 1**). This approach ensured group comparability and balance in key characteristics.

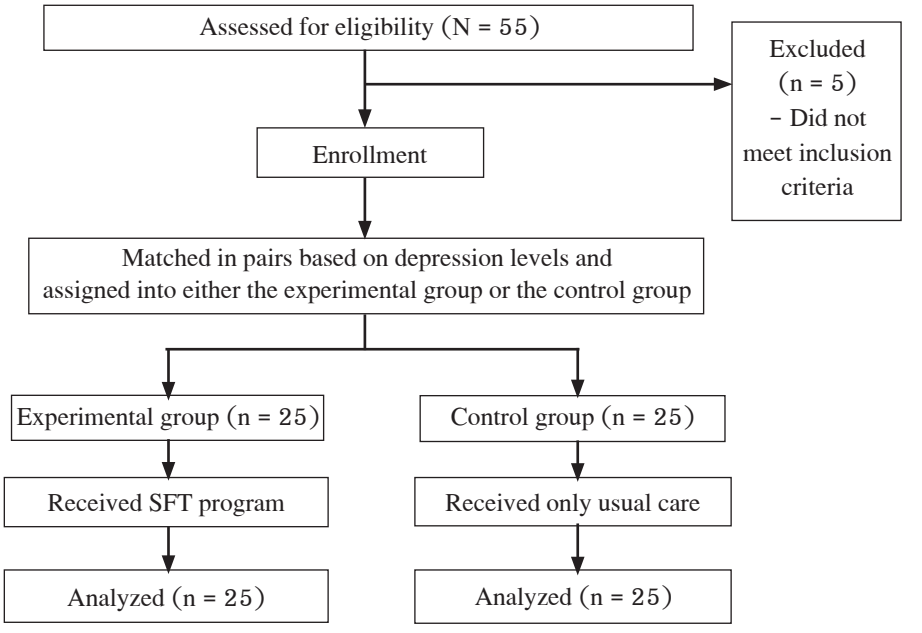

Figure 1. Flow chart of participants throughout the study

Ethical Considerations: This research received ethical approval from the Institutional Review Board (IRB) of Faculty of Nursing, Praboromarajchanok Institute, under document number 9/2566, dated January 1, 2023. The principal investigator (PI) explained the study's objectives, procedures, risks, and benefits to potential participants, ensuring they fully understood their rights, including the option to withdraw at any time without consequences. Voluntary informed consent was obtained from all participants prior to group assignments.

Instruments: Data collection utilized four instruments: the Sociodemographic Data Questionnaire, the Thai Mini-Mental State Examination, the Self-Esteem Scale, and the Thai Geriatric Depression Scale (used for screening and participant matching).

The Sociodemographic Data Questionnaire: The PI designed a 7-item form to gather demographic information on OA-WMDD, including gender, age, religion, marital status, education level, occupation, and social activity participation.

The Thai Mini-Mental State Examination (MMSE-Thai 2002): The MMSE-Thai, developed by the Institute of Geriatric Medicine, is an 11-item instrument for assessing cognitive function. Scores are adjusted based on educational levels: (1) no formal education (illiterate): below 14 out of 23 points indicates cognitive impairment; (2) primary education: below 17 out of 30 points; and (3) higher primary education: below 22 out of 30 points.[25] These criteria were used for baseline screening in line with the inclusion criteria. The MMSE-Thai has demonstrated strong validity and reliability, with a Cronbach's alpha reliability of 0.89 in both the pilot and main studies.

The Self-Esteem Scale: The Rosenberg Self-Esteem Scale (RSS), developed by Rosenberg, measures individuals' self-esteem and was translated into Thai for individuals aged 60 years and above by Mahasitthiwat.[26] In this study, the PI adapted the content to align with the context of OA-WMDD. The 10-item scale includes five negatively worded items (e.g., "You feel that you have not succeeded in anything") that are reverse-scored and five positively worded items (e.g., "You are always a source of support for your children and grandchildren") scored normally. Responses are rated on a 4-point Likert scale from 1 (strongly disagree) to 4 (strongly agree). Scores range as follows: 3.51-4.00 for very high self-esteem, 2.51-3.50 for high self-esteem, 1.51-2.50 for moderate self-esteem, and 1.00-1.50 for low self-esteem, which was used for baseline screening based on inclusion criteria. Continuous scores, where higher values indicate greater self-esteem, were analyzed to evaluate the SFT program's efficacy. Content validity was verified by three experts, a psychiatric nurse specializing in geriatric depression care, and two psychiatric nursing instructors, with a content validity index (CVI) of 0.82. A previous study using this Thai version with older adults in early-stage dementia reported a Cronbach's alpha of 0.81.[27] In this study, Cronbach's alpha was 0.85 in the pilot and 0.83 in the main research.

The Thai Geriatric Depression Scale (TGDS): The TGDS, developed by the Train the Brain Forum in Thailand, assesses emotional changes such as sadness, gloom, and unhappiness, reflecting an individual's feelings across physical, mental, and social dimensions over the past week.[28] This 30-item true/false assessment scale, designed for the Thai older adult population, assigns a score of 0 or 1 point. Ten items reflect positive feelings (e.g., "Most of the time, do you feel happy?"), a 'No' response scores 1 point, while 20 items reflect depressive feelings (e.g., "Do you often feel discouraged or sad?"). Scoring categories are 0-12 for normal mood, 13-18 for mild depression, 19-24 for moderate depression, and 25-30 for severe depression, used for baseline screening and participant matching. Higher scores indicate greater depression levels, and continuous scores were analyzed to evaluate the SFT program's efficacy. The TGDS demonstrated high reliability, with coefficients of 0.94 for females, 0.91 for males, and 0.93 overall.[28] Reliability was assessed using KR-20, with coefficients of 0.89 in the pilot study and 0.93 in the main study.

The Solution-Focused Therapy (SFT) Program

The SFT program, adapted from de Shazer's core principles, was designed to improve self-esteem and address depression in Thai OA-WMDD.[29] Tailored to this population's cultural and contextual needs, the program emphasized solutions in the here and now and the future, empowering participants to recognize their strengths and actively improve their lives. Core techniques such as the Miracle Question, Scaling Questions, and Working with Exceptions formed the program's foundation, with supporting techniques like normalizing, reframing, complimenting, coping questions, and metaphors to encourage cognitive shifts and progress. Homework assignments were incorporated to promote practical application and active participation.

The intervention consisted of six structured sessions conducted twice weekly over three weeks, each lasting 60-90 minutes, depending on individual needs. These sessions integrated core and supporting techniques to address the specific requirements of Thai OA-WMDD participants. They were conducted in a group, with the duration and activities adjusted to accommodate individual needs within the group. Each session applied these techniques to stimulate cognitive shifts and motivate progress. Guided by the SFT framework, the sessions incorporated culturally relevant examples and challenges to enhance engagement and applicability. Further details on the program structure and techniques are provided in **Appendix, Table A1.**

The SFT program in this study was validated by three experts: an advanced practice nurse specializing in mental health and psychiatry, a psychiatric nurse with over five years of experience in geriatric depression care, and a psychiatric nursing instructor. They evaluated the program's content, objectives, and alignment with therapeutic goals. The validation process resulted in a CVI of 0.89, indicating high content validity and confirming the program's relevance and suitability for the target population.

Usual Care: Usual care included self-care education, individual counseling by psychiatric nurses, informational pamphlets, supportive psychotherapy to address the emotional and psychological needs of individuals with MDD, and regular telephone follow-up to provide additional guidance and support.

Data Collection: Data collection took place from April to May 2023, following IRB approval and permission to conduct the study in the outpatient department of the designated hospital. The PI trained two registered psychiatric nurses as research assistants (RAs) to support data collection and the study process. RA 1 screened participants for eligibility, assigned them to either the experimental or control group as described in the sampling section and collected baseline sociodemographic data and pre-intervention scores for both groups. The experimental group received the SFT program, delivered by the PI, a psychiatric nursing instructor, and a certified SFT practitioner, alongside usual care. The control group received only usual care. While RA 1 was aware of group assignments, RA 2, who conducted outcome assessments one week post-intervention, remained blind to group status to minimize bias. Participants were also blinded to their group assignments.

Data Analysis: Data analysis was conducted using IBM SPSS version 26. The Shapiro-Wilk test showed significant deviations from normality for post-depression ($p = 0.001$) and post-self-esteem scores ($p = 0.003$). Consequently, the Mann-Whitney U test was applied to compare the median and interquartile range (IQR) of these scores between groups, as non-parametric methods are appropriate for non-normally distributed data.

Preliminary assumptions for the multivariate covariance (MANCOVA) analysis were assessed, including the equality of covariance matrices. Box's test was significant ($p = 0.001$), indicating a violation of this assumption. However, Levene's test confirmed equal variances for the post-self-esteem ($p = 0.71$)

and post-depression scores (p = 0.19). The balanced design with equal group sizes minimized sensitivity to these violations, contributing to the robustness of the analysis. Pillai's Trace was selected for MANCOVA due to its robustness against assumption violations, ensuring reliable results.

Chi-square and Fisher's exact tests were used to compare sociodemographic data for categorical variables between groups. Fisher's exact test reports only the p-value without a test statistic.[30] For continuous variables, descriptive statistics (mean, standard deviation, and minimum-maximum) were calculated, followed by independent t-tests to assess differences between groups. MANCOVA was used to compare post-self-esteem and post-depression scores between groups, with pre-self-esteem and pre-depression scores included as covariates due to their significant association with post-intervention outcomes.

Results

Sociodemographic data of participants

All 50 participants completed the study, with 25 in each group included in the analysis. The average age was 66.36 years (range 60-73 years). Most participants identified as Buddhist (94.0%), with the remaining 6.0% as Muslim. The majority were married and living with their spouse (52.0%). Regarding education, 66.0% had primary education or below, including no formal education. Regarding occupation, 52.0% were either in non-agricultural work or unemployed, and 64.0% participated in social activities. The average cognitive function score was 21.80 (range 16-28). Comparisons of sociodemographic characteristics, cognitive status, and pre-intervention scores showed no statistically significant differences between groups (**Table 1**).

Table 1. Sociodemographic data of two groups

Sociodemographic data	Experiment group (n = 25)	Control group (n = 25)	Statistic value	p-value
	Number (%)	Number (%)		
Gender			0.35	0.56[a]
Male	8 (32.0)	10 (40.0)		
Female	17 (68.0)	15 (60.0)		
Age (years),			-0.65	0.52[b]
Mean (SD)	66.04 (3.2)	66.68 (3.7)		
Min-Max	60-72	61-73		
Age groups (years)			0.08	0.78[a]
60-65	13 (52.0)	14 (56.0)		
66 and above	12 (48.0)	11 (44.0)		
Religion				1.00[c]
Buddhist	23 (92.0)	24 (96.0)		
Muslim	2 (8.0)	1 (4.0)		
Marital status			0.00	1.00[a]
Living alone	12 (48.0)	12 (48.0)		
Living with spouse	13 (52.0)	13 (52.0)		
Educational levels			0.80	0.37[a]
Primary or below	15 (60.0)	18 (72.0)		
Secondary or higher	10 (40.0)	7 (28.0)		
Current occupation			0.32	0.57[a]
Agriculture	11 (44.0)	13 (52.0)		
Other/Unemployed	14 (56.0)	12 (48.0)		

Table 1. Sociodemographic data of two groups (Cont.)

Sociodemographic data	Experiment group (n = 25)	Control group (n = 25)	Statistic value	p-value
	Number (%)	Number (%)		
Participation in social activities			0.35	0.56 [a]
Current	17 (68.0)	15 (60.0)		
None	8 (32.0)	10 (40.0)		
MMSE score				
Mean (SD)	21.48 (3.49)	22.12 (3.19)	-0.68	0.50 [b]
Min-Max	16-28	16-28		
No formal education,				
Min-Max	16-17	16-18		
Primary education,				
Min-Max	18-21	19-21		
Higher primary education,				
Min-Max	23-28	22-28		
Pre-depression score			0.00	1.00 [a]
Mild	19 (76.0)	19 (76.0)		
Moderate	6 (24.0)	6 (24.0)		
Pre-self-esteem score				1.00 [c]
Low	3 (12.0)	2 (8.0)		
Moderate	22 (88.0)	23 (92.0)		

Note. [a] = Chi-square test; [b] = Independent t-test; [c] = Fisher's exact test; MMSE = Thai Mini-Mental State Examination. The Thai Mini-Mental State Examination, pre-depression, and pre-self-esteem categories were used for screening. The pre-depression score was also used for participant matching.

Effectiveness of the SFT Program

MANCOVA results demonstrated significant differences between the SFT program and usual care in their effects on the two dependent variables after controlling for pre-intervention self-esteem and depression scores. Pillai's Trace was used to assess multivariate differences, ensuring robust analysis. Pre-depression scores in the matched-pair design ensured baseline similarity between the groups, while including pre-self-esteem and pre-depression scores as covariates enhanced the accuracy of the intervention's effect estimation. This approach improved internal validity by accounting for their significant associations with post-intervention scores.[31] The analysis revealed statistically significant group differences ($F = 283.01$, $p < 0.001$). Covariates, including pre-intervention self-esteem ($F = 7.94$, $p < 0.01$) and pre-intervention depression ($F = 30.72$, $p < 0.001$), were significantly associated with post-intervention outcomes. Effect sizes, calculated using partial eta squared (η^2_p), which is appropriate for MANCOVA, showed that the SFT program had a large effect on reducing depression ($\eta^2_p = 0.57$) and increasing self-esteem ($\eta^2_p = 0.26$), According to guidelines, a partial eta square value greater than 0.14 considered a large effect size[32] (**Table 3**). Post-intervention, participants in the experimental group (SFT program) presented significantly higher median self-esteem scores and lower median depression scores compared to the control group (Mann-Whitney U test = 1.00, $p < 0.001$ for both outcomes) (**Table 2**).

Table 2. Comparison of pre-and post-intervention depression and self-esteem scores between experiment and control groups

Variable		Experimental group	Control group	Mann-Whitney U	p-value
		Median (IQR) Mean Rank	Median (IQR) Mean Rank		
Self-esteem score (RSS)	Pre-self-esteem score	1.9 (1.7-2.1) 24.44	1.9 (1.75-2.1) 26.56	286.00	0.60
	Post-self-esteem score	2.9 (2.8-3.1) 37.96	2.2 (2.0-2.25) 13.04	1.00	< 0.001
Depression score (TGDS)	Pre-depression score	16.0 (14-18) 26.78	16.0 (14-17) 24.22	280.50	0.53
	Post-depression score	9.0 (9-10) 13.04	14.0 (12-15) 37.96	1.00	< 0.001

Note. IQR = Interquartile range

Table 3. Summary of the multivariate analysis of covariance (MANCOVA)

Multivariate Pillai's Trace Test				Univariate F				
Covariate	Value	F-value	p-value	Dependent variable	MS	F-value	p-value	Partial η^2
Pre-self-esteem score	0.26	7.94	< 0.01	Post-self-esteem score	0.43	15.97	< 0.001	0.26
Pre-depression score	0.58	30.72	< 0.001	Post-depression score	60.68	61.62	< 0.001	0.57
Group effect	0.93	283.01	< 0.001					

Note. MS = Mean square

Discussion

This study demonstrated that the SFT program significantly reduced depression and improved self-esteem among OA-WMDD, with large effect sizes (η^2_p = 0.57 for depression and η^2_p = 0.26 for self-esteem).[32] These findings align with prior evidence supporting the efficacy of SFT in enhancing mental health outcomes. For instance, Zhang et al. reported a moderate positive effect of SFT on psychosocial outcomes across children to adult groups in a systematic review and meta-analysis (Cohen's d = 0.34).[33] Similarly, Cooper et al. found significant reductions in depression (η^2 = 0.35) and anxiety (η^2 = 0.22) among adults in integrated care settings.[20] Wang et al. also observed reduced depressive symptoms (η^2_p = 0.03) through Solution-Focused Group Counseling among rural older adults in China.[13] Collectively, these findings highlight the broad applicability of SFT for addressing mental health challenges, including among older adults.

The program's effectiveness in improving self-esteem is particularly noteworthy. SFT's strengths-based, goal-oriented approach encouraged participants to focus on their resources and capabilities rather than limitations. Core techniques, including the miracle question, scaling questions, exception questions, and exchanging compliments, helped participants recognize their potential, set practical goals, and identify solutions to their challenges throughout the sessions. These findings align with previous research emphasizing the role of expressing strengths, fostering positive self-perceptions, and reflecting on past successes to enhance self-esteem.[13,34] The program also integrated culturally relevant themes and activities to address the unique challenges older adults face, providing emotional relief and opportunities to resolve unresolved issues in a supportive environment.[13] Since self-esteem in older adults often declines due to aging-related challenges, such as shifts in social roles and health,[35] SFT plays a vital role in helping them focus on their strengths, counteracting these declines.

In addition to enhancing self-esteem, the SFT program provided participants with practical tools to manage depressive symptoms tailored to their individual needs and contexts.[9,20] Participants developed a constructive mindset toward problem-solving by focusing on reframing problems, exploring solutions, and taking actionable steps. Techniques such as the Miracle Question helped participants visualize goals and devise clear, measurable steps to achieve them, fostering optimism and clarity.[36] The program also supported participants in understanding their depression and its impacts, equipping them with strategies learned during the sessions. This included viewing problems constructively, exploring options, taking actionable steps, and evaluating outcomes, all contributing to reducing depressive symptoms. This approach aligns with prior research highlighting SFT's focus on alleviating functional impairments caused by depression rather than addressing its root causes, fostering a collaborative and positive therapeutic relationship.[9,10] However, increases in self-esteem and reductions in depression were also observed in the control group, suggesting external factors such as life stability, family support, or routine healthcare access may have contributed to positive changes. Additionally, participation in the study may have provided participants with a sense of attention and care, influencing their overall sense of well-being.

The strengths of SFT lie in its focus on existing resources and future goals, empowering participants to take proactive steps to improve their mental health. This study adds to the evidence supporting SFT's effectiveness in enhancing self-esteem and reducing depressive symptoms among older adults.[13] Furthermore, SFT's adaptability has demonstrated success across diverse populations and settings, highlighting its flexibility as a therapeutic approach.[9,15] In conclusion, SFT provides a safe and structured method for addressing MDD in this vulnerable population, emphasizing self-esteem enhancement and depression reduction.

Limitations and Recommendations for Further Study

This study has several limitations that should be considered when interpreting the findings. First, it was conducted in Southern Thailand with a culturally specific population, which may limit the generalizability of the results to other regions, cultural contexts, or demographic groups. Future research in more diverse populations is needed to evaluate the boarder applicability of these findings. Second, this study assessed only short-term outcomes only one week post-intervention, leaving the long-term effectiveness of the SFT program uncertain. Future studies incorporating follow-up assessments could provide insights into the sustainability of the program's effects over time. Third, potential violations of MANCOVA assumptions, such as the equality of covariance matrices, may have affected the robustness of the statistical analysis. Larger sample sizes in future research could enhance statistical power, minimize assumption violations, and improve the reliability of the results.

Additionally, while this study demonstrated significant improvements in self-esteem and reductions in depressive symptoms, external factors such as natural recovery, family support, and study participation may have influenced these outcomes. To better understand the specific impacts of the SFT program, future research could include qualitative methods, such as interviews or focus groups, to explore participants' experiences and identify how specific elements of the intervention contributed to changes in self-esteem and depression.

Conclusions and Implications for Nursing Practice

This study highlights the potential of SFT to complement traditional nursing practices in addressing the mental health needs of OA-WMDD. SFT was

associated with improved self-esteem and reduced depressive symptoms. Effective implementation requires comprehensive training to ensure fidelity and consistency. Structured training programs for nurses and healthcare professionals could build the competencies needed for clinical practice. Integrating SFT into existing mental health care frameworks may enhance access to personalized care for older adults with depression. From a policy perspective, incorporating SFT training in professional development programs and promoting its application in primary care and community settings could help address the mental health needs of aging populations.

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Appendix

Table A1. Session, objective, and activities of the Solution-Focused Therapy Program

Week/Session	Objectives	Activities
Week 1 Session 1 (60-90 minutes)	Build rapport, explore the personal context of their depression and its impact, and identify strengths to establish a foundation for solutions and self-esteem	1. Greet participants and create a relaxed atmosphere 2. Use *Coping Questions* (e.g., "What has helped you manage your daily activities despite feeling depressed?") 3. Apply *Normalizing* (e.g., "Many people facing similar challenges feel the way you do—it's a common part of the process.") 4. Offer *Compliments* to highlight strengths (e.g., "It's impressive how you've managed despite the challenges.") 5. Introduce *Exception Questions* by asking, "Can you recall a time when you felt less affected by depression? What was different then?" 6. Assign *homework*: Reflect on how depression affects daily life and document findings
Session 2 (60-90 minutes)	Recognize their potential, provide emotional relief, and reflect on past successes to enhance self-esteem	1. Begin with a greeting and discuss events from the past week. Review Session 1 content and homework 2. Actively listen to identify resources and strengths from past experiences to facilitate *Reframing*, e.g., reframing "I've always struggled to keep up with daily tasks because of my low energy" as "It sounds like you've found ways to keep going despite feeling low energy—this shows resilience and determination. Let's explore what's worked for you in the past to build on those strengths." 3. Facilitate a discussion on self-care experiences during illness, using *Normalizing* to frame physical and mental illness as natural aspects of life 4. Use the *Miracle Question* (e.g., "If a miracle resolved your depression overnight, what would be different tomorrow?") 5. Revisit *Exception Questions* to identify small successes in self-care or improvement 6. Apply *Scaling Questions* (e.g., "On a scale of 1-10, where are you now, and what helped you get here?") 7. Offer *Compliments* to validate progress and strengths 8. Design actionable self-care tasks and assign as *homework*
Week 2 Session 3 (60-90 minutes)	Reframe problems and identify strengths and solutions to enhance coping, resilience, and self-esteem	1. Greet participants, discuss events from the past week, and review Sessions 1 and 2 2. Discuss sources of distress and explore coping strategies, applying *Reframing* to encourage perspective shifts 3. Use *Normalizing* to emphasize that distress is a common experience 4. Apply the *Miracle Question* to envision solutions and identify exceptions 5. Revisit *Exception Questions* to identify past instances of effective coping 6. Revisit *Scaling Questions* to assess coping levels and explore actionable steps to reduce distress 7. Offer *Compliments* to highlight resilience (e.g., "Your ability to handle these situations shows real strength.") 8. Assign a reflective activity based on coping strategies as *homework*

Table A1. Session, objective, and activities of the Solution-Focused Therapy Program (Cont.)

Week/Session	Objectives	Activities
Session 4 (60-90 minutes)	Encourage solution-focused thinking and enhance self-esteem through reflection and positive reinforcement	1. Greet participants, review Sessions 1-3, and discuss events from the past week 2. Explore positive and negative thinking patterns and their impact on depression, using *Reframing* to encourage perspective shifts 3. Facilitate a discussion on positive thinking and problem-solving with *Normalizing* to highlight its effectiveness 4. Apply *Compliments* to validate participants' strengths and efforts in adopting positive thinking 5. Use *Metaphors* to explain concepts like resilience (e.g., "Your self-esteem is like a tree that grows stronger with care") 6. Apply the *Miracle Question* to identify solutions and reflect on times of reduced distress 7. Revisit *Exception Questions* to explore previous instances of successful problem-solving 8. Use *Scaling Questions* to assess progress and set goals for improving self-worth and managing sadness. Collaborates to identify resources and strengths to develop activities that help them progress to a higher level on the scale 9. Collaborate to create an actionable activity based on scaling responses and assign *homework* for the next session
Week 3 Session 5 (60-90 minutes)	Reframe stressors, build on past successes, provide practical tools to manage depressive symptoms and enhance coping skills	1. Greet participants, review Sessions 1-4, and discuss events from the past week 2. Facilitate a discussion on current stressors and coping strategies. Encourage participants to share experiences and identify key points for *Reframing* 3. Use *Normalizing* to highlight that stress is a common experience, encourage sharing past coping strategies, and provide practical tools to manage depressive symptoms, such as time management for problem-focused coping and relaxation exercises for emotion-focused coping 4. Provide *Compliments* for managing past challenges 5. Apply the *Miracle Question* to help participants envision desired outcomes and reflect on times when they felt less stressed 6. Revisit *Exception Questions* to explore past moments of reduced stress and identify strategies for replication 7. Use *Scaling Questions* to assess participants' ability to manage stress and collaborate on identifying resources and strategies to improve their scale level 8. Design an activity based on Scaling responses and assign it as *homework* for the next session

Table A1. Session, objective, and activities of the Solution-Focused Therapy Program (Cont.)

Week/Session	Objectives	Activities
Session 6 (60-90 minutes)	Reflect on progress, affirm strengths, set goals to sustain changes and support growth	1. Greet participants, review Sessions 1-5, and discuss events from the past week 2. Discuss participants' reflections on changes experienced during the six sessions, including shifts in perspective and feedback from others 3. Facilitate a review of self-perception before and after therapy. Using *Scaling Questions* (e.g., "On a scale of 1-10, where are you now compared to the beginning?") 4. Provide *Compliments* to affirm progress and strengths 5. Use *Exception Questions* to discuss moments when participants felt most in control and how they can replicate these successes 6. Discuss maintaining progress (e.g., "What will help you sustain these changes?") 7. Highlight participants' achievements and progress, emphasizing their strengths and the potential for small steps to lead to significant future changes 8. Conclude therapy by highlighting participants' achievements and potential for future growth

Note: Each session lasts 60-90 minutes, with the duration adjusted to accommodate individual needs within the group setting.

โปรแกรมการบำบัดแบบเน้นการหาทางออกต่อความรู้สึกมีคุณค่าในตนเองและภาวะซึมเศร้าของผู้สูงอายุโรคซึมเศร้า : การศึกษากึ่งทดลอง

ไพจิตร พุทธรอด วิภาวรรณ ชะอุ่ม เพ็ญสุขสันต์ จารุวรรณ ศุภศรี*

บทคัดย่อ: โรคซึมเศร้าเป็นหนึ่งในปัญหาสุขภาพจิตที่พบได้บ่อยทั่วโลก ผู้สูงอายุเป็นกลุ่มที่มีความเปราะบาง เนื่องจากมีปัจจัยหลายประการที่เพิ่มความเสี่ยงต่อการเกิดภาวะซึมเศร้า ดังนั้นจึงจำเป็นต้องมีวิธีการบำบัดที่มีประสิทธิภาพเพื่อลดปัญหานี้ การศึกษาแบบกึ่งทดลองด้วยการวัดผลก่อนและหลังการทดลองแบบมีกลุ่มควบคุมครั้งนี้ มีวัตถุประสงค์เพื่อประเมินประสิทธิผลของโปรแกรมการบำบัดแบบเน้นการหาทางออกต่อการเพิ่มความมีคุณค่าในตนเองและลดภาวะซึมเศร้าในผู้สูงอายุโรคซึมเศร้า ภาคใต้ ประเทศไทย โปรแกรมการบำบัดแบบเน้นการหาทางออก มุ่งเน้นการหาวิธีแก้ไขปัญหาแทนการมุ่งเน้นปัญหา ช่วยให้บุคคลสามารถระบุและใช้ประโยชน์จากจุดแข็งและทรัพยากรของตนเองเพื่อเอาชนะความท้าทาย กลุ่มตัวอย่างจำนวน 50 คน ใช้วิธีการสุ่มตัวอย่างแบบเจาะจง จับคู่ด้วยระดับคะแนนภาวะซึมเศร้า โดยกำหนดให้เข้ากลุ่มทดลองที่ได้รับโปรแกรมการบำบัดแบบเน้นการหาทางออก 25 คน หรือกลุ่มควบคุมที่ได้รับการดูแลตามปกติ 25 คน วัดคะแนนความมีคุณค่าในตนเองและภาวะซึมเศร้าก่อนและหลังการทดลอง โดยใช้แบบประเมินความมีคุณค่าในตนเองและแบบประเมินภาวะซึมเศร้า วิเคราะห์ข้อมูลด้วยสถิติวิเคราะห์ความแปรปรวนร่วมแบบพหุ

ผลการศึกษาพบว่า กลุ่มตัวอย่างในกลุ่มทดลองที่ได้รับโปรแกรมการบำบัดแบบเน้นการหาทางออกมีคะแนนความมีคุณค่าในตนเองสูงและคะแนนภาวะซึมเศร้าต่ำกว่ากลุ่มควบคุมอย่างมีนัยสำคัญทางสถิติ 1 สัปดาห์หลังสิ้นสุดโปรแกรม แสดงให้เห็นว่าโปรแกรมการบำบัดแบบเน้นการหาทางออก เป็นการบำบัดที่สามารถเพิ่มความรู้สึกมีคุณค่าในตนเองและลดภาวะซึมเศร้าในผู้สูงอายุโรคซึมเศร้า พยาบาลผู้ได้รับการอบรมโปรแกรมการบำบัดแบบเน้นการหาทางออกสามารถนำโปรแกรมนี้ไปใช้ปฏิบัติงานในคลินิกเพื่อตอบสนองความต้องการอย่างเฉพาะเจาะจงในประชากรกลุ่มนี้ ควรมีการศึกษาหลายพื้นที่และเป็นการศึกษาระยะยาวเพื่อติดตามการเปลี่ยนแปลงความรู้สึกมีคุณค่าในตนเองและภาวะซึมเศร้าและเพื่อประเมินผลระยะยาวของโปรแกรม

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คำสำคัญ: โรคซึมเศร้า ผู้สูงอายุ ความมีคุณค่าในตนเอง การบำบัดแบบเน้นการหาทางออก

ไพจิตร พุทธรอด *หัวหน้าสาขาการพยาบาลสุขภาพจิตและจิตเวช วิทยาลัยพยาบาลบรมราชชนนี ตรัง คณะพยาบาลศาสตร์ สถาบันพระบรมราชชนก*
E-mail: paijit@bcnt.ac.th
ติดต่อที่ : วิภาวรรณ ชะอุ่ม เพ็ญสุขสันต์ *รองศาสตราจารย์ สาขาการพยาบาลสุขภาพจิตและจิตเวช คณะพยาบาลศาสตร์ มหาวิทยาลัยราชภัฏสุราษฎร์ธานี*
E-mail: wipawan.pen@sru.ac.th
จารุวรรณ ศุภศรี *อาจารย์ประจำสาขาการพยาบาลสุขภาพจิตและจิตเวช วิทยาลัยพยาบาลบรมราชชนนี ตรัง คณะพยาบาลศาสตร์ สถาบันพระบรมราชชนก*
E-mail: Jaruwans@bcnt.ac.th