

Effect of Cognitive Mindfulness Practice Program on Depression among Elderly Thai Women

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Abstract: Depression is a leading mental health problem and a significant contributor to human suffering and disability, especially among the elderly. Elderly women are known to be more prone to depression than are men. Using a two group, pretest-posttest, control group design, this study sought to determine if a cognitive mindfulness practice program reduced depression among elderly Thai women, with mild to moderate depression, receiving care at a community center in Chiang Mai. Participants were randomly assigned to either the experimental or control group.

The experimental group participated in a cognitive mindfulness practice program developed by the primary researcher. The control group received typical emotional support and nursing care from community nurses at the community center. Each participant's level of depression was assessed: (a) prior to the start of the program's protocol; (b) upon program completion; and, (c) three months thereafter. Data were analyzed using descriptive statistics, two-way mixed-design ANOVA, independent sample t-test and ANCOVA.

Those who participated in the cognitive mindfulness practice program, compared to those who did not participate in the program, had a greater decrease in depression scores upon completion of the program and three months after completion of the program. Findings suggest the program may have contributed to changes in the level of depression among those who participated in the program. Nurses educated, and trained, in the use of the cognitive mindfulness program, potentially, could provide a non-biological, culturally appropriate intervention for the treatment of mild to moderate depression among elderly Thai women.

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Introduction

Depression is one of the leading human mental health problems and a major cause of human suffering and disability. The World Health Organization (WHO) reported, in 2002, that approximately 121 million people suffer from depression, and that the burden of depressive

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disorders has been increasing.¹ The same WHO report predicted that, by 2020, depression will be the second greatest disease burden worldwide. Numerous epidemiological studies have found the female to male prevalence ratio of depression to be approximately 2 to 1.^{2, 3} WHO has estimated that 9.5% of women and 5.8% of men experience a depressive episode in any given year.¹ A prospective, 6-year, study of a community-dwelling older population, found women more prone than men to be depressed at five different points in time ($p < .001$), as well as more likely to remain depressed.⁴ Women have been found to be more prone to depression due to the stressors associated with managing multiple roles, including family, social, and cultural demands and emotional attachments placed upon them.⁵

The Department of Mental Health, in Thailand, revealed that 116,847 Thais suffer from depression, with a prevalence rate of 185.98 per 100,000 population.⁶ In Chiang Mai, 3,430 people were diagnosed with depression.⁶ In addition, the prevalence rate of major depression among elderly Thai women was 20.9%, compared to 13.85 among elderly Thai men.⁷ These findings are similar to the 39.7% prevalence rate found among the elderly in the municipal area of Kamphaeng Phet, wherein 20.3% had mild depression, 11.5% moderate depression and 7.9% severe depression.⁸ Given the increasing prevalence of depression, especially among elderly women, the purpose of this study was to assess the effect a researcher developed cognitive mindfulness program would have upon the level of depression among elderly Thai women.

Review of Literature

In the United States of America (USA), individuals 65 years of age and older have been reported to: suffer from forms of depression other than major depression; have greater risks of

developing major depression, physical disabilities and medical illnesses; and, have increased utilization of available health services.⁹ In addition, the prevalence of elderly community-dwellers, in the USA, with mild to moderate depression has been shown to range from 13% to 27%, with a high of 50% among elderly ill and nursing home residents.¹⁰ Furthermore, depressive symptoms have been found to affect 8% to 20% of community-dwelling elderly, with more American women than men being so affected.¹¹

Symptoms of depression in the elderly are similar to those found in younger individuals and may include, but are not limited to: fatigue; loss of appetite; insomnia; difficulty concentrating; loss of interest in life; feelings of emptiness, guilt, sadness and hopelessness; and, wishing to die, which may lead to suicide.¹² Depression in the elderly, brought about by psychosocial stress or the physiological effects of disease, can lead to: disability; cognitive impairment; suffering; family disruption; increased symptoms of medical illness; increased utilization of health care services; and, increased rates of suicide and non-suicide mortality.^{13, 14}

Depression in the elderly can be diminished in severity by a number of intervention strategies, i.e. medications; individual and group psychotherapy; and, behavioral interventions, including cognitive therapy (CT).^{15, 16, 17} Although antidepressant drugs can be used to effectively treat depression in the elderly, the medications usually are absorbed and eliminated more slowly and produce more side effects among the elderly than among younger age groups.

Meta-analyses of prior studies have shown that CT is one of the most effective cognitive interventions for elderly with mild and moderate depression.^{15-16, 18-21} According to Beck's Cognitive Theory of Depression, one's automatic negative thoughts (repetitive, unintended and uncontrollable) affect one's feelings and behavior, leading to depression.²² CT is a structured, short-term, present-

oriented psychotherapy, found to help individuals alleviate depressive symptoms by identifying their automatic negative thoughts and altering their thinking, so as to bring about enduring emotional and behavioral changes.^{22, 23} Although CT has been shown to be an effective treatment for depression among the elderly, its generalizability remains questionable,^{15,16,20} in light of the fact depressed elderly individuals often fail to acknowledge having automatic negative thoughts or other symptoms of depression.²⁴ It appears the use of CT to treat depressed elderly persons requires its' adaptation to address one's aging process and culture. One such possible adaptive intervention, in Thailand, could be incorporation of the use of mindfulness with CT, since the practice of mindfulness is well-known and practiced by the elderly.

Mindfulness ("sati") is the activity of reflecting, with non-judgmental observation, on what presently is happening.²⁵⁻²⁶ Four foundations of mindfulness comprise the main principles of mindfulness practice, which leads one to be fully present in each moment. In other words, it helps one may continuously and consciously aware of his/her body, feelings, mind and mental objects.²⁷

The four foundations of mindfulness consist of contemplation of one's body, feelings, mind and mental objects.²⁷ Such contemplation has the aim of: 1) seeing one's body merely as a body (practiced by doing mindful walking and observation of the rising and falling of your abdomen); 2) becoming aware of conditions that arise through experiencing pleasant, unpleasant and neutral feelings; 3) being aware of conditions, i.e. distraction and unfocused thinking, that arise in one's mind; and, 4) becoming aware of one's six senses (seeing, hearing, smelling, tasting, touching and proprioception). Mindfulness practice requires one to pay attention to his/her thoughts without judgment or reaction, and to accept them as they are experienced. In this manner, mindfulness functions as a way for one to become

aware of his/her thoughts, and to make a cognitive connection between his/her thoughts and depressive symptoms.

CT, on the other hand, provides the forum in which one begins to construct cognitive ability to: understand his/her depressive thoughts; not engage in thinking about the past; or, not fear what may happen in the future. In other words, CT helps one focus on the feelings being experienced at the moment.²⁸ With CT, one must recognize and identify the thoughts being experienced, i.e. automatic negative thoughts, analyze his/her thoughts, using a rational thinking process, and create a logical response to his/her thoughts.

Although, the incorporation of CT and Mindfulness has been recognized by the United Kingdom's National Health and Clinical Excellence,²⁸ as an effective intervention in the treatment of depression, studies showing a significant linkage between the use of CT and Mindfulness in the treatment of depression are missing. Although the use of CT in the treatment of depression has been found effective,^{15, 16, 20} review of randomized trials regarding use of CT and Mindfulness for treatment of depression reveals little evidence that individuals with three or more incidences of depression experience more benefit than they would from usual care.²⁹ While prior studies suggest support for the use of mindfulness, as a complimentary treatment for anxiety disorders³⁰ and stress reduction,³¹ and it has been used in an 8-week mindfulness-based CT program,³² the linkage of mindfulness with CT, in the treatment of depression, does not appear to have been investigated.

Unlike CT, little emphasis is placed on changing the content of one's thoughts when using a mindfulness-based CT (MBCT) program. Rather the focus of MBCT is to teach individuals to become more aware of their thoughts and change the relationship of their thoughts. Thus, cultivation of their detached relationships to their

depression-related thoughts and feelings are felt to be central in providing one skills to prevent escalation of negative thinking patterns at time of potential recurrence.^{32, 33} However, this has not been shown to be effective in treating individuals who are depressed.³² The researchers, however, still recommend the use of CT to help change one's automatic negative thoughts.^{32, 33}

Thus, an innovative, cognitive-mindfulness practice program (CMPP), based on mindfulness practice centered on the four foundations of mindfulness and the principles of CT, was developed by the primary researcher. The purpose of the CMPP was to determine whether elderly Thai women, with mild to moderate depression, would demonstrate lower levels of depression upon completion of the CMPP, as well as three months after completion of the program, compared to elderly Thai women who did not participate in the program. The goal of the program was to improve the women's ability to be aware of their body, feelings, mind and mental-objects. Thus, the CMPP was designed to help participants consciously identify automatic negative thoughts and problems, and develop alternative thinking patterns and problem-solving skills.

Method

Design

A two group, pretest-posttest, control group design was used to examine the effect of a cognitive mindfulness practice program among elderly Thai women with mild to moderate depression.

Sample

The sample consisted of 60 to 80 year old women, who were: residents of the Chiang Mai communities of Wat Kawnkama and Nongseang;

literate and fluent in Thai; able to obtain a score of 10 to 29 on the Beck Depression Inventory (BDI-IA);³⁴ and, able to score 26 or higher on the Mini-Mental State Exam (MMSE).³⁵ Potential subjects were excluded if they: had a previous psychiatric history; were undergoing treatment for depression or other psychiatric illness; were terminally ill; or, had suicidal ideations. Discontinuation criteria included: encountering complications, i.e. back or leg pain, during the program; being unable to participate in all intervention sessions; or, desiring to discontinue participation in the program.

Sample size was determined through Polit and Beck's³⁶ estimates for ANOVA. Eta-squared, which equals the sum of squares divided by the total sum of squares, was used to estimate the effect size. A similar study used an estimated sample size of 26 subjects per group.³⁷ However, due to potential dropout, 30 subjects per group were recruited for the study. Six participants, 3 from the experimental group (due to sickness) and 3 from the control group (due to travel and illness) dropped out during the study. Therefore, 54 participants remained, with 27 in each group.

Procedure

The study was approved by the Research Ethics Committee of the primary investigator's university. Each potential subject was: provided an explanation and written description of the study's purpose and procedure; told of potential participation risks and benefits of their participation; assured confidentiality and anonymity would be maintained; and, informed she could withdraw at any time, without negative ramifications. A code list, including participants' names, was kept separate from the code sheets. Only code numbers were placed on the questionnaires. Each participant's name and respective coded questionnaires were maintained in a locked cabinet.

Data collection and intervention were conducted over eight months (October 2006 – May 2007). Multistage cluster sampling was used to obtain the participants. First, two counties were randomly selected from the counties within the Chiang Mai municipality. Then, two communities, one from each of the two counties, were randomly selected from a list of communities provided by the municipality office. Names of potential subjects also were obtained from the municipality office. Finally, ninety-eight potential subjects (50 at Nongseng and 48 at Wat Kwankama), who meet the selection criteria, were randomly selected from the names provided.

After agreeing to participate and signing the informed consent form, they were randomly assigned, using simple random sampling, to either the experimental or control group, and informed how to complete each of the three research instruments. Those who failed to obtain a score of 10 to 29 on the BDI-IA, as well as a score of 26 or higher on the MMSE, were thanked for their time and informed they did not meet all of the selection criteria and, therefore, were not able to participate in the study. Thirty-eight were excluded because of inadequate scores.

After completion of the three research instruments, 15 experimental group subjects at Wat Kwankama and 15 experimental group subjects at Nongseng participated in a cognitive-mindfulness practice program (CMPP) lead by the primary researcher. All subjects in the two control groups (15 participants in both communities) received typical support and care, consisting of a monthly health assessment by the community nurse and activities of daily living, without interference from the researcher. None reported any emotional or physical difficulties.

The 4-week CMPP was implemented once all subjects were enrolled in the study. Intervention sessions were held at the community hall in each

community. The experimental group was provided the CMPP intervention in a private room in the respective community hall. The experimental group subjects agreed to not discuss any aspect of their participation in the intervention with the control groups' participants. In addition, the control group subjects were blinded to the activities related to the interventions provided to the experimental group.

Participants in the experimental group continued to receive typical support and care from the community nurses, in addition to the CMPP intervention. Those in the control group only received the typical support and care from the community nurses. However, recognizing the rights of the participants, those in the control group were placed on a waiting list to later participate in the CMPP.

Research Instruments

Data were collected through use of 3 instruments. They were the: Demographic Data Questionnaire; Beck Depression Inventory (BDI-IA); and, Mini-Mental Examination (MMSE). The administration of the instruments, at all points in time, took place in a private room in the community hall.

The Demographic Data Questionnaire was constructed by the primary researcher to obtain information about each participant's: age, marital status, educational level and religious preference. Participants completed the questionnaire in 10 minutes.

The Beck Depression Inventory (BDI-IA),³⁸ is a 21-item, self-report, questionnaire designed to measure the intensity of depression, both in a hospital and community setting, by assessing 13 psychological and 8 physical aspects of depression. Each psychological symptom is assessed on a Likert-like scale from 0 to 3, where 0 = "I do not feel sad" and 3 = "I am so sad or unhappy that I can't stand it." Subjects' physical

symptoms are assessed via their report of the feelings they experienced the past week, as well as on the day of the inventory. Clinical interpretation of achieved scores is accomplished through criterion referenced procedures, utilizing the following ranges: 0–9 = normal or minimal depression; 10–16 = mild depression; 17–29 = moderate depression; and, 30–63 = severe depression.³⁸ The internal consistency for the BDI-IA has been found to be 0.85.³⁹ After permission was granted, the BDI-IA was translated into Thai, by Sriyoung,⁴⁰ with reported alpha coefficients of 0.78 to 0.92. For the purpose of this study, the translated instrument was tested on 12 elderly women from the Maesa sub-district, Chiang Mai, who had characteristics similar to the study subjects. The results yielded a Cronbach's alpha coefficient of 0.88. The Cronbach's alpha coefficient, for the instrument, in this study was 0.80. Subjects took 10 to 20 minutes to complete the inventory.

The Mini-Mental Status Exam (MMSE), developed by Folstein,³⁵ is an 11-item tool used to screen for cognitive loss and dementia. It is a structured scale consisting of 30 points grouped into seven categories: orientation to place, time, registration, attention, concentration, recall, language and visual construction. Scores of: 27 or higher are considered to indicate absence of cognitive impairment; 20 to 26 imply mild cognitive impairment; 10 to 19 reveal moderate to severe cognitive impairment; and, less than 10 show severe cognitive impairment. The exam is designed to be administered by health care professionals or technicians who have received minimal instruction in its use.³⁵ It takes 5–10 minutes to complete the exam. The MMSE has been translated into Thai, tested and adapted by the Department of Mental Health, Public Health Ministry of Thailand, and used in general practice among mental health providers throughout Thailand.^{41–42}

Intervention

Prior to implementation of the CMPP, the procedure was pilot-tested using 12 persons, who had mild to moderate depression and met the study's selection criteria. The women were asked to provide feedback regarding the program's two phases (three procedural steps). Given their feedback, no major changes were made in the procedure.

The CMPP consisted of two phases, including 11 sessions over 4 weeks. Phase 1, mindfulness practice took six hours daily for 5 days the first week. Phase 2, cognitive therapy, required participants to practice 3 hours every Tuesday and Thursday the following 3 weeks. CT practice involved having participants: recognize their automatic thoughts; perform logical analysis of their automatic thoughts; and, generate rational responses and problem-solving abilities, as needed, to deal with their automatic thoughts. The program was designed so that as the participants' overall awareness increased, their misinterpretation of their thoughts and their unrealistic thinking would decrease and they would be better able to identify automatic negative thoughts when becoming depressed or having mood swings. The CMPP was conducted by the primary researcher, who had received education and training in cognitive therapy and mindfulness practice.

Phase 1: Mindfulness Practice

During the first week of the program, mindfulness practice was conducted, in a group setting in the respective community hall, from Monday through Friday, from 9 am to 3 pm, with a 15 minute break each morning and afternoon. Prior to each mindfulness practice session, the researcher explained the goal of mindfulness practice was to increase the participants' perception of their body movements and thoughts through the practice of "mindful walking" and "mindful observation of the rising and falling of their

abdomen.” These techniques allowed subjects to increase their ability to become aware of their thoughts and body movements.

Participants then were instructed to do “mindful walking,” through acknowledgement of the sensations in their feet, and “mindful observation of the rising (upward movement) and falling (downward movement) of their abdomen.” They also were encouraged to become aware of their mood by focusing attention on what was occurring at the time they became aware of what had their attention. Such awareness materialized through one or more of their six senses.

The researcher held a discussion with the participants, during their practice of “mindful walking” and “mindful observation of the rising and falling of their abdomen” sessions, to evaluate the outcome of their practice. Participants were asked if they had encountered anything they felt interfered with their practice. When necessary, the researcher discussed with them how they might manage barriers and/or distracters in the future.

Phase 2: Cognitive therapy

The CT component of the program began the second week and continued for three weeks. Sessions 6 and 7 occurred on Tuesday and Friday of the second week of the program. Session 8 occurred, from 9 am to 12 noon, on Tuesday of the third week of the program. Each session began with the subjects doing 30 minutes of mindfulness practice followed by the researcher giving: general information about depression; the CT model; automatic negative thoughts; and, how thoughts, moods and behaviors are connected. The researcher then conducted a group discussion to assist participants in recognizing their automatic thoughts and identifying feelings and symptoms of depression, by using a change in emotion as a cue to initiate self-monitoring of what was going through their mind.

Session 9 occurred, from 9 am to 12 noon, on Friday of the third week, while session 10 took place, from 9 am to 12 noon, on Tuesday of the fourth week. Both sessions began with the participants doing 30 minutes of mindfulness practice. During each session, the researcher conducted a debriefing session, designed for the purpose of assisting participants in reviewing their verbalized statements by examining: evidence that either seemed to support the accuracy or contradiction of their statements, and their thoughts, cognitive distortions and alternatives. Then through use of the Socratic method,^{22, 43} questions such as “What is the evidence to support this thought?”; “Are there any alternative interpretations?”; and, “How will you manage them, if your interpretations are true or false?” were asked to assist the subjects connect their verbalized statements with their thoughts.

The final session (11th) was conducted, from 9 am to 12 noon, the fourth Friday of the program. It began with participants doing 30 minutes of mindfulness practice prior to the researcher instructing them how to problem-solve, by: (a) brainstorming to generate solutions, without evaluating them; (b) listing advantages and disadvantages of each proposed solution; (c) choosing the solution, based upon the importance of the pros and cons listed, that seems best; and, (d) taking concrete steps to carry out the solutions.

Upon completion of the CMPP, participants were asked what benefits they felt they had received from the intervention. In addition, after establishing a date and time to collect data from both the experimental and the control group participants, they were brought together and administered the BDI-IA. Three months after completion of the CMPP, members of both the experimental and control groups were telephonically contacted, brought together and again administered the BDI-IA at the same time.

Data Analysis

Descriptive statistics, Chi-square, Fisher's exact test, two-way mixed-design ANOVA, independent t-test, analysis of covariance (ANCOVA) and repeated measures analysis of variance (ANOVA) were used to analyze the data, based on the assumptions of each statistics. Independent t-tests were used to compare the baseline depression scores of the participants in the experimental group (CMPP) and those who did not participate in the program (control group).

Results

Both the experimental and control group demonstrated no statistical differences in demographic characteristics (See **Table 1**). Subjects predominantly were: in their late sixties; had no spouse present; educated at the primary school level; and, Buddhist. Although two of the subjects in the experimental group were Christian, they did not encounter difficulties relating to the Buddhist principles that guided the mindfulness component of the intervention. In addition, the researcher reminded them they could practice mindfulness while praying or worshipping in their church.

Table 1 Demographic variables of experimental and control group

Demographics	Experimental group (n= 27)		Control group (n= 27)		Test Value	p-value
	n	%	n	%		
Age (mean in years)	69.81		68.70		.672 ^t	.51
60-69	16	59.3	18	66.7		
70-80	11	40.7	9	33.3		
Marital status						
Single	1	3.7	2	7.4	.527 ^a	.768
Married	12	44.4	13	48.2		
Widow/Separated	14	51.9	12	44.4		
Educational level						
Primary school	24	88.9	23	85.2	2.221 ^a	.528
Secondary school	2	7.4	3	11.1		
Diploma			1	3.7		
Bachelor degree	1	3.7				
Religion						
Buddhism	25	92.6	27	100	2.077 ^b	.491
Christian	2	7.4				

Note: t = t-test; a = Chi-square test; b = Fisher's exact test.

The experimental group demonstrated higher depression scores than did those in the control group (see **Table 2**). Due to their significant difference, ANCOVA was conducted, with the baseline score as the covariate, to analyze the mean differences in depression scores, in both groups,

upon program completion and three months thereafter. After controlling the baseline depression scores, a significant difference in depression scores between the experimental group and the control group remained upon program completion; as well as three months thereafter (see **Table 2**).

Table 2 Comparison of mean depression scores between experimental and control group at baseline, CMPP completion and three months thereafter

Time	Mean depression score (SD)		Test value	p-value
	Experimental group (n= 27)	Control group (n= 27)		
1	20.48(6.26)	15.15(5.45)	3.34 ^t	.002*
2	10.70(5.26)	18.15(6.09)	39.71 ^r	.000**
3	9.26(5.09)	15.37(5.64)	29.04 ^r	.000**

Note: Time 1 = baseline; Time 2 = completion of CMPP; Time 3 = three months thereafter; t = independent t-test; r = ANCOVA; **p<.001; *p <.05

To compare the depression scores, in both the control and experimental groups, at baseline with scores at program completion and three months thereafter, a one-way repeated measures ANOVA was conducted. When compared to the baseline scores, significant changes in depression

scores were found, in both groups, upon program completion and three months thereafter. The depression scores among the experimental group markedly decreased over time, while the control group scores had little change over time (see **Table 3**).

Table 3 Comparison of changes in depression scores between experimental and control group at baseline, CMPP completion and three months thereafter

Source of variation	SS	df	MS	F	p-value
Experimental	2012.67	2	1006.33	60.38	.000**
Control	150.89	2	75.44	4.24	.02*

Note: **p<.001; *p<.05

Upon post-hoc comparison of treatment pairs, a significant decrease in mean depression scores was revealed, in the experimental group, between baseline and upon program completion, and between baseline and three months after

program completion. Among the control group, a significant increase was found, in mean depression scores, between baseline and program completion (see **Table 4**).

Table 4 Pair-wise comparisons of depression scores between various points of measurement among experimental and control group

Group	Phase	Mean difference	SD	p-value
Experimental	1 and 2	9.778	1.258	.000**
	1 and 3	11.222	1.244	.000**
	2 and 3	1.444	.757	.203
Control	1 and 2	-3.000	1.085	.031*
	1 and 3	-0.222	1.135	1.000
	2 and 3	2.778	1.219	.093

Note: Phase 1 = baseline; Phase 2 = completion of CMPP; Phase 3 = three months thereafter; **p<.001; *p<.05

Discussion

Results suggest the CMPP may have contributed to a change in the participants' depression scores. The experimental group demonstrated a significant depression score reduction after participation in the program, compared to the control group.

Those in the experimental group indicated they participated daily in the CMPP. Such active engagement is similar to prior findings,³⁷ and possibly contributed to the decrease in the depression scores. Walker and Clarke,¹⁶ found older adults, who are actively engaged in cognitive behavioral therapy (a combination of cognitive and behavioral therapy based on Learning Theory) are more likely than younger adults to demonstrate more commitment to therapy, and to find it useful.

In addition, it has been noted that younger individuals tend to have higher rates of non-attendance and dropout from cognitive behavioral therapy than do older adults.¹⁶

Upon completion of the CMPP, participants reported their mindfulness practice was helpful to them in becoming aware of and detecting the presence of their automatic negative thoughts and feelings. Before entering the program, they reported being unaware of their negative thoughts and feelings, as well as their depressive symptoms. This is congruent with prior findings wherein elderly individuals with depression have been found to be less likely, than younger people, to report feelings of sadness or depression.¹⁶ These results also support findings that the elderly tend not to acknowledge depressive symptoms and automatic negative thoughts.⁴⁴ Prior to participating

in the CMPP, the subjects had not, or seldom, shared their automatic negative thoughts, feelings or problems within a group.

Automatic negative thoughts are known to precipitate misinterpretation of situations, which can lead to one having negative views of self, experiences and the future.⁴⁵ As a result, identifying and responding to negative thoughts are essential in the CT process.³⁸ Most are unaware that automatic negative thoughts precede unpleasant feelings and behaviors, which can lead to depression.²² Through mindfulness practice, participants were able to increase their ability to track more spontaneously their automatic thoughts, allowing them to make clearer interpretations.

As their mindfulness increased, subjects became more focused on using their mind to apply CT approaches to address problems. Participants were taught to identify, monitor and, ultimately, challenge their negative cognitions about themselves and their situations, and to develop more adaptive and flexible cognitions. As a result of the group discussions, they were better able to identify cognitive distortions, such as: all or nothing thinking, catastrophizing, emotional reasoning, overgeneralization and 'should' and 'must' statements.⁴⁶

Unlike a typical CT program, the effect of the CMPP, in this study, demonstrated significant results in a shorter period of time (i.e. at program completion and three months thereafter) than previously reported in the literature. Typically a CT protocol, appropriate for elderly with depression, generally consists of 16 – 20 sessions over a 3-month period, with the individual being given another 3 to 4 months to identify their automatic thought processes.^{20, 46} This study consisted of only 11 CMPP sessions over a 4-week period. The effectiveness of this compressed program may help address depression in elderly Thai women in a time-efficient manner.

Conclusions

Findings suggest the CMPP could be an effective intervention for assisting elderly Thai women with mild to moderate depression. Potentially, such a program could be used to offer a time-efficient, low-risk, culturally-appropriate intervention in Thailand. However, this study has limitations which need to be addressed. The effect the attention they received from being a participant in the CMPP had on the findings is not known. Neither is the effect of their regular interaction together, on a regular basis, at their respective community center, known. Thus, future studies need to utilize a larger, randomly-selected sample, with heterogeneous characteristics, obtained from numerous varied settings.

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ผลของการบำบัดทางสติและปัญญาต่อภาวะซึมเศร้าในผู้หญิงไทยสูงอายุ

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บทคัดย่อ : ภาวะซึมเศร้าเป็นปัญหาทางสุขภาพจิตที่สำคัญอย่างยิ่งในปัจจุบันและเป็นสาเหตุสำคัญของความทุกข์และความสูญเสียความสามารถโดยเฉพาะในผู้สูงอายุ ผู้หญิงไทยสูงอายุมิโอกาสเสี่ยงต่อภาวะซึมเศร้ามากกว่าผู้ชาย การวิจัยครั้งนี้เป็นการวิจัยเชิงทดลองแบบสองกลุ่มเพื่อศึกษาผลของโปรแกรมการบำบัดทางสติและปัญญาต่อภาวะซึมเศร้าในผู้หญิงไทยสูงอายุที่มีภาวะซึมเศร้าในระดับปานกลางและต่ำโดยเปรียบเทียบกับผู้หญิงไทยสูงอายุที่ได้รับการดูแลตามปกติในชุมชนจังหวัดเชียงใหม่ โดยสุ่มกลุ่มตัวอย่างเข้ากลุ่มทดลองและกลุ่มควบคุม

กลุ่มทดลองได้รับโปรแกรมการบำบัดทางสติ และปัญญาที่ผู้วิจัยสร้างขึ้น สำหรับกลุ่มควบคุมได้รับการดูแลด้านจิตใจและได้รับการพยาบาลตามปกติจากพยาบาลชุมชน กลุ่มตัวอย่างได้รับประเมินระดับความรุนแรงของภาวะซึมเศร้า ก่อนการทดลอง หลังเข้าร่วมโปรแกรมทันที และ 3 เดือน หลังเข้าร่วมโปรแกรม วิเคราะห์ข้อมูลโดยใช้สถิติบรรยาย การวิเคราะห์ความแปรปรวนแบบสองทางเมื่อมีการวัดซ้ำ การทดสอบค่าเฉลี่ยสองกลุ่ม อิสระต่อกันและการวิเคราะห์ความแปรปรวนร่วม

ผลการวิจัยพบว่าหลังเข้าร่วมโปรแกรม และ 3 เดือนหลังเข้าร่วมโปรแกรม กลุ่มทดลองที่ได้รับโปรแกรมการบำบัด ทางสติและปัญญามีภาวะซึมเศร้ามลดลงอย่างมาก เมื่อเปรียบเทียบกับกลุ่มที่ไม่ได้รับโปรแกรม ผลการวิจัยครั้งนี้ แสดงให้เห็นว่า โปรแกรมการบำบัดทางสติและปัญญาสามารถ ลดภาวะซึมเศร้าใน ผู้หญิงไทยสูงอายุ พยาบาลที่มีความรู้ และผ่านการฝึกอบรมสามารถใช้โปรแกรมการบำบัดทางสติและปัญญาซึ่งเป็นการบำบัดโดยไม่ใช้ยาและเหมาะสมกับวัฒนธรรมสำหรับการบำบัดผู้หญิงไทยสูงอายุที่มีภาวะซึมเศร้าในระดับปานกลางและต่ำ

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