The Thai Group Cognitive Behavior Therapy Intervention Program for Depressive Symptoms among Older Women: A Randomized Controlled Trial

Chaowanee Longchoopol, Darawan Thapinta, Ratchneewan Ross, Wanchai Lertwatthanawilat*

Abstract: Depression is a mental health problem worldwide, often a co-occurring condition with disabilities and contributes to a low quality of life and suicide. Older women are more likely to experience depression than older men and need specific interventions to reduce their depressive symptoms. This randomized controlled trial examined the effect of a group administered cognitive behavior therapy program for reducing depressive symptoms among older women. Sixty Thai older women living in the community, who met the inclusion criteria and presented at primary care units in Northern Thailand, were randomly assigned into either a group undertaking a cognitive behavior therapy program (n=30) or a usual care control condition (n=30). Depression was measured using the Patient Health Questionnaire-9, Thai version at baseline, immediately after the time needed to complete The Thai Group CBT Intervention Program, and then at 1 and 3 months follow-up. Repeated measures analysis of variance (ANOVA) and independent sample t-test were used to test the program efficacy.

Results indicated that the mean depression scores in the CBT condition at every point were significantly lower than at baseline and also statistically lower than those of the usual care condition after completing the program. Thus, The Thai Group CBT Intervention Program was found to be efficacious in reducing depression. Nurses should consider integrating this intervention for older persons with depression into primary care; however, further study is needed to demonstrate the durability of the depression reduction effects.

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Introduction

The numbers of older people are growing rapidly around the world and making up increasingly larger proportions of the population in many countries,[1,2] including Thailand.[3,4] Depression is known to be common among older persons. Although epidemiologic data for low and middle income countries are scarce[5] there is evidence that the prevalence of depression in

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older persons is relatively high in Thailand.[3,4] The World Health Organization (WHO) mentions that depression is a significant contributor to the global burden of disease, affecting people in all communities across the world, and has estimated that it could rise to first place by 2030.[6] Among older persons, WHO surveys have found that the number of women experiencing depression has continued to increase and generally has been higher than among men.[7,8] With a growing aged population in Thailand and worldwide, there will be even more people in this group suffering from unrecognized and undertreated depressive symptoms.[9]

Cognitive behavior therapy (CBT) is a form of psychotherapy that can be administered as an individual or group intervention by a CBT therapist or a trained professional, such as a general practitioner or nurse.[8,10,11] CBT has evidence of effectiveness for reducing symptoms of depression, as well as for preventing relapse and recurrence of depression among older adults across countries and settings, with evidence of effectiveness for individual as well as group CBT administration.[12,13] CBT is a structured, partially didactic approach to the treatment of depression in which persons are trained to identify and modify negative belief and maladaptive information processing proclivities in an effort to produce symptoms relief.[14] CBT has demonstrated greater efficacy more than other psychotherapy approaches[12,15,16] and has demonstrated relatively low costs compared with other therapies[17,18] and particularly for the care of depressed older persons.[12,15,19] Psychiatric nurses who can deliver CBT have an important role to play in alleviating mild depression among older adults which may be valuable in preventing future, more serious depressive disorders.[8]

Literature review

There have been studies of the efficacy of CBT for reducing depression among older adults diagnosed with major depressive disorder (MDD) in western countries[15,19] as well as meta analyses.[12] Only one study in Thailand has used CBT for reducing depression among older people and this study, which combined meditation with CBT had several limitations (see further about this below).[17] Hence, it was considered necessary to develop CBT intervention for reducing depressive symptoms among older Thai women, specifically those living in the community. A focus on community dwelling women may help in making services more accessible. This may also enable the engagement of mildly depressed older women rather than just those with major depression. Further, group administration may be more efficient and cost-effective than providing individual sessions.

Beck's Cognitive Theory of Depression[20] is a useful framework for designing a program for older women with depression. Consistent with Beck's Theory, negative automatic thoughts (NATs) appear to be the most significant causes of depression, and has been found in some studies conducted in Thailand.[17,18,20,21] These NAT patterns make older women think negatively about themselves, the world, and the future, particularly when they are faced with stressful life events.[17,20] Hence, reducing depression among older women should focus on modifying their NATs.

The Thailand Department of Mental Health (TDMH) provides treatment guidelines for MDD among older persons in which antidepressant medication is the first line treatment. TDMH's recommendations for mild and moderate depression are counseling, problem solving, CBT, and exercise therapy for mild levels of depression,[23,24] which appear to be common among older Thai adults living in the community, based on screening data.[10] Despite the TDMH guidelines, there appear to be many older women with mild depressive symptoms who experience under-treatment or inappropriate care,[11,25] which is not unique to Thailand.[1] Recently, CBT has been reported as an effective treatment for depression with recommendations to increase its availability to older persons[12,15,17] but no research has been conducted with standard CBT (12-18 sessions) interventions among older Thai women.

Review of the CBT literature from Thailand from 2009-2017, identified only one study among older adults. This study tested a cognitive-mindfulness practice program (CMPP) based on Beck's Cognitive Theory among Thai women, aged 60-80, with mild depression and included five sessions of meditation practice followed by six sessions of cognitive therapy.[17] Another 5 studies were identified in other age groups. The first tested a CBT-based guided self-help manual for decreasing expressed emotion in Thai adults, age 18-60 years, who were caregivers of moderately depressed adults. The manual contains 8 modules but only 2 modules addressed CBT components and no robust session was present.[18]

The second study tested CBT among Thai patients with MDD using 8 sessions that provided only 1 cycle of CBT examination of NATs and not provide a robust session.[21] The third study used a Cognitive Behavior Bibliotherapy self-help manual with 8 modules to reduce psychological distress among Thai people with moderate depression. The manual included only 2 modules with CBT components and did not include a robust session.[22] The fourth study was a workforce development and service evaluation that tested CBT for the treatment of MDD and found CBT was beneficial for MDD patients who had not responded to antidepressant medication therapy. The participants received 8-16 CBT sessions on a weekly or biweekly basis and the intervention did not include a robust session.[26] The final study tested the effectiveness of computerized CBT (CCBT) for adolescent offenders and found that CCBT reduced depressive symptoms among youths with depression.[27]

Our study examined the efficacy of The Thai Group CBT Intervention Program for reducing depressive symptoms among older women. It was hypothesized that those older women receiving CBT program have significantly lower mean depression scores immediately after completing the program, and at 1 and 3-month follow-up compared with baseline, and compared to those receiving usual care.

Method

Design: A randomized control trial (RCT).

Ethical consideration: The Ethical Committee (No. 102/2014) of the Faculty of Nursing at Chiang Mai University approved the study. Oral and written explanations of the study, its purpose and procedures, the right to refuse or withdraw participation, and confidentiality protections were provided to potential participants. Written consent was obtained from those who were willing to participate. Consenting participants also were informed about their right to withdraw from the study at any time without negative repercussions.

Sample and Sampling: The study was conducted from December 2014-May 2015. The sampling and study design are summarized in **Figure 1**. Inclusion criteria were: being female and ≥60 years; living in the areas under the responsibility of 6 primary care units of a provincial hospital in northern Thailand for >6 months; able to communicate in Thai; and willing to participate in the study. The exclusion criteria were: demonstrating psychotic symptoms during an intervention such as hallucinations or suicidal ideation; receiving the psychiatric medications; and having cognitive impairment measured by MMSE at pretest, or at any follow up visit.

The sample size was estimated using power analysis in order to reduce the risk of type II error. The minimum level of significance (α) to estimate the number of sample size was .05 with the power of .80 ($1-\beta$), a medium effect size, and consideration of sample sizes from previous research[17] which would yield a total sample size of n= 50 (n=25 per condition, for a total of two conditions). Anticipating potential bias due to dropouts and the desire to prevent possible low power to detect small differences, the primary researcher (PI) recruited 20% additional participants which added 5 more participants in each group[28] for a total sample size of n=60 (n=30 per condition).

The health care providers screened an initial sample of community dwelling older women (n=234)

who presented at six PCUs. This resulted in a pool of 120 eligible women who met the inclusion criteria, from whom 60 were selected for this study. A random number table was used for study randomization and for simple random assignment to either the CBT program (n= 30) or a usual care (n= 30) comparison condition. Randomization was performed by a health care provider who was not involved in the trial. No participants dropped out of the study and CBT program participants attended all sessions. (Figure 1)

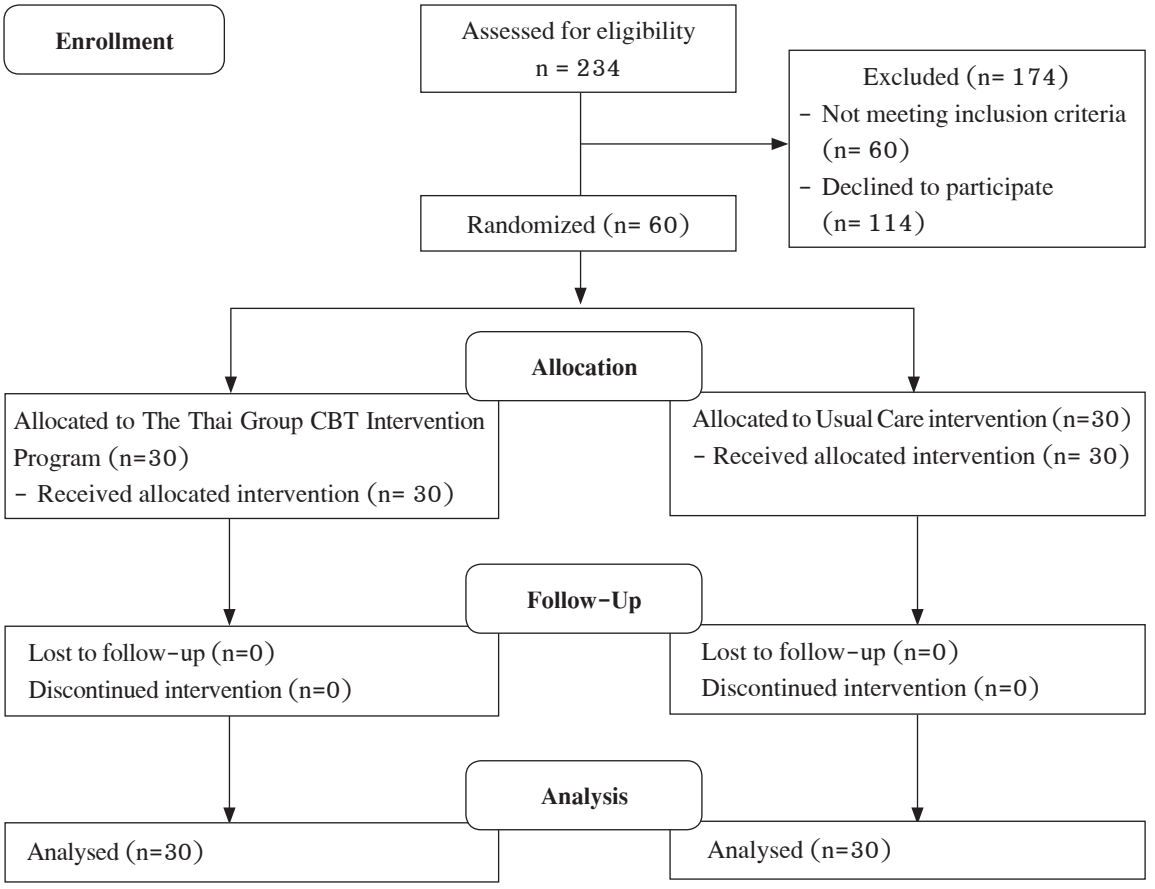

Figure 1. CONSORT flow diagram of sample involvement in study

Instruments: Three instruments were used:

A demographic data questionnaire was developed by the PI and queried participants about age, education, marital status, and any chronic illness.

Depression was measured using the Thai version of *The Patient Health Questionnaire (PHQ-9)* translated from the original by Lotrakul and colleagues.[29] The PHQ-9 is a 9 item self-report rating scale based on the DSM-IV criteria for major depressive disorders. Scores for each PHQ-9 item range from 0 (not at all), to 1 (several days), 2 (more than half of the days) and 3 (nearly every day); summed scores range from 0 to 27. Those with a score between 5 and 8, representing mild depression, were considered eligible to participate in the study. Cronbach's alpha for the total scale was .79. The PHQ-9 internal consistency was tested before use in this study with 40 participants yielding a Cronbach's alpha =.84, while the internal consistency was .89.

The Thai Group CBT Intervention Program to reduce Depressive Symptoms among Older Women was based on Beck's CBT approach (Beck, 2011).[20] This intervention was developed by the PI and her mentor in consideration of the needs of older women, as well as the theoretical background of CBT. The content validity of the program was valued through review by 3 experts in CBT: a psychiatrist, a psychologist, and a psychiatric nurse, and revised according to their recommendations. It was pilot tested with five older women who met the inclusion criteria but did not participate in the main study.

The PI, who facilitated the intervention sessions was trained in the use of CBT before conducting the study. This included certification from Department of Mental Health, Ministry of Public Health, Thailand and successful completion of CBT training at the Beck Institute for Cognitive Behavior Therapy, USA.

The Thai Group CBT Intervention Program included 12 group-administered sessions of 45-60 minutes each. These sessions took place three times per week total over the total of four weeks. The intervention components included: receiving a CBT manual, psychoeducation, case formulation, the 3 steps of CBT: (identifying NATs, evaluating them, then responding to same), homework assignments, evaluation and feedback. The activities of the CBT intervention are detailed in **Table 1**. The Thai Group CBT Intervention Program was administered by the PI and these group participants did not receive usual care.

Table 1. Summary of the 12 sessions of The Thai Group CBT Intervention Program

Session	Time (week/day/duration)	Objectives	Components activities of group CBT
1	Week 1 / Monday/ 60 min.	- Participants acquire an understanding of the patterns of cognition among depressed people. - Provision of information about the CBT intervention, cognitive model, and NATs.	1. Psychoeducation 2. Homework assignment: activity daily record 3. Evaluation and feedback
2	Week 1/Wednesday/ 60 min.	- Participants learn about case formulation - Encourage participants' understanding of how to identify NATs so they can identify NAT#1 as homework.	1. Psychoeducation 2. Case formulation 3. Identify NAT#1 4. Homework: identify NAT#1 5. Evaluation and feedback
3	Week 1/Friday/ 60 min.	Participants learning and discussion how to evaluate NAT#1.	1. Evaluating NAT#1 2. Homework: evaluating NAT#1 3. Evaluation and feedback
4	Week 2/Monday/ 50 min.	Participants learn and discuss how to respond to NAT#1.	1. Respond to NAT#1 2. Homework: respond to NAT#1 3. Evaluation and feedback
5	Week 2/Wednesday/ 50 min.	Participants practice skills and identify NAT#2.	1. Identify NAT#2 2. Homework: identify NAT#2 3. Evaluation and feedback
6	Week 2/Friday/ 60 min.	Participants practice more NAT evaluation skills and evaluate NAT#2; use Buddhist teaching for cognitive reconstructuring.	1. Evaluate NAT#2 2. Homework: evaluate NAT#2 3. Evaluation and feedback

Table 1. Summary of the 12 sessions of The Thai Group CBT Intervention Program (cont.)

Session	Time (week/day/duration)	Objectives	Components activities of group CBT
7	Week 3/Monday/ 50 min.	Participants practice more skills to respond to NAT#2.	1. Respond to NAT#2 2. Homework: respond to NAT#2 3. Evaluation and feedback
8	Week 3/Wednesday/ 50 min.	Participants practice skills to identify NAT#3.	1. Identify NAT#3 2. Homework: identify NAT#3 3. Evaluation and feedback
9	Week 3/Friday/ 60 min.	Participants practice skills to evaluate NAT#3 and use Buddhist activities for cognitive reconstructuring.	1. Evaluate NAT#3 2. Homework: evaluate NAT#3 3. Evaluation and feedback
10	Week 4/Monday/ 45 min.	Participants practice skills to respond to NAT#3, and identify benefits from changing their cognition.	1. Respond to NAT#3 2. Homework: identify, evaluate, and respond to other NATs 3. Evaluation and feedback
11 (Robust session)	Week 4/Wednesday/ 60 min.	1. Participants practice more skills and group discussion on how to identify, evaluate, and respond to other NATs. 2. Group discussion to evaluate group-administered CBT intervention and review cognitive and behavior techniques together.	1. Identify, evaluate, and respond to NATs 2. Evaluation and feedback
12 (Robust session)	Week 3/Friday/ 45 min.	Participants understand and have appropriate skills to identify, evaluate, and respond to NATs.	1. Identify, evaluate, and respond to NATs 2. Evaluation and feedback

Note: cognitive behavior therapy (CBT), negative automatic thought (NAT)

Usual care was provided only to those in the comparison condition and refers to the activities normally provided by nursing teams in PCUs to persons with mild depression. These activities followed guidelines for mild depressive disorders recommended by the Department of Mental Health, Ministry of Public Health, Thailand (2014)[24] and included only psychoeducation about depression and advice to exercise 30-45 minute at least 2-3 times per week.

Data collection: Health care providers at the PCUs collected the demographic data, MMSE, and the PHQ-9 from participants they received CBT or usual care. The PHQ-9 also was administered immediately after completing The Thai Group CBT Intervention Program or usual care (4 weeks after baseline); and at one month and three months follow-up after conclusion of the intervention and while the control group received usual care.

Data Analysis: All statistical analyses were performed using SPSS version 17.0. Descriptive statistics were performed for demographic variables as percentages and means. Chi-square and t-test were used determine the equivalence of the two conditions at baseline. Independent t-tests were used to examine the effect of The Thai Group CBT Intervention Program across time. Analysis of covariance was used compare The Thai Group CBT Intervention Program and usual care condition, with post-hoc testing of the interaction between research condition and time.

Results

The majority of the participants in both groups had completed primary school; were married; and reported some chronic illness such as hypertension and diabetes mellitus. The mean experimental group age was 70.67 years (SD = 6.66) and the control group 70.40 years (SD = 7.55) **(Table 2).** The mean depression scores of participants in the experimental group decreased significantly over time ($p < .05$) **(Table 3).** The mean depression scores of The Thai Group CBT Intervention Program also were statistically lower than those of usual care counterparts at each time point after completion of The Thai Group CBT Intervention Program ($p < .05$) **(Table 4, Figure 2)**

Table 2. Comparison of the Demographic Characteristics of the Participants by Condition

Demographic Characteristics	CBT (n= 30)		Usual Care (n= 30)		P-value
	n	%	n	%	
Age (years)					
60-69	12	40.0	18	60.0	
70-79	15	50.0	8	26.7	
80 and over	3	10.0	4	13.3	
Range	61- 85		61-85		
Mean (SD)[a]	70.67 (6.66)		70.40 (7.55)		.58
Educational level[b]					.29
Below primary school	9	30.0	16	53.3	
Primary school	21	70.0	14	46.7	
Marital status[b]					.29
Single	1	3.3	0	0.0	
Married	15	50.0	17	56.7	
Widowed/ separated	14	46.7	13	43.3	
Chronic illness[b]					.11
Yes	22	73.3	17	56.7	
No	8	26.7	13	43.3	
Depression score at baseline[a]					.15
Mean (SD)	6.43 (1.67)		6.53(0.97)		

Note [a] = t-test. [b] = Chi-square test. * $p < .05$

Table 3. Comparison of Mean Depression Scores in The Thai Group CBT Intervention Program Condition at Baseline, Immediately After Completing Program,1 and 3 Month Follow-up.

Time	Depression scores		t	*p-value*
	Mean	SD		
Baseline	6.43	1.17	-.361	.15
Immediately	2.87	1.20	-15.066	.03*
1 month follow up	2.73	2.27	-9.039	.00*
3 month follow up	2.93	2.50	-8.722	.00*

Note: Independent t-test, * $p < .05$

Table 4. Comparison of Mean Depression Scores at Different Points of Measurement within The Thai Group CBT Intervention Program and Usual Care Conditions.

Depression	Mean (SD)				1 vs 2	1 vs 3	1 vs 4	2 vs 3	2 vs 4	3 vs 4
	Baseline (1)	Immediately After Completing Intervention (2)	1 month Follow-up (3)	3 month Follow-up (4)						
CBT (n= 30)	6.43(1.17)	2.87(1.20)	2.73 (2.27)	2.93(2.50)	.00*	.00*	.00*	1.00	1.00	1.00
Usual Care(n= 30)	6.53(.97)	6.97(.89)	6.97 (1.19)	7.10(.76)						

Note: Post Hoc for One-Way Repeated Measure ANOVA, * p < .05

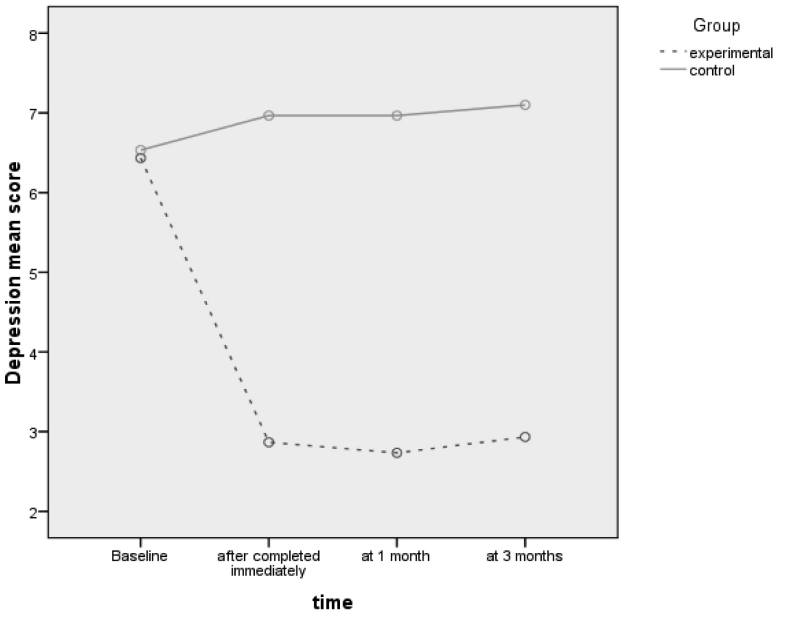

Figure2. Comparison of Mean Depression Scores between The Thai Group CBT Intervention Program and Usual Care Conditions

Discussion

The results of this study indicate that The Thai Group CBT Intervention Program led to significant reductions in depressive symptoms among older women with mild depression, compared to baseline. The Thai Group CBT Intervention Program participants had significantly lower levels of post-intervention depressive symptoms than those who received the usual care. Importantly, no women dropped out of the study and they completed all sessions.

The components and skills of The Thai Group CBT Intervention Program in this study, used Beck's Cognitive Theory and principles[20] which have demonstrated effectiveness in reducing depressive symptoms in many studies across cultures.[12,15] The elements of The Thai Group CBT Intervention Program, which draw from Beck's theoretical and clinical work are likely to account for the efficacy of CBT seen in this study. These elements include: psychoeducation to help participants to understand the causes of their depression; case formulation to help describe and explain participants'

problems in ways that are theoretical informed, coherent, meaningful and lead to effective intervention;[30,31] and homework assignments whose successful use predicts more positive outcomes.[20] Most of participants completed their homework assignments and appreciated their usefulness in reducing their depressive symptoms. Other research suggests that homework leads to better outcomes when compared to CBT without homework.[32] Integrating homework assignments with local culture, emphasizing the utility of homework, and encouraging the women to have family help them appear appropriate with older persons.[33]

This study was different from previous studies on CBT in Thailand among older adults by including multiple opportunities to work through the three steps of CBT and robust sessions. The PI facilitated the group sessions of The Thai Group CBT Intervention Program and encouraged the participants to share various methods to identify, evaluate and respond to NATs. Three cycles of identifying, evaluating, and responding to NATs were included (sessions 2-10, see Table 1) were provided along with additional behavior rehearsal in sessions 11 and 12 as a robust sessions. This combination of repeatedly working through the steps of CBT and providing further behavior rehearsal can help participants have more experiences to change their thoughts in ways that may reduce their depressive symptoms and better understand how to use these techniques on their own. The 45-60 minute sessions used here appeared appropriate for older persons who may have some limitations in their short-term memory or may be fatigued by longer sessions.[34,35] The PI covered the transportation cost for participants to attend the CBT sessions, which were performed at PCUs and which removed an obstacle to participation. This may explain help the lack of dropouts from the study and the 100% completion of the all sessions in The Thai Group CBT Intervention Program.

The cultural adaptation of CBT by the PI included participation of a monk who used Buddhist teaching about reality orientation, focusing on the here and now, and how to stop distortions of thought. These Buddhist concepts are consistent with CBT and provide a culturally appropriate way to address how NATs may be related to their depressive symptoms. CBT has been studied in relation to spirituality and religious practice. Researchers in the field often emphasize that mental health care providers should address matters of religion and belief because all major religions have models of the human psyche, and recognize the interaction between mind and spirit.[36,37]

This study adds to the evidence that The Thai Group CBT Intervention Program is efficacious in reducing depressive symptoms among older women with mild depressive symptoms. One possible future direction would be to see if The Thai Group CBT Intervention Program can prevent depressive disorder among older persons. Most CBT research has focused on treatment, but some CBT researchers have suggested clinical trials of interventions for depression among older persons should be shifting the paradigm from treatment to prevention and that CBT principles can be used for prevention as well as treatment.[8,12,26]

Limitations

The outcome of the study relied on self-report measurement with the PHQ-9, which may be susceptible to social desirability and recall biases. Studies with longer-term follow-up are needed to investigate the durability of CBT's effects.

Conclusions and Implications for Nursing Practice

The findings indicated that The Thai Group CBT Intervention Program was more effective than usual care and was able to reduce depression symptoms among older Thai women with mild depression. This appears to be an efficacious intervention that psychiatric nurses can use with older Thai women with mild depression who are seen in PCUs. A useful extension

of this study would be to look at effects in male as well as female older adults with mild depression. It also may be helpful to evaluate specific components of the intervention to determine if there are ways to make this intervention briefer and better adapted to settings where participants cannot attend 12 sessions over a one month period. Although this intervention may be low in cost relative to other kinds of psychotherapy, there is a need to examine the cost effectiveness of group CBT program like this one.

Conflict of interest

All authors declare that they have no conflict of interest.

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โปรแกรมการบำบัดความคิดและพฤติกรรมไทยแบบกลุ่มสำหรับอาการซึมเศร้าในผู้สูงอายุหญิง:การทดลองแบบสุ่มและมีกลุ่มควบคุม

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บทคัดย่อ: ภาวะซึมเศร้า คือ ปัจจัยสำคัญนำไปสู่ปัญหาสุขภาพจิตทั่วโลก บ่อยครั้งที่พบร่วมกับปัจจัยสำคัญของภาวะทุพพลภาพ และเป็นปัจจัยที่มีผลให้คุณภาพชีวิตต่ำและการฆ่าตัวตาย ผู้สูงอายุหญิงมีแนวโน้มที่จะมีประสบการณ์ซึมเศร้ามากกว่าชายและต้องการการบำบัดเฉพาะที่สามารถช่วยลดอาการซึมเศร้า การวิจัยเชิงทดลองแบบทดลองแบบสุ่มและมีกลุ่มควบคุมนี้เพื่อทดสอบผลของโปรแกรมการบำบัดความคิดและพฤติกรรมแบบกลุ่มต่ออาการซึมเศร้าในผู้สูงอายุหญิง ผู้สูงอายุหญิงไทย 60 คน ที่อาศัยอยู่ในชุมชนที่มีคุณสมบัติตามเกณฑ์และเข้ารับบริการที่หน่วยบริการปฐมภูมิในภาคเหนือของประเทศไทย ถูกสุ่มเข้าสู่กลุ่มที่ได้รับโปรแกรมการบำบัดความคิดและพฤติกรรมแบบกลุ่ม(จำนวน 30 คน) หรือกลุ่มที่ได้รับการดูแลตามปกติ (จำนวน 30 คน) ภาวะซึมเศร้าวัดโดยแบบสอบถามสุขภาพ 9 คำถาม ฉบับภาษาไทย ในระยะก่อนเริ่มโปรแกรม หลังสิ้นสุดโปรแกรมการบำบัดความคิดและพฤติกรรม ทันทีและติดตามหลังสิ้นสุดโปรแกรม 1 เดือนและ 3 เดือน วิเคราะห์ข้อมูลโดยการวิเคราะห์ความแปรปรวนแบบทางเดียวแบบวัดซ้ำและการทดสอบความแตกต่างค่าเฉลี่ยของกลุ่มตัวอย่าง 2 กลุ่มที่เป็นอิสระต่อกัน เพื่อทดสอบประสิทธิภาพของโปรแกรม

ผลการวิจัยพบว่า ค่าเฉลี่ยคะแนนอาการซึมเศร้าของกลุ่มการบำบัดความคิดและพฤติกรรมทุกช่วงเวลาลดลงกว่าค่าเฉลี่ยคะแนนอาการซึมเศร้าพื้นฐานที่วัดก่อนเริ่มโปรแกรมอย่างมีนัยสำคัญทางสถิติ นอกจากนั้น ค่าเฉลี่ยอาการซึมเศร้าของกลุ่มการบำบัดความคิดและพฤติกรรมลดลงกว่ากลุ่มที่ได้รับการดูแลตามปกติ หลังสิ้นสุดโปรแกรมทุกช่วงเวลาอย่างมีนัยสำคัญทางสถิติ ดังนั้นการบำบัดความคิดและพฤติกรรมแบบกลุ่ม พบว่า **มีประสิทธิภาพมากกว่าการดูแลตามปกติในการลดภาวะซึมเศร้า พยาบาลควรพิจารณาบูรณาการการบำบัดนี้สำหรับผู้สูงอายุที่มีภาวะซึมเศร้าในการดูแลในหน่วยบริการปฐมภูมิ** อย่างไรก็ตาม **การศึกษาครั้งต่อไปควรมีการทดสอบความคงอยู่ของผลของโปรแกรมในการลดภาวะซึมเศร้า**

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คำสำคัญ : การบำบัดความคิดและพฤติกรรมแบบกลุ่ม อาการซึมเศร้า โปรแกรมการบำบัด ผู้สูงอายุหญิง หน่วยบริการปฐมภูมิ การทดลองแบบสุ่มและมีกลุ่มควบคุม ประเทศไทย

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