

CHAPTER 1

INTRODUCTION

Background and Significance of the Research Problem

The estimated annual loss of life due to depression related suicide is 850,000 deaths per year (World Health Organization, 2005). The World Health Organization (WHO, 2005) predicts that by the year 2020, depression will be the second leading cause of health impairment worldwide that leads to suicide. In Thailand, the number of new cases of depression and depression-related suicide has increased steadily since 1998. From just over 30.63 thousand cases of depression in 1998, the number had increased to 80.67 thousand in 2001 and then to 109.76 thousand in 2003 (Department of Mental Health, Ministry of Public Health, 2005). In 1998, the number of persons hospitalized for depression related attempted suicide in Thailand was 16.41 thousand. By 2001, this number had increased to 19.01 thousand and by 2003 the number had reached 256.57 thousand (Department of Mental Health, Ministry of Public Health, 2005).

Based on these statistics, adolescents have been identified as the population group with the highest probability risk for depression, especially adolescent students in secondary school, both males and females aged 15 to 19 years (Ministry of Public Health, 2003). Rates of depressive illness among Thai adolescents have been reported to range from 5% to 8% for major depression and 1.6% to 8.0% for dysthymia (Suampun, 2004). Rates of behavioral disorders, such as conduct disorder, academic

failure, substance disorder, and personality disorder in Thai adolescents are considerably lower (Hongsangunsri & Limsuwan, 2004).

Increased risk of depression has been associated with negative thoughts (Beck, Rush, Shaw, & Emery, 1979). Before starting this study, the researcher developed a preliminary focus group study to explore the leading causes of depression between 42 depressed and 43 nondepressed Thai adolescent students in secondary schools. Results found that adolescent students are more likely to be depressed if they think they must meet performance expectations that they think they are unable to achieve. This thought leads to internal conflict that induces feelings of guilt, low self-esteem, helplessness, hopelessness, and depression. This association of depression and perceived lack of ability to meet the expectations of others was replicated in the findings of a preliminary focus group study of depressed and nondepressed Thai adolescent students in secondary schools. In that study, depressed and nondepressed adolescents primarily differed in their concern with and their description of the perceived expectations of others at home and at school (Aekwarangkoon, 2005).

Depressed adolescent students in the focus group expressed their perceptions about the leading causes of depression. They felt that they were expected to be always good students: to be good in their lessons, never to oppose school regulations, always to suppress strong emotions such as love, anger, or sadness, never to disobey adults, particularly parents and teachers. In addition, they were also expected to do more work at home and expressed significantly greater psychological sensitivity to interpersonal conflict, particularly family and parental conflict. Adolescents in the focus group who were not depressed did not share these perceptions. They did not think they were expected to accept or strive to achieve such rigid standards of

behavior. The association between negative thoughts and depression can obviously appear to be a simple cause and effect relationship but the actual association is highly complex. Negative thinking can precede the onset of depression, occur as a symptom of depression, or develop as a learned coping response to other symptoms of depression (Beck, et al., 1979; Nolen-Hoeksema, 1987).

Findings from well-designed studies consistently have shown that cognitive therapy for depression can be effective in treating as well as preventing depression in persons predisposed to symptom onset, especially for the person who suffers from mild to moderate depression and who is at risk for severe depression (Embling, 2002; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Harrington & Dubicka, 2002). In effect, by addressing the negative thinking associated with depression, cognitive treatment therapies can be effective at many different levels of treatment (Beck, Steer, & Garbin, 1988).

A systematic review of clinical research literature revealed that cognitive therapy is effective for treating moderately depressed adolescents (Lockwood, Page, & Conroy-Hiller, 2004). This study is related to the 14 meta-analyses reviewed that have investigated the efficacy of cognitive therapy in adolescent depression. The findings revealed that cognitive therapy was superior to “other” psychotherapies (Butler & Beck, 2000). In addition, Embling (2002) examined the effectiveness of treatment of cognitive therapy with depression; the results confirm those of previous outcomes of studies that cognitive therapy is an effective treatment for depression. However, there are limitations to the use of cognitive therapy with adolescent students in school because it requires specialists for its correct application but, in the real situation there is a lack of specialists, especially in countries like Thailand.

Brief intervention is another effective strategy that has been studied extensively for helping adolescents to cope with their psychological and behavioral problems (Budman & Gurman, 1988; Fagan, 2003). The brief intervention process consists of FRAMES, which are feedback (F) to increase the person's symptom awareness and to decrease the social stigma, responsibility (R) to increase awareness of self-management as a means of achieving therapeutic changes, advice (A) to identify and challenge distorted and adopt more realistic thoughts, a menu of options (M) to construct a set of self-management options in reducing negative thoughts, empathy (E), and self-efficacy (S) to encourage self-management (Fagan, 2003). The structure of this intervention is simple. Trained school personnel can deliver this intervention in a short period to improve the adolescents' psychological well-being.

In this study, cognitive theory using brief intervention process are of special interest for helping individuals to identify, challenge, and replace distorted, negative thinking associated with symptoms of depression in adolescent students in the school, a treatment that best fits and is feasible within the Thai context. Cognitive intervention focuses on eliminating inappropriate or negative thought, whereas brief intervention provides the step to reach the objective of the cognitive goals. However, brief-cognitive intervention alone can be less effective than combined treatment in preventing depression in adolescents.

Clinical studies on either cognitive therapy or brief intervention to prevent depression have shown that the preventive effects of cognitive intervention may be significant only when relevant social support intervention is added (Finfgeld-Connett, 2005; Reunthongdee, 2001). For adolescents, combined brief-cognitive and support interventions may be more effective in significantly reducing the risk of depression

onset by promoting positive interpersonal interactions to counter their negative thinking (Brown, 2001; Finfgeld-Connett, 2005; Hupcey, 1998; Piper, Joyce, McCallum, Azim, & Ogrodniczuk, 2002; Sullivan, 1998). Effective brief cognitive-support treatment must address adolescent cognitive distortions and interpersonal sensitivity as interrelated risk factors for depression.

Presently, in addition to their classroom teaching assignments, small numbers of Thai secondary school teachers also provide basic mental health counseling for students who appear to be depressed. Limited to one session, the guidance teacher must assess the severity of the student's depression and counsel the student in basic methods of problem solving and relaxation. If the guidance teacher sees no improvement in the student's depression or considers the student's depression to be severe, the student is then referred to the district nurse assigned to cover the school. Qualified district nurses are staff nurses who work at the local hospital in the inpatient mental health unit.

The researcher is interested in finding an effective model of brief cognitive intervention that can be increased by adding relevant or contextual social support resources for helping adolescent students with mild to moderate depression (Brown, 2001; Embling, 2002). This study focused on Thai adolescent students attending school in Thasala District, Nakonsithammarat Province, Southern Thailand. The statistics of depressed adolescent students in Thasala District was 21.5 percents, which is comparable to other districts in Nakonsithammarat Province and to other parts of Thailand which has rates from 16.3 to 24 percents (Petchsirasun, Aekwarangkoon, & Noonil, 2005). Thus, this locality has a number of depressed adolescents representative of depressed adolescent students elsewhere.

The aim of this study was to test if this treatment can decrease depressive symptoms in depressed adolescent students. The researcher compares the effectiveness of this treatment with the usual care given. The treatment combines brief cognitive intervention, as the main therapeutic component, to transform the depressed student's inappropriate thoughts to appropriate ones, with social support from among adolescent students, parents/guardians, teachers, peers, and nurses as a school supportive environment component to improve the effectiveness of brief cognitive intervention. Perceptions of treatment effectiveness of mild to moderately depressed Thai adolescent students who received the brief cognitive-support treatment, of their parents/guardians, and of their teachers were tested in the study to confirm the effectiveness and feasibility of the treatment in the Thai context.

Objective of the Study

The aim of the study is to examine the effectiveness of the brief cognitive-support treatment compared to usual care in reducing depressive symptoms among Thai adolescent students with mild to moderate depression, using Beck Depression Inventory (BDI), Hamilton Rating Scale for Depression (HRS), and students', parents/guardians', and teachers' perceptions of treatment effectiveness.

Research Question

Will the brief cognitive-support treatment be more effective than the usual care in reducing depressive symptoms in Thai adolescent students with mild to moderate depression, using BDI, HRS, and students', parents/guardians', and teachers' perceptions of treatment effectiveness?

Conceptual Framework

Brief cognitive-support treatment was developed based on the framework of cognitive theory (Beck et al., 1979), brief therapy (Fagan, 2003), and social support (Finfgeld-Connett, 2005; Piper et al., 2002) which has been accepted for reducing depressive symptoms among adolescent students with mild to moderate depression. The treatment combined brief cognitive and supportive interventions to promote positive interpersonal interactions that in turn can counter negative thinking and internalized conflicts and frustrations that increase the risk of depression.

Brief cognitive intervention was developed based on fundamental principles of cognitive theory using a brief intervention process as the main therapeutic component for helping individuals in three weeks to identify, challenge, and replace distorted thoughts. Cognitive theory focuses on eliminating the negative thought, whereas the brief intervention provides a step to reach the objective of the cognitive goals.

The brief cognitive interventions are known as "FRAMES" components that consist of feedback (F), responsibility (R), advice (A), menu of options (M), empathy (E), and, self-efficacy (S). The brief cognitive intervention first addresses negative

thinking, then is used to eliminate the negative thinking shown to be associated with depression (Beck et al., 1979; Fagan, 2003). The structure of this intervention is simple. Trained school personnel can deliver this intervention in a short period to improve the adolescents' psychological well-being.

Multiple modes of support interventions consist of parents/guardians, teachers, peers, and nurses as contextual social support resource to improve the effectiveness of brief cognitive intervention combined with brief cognitive interventions over the same 3-week period. Each support intervention was designed to provide the adolescent with opportunities for positive interpersonal interactions to increase their positive coping responses to depression, to address personal and social problems that were perceived as being linked to their depression, and to promote the gains of the treatment achieved by brief cognitive intervention (Finfgeld-Connett, 2005; Oakley & Kane, 1999; Oakley, Kutil, & Brown, 1999; Piper et al., 2002). Effective brief cognitive-support treatment must address adolescent cognitive distortions and interpersonal sensitivity as interrelated risk factors for depression.

Hypothesis

The brief cognitive-support treatment will be more effective than usual care in reducing depressive symptoms in Thai adolescent students with mild to moderate depression, evaluated by BDI, HRS, and perceptions of treatment effectiveness.

Definition of Terms

Brief cognitive-support treatment is an intervention developed by the researcher to reduce mild to moderate depressive symptoms in Thai adolescent students. Treatment is combined with brief cognitive intervention and supportive intervention. Brief cognitive intervention focuses on cognitive theory (Beck et al., 1979) using brief intervention process (Fagan, 2003) followed by steps of FRAMES to eliminate the negative thoughts that provided by the guidance teacher in three weeks. Supportive intervention (Finfgeld-Connett, 2005; Piper et al., 2002) included parents/guardians, teachers, peers, and nurses over the same period to provide positive activities to promote gains achieved by using the treatment of brief cognitive interventions.

Usual Care is the usual counseling services at the secondary school that is provided by the guidance teacher. A single 30 to 40 minute individual session of problem-focused counseling is aimed at helping and encouraging students to reduce their depression by solving distressing problems. An in-depth interview method is used to comprehensively assess the student's problem. After identifying and describing the student's problems in detail, the guidance teacher provides instructive information on the use of distraction as a problem-solving method. It will be suggested that students will be distracted from their negative thought and try to find more enjoyable activities that make them feel better.

Depressive symptoms include these four symptoms (Beck et al., 1979; National Institute of Mental Health, 2000; Webster, 1995; Westermeyer, 2003): (1) emotional symptoms: sadness, guilt, past failure, anhedonia, (2) physical symptoms:

agitation, insomnia, decreased appetite, loss of energy, fatigue, lack of interest in sex, (3) cognitive symptoms: diminished concentration, hopelessness, worthlessness, self-dislike, self-blame, and (4) behavioral symptoms: loss of interest in activities, suicidal thoughts, crying, punishment, irritability.

Effectiveness of the treatment is the effectiveness of the brief cognitive-support treatment in reducing depressive symptoms in Thai adolescent students. The treatment effectiveness is assessed by (1) depression scores: Beck Depression Inventory (BDI) and Hamilton Rating Scale for Depression (HRS) scores, and (2) adolescent students', parents/guardians', and teachers' perceptions of treatment effectiveness.

Adolescents are Thai students aged 15 to 19 years attending Thasala District secondary schools in Nakonsithammarat Province, Southern Thailand. All adolescent participants had mild to moderate symptoms of depression as assessed by a Beck Depression Inventory (BDI) self-rating score of 10 to 19 and Hamilton Rating Scale for Depression (HRS) clinician-rating score of 8-17.