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Depressive and Older People

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My heartfelt congratulations to the Mental Health Association of Hong Kong on the Association's 60th anniversary. I wish the Association all the best in its future endeavour. I also bring to you greetings from the University of Newcastle, Australia.

In this presentation, I would share studies related to old age depression which were conducted in Hong Kong and Singapore. I would also share some recent work that I have engaged in Australia. I hope that such sharing could bring about future collaborations in the Asian Pacific region.

Old age depression

Globally about 350 million people are suffering from depression. The literature on the prevalence of old age depression is inconsistent. The findings are mostly context-specific and depend much on how depression was defined, what instrument was used to measure depression, and where the participants were recruited. For example, studies in Australia on community-dwelling older people showed the prevalence of depression ranged from 6% to 20%. But when the participants were recruited from institutions such as age care facilities, the prevalence of depression was much higher, could be up to more than 50% (National Ageing Research Institute, 2009).

The extent of pain and suffering of people with depression is difficult to measure. I show you this painting by Van Gogh which could perhaps represent the inner mind of the depressed person. It is well known that Van Gogh might have suffered from depression and have taken his own life. This painting shows how the depressive mood distorts the painter's perception of the world - so dark and lonely. The depressed persons' view of the world is negative. Depression also adversely affected their perceived quality of life, physical health and daily functioning (Chan, Jia, Chiu, Thompson, Hu, Lam, 2009).

In a study conducted in Hong Kong some years ago, we recruited older persons who were newly diagnosed as having depression. We measured their level of depression, perceived quality of life, physical health and level of functioning at the point of diagnosis. We then followed them up for 12 months to monitor the progress. This study found that treatment for depression did not just improve older persons' depressive mood but also improve their perceived quality of life and physical health, as well as their level of functioning. This study concurred that depression does not only affect the persons' mood but also the whole person and how they perceive the world. Treatment of depression could improve their mood and also their perceived general well-being (Chan; Chiu, Chien, Goggins, Thompson, Hong, 2009).

Chronic diseases are often closely associated with depression. A person with chronic disease, such as diabetes or stroke, is more likely to develop depression. Prospective studies also found that persons with depression

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were more prone to developing physical disease such as stroke, cardiovascular disease, and dementia (Moussavi, Chatterji, Verdes, Tandon, Patel and Ustun, 2007). This explains the importance of not to separate the mind and body. It is essential to care for a person holistically and in a person-centred approach.

Treatment is essential to improve the depressive condition. However, more than 50% of people with depression, especially older adults, do not have full access to treatment. Some of them refuse treatment because of the stigma, and the others are concerned about the side effects of medication. Some may not receive formal psychotherapy because they cannot afford the cost of psychotherapy and the time or travel expenses to the counsellor's office.

To address such issues, affordable options of intervention need to be identified. Recent efforts have been made to deliver psychological interventions for depression by using the Internet (e.g. MoodGYM) (Chan & Li, 2013). Access to the Internet would be a prerequisite. Unfortunately, in Asian settings, like Singapore or Hong Kong, many older persons do not have access to the Internet through a computer or a smartphone.

Cognitive Behavioral Bibliotherapy

Self-help books have been developed to address access issue. Self-help therapy can be used by the individual without having to receive therapy directly from a healthcare worker. Bibliotherapy is a 'standardised treatment in the book form'. An individual works through the exercise in the book without personal assistance from healthcare professionals (Jorm, Christensen, Griffiths & Rodgers, 2002, s89). Bibliotherapy provides information and outlines strategies that the participant can use to generate insight, stimulate awareness of negative emotions and cognitions. The book suggests solutions to problems, and encourages the user to actively practise these strategies in everyday life. This self-administered therapy works similarly to that administered by a therapist. The most common type of approach used in bibliotherapy is cognitive-behavioural therapy. Cognitive-behavioural bibliotherapy (CBB) involves helping users identify their distorted and depressogenic thinking, and learn realistic ways to frame their experiences by reading and doing exercises at home with minimal or no supervision from a therapist. It also involves engaging individuals in monitoring and increasing their activity levels (Phipps & Edelman, 2004).

In Singapore, we had conducted a feasibility study on this bibliotherapy with funding support from the Virtual Institute for the Study of Aging. We developed and tested the feasibility of the CBB. With permission from the Life Line South Coast, Australia, we adopted and modified a bibliotherapy 'The Good Mood Guide'. It is a self-help manual consisted of eight chapters (Phipps & Edelman, 2004). Each chapter focuses on various components, such as sleep improvement, and distorted thoughts, etc.

To facilitate use of the book by older adults, modifications were made to the original version of CBB. We simplified the original contents. We wrote it in a language that a sixth-grade graduate can understand. That means if a person has primary six education qualification they should be able to follow this guide book. We rearranged the content. For example, in the original book, the first chapter provided information on the relationship between thinking, feeling and behaviour, and then analysis of negative thoughts. This chapter seems a bit difficult for older people to start with. In the modified version, the users would learn to monitor their sleep patterns in the first chapter. It is quite common that people go to see a doctor not because they know they are depressed but because they cannot sleep. We therefore considered it necessary to help users manage their immediate insomnia problem in the first chapter of CBB. The book then goes on with monitoring mood changes

and managing negative thoughts. The modified version has been validated by the expert as well as lay person panels. Regular support was provided by a nurse calling the user every week. It is therefore a low intensity self-help program (Chan & Li, 2013).

We conducted a pilot study on the outcomes of the modified CBB. The study was a one-group pre-test and post-test design. We also interviewed the participants at the end of study. We recruited participants who were able to read English and newly diagnosed with mild or moderate depressive symptoms from a clinic in Singapore. We excluded those who are severely depressed because they might not have the energy to follow a book so effectively. We monitored their level of depression, distress and resilience. The participants had to have a working telephone so that the nurse can call them.

A total of 25 participants were recruited with 17 (68%) females and 8 males (32%). In general more females seek help for their depression. Thus there were more female participants in this study. The majority of the participants were Chinese (n=20, 80%) with few Malays and Indians which was consistent with the demographic distribution in Singapore. We measured their clinical conditions at the baseline and immediately after the intervention, then two months after the intervention (Table 1). All the participants had significant improvement from the baseline to Post-1, and from Post-1 to Post-2. They were able to maintain improvement in depressive symptoms, level of distress, and their resilience (Chan & Li, 2013).

We interviewed the participants after the intervention. One said: 'the book makes me more aware of my depression'. Another participant said: 'I like the changing negative thinking pattern exercise. I practice it often.' One participant said: 'I like the sleep monitoring and tips'. It appeared that the CCB did enhance their self-awareness. The practice helped the participants recognised their assumptions and develop personal ability to modify own negative thoughts and improve self-help behavior (Chan & Li, 2013).

In this study, the participants were recruited from a mental health clinic and had been diagnosed as having depression and were on anti-depressants. One could argue that the improvement was due to the anti-depressants.

Table 1
Cognitive Behavioural Bibliotherapy Intervention - Outcomes (n=25)

Outcomes	Baseline (mean, SD)	Post-1 (8^{th} week)	Post-2 (2-month after intervention)	F	*P*
Depressive Symptoms [1]	37.72 (10.51)	22.52 (10.28)	22 (9.64)	53.99	<0.001
Distress [2]	27.32 (7.13)	37.20 (6.77)	38.08 (6.521)	40.31	<0.001
Resilience [3]	99.2 (27.16)	119.84 (24.88)	125.56 (21.60)	28.09	<0.001

[1] Centre for Epidemiologic Studies Depression Scale
[2] Kessler Psychological Distress Scale
[3] Resilience Scale

The study outcomes showed that apart from the improvement in depressive symptoms, there was a reduction in the level of distress and an increase in the level of resilience. The qualitative data obtained in the interview concurred that the participants found the CBB helpful in enhancing self-awareness, modifying negative thoughts, and self-management. We therefore concluded that CBB might have a positive impact on people with mild or moderate level of depressive symptoms. The CBB was culturally acceptable and beneficial.

The original CBB was developed in English. We are working with researchers in Beijing to translate and modify the CBB in Chinese to fit into the Chinese culture. We have also developed this CBB into a web-based intervention. Given the increasing use of Internet in older adults, we are confident that, in the near future, many older persons will be able to use web-based intervention.

Enhancing mental wellbeing in older persons

The second part of my presentation would focus on prevention of depression. A positive way to address this question is not to put the focus on the disease, but rather on enhancing wellbeing of the older persons. For all health promotion programmes, a strong theoretical base would allow valid outcome evaluations at the completion of the programmes.

In an action study conducted in Singapore, we employed the theory of salutogenesis to develop a self-care programme entitled 'Resource Enhancement and Activation Programme' (REAP) (Tan, Chan, & Vehviläinen-Julkunen, 2014a). The term 'salutogenesis' comes from two Latin words: salus means health, genesis means origin - i.e. 'the origin of health'. Sense of coherence (SOC) is the concept central to salutogenesis. SOC refers to the belief that one's life is predictable and is under control - the person can manage a situation and has optimism and hope in the future. The concept SOC helps to answer the question why some people can stay well despite under very stressful circumstances and the components within themselves that help them stay well (Tan, Chan, & Vehviläinen-Julkunen, 2014b). Salutogenesis is a useful theory to incorporate into health promotion programmes.

The objectives of the REAP were to enhance older persons' perception of their quality of life, SOC, motivation and resilience. It was a 12-week programme with 24 activities conducted twice a week. The REAP adopted an interdisciplinary approach. The programme team involved nurses, occupational therapists, physiotherapists, social workers, police officers, as well as volunteers. The major topics of the REAP included promoting mental health; engaging with the community/ environment; improving nutrition, physical health and exercise; finance management; and home safety. There were classroom sessions as well as community activities, such as visiting a supermarket to learn buying nutritious food within a budget (Tan, Chan, & Vehviläinen-Julkunen, 2014a).

To evaluate the effectiveness of REAP, we conducted a feasibility randomised control trial to evaluate the outcomes of this programme. We recruited old persons (n=64 with 32 per group) from a senior activity centre in Singapore. The majority of our participants were female which matched the demographics of those attending the centre. At the baseline and at 12-week after intervention, the data showed that the experimental group (those attending the REAP) showed significantly better improvement in SOC and the psychological component of QOL when compared with the control group. The improvement of SOC might help to enhance participants' resilience and coping, thus their mental wellbeing (Tan, Chan, Wang &Vehviläinen-Julkunen, 2015).

There is a need to conduct more systematic evaluation and longer-term follow-up to

understand whether the impacts of REAP could be sustained. We believe that self-help programmes like REAP do have potential in promoting older people's mental health.

Mental health for men

In terms of mental health of older people, men's mental health has become a significant issue. We know that females have higher prevalence of depression but more men died of suicide. It seems to be universal that more females than males seek help for their depression, and attend activities in community and day care centres. The challenge is how to engage men in health and social services.

In Australia, several initiatives specifically developed for men are taking place, for examples, 'Man Therapy' (https://www.beyondblue.org.au/about-us/programs/mens-program/program-activities/man-therapy), or 'Men's Shed' (http://www.mensshed.org/what-is-a-mens-shed). Their experiences and programme outcomes should deserve our attention.

Use of technology in care provision

With fast advancement in technology, there are many successful stories of adopting technology in delivering effective healthcare interventions and health promotion activities. For example, a companion robot that could offer companionship (http://www.newcastle.edu.au/research-and-innovation/centre/engineering-built-environment/newcastle-robotics-laboratory/emotional-ai-and-companion-robots). One of my colleagues in the University is developing such robot. In the future, we may use the robot to assess mood and emotions. I am also building psychoeducation programmes delivered through mobile devices such as iPhone or iPad for different types of clients.

Innovation has no boundaries. We wonder whether technology can replace human touch. Everyone says 'No'. Technology works much better together with real human engagement. I believe as we live longer, we are capable of living a meaningful life in full. We can make good use of advanced technology to further improve our services to our clients and further improve their quality of life.

I appreciate very much the opportunity to share some of my studies and my thoughts. I enjoy every moment in this celebration of the 60th anniversary of the Mental Health Association of Hong Kong.

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