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Original Article

Effect of Strength-Based Narrative Therapy on Depression Symptoms and Quality of Life in the Elderly

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Abstract

Background: Depression is a common psychological problem among the elderly. It undermines the elderly's quality of life and imposes a heavy economic burden on society and families. Depression in this group must be addressed, but effective intervention therapies remain absent in existing studies. Strength-based cognitive behavior theory was combined with narrative therapy in this study. Its effect on depression in the elderly was verified through an intervention experiment.

Methods: From April to June 2024, 319 elderly people were recruited from Huoju Community in Changsha, Hunan Province, China to examine the factors influencing depression. A total of 85 of them with depression symptoms were included in a randomized intervention experiment and divided into two groups: 42 in the experiment group and 43 in the control group. The experiment group was intervened with strength-based narrative therapy, whereas the control group was given no targeted intervention.

Results: After the intervention, 1) the total depression score of the experiment group was significantly lower than that of the control group (P=0.001); 2) the mental state score of the control group decreased more significantly than that of the experiment group (P<0.05); and 3) the quality-of-life score of the experiment group was significantly higher than that of the control group at different time points (P<0.05).

Conclusion: Strength-based narrative therapy can effectively alleviate depression symptoms in the elderly, improve their mental state, delay their cognitive decline, and enhance their quality of life. It is an effective option to promote the elderly's mental health.

Keywords: Narrative therapy; Strength; Elderly

Introduction

Depression, as a major public health problem, has been prevailing among the middle-aged and elderly. Approximately 32 million people worldwide suffer from depression, which is expected to be the chief cause of global disease burden by 2030 (1). Professor Huang found that the lifetime incidence rate of depression in Chinese people was 6.9%, and the 12-month incidence rate was 3.6% (2). At present, there are over 95 million patients with depression in China, which means that depression has surpassed cancer and become the second predominant disease after cardiovascular and cerebrovascular diseases (3). Depression is an increasingly serious problem that not only reduces patients' quality of life and social functions but also often coexists with multiple

common diseases; it has become a common psychological problem among the elderly population (4). Severe depression can lead to suicide. The incidence of depression in China was 4.2%, with a conservative estimate of over 54 million elderly patients (5), of which 90% did not receive timely and regular treatment (6). Thus, the current situation of depression in the elderly must be assessed, and intervention schemes that can effectively cope with depression in the elderly must be explored.

Narrative therapy (NT) is considered one of the most influential psychological treatment approaches in the field (7). Through guiding service recipients to tell their own stories, this approach makes them realize that the current problem is the result of negative meanings assigned by individuals under mainstream narrative oppression, helps them identify exceptional events and reconstruct their life stories, and awakens their motivation and efficacy to change their lives (8). To date, NT has been combined with other therapies and applied in clinical psychology to intervene in problems such as obsessive-compulsive disorder, substance abuse, social phobia, schizophrenia, post-traumatic emergency disorder, and psychosocial adaptability of patients with AIDS (9-11). NT is also applicable to a number of groups such as children, adolescents, adults, and the elderly and used under different therapeutic contexts such as communities and college counseling centers (10-11). In the context of outpatient and inpatient treatment, NT is mainly implemented through narrative nursing, which can improve patients' emotions and is conducive to rehabilitation (12).

Although medication has been verified in existing studies to have a certain effect on depression, the disease is prone to relapse after discontinuation. Therefore, psychological therapies are often adopted as adjunctive treatments to improve clinical efficacy (13). Conventional psychological therapies often start from the perspectives of explanation, comfort, and counseling, which can meet patients' emotional needs to a certain extent but have poor intervention effects on some patients. Although there is a relatively consistent, standardized procedure for the clinical application of NT, theoretical support and evidence-based evidence are still absent for practical operation. Thus, NT was combined with strength-based cognitive behavior therapy (SBCBT) in this study to develop an anti-depression intervention scheme suitable for the elderly population according to their psychological characteristics. SBCBT is a cognitive behavior treatment based on strengths aimed at helping patients with mental illness identify their personal goals and utilize their strengths and resources to construct their own psychological and healthy rehabilitation pathways. In response to this emerging treatment method, researchers have conducted preliminary tests on its intervention effect and obtained positive results (14,15). Given the lack of studies targeting the elderly population, the therapeutic effect of SBCBT on depression in the elderly still needs to be evaluated. This study was conducted to improve the existing SBCBT intervention model by incorporating NT and test the effect of the combined intervention scheme in alleviating negative psychological issues such as depression in the elderly.

We explored an effective treatment option suitable for the elderly with depression and provides reference for the improved treatment of depression in the elderly population.

Materials and Methods

Using voluntary registration, elderly people living in Huoju Community, Changsha, Hunan Province, China were selected as the participants from April 2024 to June 2024 through convenience sampling. The inclusion criteria were as follows: 1) elderly individuals aged ≥ 65 years old; 2) elderly individuals residing in this community for at least 1 year; 3) elderly individuals capable of communicating effectively with clear mind; and 4) elderly individuals who participated in this study voluntarily and singed the informed consent. The exclusion criteria were as follows: 1) elderly individuals with severe organ dysfunction, or in the critical stage of a disease, or at the end

of their life (life expectancy<6 months, unable to participate in the study); 2) elderly individuals with severe hearing and visual impairments, communication barriers, and mental and cognitive impairments; and 3) elderly individuals who cannot cooperate properly to complete scale filling. Using continuous enrollment, 319 elderly residents in the community were included in this study. The participants with depression symptoms were included in the experiment and randomly divided into the experiment group (N=42) and the control group (N=43). Prior to the implementation of this study, the purpose, main workflow, and precautions of the study were explained to the participants and their families, and all scales were filled out anonymously. This study was reviewed and approved by the hospital's medical ethics committee.

Research tools

1) Demographic Information Scale: It involves gender, age, education level, living status, financial condition, sleep quality, vision, hearing, and chronic diseases.

2) HAMD (16): Developed by Hamilton, this scale is currently widely used to assess adults' depression level (17). This scale has been jointly verified by multiple institutions in China to have good reliability and validity in assessing the severity of depression symptoms. In this study, it was used to evaluate the depression state exhibited by the participants in the past week, and the results were divided into three levels of scores: 0–7 (no depression symptoms), 8–17 points (mild or moderate depression symptoms) and ≥ 18 points (severe depression). A higher total score indicates more severe depression. Meanwhile, the scale can be classified into factor structures such as somatization, cognitive impairment, delay, and sleep disorders. Changes in the scores of factor structure items can reflect the therapeutic effect (16).

3) MMSE (18): Currently, it is the most commonly used test to quickly assess one's mental state and is widely used for cognitive screening in the elderly. Scores are divided to 25–30 points (normal), 21–24 (suspected mild cognitive impairment), 10–20 points (suspected moderate cognitive impairment), and 0–9 points (suspected severe cognitive impairment).

4) SF-12 (19): It includes 12 items, requires a short survey time, and can effectively reduce the burden on research participants. Moreover, it has good internal consistency and validity among the elderly population in China and is suitable for evaluating the daily quality of life of elderly individuals in the Chinese social and cultural background. The scale adopts a 100-point scoring system, with higher scores indicating higher levels of quality of life.

Intervention method

The control group was given routine intervention, health education, and routine care, including psychological knowledge and health education, psychological counseling, health guidance, observation of adverse reactions, and daily living ability training. In addition to these treatments offered to the control group, the experiment group received psychological treatment using strength-based NT. The intervention lasted 12 weeks, once a week. The specific workflow was as follows. Five-step NT nursing was implemented. 1) Story narrating. 2) Problem externalization. 3) Story deconstruction: In-depth conversations were conducted with the participants, during which they were guided to fully express and vent, with a focus on reviewing life events and capturing past successful experiences. 4) Story rewriting. 5) External witnessing: Personal stories were shared with their most trusted family members or friends through on-site communication or WeChat group or phone calls to gain support. Throughout the entire process, emphasis was placed on tapping into the elderly's internal strengths, such as instilling hope and motivation. At week 6 and week 12 of the experiment, Hamilton Depression Scale (HAMD), Mini-Mental State Examination (MMSE), and Quality of Life Rating Scale-Short Form 12 (SF-12) were used to assess the intervention effects on the two groups.

Statistical methods

SPSS 27.0 statistical software (IBM Corp., Armonk, NY, USA) was used for data processing.

The measurement data conforming to normal distribution were represented as x±s. Independent sample t-test was used for inter-group comparison, and ANOVA was used for multi-group comparison. The measurement data that did not conform to normal distribution were represented by M. The Mann-Whitney test was used for inter-group comparison, and the Kruskal-Wallis H test was used for multi-group comparison. The count data were presented by number of cases and percentages and analyzed using chi square test. Statistically significant differences were set at $P<0.05$.

Results

Factors influencing depression in the elderly in the community

A total of 319 participants (volunteers) were included in the study. As shown in Table 1, living status, presence of two or more chronic diseases, senility, age, marital status, financial condition, exercise frequency, sleep quality, and self-care ability were all found to be important factors affecting the level of depression in the elderly.

Among the participants, those who lived alone, suffered from multiple chronic diseases, were in a state of senility, at a ripe old age and divorced or widowed, had financial difficulties, lacked exercise, had sleep disorders, and suffered from decline or dysfunction in self-care ability had significantly higher total depression scores than the other groups ($P<0.001$). Thus, these factors significantly increased the risk of depression in the elderly.

Comparison between the experiment group and the control group in depression before and after the intervention

As shown by the results of the comparison between the experiment group and the control group in terms of gender, age, marital status, financial condition, living status, exercise frequency, presence of two or more chronic diseases, sleep quality, senility, and self-care ability, there were no significant differences in these variables between the two groups ($P>0.05$). As shown in Table 2, the total HAMD-17 scores of the two groups were similar at baseline, with no statistically significant difference ($t=0.901$, $P=0.372$), indicating that the level of depression was comparable between the two groups before the intervention. After 6 weeks of intervention, although the total HAMD-17 score of the experiment group decreased, this decrease was not significantly different ($t=0.543$ and $P=0.59$) compared with the control group. Thus, there was no significant difference in the alleviation of depression symptoms between the two groups after the short-term intervention. Nevertheless, at week 12 of the intervention, the total HAMD-17 score of the experiment group was significantly lower than that of the control group ($t=-3.666$ and $P=0.001$**). Thus, the experiment group experienced more significant alleviation of depression symptoms after the long-term intervention than the control group.

Comparison between the experiment group and the control group in mental state before and after the intervention

As shown in Table 3, the MMSE scores of the two groups were similar at baseline, and their *t*-test results showed no significant difference ($t=1.211$ and $P=0.232$). Nevertheless, at week 6 of the intervention, although the score of the experiment group was slightly lower than the baseline and the score of the control group also decreased, the difference between the two groups was not significant ($t=1.895$ and $P=0.065$). At week 12 when the intervention ended, although the MMSE score of the experiment group continued to decrease, the decrease in the score of the control group was more remarkable, and the difference between the two groups was statistically significant ($t=2.662$ and $P=0.011$*).

Table 1: Univariate analysis of depression in the elderly in the community

Risk factors	N	Depression score	t/F	*P*
Gender				
Male	164	8.91 ± 9.81	1.041	0.299
Female	155	7.83 ± 8.56		
Living status				
Not living alone	155	5.59 ± 2.81	-5.503	<0.001
Living alone	164	11.03 ± 12.01		
Suffer from two or more chronic diseases				
No	152	5.77 ± 2.80	-5.01	<0.001
Yes	167	10.77 ± 12.00		
Senility				
No	152	5.32± 2.21	-5.969	<0.001
Yes	167	11.18 ± 11.92		
Age				
65-70	110	5.11 ± 1.82	22.724	<0.001
71-80	98	7.16 ± 6.07		
81 and above	111	12.71 ± 13.39		
Marital status				
Married	85	4.72 ± 1.88	22.817	<0.001
Unmarried	79	5.33 ± 1.89		
Widowed	82	9.59 ± 9.43		
Divorced	73	14.62 ± 14.18		
Financial condition				
Surplus	102	4.78 ± 1.95	50.714	<0.001
Balance of incomes and expenses	107	5.39 ± 1.95		
Running behind expenses	110	14.64 ± 13.45		
Exercise frequency				
Frequent	76	5.03 ± 1.86	22.786	<0.001
Occasional	72	5.03 ± 2.01		
Seldom	90	8.29 ± 8.30		
Never	81	14.63 ± 13.95		
Sleep quality				
No sleep disorders	96	5.07 ± 1.68	38.714	<0.001
Suspected insomnia	106	5.46 ± 2.94		
insomnia	117	13.752± 13.32		
Self-care ability				
Normal	90	5.11 ± 1.83	26.614	<0.001
Decline	107	6.10 ± 4.65		
Dysfunction	122	12.80 ± 13.04		

Table 2: Comparison between the two groups in the total HAMD-17 score before, during, and after the intervention

Time	Experiment group (n=42)	Control group (n=43)	t	*P*
Baseline	13.227±3.491	12.48±2.104	0.901	0.372
Week 6	12.455±3.291	12.04±1.814	0.543	0.59
Week 12	11.045±4.445	16.24±5.174	-3.666	0.001**

Note: *P<0.05, **P<0.01.

Table 3: Comparison between the two groups in the total MMSE score before, during, and after the intervention

Time	Experiment group (n=42)	Control group (n=43)	t	*P*
Baseline	25.045±1.495	24.520±1.475	1.211	0.232
Week 6	24.182±1.181	23.360±1.705	1.895	0.065
Week 12	23.455±1.371	21.800±2.614	2.662	0.011*

Note: *P<0.05, **P<0.01.

Comparison between the experiment group and control group in quality of life before and after the intervention

As shown in Table 4, the time effect was significant (F=117.406, P=0.001), indicating significant differences in the SF-12 score at different time points (i.e. baseline, week 6, and week 12). The grouping effect was also significant (F=8.863, P=0.005), indicating a difference in the SF-12 score between the experiment group and the control group. The time–grouping interaction effect was also extremely significant (F=3131.721, P=0.001*), further indicating significant differences in the changing trend of the SF-12 score between the two groups at different time points.

Table 4: Repeated measures ANOVA of SF-12 scores

Time	Experiment group (n=42)	Control group (n=43)	Time effect	Grouping effect	Time*Grouping effect
Baseline	42.09±2.41	43.08±2.08	117.406**	8.863**	3131.721**
Week 6	41.14±2.38	42.08±2.08			
Week 12	46.09±2.41	38.28±2.26			

Note: *P<0.05, **P<0.01

Discussions

Effect of Strength-based NT on Depression in the Elderly

In this study, after the short-term intervention, we found no significant difference in the HAMD-17 score between the two groups at week 6 of the intervention (P>0.05). The reasons may include the lack of enthusiasm in the elderly participants of the experiment group at the beginning of taking part in NT, which inhibited them from carefully exploring their own psychological resources, weakened their social connections, made it difficult to relieve their negative internal emotions, and led to the failure of this treatment method to address the root cause of the problem (20). This subsequently affected the efficacy of NT and resulted in an overall increase

in HAMD-17 score. Nevertheless, at week 12 of the intervention, the total depression score of the experiment group was significantly lower than that of the control group (P=0.001), indicating that the long-term application of strength-based NT could significantly alleviate depression symptoms in the elderly. This result was consistent with the research results obtained by Su et al (21) and other researchers. NT, according to its workflow, could effectively help the elderly clarify their psychological problems, become the masters of their own psychological issues, and engage in reflection on their own psychological state through a construction–deconstruction–reconstruction narrative process (22). This intervention experiment also made the elderly realize that their personal life value did not gradually decrease with age, but rich life experiences would bring them a positive way of thinking in life. SBCBT was combined with NT in this study to absorb their advantages. During the treatment process, the elderly were guided to understand and deal with psychological issues and external obstacles that affected them and encouraged to take measures proactively, which would facilitate their recovery from depression. When strengths were identified and utilized, the so-called problem or previous negative cognition, would also be addressed.

Effect of Strength-based NT on Mental State in the Elderly

A decrease in the MMSE score indicates a decline in cognitive function and mental state. Compared with the baseline, after 6 weeks of intervention, the MMSE scores of both groups showed a downward trend, but the difference between the two groups was not significant (P>0.05). At week 12 when the intervention ended, although the MMSE score of the experiment group continued to decline, the decrease in the score of the control group was more significant (P<0.05), indicating that strength-based NT could effectively improve mental state in the elderly and delay the progression of cognitive decline (23). From the perspective of neuroscience, the intervention implemented in this study externalized the problems that plagued the participants by rearranging and interpreting their own life stories, thereby forming a positive, powerful self-concept and endowing them with positive and proactive energy. Moreover, the positive emotions generated from the identification and utilization of strengths can stimulate the preference of the right brain for novelty and insightfulness, slowing down the decline of cognitive function in the brain (23). Structured conversations were made with visitors during a single treatment session, guiding them toward elements such as “hope,” “longing,” “enthusiasm,” and “social participation.” When the elderly engage in “storytelling,” these key elements of storytelling can bring them the feeling of pleasure and effectively improve their mental state.

Effect of Strength-based NT on Quality of Life in the Elderly

In this study, we noted significant differences in the SF-12 score between the two groups at different time points (i.e., week 1, week 6, and week 12). In addition, the SF-12 score of the experiment group showed an increasing trend over time, whereas the SF-12 score of the control group exhibited a decreasing trend over time, and the differences were statistically significant (P<0.05). These results indicated that strength-based NT could improve quality of life in the elderly. NT adheres to the view that “separating the person from problems” is the key to solving individual problems. The elderly’s depression symptoms are externalized as a part outside the individual, and the source of the problem is identified (24, 25). Patients are guided to tell new stories and tap into their own potential from positive events to solve problems. Consequently, their coping ability can be improved, alleviating anxiety and depression. NT provides participants with an opportunity to express their inner needs and be attentively listened to by others through the process of storytelling, allowing them to vent and release their depressive emotions and establish close cooperative relationships (26). Participants are inspired to recall positive events and shining points with special implications in their

lives, rebuild their sense of self-identity, evoke their positive emotions, and improve their positive psychological sources such as hope. Third, NT is a form of group therapy aimed at increasing participants' social engagement. Participants are provided with opportunities to cope with sadness and other negative life experiences within the group, thereby alleviating their negative emotions and depression symptoms and underlining their subjective life experiences, such as satisfaction and happiness.

Conclusion

This study was the first to combine SBCBT with NT, in which a comprehensive psychological intervention therapy was generated to intervene in depression in the elderly for 12 weeks. The depression, mental state, and quality of life levels of the two groups were measured at week 1, week 6, and week 12 of the intervention. Results showed that this comprehensive psychological therapy could effectively alleviate depression symptoms, improve mental state, delay cognitive decline, and enhance quality of life in the elderly. Moreover, the results revealed the need to arrange long-term continuous intervention, considering the weak efficacy of short-term intervention. Strength-based NT is highly suitable for application and promotion to improve the elderly's mental health. It can also provide scientific reference for designing depression intervention schemes targeted at the elderly. The limitation of this study was the use of self-reported scales, which led to the absence of physiological indicators. In future studies, the measurement of physiological responses (e.g., blood pressure, heart rate, and respiratory rate) or monitoring methods (e.g., electroencephalography and serological evaluation) can be incorporated to assess the efficacy of interventions objectively.

Journalism Ethics considerations

Ethical issues (Including plagiarism, Informed Consent, misconduct, data fabrication and/or falsification, double publication and/or submission, redundancy, etc.) have been completely observed by the authors.

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Conflict of Interest

The authors declare that there is no conflict of interests.

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