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Emerging Trends On Depression, Anxiety & Quality Of Life With Special Reference To Cognitive Behavioural Therapy (Cbt) And Mindfulness-Based Cognitive Therapy (Mbct)

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ABSTRACT:

Mindfulness-based cognitive therapy (MBCT) was developed as a psychological intervention for individuals at risk of depressive relapse. Possible mechanisms of change for this intervention are in line with its theoretical underpinnings, and include increases in mindfulness and/or decreases in negative repetitive thoughts. MBCT draws from cognitive behavior therapy (CBT) and traditional mindfulness practices. Mindfulness is defined as non-evaluative present-moment awareness, and is used within MBCT to help individuals disengage from their ruminative thoughts and to promote detachment and decentering from depression-related thoughts and feelings. In this article, emerging trends on depression, anxiety & quality of life with special reference to cognitive behavioral therapy (CBT) and mindfulness-based cognitive therapy (MBCT) has been highlighted.

Keywords: CBT, MBCT, Depression, Anxiety.

INTRODUCTION:

Numerous studies show that CBT and interpersonal therapy are the most successful psychological treatments for many older people who suffer from sadness and anxiety (Arean and Cook 2002). Furthermore, several researchers came to the conclusion that mindfulness-based therapy could greatly benefit elderly people's mental health (Baer, 2003). However, there is little supporting research in this regard. In place of CBT, mindfulness-based therapy will be used in this study to enhance older participants' mental health. There aren't many studies comparing mindfulness-based therapy with cognitive behavioural therapy for enhancing older patients' mental health. This study tries to do that. There are also few studies that look at the effectiveness of methods other than pharmacological ones for enhancing elderly people's mental health. With the help of interventions like MBCT and CBT, this study aims to better understand how much progress in the mental health of the elderly

may be anticipated. The study's secondary goal is to determine which of the two widely used non-pharmacological treatments (MBCT and CBT) is more effective at enhancing elderly people's mental health. According to a preliminary examination of the literature, no such study has been carried out.

The aged population is prone to anxiety and despair. Even a small number of these diseases might have a negative impact on a person's mental health. The elderly's physical, emotional, psychological, and spiritual health are all impacted by their mental health. And studies have revealed a link between poor mental health and suicide (Morn, 1996). Many pharmaceutical and non-pharmacological therapy methods have been created to enhance the mental health of the elderly. The non-pharmacological methods of CBT and MBCT are both very well-liked.

CBT has been proven to be successful in treating anxiety and depression in various trials. In another 2013 study, Onigder demonstrated the effectiveness of CBT for symptoms of sadness, anxiety, and loneliness. However, there aren't many studies on the effectiveness of MBCT. Recurrent depression can be effectively treated with MBCT. The findings of one study regarding the efficacy of MBCT are ambiguous. Following Baer's 2003 meta evaluation of 15 trials, it was concluded that MBCT might be effective in treating anxiety and mood disorders (Baer 2003). Researchers did a meta review of 15 papers and concluded that MBCT has a consistent impact on these issues. According to Hoffman and Stefan's recent meta assessment of 39 studies, MBCT was only modestly efficient at reducing anxiety and depressive symptoms. Numerous studies have compared MBCT to CBT in the treatment of depression, including one by Parker and colleagues from 2011. According to early research, there hasn't been a comparison of MBCT and CBT's effectiveness in treating anxiety or enhancing quality of life. The literature search turned up no research contrasting the effectiveness of MBCT and CBT in promoting older patients' mental health.

Behavior therapy can be categorised into three main waves. The first wave, which dates back to the 1950s, consists of three separate movements. First, in South Africa, according to Joseph Wolpe's book Psychotherapy by Reciprocal, which describes behaviour therapy as a treatment for phobias and anxiety disorders, At the same time, Ogden Lindsley employed operant reinforcement to treat schizophrenia. And finally, Eysenck referred to an alternative to psychoanalysis in his seminal 1952 paper since he found no treatment to be as successful as psychoanalysis. When Aaron Beck developed Cognitive Therapy in the 1970s, the second wave of behaviour therapies was officially launched. The effectiveness of CT as a treatment for depression, anxiety, and eating disorders has been demonstrated (Hayes 2004). Behavior and cognitive therapies were combined in the 1980s and 1990s to form cognitive behaviour therapy, which has the most empirical support of any therapy (Roth and Fonagy 2005).

PREVALENCE OF DEPRESSIVE DISORDERS:

To ascertain the median prevalence rate of depression in the older population of India and many other nations around the world, Barua, Kar, Ghosh, and Basilio (2011) conducted an analysis of numerous research conducted between 1995 and 2005. The elderly were chosen for the experiments from a homogeneous elderly population using a straightforward random sample procedure. They discovered that the median depression prevalence rate in Indians was almost 21.3%, compared to a global prevalence of depression of 10.3 percent. Even though the prevalence of geriatric depression has greatly decreased globally, it has recently increased among Indians relative to the rest of the globe. Researchers (Chuan et al. 2018) carried out a study to determine the prevalence of depression among senior hospital patients. They came to the conclusion that 32.8 percent of elderly patients in hospitals had depression. Numerous independently linked characteristics, including cognitive decline, frailty, and poor family functioning, were discovered to be connected with depression.

Prevalence and risk factors for depression and anxiety in people in the community and residential care (Anstey, von Sanden, Sargent, Cox, and Luszcz, 2007) based on their study on the prevalence of depression and anxiety concluded that compared to elderly people living in the community who experience depression at a rate of 14%, those living in residential homes experience it at a rate of 32%. And whereas just 9% of older people in the community experience worry, this number rises to 14% for those living in residential homes. Additionally, they discovered that depression was unrelated to hypertension, diabetes, or stroke but was related to education, sex, and marital status.

According to a community-based research of psychiatric diseases affecting old Delhi residents (Chowdhury and Rasania, 2007), depression affects 23.6 percent of Delhi's elderly population, compared to anxiety, which affects 10.8 percent of the elderly population. The study's authors found that the senior population is at significant risk for the incidence of mental disease. They also cautioned that the significant frequency of psychiatric problems among seniors from low-income households presents a challenge for the nation's mental health services. According to Kay, Beamish et al. (1964) and Bhutia et al. (2000), who diagnosed depression prevalence rates of 40 percent and 44 percent, respectively, in the literature, there is a prevalence rate of depression that is similar to that of Chowdhury and Rasania.

In their study on social and cultural factors in the late onset of depression and anxiety, Ramachandran, Menon, and Arunagiri (1982) came to the conclusion that depression was the most commonly diagnosed condition, with 24.1% of cases. Female sex, unemployment, low social standing, widowhood, nucleus family, physical disease, and living alone are all risk

factors for depression. In terms of gender, females are more likely to report having depression. They discovered that depression was more prevalent among widows due to a general lack of meaning and discontent in life. Another study conducted in 1964 found a similar prevalence rate of depression (24%) to that reported by Ramchandran and colleagues (Kay et al., 1964).

RELATIONSHIP BETWEEN DEPRESSION, ANXIETY AND QUALITY OF LIFE:

Proximal predictors of quality of life at older ages (Webb, Blane, McMunn, and Netuveli, 2010) studied a nationally representative sample of non-institutionalized adults over the age of 50 living in England with non-missing data for the variables of interest and found that the maintenance of good QoL in elderly populations enables them to avoid depression, maintain good physical health, social relationships, and good environmental standards.

Quality of Life in People with Anxiety Disorders: It was demonstrated via their research how quality of life and psychosocial functioning are significantly impacted by anxiety disorders as illnesses. Individuals with sub-threshold forms of anxiety disorders may also exhibit significant impairment. It has been demonstrated that patients with panic disorder, social phobia, and post-traumatic stress disorder can improve their quality of life with successful pharmaceutical or psychotherapy therapies.

Loneliness and health-related quality of life for elderly people in a rural region of a hilly country in China: The lowering levels of loneliness may enhance the quality of life for empty-nester elderly people. They came to the conclusion that those without children or grandchildren have a bad quality of life.

By concentrating on how caring for elderly dependents affects the carer's quality of life, Jones and Peters' article from 1992, "Caring for Elderly Dependents: Effects on the Carer's Quality of Life," has made a significant contribution. Caregivers reported that providing for others had an impact on many facets of their social and familial lives, as well as their physical and mental health. For many, the act of giving was a constant. Daughters were often more likely to report negative impacts on their lives. Relationships between caregiver and dependent, caregiver sex, and effects on social and family life were the main factors linked to stress. Although sex and relationships were also linked to anxiety, loneliness was the main cause of anxiety and sadness. Stress was linked to the dependent's older age, caregivers' handicap was linked to anxiety, and depression in the elderly was linked to depression in careers.

THE MBCT PSYCHOTHERAPY LITERATURE:

Theoretical features of MBCT: MBSR and CBT are combined in MBCT. It contains some elements of CBT for depression as well as the structure and procedures of MBSR. Most often, it is taught during an eight-week period to a maximum of twelve students.

Mindfulness: A number of religious and spiritual practices are the roots of mindfulness. It has been regarded as a crucial component of Buddhism. Buddhism uses mindfulness to help people understand the cause of pain and its cessation. Additionally, it is a way to prevent us from adding agony to our already excruciating pain and suffering (Gunaratana, 2002). Programs for mindfulness must include these three components.

- Developing Awareness: The first part of a mindfulness programme deals with developing awareness using a systematic approach which incorporates various practices such as body scan, sitting meditation and mindfulness walking etc.

- Developing a specific attitudinal framework: Mindfulness encourages us to cultivate an attitude of kindness, curiosity, willing to experience the present and its acceptance. These attitudes are deliberately practiced and emerge out after systematically performing mindfulness practices.

- Developing an understanding of human suffering: This is basically done with the first listening of the teachings by the teachers and then validate the same through our experiences. We come to know how suffering is the part of human nature and how we collaborate to perpetuate our sufferings.

Mindfulness Based Stress Reduction Programme (MBSR): John Kabat Zinn, in the nineties, pioneered the integration of traditional buddhist meditation practices into an accessible psycho-educational programme called Mindfulness based stress reduction. The goal of Kabat Zinn was to bring these ancient practices into the mainstream by creating a secular framework to help people suffering from chronic pain and variety of other disorders. The programme involves intensive training in mediation in groups and enabling participants using these learning to the challenges they face in daily life.

There are eight psycho-educational sessions in the programme. In these MBSR and MBCT sessions, the ordering of various mindfulness techniques is remarkably similar. The modifications made depending on the participants are the only significant distinction between the lessons learned. There are seven attitudinal characteristics that support effective mindfulness practices. These qualities can be brought into practice and their consequences can be seen. These are listed below:

Non-Judgment: We add awareness to the stream of experience without interpretation or judgment. In this way, we become clear about the internal process of adding judgment and reaction to the experience.

Patience: The process of investigation takes place with time. We cannot push change, but it takes place in its own time. One has to learn to be with the moment patiently, without expecting anything.

Trust: Participants are encouraged to show trust in their sensations, experience and intuitions. The teacher also conveys trust in the participants' ability to relate with their experiences.

Beginner's mind: A key intention is to spark interest in person; the process feels at best fresh and vital. The engaged exploration is in the "how" and "why" of experience rather than what.

Non-striving: The participants are asked not to hold on to the moment or try to change it. The orientation should be to live in the moment.

Acceptance: We accept the moment as it is, without trying to change it. It is a way of being with reality without changing it.

Letting go: Finally, after accepting the experience as it is, mind helps us to learn to let go our habitual way of focusing on thinking about experiences.

The three developers of MBCT are Mark Williams, John Teasdale and Zindel Segal. These researchers were trying to gain the theoretical understanding of depressive relapse occurrence. The key insight of the developers was that the protective mechanism in preventing the depressive relapse is the ability to "de-centering" or step back from our thought process. And they reach the conclusion that such de-centering can be achieved through developing skills of Mindfulness. In order to develop such a programme, they borrowed features from two different approaches which are discussed below:

Cognitive Behavior Therapy (CBT): MBCT also incorporate features from the CBT which is a very popular therapy of treatment for depression and anxiety. This integration takes two forms:

1) It provides the cognitive framework and understanding developed from CBT conceptualization (Beck and Emery, 1979). The CBT conceptualization is very helpful teaching process and helps in linking learning and insight gained to depression.

2) It also borrows various curriculum events which are integral part of CBT programmes used for treatment of depression and anxiety.

The research demonstrates that older adults are viewed as unsuitable subjects for psychotherapy. According to several academics, elderly individuals view psychotherapy as a symptom of mental fragility (Casey and Grant 1993). Even Freud admitted that elderly people are unsuitable for psychoanalysis because their minds are no longer flexible enough to engage in such an investigation (Freud 1950). The opinions of many successful therapists have been influenced by Freud, as they have been by many other fields and schools in psychology. But in recent years, there has been growing evidence that older adults can successfully use psychotherapies (Scogin and McElreath 1994). In several studies, CBT has been demonstrated to be effective in treating elderly depression. Psychotherapy is supported by studies by Gallager and Thompson (1983, 1984) as an effective treatment for depression in the elderly. A mental analysis revealed that psychosocial interventions, such as CBT, have a significant mean effect size. Dobson also performed a meta-analysis, finding that CBT is useful for treating older people but not as well as it is for treating younger people (Dobson, 1989).

According to additional research, CBT for the elderly is only beneficial when there is a specific precipitating factor or problematic scenario that may be targeted by a CBT strategy (Thompson 1991). The presence of such qualities, according to some researchers, is advantageous but not necessary for using CBT on elderly people (Casey 1993). There are some circumstances in which CBT for seniors can stop working. These conditions include acute medical fragility and instability, unfavorable sensory losses, severe psychomotor agitation, or major cognitive impairment in the elderly.

THE CBT PSYCHOTHERAPY LITERATURE

The cognitive therapy family of interventions offers a rational and scientific method to assist participants in overcoming their obstacles. Critical rationalism serves as the philosophical basis for CT (Popper 1959). The fundamental tenet of critical rationalism is that scientifically generated hypotheses can be tested one at a time to arrive at a more precise one. This is predicated on the corollary premise that reality is unbiased and verifiable. In CBT, the client is asked to develop and test hypotheses based on his beliefs. The Socratic Method is a key component of CT; it is used to identify dysfunctional beliefs, which are then challenged and replaced with empowered ones in conjunction with the client.

Relationship between Emotions and Cognitions:

The CT model proposes a causal relationship between emotions, behaviour, and cognitions. Because of the reciprocal nature of their relationship, we can alter our emotional and behavioural states in order to alter our cognitions. Other psychologists, however, argue that, while not insignificant, cognitions do have a significant effect on behaviour. According to the

cognitive therapy (CT) approach, how you perceive a situation or experience affects how you react to it. The primary causes of psychopathology are negative cognitions and cognitive distortions. The CBT approaches are in line with the most recent emotional research by Gross and colleagues. Antecedent techniques (applied before the emotion cycle is fully triggered) or respondent methods can be utilized to accomplish emotional regulation (used after the emotion cycle is fully activated). Cognitive appraisal is a CT technique that deals with antecedent coping. Respondent coping includes relaxation methods, which are also employed in CT.

The biological correlations of cognitions and CT:

Numerous studies in the field of neuroscience demonstrate that self-conscious or emotional self-regulation of behaviour alters the electrodynamics of the brain. According to research by Gross and colleagues, altering how individuals respond to unpleasant stimuli improves their mood and their brain activity patterns. The amygdala and orbital frontal cortex's activity decreased as a result of the unpleasant circumstance being reevaluated, while the left lateral prefrontal cortex and medial frontal cortex's activity increased. Additionally, CT has been linked to alterations in the midline structure of the anterior and posterior cortex, which is involved in the processing of self-referential information.

CT is more effective than other form of psychotherapies:

Tolin carried out a quantitative review to evaluate the effectiveness of CBT in treating different types of psychiatric problems compared to other psychotherapies. When compared to psychodynamic treatment, CBT was found to be superior, but not to interpersonal therapy.

In this particular study, researchers' loyalty to CBT was positively correlated, yet even after correcting for this effect, CBT was still superior. Additionally, it was evident that CBT outperformed alternative psychotherapies for treating depression and anxiety, even after correcting for various side effects (David 2010). The study's findings, however, differ from those of Butler and colleagues in that they discovered that CBT is a successful treatment for a variety of mental diseases in addition to depression and anxiety (Butler, Fennell et al. 1991).

CT as group therapy: According to group therapy literature, the intervention is the group processes themselves. Burlingame and colleagues say in a 2004 study of the conventional group approach, "High significance is put on the interpersonal and interactional climate of the group, underpinned by the assumption that the group is the vehicle of change and that member-to-member interaction is a primary mechanism of change." Contrary to the CBT group approach, group literature is considered to provide some insights into group

dynamics. Here, two key group dynamics techniques are examined. One was provided by Irvin Yalom, a psychologist, who is featured in his 1995 book The Theory and Practice of Group Psychotherapy. The alternative strategy uses the theoretical framework presented by Burlingame and associates.

Burlingame, MacKenzie and Strauss Group Model:

By creating literature on the effectiveness of the treatment of particular disorders using a group method, on the one hand, and by drawing inspiration from Yalom's components, on the other hand, Burlingame and his colleagues built another theoretical framework.

Formal Change theory:

In the context of CBT, it would be equivalent to a protocol or session plan outlining the CBT techniques and concepts to be applied.

Small group process:

This in large part corresponds to the Yalom group factors, which are explored subsequently.

Patient:

He brings not only specific diseases to the group but also his interpersonal and personal traits, which can help or hurt the group dynamics.

Group structural factors:

Include details such as the number of sessions, their duration, frequency, group size, and the location where the treatment would be delivered.

Leaser:

The group process is greatly influenced by the style and actions of the leader. The leader's interpersonal style (warmth, openness, etc.) has an impact on the group dynamics and final product.

Yalom's Group Factors (1995):

It tells the story of how the person overcame their obstacles. It is the main component of self-help organizations like Alcoholics Anonymous.

Universality:

You come to the realization that your problems are not as unique as you once believed and that many other individuals experience similar problems.

Imparting of information:

In a group environment, the information that a participant gets might be of two types: didactic and direct advice. Both types of knowledge are necessary for a more accurate conception and understanding of the issue.

Altruism:

The chance that is given in a group situation to assist other group members.

Corrective recapitulation of the primary family group and interpersonal learning:

The social microcosm of the group environment reflects the interpersonal tendencies of the individual based on his interactions with important people in his life. If any flawed patterns were created, the group members offer corrective comments to make it better.

Socializing technique:

The group provides possibilities for social skill development, either explicitly through role-playing or implicitly through group interactions.

Group cohesion:

It can be characterized as the attraction that group members have for one another and for the group as a whole. Yalom believes that it is essential to the group's smooth operation.

Catharsis:

The group members' sharing of their sometimes-unspoken and unconscious emotions It is not necessarily linked to successful outcomes. Positive feedback is essential for being beneficial.

Applicability of traditional groups factors in CBT groups:

In a CBT group, emphasis is typically placed on the model for individuals' struggles and potential for change. This procedure is congruent with the instillation of hope and the dissemination of instructive knowledge. Sharing facts about one's issues also reduces personalization and helps people realize how common their issues are. Every time a new

tactic is taught in a CBT group setting, members are given the chance to demonstrate their compassion by offering to give examples. Socializing techniques and imitative conduct also become more significant when CBT group processes and different behavioural strategies are developed.

Another crucial element in the CBT group procedure is group cohesion. The factors that help and hinder this characteristic are less well known. Two criteria might not be as important in the CBT group. The CBT method is incompatible with catharsis and corrective recapitulation of the original family group. First off, the majority of CBT practitioners do not view catharsis as a goal. Although disclosing private information may be useful, treatment does not necessarily result from doing so. Second, corrective recapitulation of the primary family group, which has a strong emphasis on the past, differs greatly from CBT, which places a strong emphasis on the present. However, it must be acknowledged that a CBT practitioner may occasionally be interested in the client's past in order to comprehend the source of basic beliefs.

CONCLUSION:

New treatments have become available over the past 15 years. Along with their new qualities, they also share some characteristics with earlier therapies. The fundamental components of these therapies include elements like mindfulness, acceptance, the patient's value system, the significance of relationships, the justification for the course of therapy, and the client-therapist relationship (Hayes). Some researchers, however, disagree with this classification and claim that the features of older therapies have been incorporated into the new wave of therapy (Hofmann and Asmundson 2008).

One crucial thing to keep in mind is that the strategies utilized in the MBCT programmes are applied with a certain orientation. The various components of CBT are blended into the mindfulness-based attitudinal framework. In the CBT framework, these strategies might be used to recognized automatic thoughts and then challenge them, whereas in the MBCT programme, the emphasis is on developing a de-centering viewpoint, understanding the causes of depression, and developing skills that can help people overcome it.

Many themes from the Burlingame model are present in CBT groups as a whole. CBT groups are often closed, so joining in the middle is not an option. This is done because CBT places more emphasis on content modality than process because acquiring particular abilities is best accomplished in a sequential fashion. The CBT group typically meets for 1-2 hours over two days, once or twice a week. The frequency of meetings is continuous. Second, the Burlingame model places a focus on leadership. The leadership approach used by the therapist in a group context is quite similar to CBT for individuals. The CBT group's therapist

faces a variety of difficulties. The group dynamic and the requirement to impart certain concepts and related procedures must be balanced by CBT therapists.

REFERENCES:

Anstey, K.J., Von Sanden C., Sargent – Cox., & Luszcz, M. A. (2007). Prevalence and Risk Factors for Depression in a Longitudinal, Population-Based Study Including Individuals in the Community and Residential Care. American Journal Of Geriatric Psychiatry, 15 (6),497-505.

Arean, P. A. & B. L. Cook (2002). Psychotherapy & combined psychotherapy/ pharmacotherapy for late life depression. Biological Psychiatry. 52 (1): 293-303.

Baer, R. A. (2003). Mindfulness Training as a Clinical Intervention: A Conceptual & Empirical Review. Clinical Psychology: Science & Practice 10 (2): 125-143.

Barua, A., N. Kar, M. Ghosh & M. Basilio (2011). Prevalence of depressive disorders in the elderly. Annals of Saudi Medicine 31(6), 620-4.

Bhutia, T., I. Walia & A. Singh (2000). Social & mental health of elderly in Chandigarh. Bulletin of PGI 34 (3), 98-101.

Butler, G., M. Fennell, D. Robson & M. Gelder (1991). Comparison of behaviour therapy & cognitive–behaviour therapy in the treatment of generalised anxiety disorder. Journal of Consulting & Clinical Psychology 59 (1),167-175.

Casey, D. A. & R. W. Grant (1993). Cognitive therapy with depressed elderly in patients. In J. Wright, M. Thase, A. T. Beck, & J. Ludgate (Eds.), Cognitive therapy with inpatients. New York: Guilford Press.: 295-314.

Chowdhury A., Rasania S.K. (2008). A community based study of psychiatric disorders among the elderly living in Delhi. The Internet Journal of Health. 2008 7(1)

Chuan, Z., C. Shanping, S. Jing, X. Zheng, W. Lingxiao, G. Lijuan, L. Qian & Y. Yongxue (2018). Prevalence & associated factors of depressive symptoms among elderly inpatients of a Chinese tertiary hospital. Clin Interv Aging 13, 1755-1762.

David, F. T. (2010). Is cognitive–behavioural therapy more effective than other therapies? A meta-analytic review. Clinical Psychology Review 30 (6), 710–720.

Dobson, K. S. (1989). A meta-analysis of the efficacy of cognitive therapy for depression. Journal of Consulting & Clinical Psychology 57 (3), 414-419.

Freud, S. (1950). On psychotherapy. Collected papers (Vol. 1, pp. 249-263). London: Hogarth Press.(Original work published 1904).

Gallagher, D., G. Nies & L. W. Thompson (1982). Reliability of the Beck Depression inventory with older adults. Journal of Consulting & Clinical Psychology, 50(1): 152-153.

Hayes, S. C. (2004). Acceptance & commitment therapy, relational frame theory, & the third wave of behavioural & cognitive therapies. Behaviour Therapy 35 (4), 639-665.

Hofmann, S. G. & G. J. G. Asmundson (2008). Acceptance & mindfulness-based therapy: New

wave or old hat? Clinical Psychology Review 28 (1), 1-16.
Kay, D. W. K., P. Beamish & R. Martin (1964). Old age mental disorders in Newcastle Upon Tyne. Part I. A study of prevalence. British Journal of Psychiatry 110 (465), 146-158.
Mourn, T. (1996). Subjective well-being as a short- and long-term predictor of suicide in the general population. World Conference on Quality of Life, University of Northern British Columbia, Prince George, Canada, August 22-25.
Popper, K. R. (1959). The logic of scientific discovery.New York: Basic Books.
Ramachandran, V., M. S. Menon & S. Arunagiri (1982). "Socio-cultural factors in late life depression." Indian J Psychiatry 24(3): 268-273.
Roth, A. & P. Fonagy (2005). "What works for whom? A critical review of psychotherapy research (2nd ed)." New York: Guilford Press.
Scogin, F. & L. McElreath (1994). "Efficacy of psychosocial treatments for geriatric depression: A quantitative review." Journal of Consulting & Clinical Psychology, 62 (1), 69-74.
Thompson L.W., Gallagher D., Nies G., & Epstein. (1983). Evaluation of the Effectiveness of Professionals and Nonprofessionals as Instructors of “Coping with Depression” Classes for Elders, The Gerontologist, 23 (4), 390–396.
Webb, E., D. Blane, A. McMunn & G. Netuveli (2010). Proximal predictors of change in quality of life at older ages. Journal of Epidemiology & Community Health 65(6): 542-547.