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Effects of a Mind Caring Support Program on Depression among Older Adults with Chronic Illnesses Living in the Community in Nakhon Si Thammarat Province, Thailand

Wachira Chaidet[1], Saifon Aekwarangkoon[2,*] and Naiyana Noonil[2]

[1]Master of Nursing Science in Community Nurse Practitioner, School of Nursing, Walailak University, Nakhon Si Thammarat 80160, Thailand
[2]School of Nursing, The Excellence Center of Community Health Promotion, Walailak University, Nakhon Si Thammarat 80160, Thailand

([*]Corresponding author's e-mail: saifon.aekwarangkoon@gmail.com)

Abstract

This quasi-experimental study aimed to examine the effects of a Mind Caring Support program on depression among older adults with chronic illnesses living in the community by comparing median depression score changes within the experimental group and between the experimental and control groups. The sample consisted of 78 older adults with mild to moderate depression who had chronic illness and were living in primary care unit areas of Nakhon Si Thammarat Province, Thailand. Participants were equally assigned to an experimental group (n = 39) and a control group (n = 39). The control group received routine care, while the experimental group participated in a Mind Caring Support program consisting of five sessions, each lasting 40 - 90 minutes, conducted during weeks 1, 2, 4, 8, and 12 over a 12-week period. Research instruments included a personal data questionnaire, the Thai Geriatric Depression Scale, a pictorial depression assessment tool, a Mind Caring Support activity set for older adults with chronic illnesses in the community, and a self-assessment and mind caring manual. Descriptive statistics were used to analyze personal characteristics. The Wilcoxon signed-rank test and Mann–Whitney U test were used to compare depression scores within and between groups, respectively. The results showed that the median depression score in the experimental group significantly decreased from 14 at pre-intervention to 7 at post-intervention ($Z = -5.461$, $p < 0.001$). In addition, the reduction in depression scores (median change = −8) in the experimental group was significantly greater than that in the control group (median change = 0.00) ($Z = -7.202$, $p < 0.001$). These findings demonstrate that the Mind Caring Support program is effective in reducing depression among older adults with chronic illnesses living in the community. It is recommended that this program be integrated into routine community-based care for older adults with chronic conditions, and further studies should examine its long-term effects and applicability in other community settings.

Keywords: Mind caring support, Depression, Older adults, Chronic illness, Community-based care

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Introduction

Depression among older adults with chronic illness constitutes a serious and rapidly escalating public health concern worldwide, including in Thailand (World Health Organization, 2023). The accelerated growth of the aging population has been accompanied by a substantial increase in the prevalence of chronic illnesses, markedly elevating the risk of depression among older adults due to age-related physical decline and prolonged disease burden (Setapura & Chaisongkram, 2022). Global evidence indicates that approximately one in four older adults with chronic illness experiences clinically significant depressive symptoms, underscoring the magnitude of the problem (Department of Mental Health, 2021). In Thailand, more than 50% of older adults live with at least one chronic illness, and nearly 20% of community-dwelling older adults are classified as being at high risk for depression (Junkeaw et al., 2024; Foundation of Thai Gerontology Research and Development Institute, 2021). Notably, Nakhon Si Thammarat Province has the largest older adult population in Southern Thailand; however, systematic screening, early detection, and structured community-based interventions for depression among older adults with chronic illness remain limited. This persistent service gap highlights the severity of the situation and signals an urgent need for targeted, evidence-based interventions within primary care and community health systems (Ministry of Public Health, 2024).

Depression in older adults with chronic illness is associated with adverse health outcomes, including poor disease prognosis, increased functional disability, reduced treatment adherence, and elevated risk of suicidal ideation (Thongkhum et al., 2022). Functionally, depression impairs both basic and instrumental activities of daily living (ADL/IADL), accelerating dependency and diminishing quality of life (Sethboonsang & Prasomrak, 2024). Psychologically, depression is characterized by persistent sadness, hopelessness, social withdrawal, and diminished self-worth, which further exacerbate the challenges of living with chronic illness and increase caregiver burden (Srijai, 2023).

The development and persistence of depression in older adults with chronic illness are multifactorial, involving biological, psychological, and social mechanisms. Chronic inflammation, physical deterioration, and prolonged stress activate the hypothalamic–pituitary–adrenal (HPA) axis, resulting in elevated cortisol levels and reduced serotonin availability, both of which contribute to depressive symptoms (Troubat et al., 2021). Additionally, vascular and metabolic pathways link chronic conditions such as diabetes, cardiovascular disease, and stroke to depression, reinforcing the bidirectional relationship between physical illness and mental health (Garrels et al., 2023).

From a nursing and psychosocial perspective, depression in this population is strongly associated with impaired mental self-care, particularly in the domains of self-awareness and self-management. Self-awareness refers to the capacity to recognize emotions, depressive symptoms, stressors, and the psychological impact of chronic illness (Kollin et al., 2024). Older adults with limited self-awareness may fail to identify early depressive symptoms, delaying help-seeking and appropriate intervention. Self-management involves the ability to regulate emotions, cope with stress, engage in adaptive problem-solving, and sustain motivation for self-care behaviors despite chronic

illness (Srijai, 2023). Deficits in self-management often lead to emotional dysregulation, avoidance, and feelings of helplessness, thereby intensifying depressive symptoms, especially among older adults with limited social support (Mussa et al., 2024).

Mind Caring Support is a structured, nurse-led psychological intervention designed to enhance mental self-care among older adults with chronic illness by strengthening self-awareness and self-management capacities (Karam et al., 2021; Thongkhum et al., 2022). Grounded in the principles of Social and Emotional Learning (SEL) and mental self-care theory, Mind Caring Support emphasizes emotional recognition, acceptance of illness-related stress, adaptive coping, emotion regulation, and reflective problem-solving (Collaborative for Academic, Social, and Emotional Learning [CASEL], 2018; Rueda et al., 2023). Through guided activities, supportive interaction, and experiential learning, the intervention aims to empower older adults to actively manage depressive symptoms within the context of chronic disease (Chomchuen, 2023; Huang et al., 2024).

Previous studies have demonstrated that psychological support delivered by nurses, combined with group-based activities and mindfulness-oriented approaches, can significantly reduce depression and enhance emotional resilience among older adults (Karam et al., 2021). However, existing research has largely focused on general mental health or caregiver perspectives, with limited empirical evidence regarding targeted interventions that explicitly strengthen self-awareness and self-management among older adults with chronic illness in community settings.

While standard psychological support often relies on general counseling or passive listening, the novelty of this Mind Caring Support program lies in its structured integration of Social and Emotional Learning (SEL) principles tailored specifically for the context of chronic illness. Many existing interventions for older adults with chronic illnesses primarily emphasize psychoeducation, symptom management, or social support (Chomchuen, 2023; Huang et al., 2024) This distinct approach shifts the paradigm from passive care to active empowerment, enabling older adults to autonomously regulate illness-related distress and bridging a critical gap in current community-based mental health interventions. (Rueda et al., 2023; Thongkhum et al., 2022)

Therefore, this study aimed to examine the effects of Mind Caring Support on depression among older adults with chronic illnesses living in the community of Nakhon Si Thammarat Province. By focusing on individuals with mild to moderate depression, this study seeks to provide theoretically grounded and practically applicable evidence to support the integration of Mind Caring Support into community nursing and primary care practice to prevent the progression of depression and improve psychological well-being among older adults with chronic illness.

Research objectives

1. To compare the median depression scores of older adults with chronic diseases in the experimental group before and after receiving the Mind Caring Support program.

2. To compare the median depression scores between the experimental group, which received the Mind Caring Support program, and the control group, which received routine care.

Methodology

Research design

This study employed a quasi-experimental research design with a pretest-posttest control group approach. The study aimed to compare the median depression scores within the experimental group before and after receiving the Mind Caring Support program, and to evaluate differences in mean depression scores between the experimental and control groups following the intervention.

Population and sampling

This quasi-experimental study involved a sample of 78 older adults with mild to moderate depression residing in the primary healthcare service areas of Nakhon Si Thammarat Province. The participants were assigned into two groups: An experimental group and a control group (n = 39 per group).

Inclusion and exclusion criteria

The inclusion criteria for this study were: (1) older adults with chronic diseases aged 60 - 74 years; (2) scoring between 13 - 24 on the Thai Geriatric Depression Scale (TGDS), indicating mild to moderate depression; (3) having stable and controlled chronic conditions; (4) being independent in activities of daily living, with an Activity of Daily Living (ADL) score ≥ 12; (5) possessing intact cognitive function, with a Mini-Cog score > 3; (6) being able to hear, communicate, and read Thai effectively; (7) having access to a mobile phone or communication device (either personal or through a family member); and (8) willingness to participate throughout the entire study duration.

The exclusion criteria included: (1) having a prior diagnosis of psychiatric disorders or currently receiving psychiatric medication; (2) experiencing acute or severe illness requiring hospitalization; and (3) concurrent participation in other depression-related therapy or intervention programs.

Sample size and sampling

The sample size was calculated using G*Power software. Assuming a large effect size (d = 0.80), a statistical power of 0.95, and a significance level ($\alpha = 0.05$) for a one-tailed test, the required sample size was 35 participants per group. To account for a potential 10% attrition rate (Ratchawijak, 2024), four additional participants were added to each group, resulting in a final sample of 78 older adults with chronic illness and mild to moderate depression (39 in the experimental group and 39 in the control group).

Study areas were purposively selected from two districts in Nakhon Si Thammarat Province with a high prevalence of depression among older adults with chronic illness and strong local readiness to address the problem: Tha Sala District and Sichon District.The two districts were randomly assigned using simple random sampling (lottery method), with Tha Sala District allocated to the experimental group and Sichon District to the control group. Within each district, two primary care units (PCUs) were selected using simple random sampling. Eligible participants who met the

inclusion criteria were then recruited from the selected PCUs using simple random sampling (lottery method) until the required sample size for each group was achieved.

Research instruments and their validity and reliability testing

The research instruments were classified into two categories: Data collection tools and intervention materials. (1) Personal Data Questionnaire: A 9-item tool covering demographics, socio-economic status, underlying diseases, and primary caregivers. (2) Thai Geriatric Depression Scale (TGDS-30): A 30-item "Yes/No" scale. It has a reported overall reliability of 0.93 (0.94 for females; 0.91 for males). Scoring: 0 - 12 (normal), 13 - 18 (mild), 19 - 24 (moderate), and 25 - 30 (severe). (3) Pictorial Depression Assessment Tool: The Sukontip Face Mood Pictorial Tool served as a visual aid for mood comparison. (4) Psychological Support Activity Set: Specifically designed for older adults with chronic diseases in the community. (5) Self-Assessment and Mind Caring Manual: This manual covers four areas: (1) deep self-awareness; (2) education on depression and self-assessment; (3) depression management strategies; and (4) recognizing warning signs and seeking professional help. The manual's content validity (IOC) ranged from 0.60 to 1.00.

Data collection

The data collection process was divided into three phases:

Phase 1: Preparation phase

1. Researcher and research assistant training: The principal researcher was trained by experts in geriatric depression care on program implementation and assessment tools. Research assistants were trained on the administration of the Thai Geriatric Depression Scale (TGDS-30) to ensure standardized procedures and inter-rater reliability.

2. Institutional Permission: Formal request letters from the Dean of the School of Nursing, Walailak University, were sent to the District Public Health Offices of Thasala and Sichon. Permission was subsequently obtained from the directors of relevant Sub-district Health Promoting Hospitals in Tha Khuen and Saopha Sub-districts.

3. Participant Recruitment and Consent: The researcher coordinated with eligible older adults to explain the study's objectives. Participation was entirely voluntary, with a clear statement regarding the right to withdraw at any time without penalty. Written informed consent was obtained from all participants.

4. Baseline Assessment: Upon obtaining consent, research assistants collected baseline data (Time 1) using the Personal Data Questionnaire and the TGDS-30.

Phase 2: Intervention phase

The intervention was conducted over 12 consecutive weeks according to the research plan: **Experimental Group:** Participants received the Mind Caring Support Program, consisting of 5 sessions (40 - 90 min each) conducted during Weeks 1, 2, 4, 8, and 12. Specifically, Session 1

(Week 1) focused on self-awareness through ice-breaking activities, depression psychoeducation, and self-assessment training using pictorial tools. Session 2 (Week 2, home visit) emphasized experiential learning and appreciative coaching to enhance understanding of personal emotional triggers. Sessions 3 and 4 (Weeks 4 and 8, telephone follow-ups) utilized appreciative coaching to review self-care homework and monitor emotional warning signs. Finally, Session 5 (Week 12) integrated grounding exercises with body awareness and evaluated the participants' overall progress in self-management. and **Control Group:** Participants received routine nursing care provided by the primary healthcare unit, which included standard advice on depression prevention, relaxation techniques, and appropriate physical exercise.

Phase 3: Evaluation phase

In Week 12, post-intervention depression levels were assessed in both the experimental and control groups using the TGDS-30 (Time 2). This assessment was conducted by the research assistants to minimize bias. The researcher then verified the completeness and accuracy of all questionnaires before proceeding with statistical analysis.

Data analysis

Data were analyzed using descriptive statistics (frequency, percentage, mean, and standard deviation). Given the non-normal distribution of the data, non-parametric tests were applied: The Wilcoxon Signed-Rank Test for within-group comparisons and the Mann–Whitney U Test for between-group comparisons.

Ethical consideration

This study received ethical approval from the Ethics Review Committee of Walailak University (WUEC-25-124-01). Prior to obtaining written informed consent, eligible participants were fully informed about the study's objectives, methodology, potential risks and benefits, confidentiality safeguards, and their right to withdraw at any time without penalty. All collected data were securely stored in a locked cabinet and treated with strict confidentiality. The data will be retained for three years, after which they will be permanently destroyed. Study results will be reported anonymously and used solely for academic and healthcare purposes.

Results and discussion

General characteristics of the participants

The results showed that most participants in the experimental group were female (82.05%), with a mean age of 68.64 years (SD = 4.27). Regarding age distribution, 61.54% were classified as young-old (60 - 69 years). All participants were Buddhist (100%). In terms of marital status, 69.23% were married, while 28.21% were widowed, divorced, or separated. For educational attainment, 76.92% had completed primary education. The mean monthly income was 5,192.31 THB (SD = 2,609.74), with 48.72% reporting sufficient income with savings. The most prevalent underlying

diseases were diabetes (82.05%) and hypertension (74.36%). Regarding primary caregivers, the majority were children (48.72%), followed by spouses (46.15%).

In the control group, 74.36% were female, with a mean age of 67.54 years (SD = 6.09). Most were also in the young-old category (64.10%). All were Buddhist (100%). Regarding marital status, 71.79% were married, and 23.08% were widowed, divorced, or separated. Over half had completed primary education (58.97%). The mean monthly income was 5,884.62 THB (SD = 2,363.27), with 43.59% reporting sufficient income without savings. The most common underlying diseases were hypertension (89.74%) and diabetes (79.49%). The primary caregivers were predominantly children (43.59%), followed by spouses (33.33%).

Comparative analysis revealed no statistically significant differences in baseline personal characteristics between the experimental and control groups ($p > 0.05$), indicating that the groups were comparable at baseline (**Table 1**).

Table 1 Personal characteristics of participants.

General Information	Total (n = 78)	Experimental group (n = 39)	Control group (n = 39)	t	x^2	*p*-value
	Frequency (%)	Frequency (%)	Frequency (%)			
Sex				-	0.67[a]	0.41
Male	17 (21.79%)	7 (17.95%)	10 (25.64%)			
Female	61 (78.21%)	32 (82.05%)	29 (74.36%)			
Age	($\bar{x}$ = 68.09, SD = 5.26, Min − Max = 60 - 79)	($\bar{x}$ = 68.64, SD = 4.27, Min − Max = 61 - 77)	($\bar{x}$ = 67.54, SD = 6.09, Min − Max = 60 - 79)	0.93	-	0.36
Age groups				-	0.06[b]	1.00
Young-old (60 - 69 years)	49 (62.82%)	24 (61.54%)	25 (64.10%)			
Middle-old (70 - 79 years)	29 (37.18%)	15 (38.46%)	14 (35.90%)			
Status				-	0.55[a]	0.76
Single	3 (3.85%)	1 (2.56%)	2 (5.13%)			
Married	55 (70.51%)	27 (69.23%)	28 (71.79%)			
Widowed/Divorced/ Separated	20 (25.64%)	11 (28.21%)	9 (23.08%)			
Education				-	2.93[b]	0.23
Primary education	53 (67.95%)	30 (76.92%)	23 (58.97%)			
Secondary education	20 (25.64%)	7 (17.95%)	28 (71.79%)			
Bachelor's degree	5 (6.41%)	2 (5.13%)	3 (7.70%)			
Mean monthly income	($\bar{x}$ = 5,538.46, SD = 2,497.46, Min – Max = 1,000 - 14,000)	($\bar{x}$ = 5,192.31, SD = 2,609.74, Min – Max = 1,000 - 10,000)	($\bar{x}$ = 5,884.62, SD = 2,363.27, Min − Max = 3,000 - 14,000)	−1.23	-	0.22
Income adequacy				-	2.22[a]	0.53
Sufficient with savings	33 (42.31%)	19 (48.72%)	14 (35.90%)			
Sufficient without savings	32 (41.03%)	15 (38.46%)	17 (43.59%)			
Insufficient without debt	12 (15.38%)	5 (12.82%)	7 (17.95%)			

General Information	Total (n = 78)	Experimental group (n = 39)	Control group (n = 39)	t	x^2	*p*-value
	Frequency (%)	Frequency (%)	Frequency (%)			
Insufficient with debt	1 (1.28%)	0 (0%)	1 (2.56%)			
Underlying diseases*						
Cancer	4 (5.13%)	0 (0%)	4 (10.26%)		4.22[b]	0.12
DM	63 (80.77%)	32 (82.05%)	31 (79.49%)		0.08[a]	0.77
HTN	64 (82.05%)	29 (74.36%)	35 (89.74%)		3.13[a]	0.07
CKD	1 (1.28%)	0 (0%)	1 (2.56%)		1.01[a]	0.31
CVD	4 (5.13%)	1 (2.56%)	3 (7.70%)		1.05[a]	0.30
Stroke	2 (2.56%)	2 (5.13%)	0 (0%)		2.05[a]	0.15
Others	47 (60.26%)	20 (51.28%)	27 (69.23%)		3.76[a]	0.15
Caregivers				-	5.52[a]	0.24
Spouses	31 (39.74%)	18 (46.15%)	13 (33.33%)			
Children	36 (46.15%)	19 (48.72%)	17 (43.59%)			
Grandchildren	5 (6.41%)	1 (2.56%)	4 (10.26%)			
Siblings	1 (1.28%)	0 (0%)	1 (2.56%)			
Alone	5 (6.41%)	1 (2.56%)	4 (10.26%)			

[a]Chi-square test, [b]Fisher's exact test

* Multiple responses allowed.

Baseline depression scores comparison

Prior to the intervention, a Mann-Whitney U test was conducted to compare the baseline depression scores between the experimental and control groups. The analysis revealed no statistically significant difference in the median baseline depression scores between the experimental group (Median = 14) and the control group (Median = 15) (U = 575.000, $p = 0.058$). This confirms that both groups were comparable in terms of depression levels before receiving the intervention.

Comparison of depression scores within groups (pre-test vs. post-test)

The results of the within-group analysis showed that the experimental group, which received the psychosocial support intervention, had a significant reduction in depression scores. The median depression score, measured by the Thai Geriatric Depression Scale (TGDS), decreased from 14 at pre-test to 7 at post-test. This difference was statistically significant ($Z = -5.461$, $p < 0.001$), indicating that the intervention effectively reduced depression levels among the participants.

In contrast, the control group, which received routine care, showed no statistically significant change in depression levels. The median depression score remained at 15 for both pre-test and post-test ($Z = -1.871$, $p = 0.061$). These findings suggest that depression levels did not improve spontaneously over time or due to external factors without the specific intervention, as shown in **Table 2**.

Table 2 Comparison of depression scores pre-test and post-test within the experimental and control groups (N = 78).

Sample	Groups	n	Depression Scores				
			Max	Min	Median	*p*-value	z
Experimental group	Before	39	22	13	14	< 0.001	−5.461[b]
	After	39	16	4	7		
Control group	Before	39	19	13	15	0.061	−1.871[b]
	After	39	18	12	15		

*$p < 0.05$, [b] = Base on positive ranks.

Comparison of depression score changes between the experimental and control groups

The analysis of the differences in depression score changes between the two groups revealed a statistically significant difference ($Z = -7.202$, $p < 0.001$). When examining the median change scores (post-test minus pre-test), the experimental group showed a median reduction of −8.00, indicating a substantial decrease in depression levels. In contrast, the control group showed a median change of 0.00, representing no clinical change during the study period. These findings clearly demonstrate that the psychosocial support intervention was significantly more effective in reducing depression levels compared to routine care, as shown in **Table 3**.

Table 3 Comparison of depression scores and score changes between the experimental and control groups (N = 78).

Sample	n	Depression Scores				
		Median of Change score	Mean Rank	Mann-Whitney U	*p*-value	z
Experimental group	39	−8.00	21.14			
Control group	39	0.00	57.86	44.5	< 0.001	−7.202

*$p < 0.05$

Discussion

This study examined the effects of the Mind Caring Support program on depression among older adults with chronic illness living in the community of Nakhon Si Thammarat Province. The findings provide strong evidence that a structured, nurse-led psychosocial intervention can significantly reduce depressive symptoms in this vulnerable population. The results are discussed in relation to the two research hypotheses, with particular emphasis on the mechanisms through which the program influenced depression outcomes.

Effects of mind caring support on depression within the experimental group

Consistent with the first hypothesis, depression scores in the experimental group significantly decreased after participation in the Mind Caring Support program, whereas no significant change was observed in the control group. Previous evidence has shown that depression among older adults with

chronic illness rarely improves without structured psychosocial intervention (Thongkhum et al., 2022). The reduction in depression observed in this study can be explained by the program's emphasis on enhancing mental self-care through self-awareness and self-management, which are core competencies of Social and Emotional Learning (SEL) (CASEL, 2018). Nurse-led interventions that integrate these competencies have been shown to be particularly effective for managing depression in older adults (Karam et al., 2021).

In the context of chronic illness, depressive symptoms are often exacerbated by limited emotional insight, persistent illness-related stress, and ineffective coping strategies (Kanokporn et al., 2022). The Mind Caring Support program enhanced self-awareness by enabling participants to recognize depressive symptoms and emotional triggers at an early stage, an ability identified as essential for depression management in later life (CASEL, 2018). Guided reflection and visual self-assessment facilitated emotional acceptance and reduced internalized stigma, processes that have been linked to improved emotional stability and adaptive self-care in older adults with chronic conditions (Karam et al., 2021). By improving self-awareness, participants were better able to acknowledge depressive symptoms rather than normalize them as an inevitable consequence of aging and chronic disease.

Self-management constituted a second key mechanism through which the Mind Caring Support program reduced depression. Research has shown that older adults with chronic illness who lack effective self-management skills are more vulnerable to rumination and emotional dysregulation, key cognitive features of depression (Kollin et al., 2024). In this study, participants developed skills to regulate negative emotions, maintain present-moment awareness, and apply adaptive coping strategies during illness-related challenges, consistent with SEL-based self-management principles (CASEL, 2018). Techniques emphasizing body awareness and emotional regulation supported participants in interrupting catastrophic thinking, thereby enhancing perceived control and self-efficacy—factors shown to be critical for reducing depressive symptoms and sustaining psychological well-being in later life (Huang et al., 2024; Kollin et al., 2024).

Comparison of depression outcomes between experimental and control groups

Supporting the second hypothesis, post-intervention depression scores in the experimental group were significantly lower than those in the control group. This between-group difference underscores the added value of Mind Caring Support beyond routine care for older adults with chronic illness. While routine care in community settings primarily emphasizes physical disease management and general advice, it often lacks structured strategies that directly target the emotional, cognitive, and behavioral processes underlying depression (Huang et al., 2024).

The superiority of the Mind Caring Support program can be explained by its integrated psychosocial framework, which simultaneously addressed multiple determinants of depression. First, emotional regulation was strengthened by enabling participants to recognize and interrupt negative emotional cycles commonly associated with chronic illness, such as helplessness and hopelessness. Enhancing emotional understanding has been identified as a critical prerequisite for meaningful

behavioral change in individuals experiencing depression (Rueda et al., 2023). In contrast, participants in the control group, who received routine advice alone, lacked opportunities to develop these regulatory skills, resulting in persistently elevated depression scores.

Second, the program improved knowledge and attitudes toward depression by reducing fear, guilt, and self-blame—psychological barriers that frequently prevent older adults from acknowledging depressive symptoms and seeking support (Rueda et al., 2023). By normalizing depression as a manageable condition rather than a personal weakness, the Mind Caring Support program promoted a more adaptive cognitive appraisal of illness-related distress. This cognitive shift was largely absent in the control group, which may explain the limited change in depressive symptoms.

Third, mindfulness-based strategies embedded in the program encouraged non-judgmental awareness of thoughts and emotions, allowing participants to observe depressive cognitions without becoming emotionally overwhelmed. Such present-moment awareness has been shown to reduce emotional reactivity and vulnerability to recurrent depressive episodes among older adults (Rueda et al., 2023). Finally, sustained support through nurse follow-up and family involvement reinforced newly acquired self-management skills, facilitating continued engagement in mental self-care behaviors. Social support has been consistently recognized as a protective factor against depression in older adults with chronic illness, particularly when integrated into structured interventions.

Collectively, these findings indicate that Mind Caring Support is more effective than routine care because it actively engages older adults in the management of their depressive symptoms through enhanced self-awareness, self-management, and social support. By addressing the emotional and cognitive dimensions of depression alongside chronic disease management, the program enabled participants in the experimental group to move from passive recipients of care to active agents in their own mental health, resulting in significantly greater reductions in depression compared with the control group.

Limitations of the study

Although the study utilized random sampling for selecting districts and primary care units, the recruitment of participants was ultimately limited to only two districts in Nakhon Si Thammarat Province. This geographic limitation, while necessary due to feasibility and resource constraints, may introduce a potential risk of selection bias. Consequently, the findings may have limited generalizability to older adults with chronic illnesses residing in different cultural or socioeconomic contexts across Thailand. Future studies should consider a multi-center approach across diverse geographic regions to enhance the external validity of the intervention.

Conclusions and implications for nursing and community-based care

This quasi-experimental study demonstrated that the Mind Caring Support program effectively reduced depression among older adults with chronic illness in community settings. The 12-week nurse-led intervention, grounded in Social and Emotional Learning principles and

emphasizing self-awareness and self-management, produced significantly greater reductions in depression compared with routine care.

The absence of baseline differences between groups confirms that the observed improvements were attributable to the intervention. These findings indicate that enhancing emotional awareness and strengthening self-management skills are key mechanisms for alleviating depression in older adults with chronic conditions.

Mind Caring Support offers a feasible, theory-based model that can be integrated into primary care and community nursing practice to support early detection, effective management, and prevention of depression progression. Future studies should examine long-term outcomes and scalability across diverse community contexts.

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Declaration on AI

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