

Battling Late-Life Depression:



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Key Words: psychotherapy, depression, geriatrics, elderly

Abstract

Depression ranks among the leading causes of disability worldwide even though medications, psychotherapy, and other treatments reduce symptoms related to the illness. However, the side effects of drugs, especially in older adults, and the less-than-universal effectiveness of current therapies prompt the continued search for alternate safe treatment interventions. Numerous research studies report the use of psychotherapeutic approaches and compare them to medical therapies. This article reviews the randomized controlled trials, conducted during the last 5 years, involving psychotherapy with or without antidepressant medication in older adults. Meta-analysis, guidelines developed by expert panels, and systematic reviews of previous studies provide further data on the value of psychotherapy in the treatment of depression in the elderly.



Short Term Psychotherapy for Depression in Older Adults—A Review of Evidence-Based Studies Since 2000

By Kay McFarland, MD

Background

Advancing age brings with it loss. The depressive feelings that result at first constitute a natural process, a part of normal bereavement. Loss, change, and illness in particular require constant adaptation and may challenge coping skills. When aging or disease processes strain adaptive mechanisms, the area where normal aging and bereavement intersect with disease sometimes becomes blurred. What appears to some social groups as a normal emotional response may count as a depressive disorder to others (Kleinman, 2004). However, when severe or long lasting, depression clearly becomes abnormal.

Depression now ranks fourth among the leading causes of disability worldwide (World Health Organization, 2005) and constitutes the most common mental health disorder of later life. The disorder accounts for significant economic burdens, increased mortality due to suicide and medical illnesses, and heightened family and social turmoil. As the world's population continues to age the burden attributable to depression is expected to increase.

Depression affects the quality of subjective and objective aging measured in terms of physical health, death, and disability before age 80, social supports, mental health, instrumental activities of daily living, and life enjoyment (Kivela & Pakkala, 2001; Vaillant & Mukamal, 2001). In addition, depression and medical illness may coexist (Roose, Glassman, & Seidman, 2001). Some evidence, gathered primarily from observational studies, shows that depression treatment may improve some comorbid medical outcomes, though relief of depression may not significantly affect the course of other coexistent medical illnesses (Jackson, DeZee, & Berbano, 2004).

Randomized control trials comparing psychotherapy and pharmacotherapy began appearing more than 15 years ago,

with 6 studies summarized in a 2002 review (Casacalenda, Perry, & Loper, 2002). However, few rigorously controlled randomized trials specifically evaluate psychotherapeutic interventions in older adults. For example, no studies of psychological therapies for treatment of depression in older people met inclusion criteria in a systematic review published in 2001 (Freudenstein, Jagger, Arthur, & Donner-Banzhoff, 2001).

Recognizing that older adults take more medications and have more adverse reactions to medications than do young adults, this study reviews the evidence for psychotherapy alone or in combination with antidepressant medication for depression in adults over age 60. Table 1 summarizes the randomized control trials published since 2000. This article also considers meta-analysis and systematic reviews that provide data about treatment outcomes. Few studies address methods to prevent depression, though psychological interventions also deserve consideration for maintenance therapy (Cole & Dendukuri, 2004).

Methods

This article discusses the brief forms of psychotherapy used in one or more randomized control trials published since 2000. These treatments include cognitive therapy, dialectical behavioral therapy, interpersonal therapy, life review or reminiscence therapy, and problem-solving therapy. Many used antidepressants as a first-line treatment and then added psychotherapy if medications were not effective or were unacceptable for medical reasons or patient refusal. Others stressed a collaborative care approach with medication and/or psychotherapy as a treatment option. The review focuses on randomized control trials of psychotherapy identified through a search of MEDLINE and PsycINFO databases. In addition, the bibliographies of meta-analysis and review

articles on depression treatment outcomes were researched to cross check completeness of the searches. This review includes studies involving adults age 60 or older and studies in which the mean age of participants was over age 60.

Results

Cognitive behavioral therapy aims to modify thought patterns, enhance coping, and change feelings. Thompson, Coon, Gallagher, and Koin (2001) compared cognitive behavioral therapy to desipramine in the treatment of 102 elderly outpatients with mild to moderate depression. The patients were randomly assigned to one of three groups: 1) desipramine alone, 2) cognitive behavioral therapy alone, or 3) desipramine plus cognitive behavioral therapy for 16–20 therapy sessions. Note this trial did not have a placebo group and all treatments resulted in substantial improvement.

In most analyses, the groups that received desipramine plus cognitive behavioral therapy showed greater improvement than the groups taking medication alone, whereas the group receiving cognitive therapy alone showed only marginally more improvement (Thompson et al., 2001). The study suggests that cognitive therapy alone and in combination with medication offers effective treatment for mild-moderate depression in the elderly (Thompson et al.). Randomized control trials are not available to adequately access the efficacy of cognitive therapy for the treatment of severe depression (Tovey, Bedford, Amore, & Pettersen, 2004).

In addition, cognitive behavioral therapy may be helpful in treating depression-associated medical illnesses. For example, the increased morbidity and mortality in patients with coronary heart disease (Bush et al., 2001) led the Enhancing Recovery in Coronary Heart Disease Patients (ENRICH) investigators to try to determine if cognitive therapy in depressed

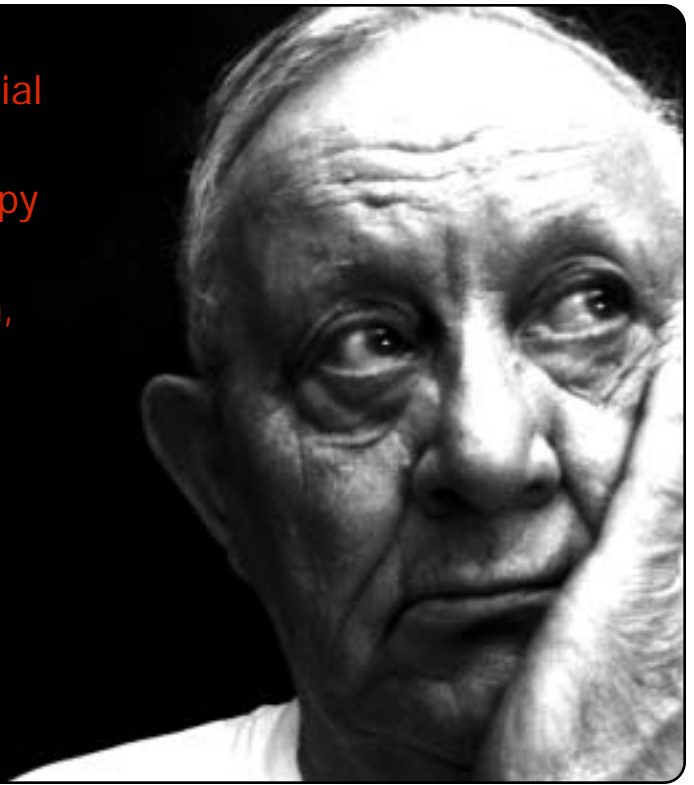
Table 1. Psychotherapy in Older Adults with Depression: Summary of Randomized Control Trials 2000-2004

1st author, year, trial name, duration	Subjects	Treatment groups	N	Outcome measures	Results at study conclusion
Cognitive Therapy					
Thompson, 2001, 3-4 months	102 persons \geq age 60 with major depression	1. Desipramine 2. CBT 3. Both 1 + 2	33 31 36	SADS BDI-SF Ham-D	All 3 treatment groups improved ($P < .05$ for all comparisons). CBT + desipramine improved $>$ desipramine alone ($P < .05$).
ENRICH investigators, 2003, 29 months	Patients with recent myocardial infarction & depression or low perceived social support; mean age 61	1. CBT 2. Usual care	1238 1243	Recurrent MI All cause mortality; BDI HRSD; ESSI	No difference between groups in recurrent MI or all cause mortality. Intervention $<$ depression ($P < .001$) and $>$ social support compared to usual care at 6 months. No benefit of intervention at 30 months for BDI or by 42 months for ESSI.
Dialectical Behavioral Therapy					
Lynch, 2003, 28 weeks Pilot Study	Depressed individuals age \geq age 60	1. Antidepressant 2. Antidepressant + dialectical behavior group therapy (DBT) + therapist telephone call	17 17	17-item Ham-D DBT	Antidepressant + DBT decreased self-rated depression more than antidepressant alone group. Interviewer-rated depression scores decreased for both groups.
Interpersonal Therapy					
Bruce, 2004, PROSPECT 12 months	Primary care patients \geq age 60 with depression	1. PROSPECT intervention (stepped care – antidepressant, interpersonal psychotherapy, + depression care managers) 2. Usual care	320 278	24 item – HDRS Scale for Suicide Ideation (SSI)	Suicidal ideation declined faster ($P < .01$) in intervention patients compared with usual care patients. Intervention patients had more favorable course of depression in degree and speed of symptom reduction. The effects on depression was not significant among patients with minor depression unless suicidal ideation was present.
Dew, 2001, Treated until 16 weeks after HAM-D score \leq 10; 3 years maintenance or until major depression recurrence	140 persons \geq age 60	Initial treatment 16 weeks IPT + nortriptyline Maintenance 1. PT + nortriptyline 2. IPT 3. Nortriptyline 4. Placebo	29 #2 & 3 = 60 33	Recovery rate HAM-D score \leq 10 Time to depression recurrence	Rapid initial responders showed lower recurrence risk with combined or monotherapy relative to placebo. IPT or nortriptyline alone were equally effective in rapid responders. In mixed and delayed responders, only combined therapy was superior to placebo. Maintenance treatment was not of benefit in prolonged nonresponders.
Lenze, 2002, (same as Dew 2001)	See Dew 2001 above	See Dew 2001 above	See Dew 2001	Social Adjust Scale	IPT = nortriptyline patients maintained social adjustment, which declined in those receiving monotherapy.
Life Review or Reminiscence					
Davis, 2004, Pilot study 11 weeks	Patients in a rehabilitation center following a stroke	1. Life review 2. Control	7 7	Zung Depression Scale; Life Satisfaction Index – Form Z	Life review group had lower depression scores ($P < .01$) and $>$ life satisfaction ($P < .01$) than control group.
Hanaoka, 2004 8 weeks	Elders with no mental disorder \geq age 65 at 2 day care centers & 4 nursing homes	1. Group life review 2. Control	42 38	Maudsley Personality Inventory; Life Satisfaction Index; Rosenberg Self-Esteem Scale; GDS; Beck Hopelessness Scale	Group life review subjects had $<$ depression ($p = .04$) and hopelessness ($P = .04$) than control group.

1st author, year, trial name, duration	Subjects	Treatment groups	N	Outcome measures	Results at study conclusion
Life Review or Reminiscence (continued)					
Watt, 2000, 6 weeks treatment with 3 month follow up	Community residing adults with moderate to severe depression	Reminiscence Group Therapy 1. Integrative 2. Instrumental 3. Control	26 total	GDS Social Adjustment HRSH	Integrative intervention > decrease GDS scores (p<.01) at 6 weeks and HRSD (p<.01) at 3 months compared to control group. No significant difference between # subjects in integrative and control groups who improved on SAS at end of treatment.
Problem-Solving Therapy					
Williams, 2000, 11 weeks	Primary care patients with minor depression or dysthymia	1. Paroxetine 2. Placebo 3. Problem solving	137 140 138	HDRS HSCL-D SF-36 (physical) SF-36 (mental)	No > symptom resolution in problem solving compared to placebo (P=.13); paroxetine group > symptom resolution than placebo (P=.004); problem solving (p=.02) and paroxetine (p=.02) groups > mental health functioning in patients in lowest tertile of baseline functioning than placebo.
Unutzer, 2002, IMPACT 12 months	1801 patients >= age 60 from 18 primary care clinics @ 8 sites with major depression or dysthymia	1. Collaborative care with antidepressant &/or 6-8 sessions problem solving therapy 2. Usual care	905 895	20 questions Symptom Checklist-90 SCID; RAND 12; Cornell Services Index	45% of collaborative care patients >= 50% reduction depressive symptoms from baseline compared to 19% in usual care; collaborative care patients < functional impairment and > quality of life compared to usual care; estimated cost per collaborative care patient \$533.
Lin, 2003, IMPACT 12 months	Patients from IMPACT trial (see Unutzer above) who had arthritis	1. Collaborative care with antidepressant &/or 6-8 sessions problem solving therapy 2. Usual care	506 495	HSC; Arthritis pain intensity scale; Interference activities scale; 2-items RAND 12-item Short Form; General health status; Quality-of-life	Intervention patients 2 X as likely as usual care patients to have 50% decrease HSC score (P<.001). Intervention patients reported less interference in daily activities due to arthritis than usual care patients. Pain intensity decreased in intervention group at 2 & 12 months; enhanced depression care reduced pain-associated functional impairment; Intervention patients < health-related functional impairment, better health status, and higher quality of life than usual care.
Williams, 2004, IMPACT 12 months	Patients from IMPACT trial (see Unutzer above) who had diabetes	1. Collaborative care includes antidepressant &/or 6-8 sessions problem solving therapy 2. Usual care	111 112	SCL-20 score, SF-36 health-related functional status, Summary of Diabetes Self-care Activities, Hemoglobin A1C	Depression < severe intervention group compared to usual care at all follow-up points. No interaction between the intervention and diabetes status at any time point. At 12 months the intervention group had significantly improved on mental and physical health. HbA1c decreased in both intervention and usual care groups. Intervention group showed > increase in exercise day at 12 months.
Ciechanowski, 2004, PEARLS	12 months 138 patients aged >= 60 (79% female) with minor depression or dysthymia	1. PEARLS – includes PST 2. Usual care	72 66	Baseline, 6, 12 months HSCL-20 Health care utilization	At 12 months PEARLS patients had less depressive symptoms, >health-related quality of life improvement in functional well-being (p=.001) and emotional well-being (p=.048) than usual care patients.

BDI-SF = Beck Depression Inventory – Short Form; CBT = Cognitive behavioral therapy; DBT = dialectical behavior group therapy; ENRICH = Enhancing Recovery in Coronary Heart Disease Patients; GDS = Geriatric Depression Scale; HAM-D & DRS = Hamilton Depression Rating Scale; HSCL-D-20 = Hopkins Symptom Checklist Depression Scale; PEARLS = Program to Encourage Active, Rewarding Lives for Seniors; PROSPECT = Prevention of Suicide in Primary Care Elderly: Collaborative Trial; PST = problem solving therapy; SF-36 = Medical Outcomes Study-Short Form 36; (physical) = physical health component; (mental) = mental health component; physical = (physical) health component; wk = weeks; mo = months; years = years

“ Interpersonal therapy proves beneficial in the treatment of depression. This brief form of short-term psychotherapy usually addresses relationships and often focuses on grief, role transition, and interpersonal conflicts. ”



patients or in those who had low perceived social support would reduce morbidity or mortality after myocardial infarction. The mean age of the 2,481 patients in this study was 61 years, with 1,238 patients randomized to cognitive behavior therapy and 1,243 to usual care. Patients who showed less than a 50% reduction in Beck Depression Inventory (BDI) scores or scored higher than 24 on the 17-item Hamilton Rating Scale for Depression (HRSD) after 5 weeks were eligible for sertraline. Cognitive therapy decreased depression and increased social support during the first 6 months of the study, but did not provide a survival benefit at a mean follow-up time of 29 months. However, standard treatments for depression in the usual care group could have obscured the effect of psychotherapy in the intervention group (ENRICH investigators, 2003).

Dialectical behavior therapy has also been studied. Lynch and colleagues compared antidepressant medication plus clinical management with dialectical behavior skill-training plus scheduled telephone coaching sessions. The study lasted 28 weeks and included 34 depressed older adults. Only those randomized to the

medication-plus-therapy group demonstrated decreases in self-rated depression scores; both groups had decreases on interviewer-rated depression. At 6-month follow up, 71% of the patients on medication and in the therapy group were in remission, compared to 47% of those receiving medication and clinical management only (Lynch, Morse, Mendelson, & Robins, 2003). This study suggests that dialectical behavior therapy needs further attention as a treatment for depression in older adults.

Interpersonal therapy proves beneficial in the treatment of depression. This brief form of psychotherapy usually addresses relationships and often focuses on grief, role transition, and interpersonal conflicts. Several reports detail favorable results with interpersonal therapy alone or in combination with antidepressant medication. For example, combination nortriptyline and psychotherapy helped maintain social adjustment more than either treatment alone (Lenze et al., 2002). Further, in patients who improved rapidly with therapy, combined treatment, nortriptyline alone, and interpersonal therapy proved superior for maintenance to placebo. Prolonged nonresponders did not benefit

from maintenance treatment (Dew et al., 2001).

Another multicenter trial, the Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT), randomized patients from 20 primary care practices who screened positive for depression to usual care or the PROSPECT intervention. PROSPECT utilized a planned treatment approach that started with an antidepressant, usually citalopram. When medication was not acceptable, interpersonal psychotherapy became an option. In contrast, the usual care control group received treatment by physicians who were notified when a patient met criteria for depression. The study covered the costs of both the drug and psychotherapy in the intervention group, but not in the usual care patients.

Rates of suicidal ideation declined faster in the intervention patients compared with usual care patients. In addition, the intervention patients with major depression had a more rapid recovery and less severe depressive symptoms. The intervention did not affect depression in those with minor depression unless suicidal ideation was present. This suggests that the antidepressants or psychotherapy may

reduce suicide risks in older adults (Bruce et al., 2004).

The study Improving Mood—Promoting Access to Collaborative Treatment (IMPACT) included 1,001 patients from 18 primary care clinics who had depression or dysthymia and arthritis. The IMPACT intervention care team included a nurse or psychologist who worked with a primary care physician. The care manager helped patients identify preferred treatment options, which included antidepressant medications or 6–8 weeks of interpersonal therapy. In addition to a reduction in depressive symptoms, the collaborative care management group had lower mean scores for pain intensity and interference with daily activities due to arthritis than the usual care group. This suggests that benefits of improved depression care can include decreased pain, improved functional status, and increased quality of life in addition to a reduction in depression symptoms (Lin et al., 2003).

Life review and reminiscence therapy are particularly suited for elders. Reflection on life experiences offers an opportunity to deal with feelings of regret, guilt, and loss. Particularly at the end of life, existential issues gather more attention as the dying person seeks to find meaning and purpose in his or her life. Apart from reducing depression, reminiscence may increase life-satisfaction, self-esteem, and wellbeing (Bohlmeijer, Smit, & Cuijpers, 2003). A meta-analysis of reminiscence and life review included 20 controlled outcome studies that showed a statistical and clinically significant reduction in depression (Bohlmeijer et al.). Another meta-analysis of nine studies involving reminiscence therapy showed that about half of the studies indicated a statistically significant decrease in depression (Hsich & Wang, 2003). Another study involved 80 elderly persons randomly assigned to a life review group or a control group that discussed health subjects. At the conclusion of the study, based on an analysis of covariance, life review participants showed lower depression and hopeless scores (Hanaoka & Okamura, 2004).

A pilot study sought to determine if life review would affect depression and life sat-

isfaction in patients after a stroke. Patients were randomly assigned to receive three 1-hour sessions of life review therapy or to view three 1-hour videos with a follow-up discussion. Those in the life review group had significantly lower depression scores and significantly higher life satisfaction than the control patients (Davis, 2004).

Many reports of reminiscence therapy do not utilize a randomized control design or a standardized treatment protocol. However, Watt and Cappeliez (2000a, 2000b) studied integrative reminiscence, a method that promotes acceptance of negative events and the reconciliation of difference in the ideal and reality. The investigators contrasted it to instrumental reminiscence in which recollections of past successful coping provide encouragement and positive effects on self-esteem. The control group consisted of participants assigned to an active socialization group. The authors developed manuals detailing the integrative and instrumental reminiscence interventions and randomly assigned participants to one of the three groups: integrative, instrumental, or active socialization. The 26 participants, recruited through mental health agencies and community advertising, had clinically significant depression. Both integrative and instrumental reminiscence led to significant improvement in depressive symptoms compared to the control group (Watt & Cappeliez, 2000a; Watt & Cappeliez, 2000b). However, the small sample size and 3-month trial length indicate that wide acceptance of these therapeutic interventions will require verification in a larger sample over a longer time interval.

Problem solving therapy occurs in sequential steps beginning with defining the problem and selecting achievable goals. Then comes the generation of solutions, choosing preferred solutions, and implementing the choices. The therapy ends with an evaluation. The treatment, delivered in six sessions, uses a structured approach (Mynors-Wallis, Gath, Day, & Baker, 2000). A primary care study compared the effectiveness of problem-solving treatment (N=137) and paroxetine (N=138) in elders with dysthymia or minor depression. One hundred forty

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patients served as controls. The drug and placebo groups received symptom and drug monitoring during six visits over the 11-week period during which the problem-solving treatment group received psychotherapy. After 11 weeks the patients who received medication showed greater change in their Hopkins Symptoms Checklist Depression Scale scores than the placebo patients. Those treated with psychotherapy did not show a significant improvement. The problem-solving treatment had smaller effects than did paroxetine and a slower onset of effect (Williams et al., 2000).

A large study involving 1,801 elders with major depression, dysthymic disorder, or both compared the effectiveness of a collaborative care management program to usual care. The collaborative care patients had access to a nurse or psychologist who offered education, care management, support of antidepressant management prescribed by the primary care physician, and 6–8 problem solving psychotherapy sessions during the 12 months of follow up. Although most participants preferred counseling or psychotherapy to antidepressant medications, only 8% actually received such treatment and only 1% reported four or more sessions (Unutzer et al., 2002, 2003).

Men, African American individuals, Latino individuals, patients with two or more prior depression episodes, and those who preferred counseling to antidepressant medications reported significantly lower rates of depression care. The authors offer several possible explanations for these

findings. For example, these groups may not report depressive symptoms as frequently as other groups, or they may have different attitudes about treatment acceptance. In addition, primary care providers may be less likely to initiate treatment in certain groups of individuals. Another explanation could be that access to psychotherapy may be less available than medications due to increased costs resulting from a 50% co-payment for outpatient psychotherapy under Medicare (Unutzer et al., 2002, 2003). At 12 months, only 45% of the intervention patients had at least a 50% reduction in depressive symptoms from baseline and only a quarter were depression free. The usual care group had even worse results, with only 19% having at least a 50% reduction in depressive symptoms; only 8% were depression free. Nevertheless, the collaborative care model appeared more effective than usual care (Unutzer et al., 2003).

Another study of 138 older patients (79% women) randomized to usual care or to the intervention called Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) sought to determine the effectiveness of a home-based program for detecting and managing minor depression or dysthymia. The intervention group participants were scheduled for eight 50-minute in-home sessions over 19 weeks. After the 19th week, therapists maintained monthly telephone contact with patients. Problem solving sessions emphasized the value of engaging in pleasant activities between sessions and participating in more physical and social activities.

Those receiving the PEARLS intervention were more likely to have a reduction of depressive symptoms of 50% or more and to have achieved complete remission from depression. In addition, they had greater improvements in functional and emotional wellbeing. However, only a third of patients in the intervention group and 12% in the usual care group experienced remission of depression. There was no difference between groups in physical and social wellbeing and quality of life (Ciechanowski et al., 2004).

The IMPACT trial also studied the

effects of collaborative care in older adults with diabetes to determine if enhancing management of depression would affect depression and diabetic outcomes. Of the original 1,801 patients, 417 had coexisting diabetes. The care manager offered education, problem-solving, and support for medication adherence, but did not specifically address diabetes care. At 12 months, the patients with diabetes in the intervention group had less severe depression and greater overall functioning than those in the usual care group. However, there was no difference between groups in mean blood sugar levels as measured by hemoglobin A1c levels. Thus, in this study, collaborative care improved depression but did not significantly influence glucose levels (Williams et al., 2004).

Summary of Recommended Treatments and Published Guidelines

Consensus panels rely on clinical trials and meta-analysis to develop treatment recommendations. In addition to weighing different types of treatment, most groups advise that the therapeutic plan take into account individual patient preferences, coexisting medical conditions, suicide risks, and educational needs. Most groups that develop clinical practice guidelines for adults of all ages conclude that both antidepressant medication and psychotherapy are effective in the treatment of depression (Baldwin et al., 2003; Crystal, Sambamoorthi, Walkup, & Akincigil, 2003; Ellis, 2004; Karel & Hinrichsen, 2000; Pampallona, Bollini, Tibaldi, Kupelnick, & Munizza, 2004; Segal, Whitney, Lam, & Group, 2001; Thorpe, Whitney, Kutcher, Kennedy, & Group, 2001; World Health Organization, 2005). Most individuals treated by psychiatrists in the American Psychiatric Association's Practice Research Network receive a combination of medication management and psychotherapy, which is consistent with current expert panel recommendations (Colenda et al., 2003).

There is also evidence to support the use of psychotherapy in maintenance and secondary depression prevention (Baldwin et al., 2003; Fochtmann & Gelenberg, 2005; Segal et al., 2001; Thorpe et al., 2001).

Although cognitive behavioral or interpersonal therapy have been studied more frequently than other psychotherapeutic approaches, several other types of brief psychotherapy appear to be of comparable efficacy (Fochtmann & Gelenberg, 2005). Psychotherapy alone is not recommended for severe depression (Ellis, 2004).

Conclusion

Randomized controlled trials during the past 5 years provide data supporting the effectiveness of psychotherapeutic interventions and drug therapy in the treatment of depression in the elderly. Brief psychotherapy, specifically cognitive behavioral and interpersonal psychotherapy, have been studied more frequently than other types of therapy. However, clinical trials during the last 25 years offer evidence of the effectiveness of other psychological treatments, including problem-solving therapy and reminiscence therapy. Multimodal therapy, combining drug and psychotherapy, appears to be an optimal treatment for preserving recovery. The frequency and seriousness of depression, the side effects of antidepressant drugs (especially in older adults), and the less-than-universal effectiveness of current therapies prompts the continued search for the most effective, economically beneficial, and safest treatment for the elderly.

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