
Psychotherapy and Combined Psychotherapy/Pharmacotherapy for Late Life Depression

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Over the past 20 years, numerous studies have investigated the efficacy of psychotherapy for treating late life depression and, to a lesser degree, the efficacy of psychotherapy combined with antidepressant medication. Of the intervention studies, cognitive-behavioral therapy and interpersonal psychotherapy combined with antidepressant medication have the largest base of evidence in support of their efficacy for late life depression. To a lesser degree, there is support for stand-alone interpersonal psychotherapy, brief dynamic therapy, and life review treatments. The purpose of this review is to present data on the acute and long-term effects of cognitive-behavioral therapy, interpersonal psychotherapy, brief dynamic therapy, and combined antidepressant medication and psychotherapy to discuss the generalizability of these interventions, and to discuss future research directions and the need for increased opportunities for this area of research. Biol Psychiatry 2002;52:293–303 © 2002 Society of Biological Psychiatry

Key Words: Psychotherapy, cognitive-behavioral therapy, interpersonal psychotherapy, reminiscence therapy, brief dynamic therapy, psychoeducation, depression, older adults, elderly, geriatric

Introduction

The efficacy of psychotherapy for the treatment of late life depression has been a topic of lively debate during the last 10 years. In 1991, the National Institutes of Health consensus statement on the treatment of late life depression ranked psychotherapy as third in a line of treatment options (antidepressant medication first and electroconvulsive therapy second), indicating that there was insufficient evidence to recommend psychotherapy as a first-line treatment for depression in older adults. Since that time,

numerous articles have been written reviewing the psychotherapy research in older adults, and one meta-analysis of existing trials has been conducted (Table 1). In addition, several randomized clinical trials have evaluated psychotherapy as a treatment for late life depression (Table 2). Most of these studies have focused on the evaluation of cognitive-behavioral therapy (CBT) and interpersonal psychotherapy (IPT) and, to a lesser degree, brief dynamic therapy (BDT) and combined antidepressant medication and psychotherapy (CAMP).

Previous reviews have attempted to determine the evidence base for psychotherapy in late life mood disorders by evaluating clinical studies against an *a priori* set of criteria (Chambless and Hollon 1998). Even though the research to date has provided additional evidence that psychotherapy is a useful treatment alternative for late life depression, disagreement remains among persons who have reviewed this literature. Some reviews claim that psychotherapy is as effective as antidepressant medication (Karel and Hinrichsen 2000), whereas others are more conservative, stating that these interventions should not be considered well established or conclusively evidence-based treatments (Gatz et al 1998). Although determining the rigor with which randomized trials are conducted is crucial in evaluating the evidence base for any intervention, this step is only one facet of a complex evaluation process. To determine which psychotherapies qualify as evidence-based treatments for late life depression, we must not focus solely on the quality of the design but on long-term treatment effectiveness and data generalizability. The purpose of this article is to review the literature with an eye toward what we know and do not know about the efficacy of psychotherapy and its combination with medication in the treatment of late life depression.

Behavioral and Cognitive-Behavioral Therapies

Behavioral therapy (BT) and CBT have received the most research attention of any psychotherapy for late life depression. Although several types of interventions fall

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Table 1. Literature Reviews of Psychotherapies for Late Life Depression

Author(s) (year)	Type of review	Therapies reviewed	Conclusions
Charatan (1985)	Summary	Antidepressants, ECT, psychotherapies	All modalities useful
Morris and Morris (1991)	Literature	CBT, RT, PST, skills training	Therapies efficacious, cognitive impairment special consideration
Reynolds (1992)	Literature	Antidepressants, IPT, CBT, combined treatment	Individual and combined treatments efficacious
Areán (1993)	Literature	CBT	Efficacious treatment
Clark and Vorst (1994)	Summary	Group	Need more research on group therapy with depressed elderly
Scogin and McElreath (1994)	Meta-analysis	BT, CT, psychodynamic RT, eclectic	Moderately/highly efficacious
Reynolds et al (1995)	Literature	Antidepressants, IPT	Both efficacious for long-term maintenance, review challenges in maintenance research
Koder et al (1996)	Literature	CT	Efficacious, insufficient evidence as to efficacy of adaptations
Thompson (1996)	Literature	CBT	CBT efficacious, minor adaptations for older adults
Lebowitz et al (1997)	Literature	CBT, IPT, PST	Efficacious
Zeiss and Breckenridge (1997)	Literature	CT, BT, IPT, BDT	CT/BT most cost-effective
Gatz et al (1998)	Literature	CBT, IPT, BDT	CT, CBT, BDT probably efficacious, IPT promising
Niederehe and Schneider (1998)	Literature	Antidepressants, ECT, psychosocial	Efficacious
Klausner and Alexopoulos (1999)	Literature	CBT, PST, IPT, psychodynamic, RT	Acute treatment efficacious, probably efficacious for continuation, maintenance
Knight and Satre (1999)	Literature	CBT	Efficacious with suggested adaptations
Pachana (1999)	Literature	CBT, antidepressants, family, relaxation, combined	Efficacious, need more research on combined treatments, family and substance abuse treatment
Draper (2000)	Literature	Antidepressants, CT, CBT, psychodynamic, exercise, music, ECT	Few studies, insufficient empirical evidence for efficacy of psychotherapies with medically ill elderly
Karel and Hinrichsen (2000)	Literature	CBT, IPT, psychodynamic, life review, group, family	CBT, IPT most empirical support, combined therapy/medications best for more severely depressed elderly
Areán et al (2001)	Literature	CBT-PC, PST-PC, IPT-PC	All feasible and effectively adapted to primary care settings

ECT, Electroconvulsive Therapy; CBT, Cognitive-Behavioral Therapy; RT, Reminiscence Therapy; PST, Problem-Solving Therapy; IPT, Interpersonal Psychotherapy; BT, Behavioral Therapy; CT, combined therapy; BDT, Brief Dynamic Therapy; PC, primary care.

under this category of psychotherapy, to date, only BT, CBT, and problem-solving therapy (PST) have been evaluated in older adults (although BT has been used primarily as a comparison condition with CBT). These interventions share the theoretical assumption that human behavior is learned. To varying degrees, these interventions employ strategies such as changing how people process information from their psychosocial environment (cognitive restructuring), skill building (problem-solving, communication skills), and mood regulation skills (behavioral activation). Behavioral therapy tends to focus primarily on skill building and assumes that changes in information processing are achieved via increased positive experiences with new behavior. Problem-solving therapy and CBT involve a combination of skill building and cognitive restructuring; however, PST is focused explicitly on im-

proving problem resolution skills, and CBT focuses on affect and cognitive regulation skills. Although these interventions share the same theoretical roots, they differ in the process of behavioral and affective change.

Since the early 1980s, approximately 15 randomized clinical trials have been published, along with a handful of single case studies. Behavioral therapy, CBT, and PST have been compared with placebo, usual care, other brief therapies, and medication. These studies have found no differences between the modes of treatment delivery; group therapy works as well as individual therapy (Areán and Miranda 1996). Some studies have included 1- to 2-year follow-up periods to determine the permanence of treatment outcome. These interventions have been evaluated in medically ill elderly, rural, and homebound people, and in adults with cognitive impairment. Although most of

Table 2. Treatment Outcome Research: Psychotherapies for Late Life Depression

Author(s) (year)	Number of subjects	Age (years)	Populations	Experimental condition(s)	Control condition	Outcome
Hussian and Lawrence (1981)	36	55+	Nursing home residents with elevated BDI scores	Social reinforcement, PST	Wait-list	PST most efficacious
Jarvik et al (1982)	58	55-80	Outpatients with MDE	Imipramine or doxepin, psychodynamic group, CBT group	Pill-placebo	Antidepressants most efficacious, group therapy somewhat efficacious, placebo least improved
Gallagher and Thompson (1982, 1983)	30	59-80	Outpatients with MDE	CT, BT, brief relational/insight	NA	All efficacious at posttreatment, BT and CT better at 1-year follow-up
Fry (1983)	162	65-82	Community-dwelling, depressive symptoms	Life review, unstructured reminiscence	No treatment	Both treatments efficacious
Fry (1984)	75	67-80	Community-dwelling, depressive symptoms	Immediate vs. delayed CBT treatment package	NA	CBT package efficacious in immediate and delayed treatment subjects
Steuer et al (1984)	33	55-80	Community-dwelling with MDE	CBT group, psychodynamic group therapy	NA	CBT better at 36 weeks
Sloanes et al (1985)	24	Mean, 64		IPT, nortriptylene	Pill-placebo	IPT as good as NT
Beutler et al (1987)	56	Mean, 71	Outpatients with MDE	Alprazolam, pill-placebo, CT plus pill-placebo, CT plus alprazolam	Pill-placebo	Groups receiving CT show improvement, but no CT group
Goldwasser et al (1987)	27	NA	Nursing home residents	Reminiscence, supportive	No treatment	RT decreases depression
Thompson et al (1987)	91	60+	Community elders with MDD	BT, CT, BDT	Wait-list	All three efficacious
Thompson et al (1988)	79	Mean, 66.33	Depressed elderly	CT, BT, or BDT	NA	Patients with personality disorder benefit less
Viney et al (1989)	30	Mean, 74.62	Elderly	Personal construct therapy	No treatment control group	Psychotherapy group showed less anxiety and depression
Gallagher-Thompson et al (1990)	91	60+	MDD-diagnosed patients	BT, CT, or psychodynamic	NA	All efficacious, no significant treatment differences between three
Haight (1988, 1992)	51	61-99	Homebound elderly	Life review	Attention, no treatment	No significant reductions in depressive symptoms
Campbell (1992)	103	64-82	Community dwelling	CBT, crafts	No treatment	CBT efficacious in reducing depression
Dhooper et al (1993)	16	64-94	Nursing home elderly with mild/moderate depression	Life review plus PST	No treatment	Life review efficacious in reducing depression
Leung and Orrell (1993)	27	61-82	MDE, dysthymia cyclothymia	CBT group	None	CBT most efficacious for MDE
McMurdo and Rennie (1993)	49	63-91	Nursing home elderly	Group reminiscence, exercise	NA	Reminiscence efficacious in reducing depression
Gallagher-Thompson and Steffen (1994)	66	Mean, 62	Depressed family caregivers	CBT, BDT	NA	BDT better for "new" caregivers, CBT better for "seasoned" caregivers
Areán and Miranda (1996)	182	60+	Medically ill outpatients	Individual and group CBT	NA, naturalistic follow-up	Psychotherapies effective in medically ill elderly are
Mossey et al (1996)	76	60+	Recently released hospitalized elderly with minor depression	IPC	Usual care	IPC more efficacious at 6-month follow-up
Klausner et al (1998)	13	55+; mean, 66	Outpatients	Goal-focused group therapy, RT	NA	GFGP more efficacious at reducing depressive symptoms
Blanchard et al (1999)	64	Mean, 78.2	Depressed residents	Comprehensive intervention with psychotherapy/medication	No treatment	Psychotherapeutic interventions efficacious for maintenance
Reynolds et al (1999b)	187	Mean, 67	Community elders with recurrent MDD	NT, NT plus IPT, IPT plus pill-placebo	Pill-placebo	NT plus IPT most efficacious
Reynolds et al (1999a)	80	50+	Grief-related MDD	NT plus IPT, NT alone, IPT plus pill-placebo	Pill-placebo	NT plus IPT most efficacious
Williams et al (2000)	415	Mean, 71	Primary care patients with minor depression or dysthymia	Paroxetine and PST	Pill-placebo	Paroxetine moderately efficacious, PST more variable in efficacy
Rokke et al (2000)	34	Mean, 67.2	Recruited patients with MDE	Self-management therapy, educational group therapy	Wait-list	Therapies reduced depressive symptoms as compared with controls
Kuniks et al (2001)	56	60+	Veterans with COPD	One CBT session plus follow-up telephone	COPD education	CBT reduced depressive and anxious symptoms
Thompson et al (2001)	102	60+	Veterans with MDD	Desipramine alone, CBT alone, CBT plus desipramine	NA	Combined therapy most effective for most severe depression

BDI, Beck Depression Inventory; PST, Problem-Solving Therapy; MDE, major depressive episode; CBT, Cognitive-Behavioral Therapy; CT, combined therapy; BT, Behavioral Therapy; IPT, Interpersonal Psychotherapy; RT, Reminiscence Therapy; MDD, major depressive disorder; BDT, Brief Dynamic Therapy; IPC, Interpersonal Counseling; COPD, chronic obstructive pulmonary disease.

this research has focused on the treatment of major depression, there are preliminary data investigating the utility of these interventions for older adults with dysthymia or minor depression.

Major Depression

COMPARISON WITH PLACEBO OR WAIT-LIST CONTROLS. There have been five randomized trials comparing CBT with usual care or wait-list control and one study comparing PST with wait-list control. All of the studies found that CBT was superior to usual care for depression (Campbell 1992), wait-list control (Rokke et al 2000), pill-placebo (Jarvik et al 1982), and no treatment (Viney et al 1989). Problem-solving therapy has also been found to be superior to wait-list controls (Areán et al 1993). These studies not only found differences acutely but also demonstrated that treatment gains persist. For instance, Rokke et al (2000) found that two CBT interventions showed significant improvement of depressive symptoms over a 1-year period in comparison with a wait-list control condition. The research base suggests that CBT and PST are better than no treatment or usual care of late life depression.

COMPARISONS WITH OTHER PSYCHOTHERAPIES. Most research that has compared CBT with other psychologic interventions has yielded mixed results. Studies comparing CBT with BDT have uniformly found that, although both treatments are efficacious, there is relatively little difference between the two interventions in treatment outcome (Gallagher and Thompson 1983; Jarvik et al 1982; Steuer et al 1984). The most notable of these studies by Thompson et al (1987) compared CBT, BT, and BDT in 91 older adults who had met criteria for major depression. All of the patients were randomized and observed for 1 year after treatment termination. Participants showed significant improvement over wait-list controls, but no one intervention was found to be superior to the others. All three interventions demonstrated positive outcomes that were maintained over a 1-year period.

The research on PST has found results that are more consistent when PST has been compared with other psychotherapies. For instance, Areán et al (1993) found that PST was not only superior to a wait-list control but to reminiscence therapy (RT) as well. Reminiscence therapy resulted in statistically and clinically significant changes in depression symptoms; however, PST produced even greater symptomatic change than RT and tended to have changes that were more permanent at a 3-month follow-up. Klausner et al (1998) found similar results as Areán et al (1993) in that patients who received goal-focused treatment (an intervention similar to PST) had better outcomes than patients randomized to RT.

Research seems to indicate that matching therapies to patient concerns may be an important factor in treatment outcome and explains why, with the exception of PST, there has been little difference between CBT and other therapies. In one study by Gallagher-Thompson and Steffen (1994), 66 depressed caregivers (who were older than 55 years of age) were randomized to CBT or BDT. Although no differences were found between the two interventions when aggregate outcomes were assessed, there were notable differences in outcome when the length of time care giving was considered. Persons who were caregivers for more than 44 weeks were more responsive to CBT than BDT, and persons who were caregivers for less time were more responsive to BDT than CBT. It was suggested that this difference in response to treatment may be due to the fact that persons who have been caring for demented family members may be faced with a need to perform more structured problem solving around coping with the care recipients' cognitive decline, whereas newer caregivers may be more interested in coping with and processing affect around the diagnosis of dementia. Treatment matching may be important in strengthening the effect of CBT.

COMPARISON WITH ANTIDEPRESSANT MEDICATION. Only one study has compared CBT with antidepressant medication in the treatment of major depression in older adults. Cognitive-behavioral therapy was compared with desipramine and a combination of CBT and desipramine in 100 older adults. The study results suggested that CBT and the combination of CBT and desipramine were more efficacious in treating depression symptoms than was desipramine alone (Thompson et al 2001). Beutler et al (1987) compared alprazolam, an antianxiety medication chosen because of possible medical risks of tricyclic antidepressants in older adults, with group CBT in the treatment of major depression in older adults. This study found that group CBT was effective in reducing self-reported symptoms of depression among older adults with major depression, independent of the effects of alprazolam (Beutler et al 1987). The study is difficult to interpret given that alprazolam is not an antidepressant (Niederehe and Schneider 1998). To date, no geriatric research has compared CBT with the newer antidepressant medications (e.g., selective serotonin reuptake inhibitors) for major depression.

LONG-TERM EFFECTS AND RELAPSE PREVENTION. Few studies have observed older adults past a 1-year period, and data on the permanence of treatment outcome for CBT are limited. Persons who respond to CBT tend to maintain those treatment gains up to 2 years (Gallagher-Thompson et al 1990). Some research suggests that CBT

may have better long-term outcomes than BDT (Arean et al 1993; Gallagher and Thompson 1982), but, in general, the most salient finding is that persons who respond to treatment tend not to relapse within a 2-year window.

Dysthymia and Minor Depression

The literature on the efficacy of CBT and PST for treating dysthymia and minor depression in older adults is limited and is nonexistent for BT. This lack of information is unfortunate, given that these disorders are far more prominent in older adults than is major depression. To date, three studies have investigated the impact of CBT on these disorders. Leung and Orrell (1993) studied the efficacy of CBT in older adults with major depression, dysthymia, and cyclothymia. They found that, although 92% of the participants with major depression experienced symptom remission at 1 year, only 50% of subjects with dysthymia or cyclothymia were no longer depressed, a rate not as substantial as that for major depression. Two other studies show that CBT delivered as bibliotherapy was more efficacious in treating mild-to-moderate depressive symptoms in older adults than attention control (Scogin et al 1987) and no treatment (Scogin et al 1989). Treatment gains persisted 2 (Scogin et al 1990) and 3 years out (Smith et al 1997).

In another study, an abbreviated version of PST designed for primary care medicine (PST-PC; Mynors-Wallis 1996) was compared with Paxil and pill-placebo for the treatment of minor depression and dysthymia in older and younger adults in a primary care setting (Williams et al 2000). The study found that both active treatments were efficacious in decreasing depressive symptoms and improving functioning; however, PST-PC was not as effective as Paxil, had a slower onset of treatment effect, and was impacted by the degree of therapist training in learning-based strategies (Hegel et al 2000). A limitation of this study is that PST-PC was not adapted with the needs of a geriatric population in mind and, indeed, may not be inappropriate for older adults. Abbreviated PST is much shorter in length than PST (four to six, 30-min sessions delivered over 8 weeks). Geropsychologists agree that, due to the emphasis on learning new skills for coping with life stress, the delivery of interventions like PST must be altered so that it can accommodate the negative changes associated with aging (cognitive slowing, changes in working memory, cohort biases, disability) and the positive aspects of aging (greater fund of experience and learning history). These interventions should be modified by slowing the pace at which material is presented, emphasizing repeated review of material and relying on multiple modes of information transmission (Gallagher-Thompson et al 2000). These adaptations usu-

ally result in more treatment time with the patient than is needed with younger people. Given these considerations, it is likely that participants in this study did not have adequate exposure to PST (Williams et al 2000).

Overall, the results from these two studies indicate that CBT and PST are potentially helpful in reducing depressive symptoms in older adults with dysthymia or minor depression, but that treatment gains are not as promising as those found for major depression.

Summary and Limitations

Research on the efficacy of CBT and PST for major depression is compelling and suggests that they are viable therapeutic treatment options for older adults sustaining major depression and, to a much lesser degree, dysthymia and minor depression. The methodological strengths of this literature include the variety of investigators who have evaluated CBT and PST (CBT has been studied in four laboratories and PST in three laboratories), the sound implementation of the studies (RDC or DSM diagnostic criteria, the use of manuals and therapist supervision, control comparisons), and the use of long-term follow-up in at least two studies. Nevertheless, several drawbacks limit the degree to which the findings from these studies support the overall efficacy of CBT. First, most of the randomized trials have had small sample sizes. Although the studies comparing CBT with no treatment or usual care have adequate power to detect a true difference between the two conditions, the studies that have compared CBT with other psychotherapies may not have adequate power. A second limitation is that existing data are limited in terms of generalizability because there are insufficient data on the efficacy of CBT for minority elderly, frail elderly, and older adults with mild cognitive impairment.

Interpersonal Psychotherapy

Although IPT is considered to be on a par with CBT as an evidenced-based psychotherapeutic intervention for depression in younger adults, there are far fewer studies investigating the efficacy of IPT for older adults with depression. Interpersonal psychotherapy (Klerman et al 1996) consists of elements of psychodynamic-oriented therapies (exploration, clarification of affect) and CBT (behavior change techniques, reality testing of perceptions) that are used to address four areas of conflict: unresolved grief, role transitions, interpersonal role disputes, and interpersonal deficits. A strength of the IPT literature is the number of longitudinal studies with longer-term follow-up. A major limitation of the IPT literature is that most research has studied IPT in conjunction with medication or pill-placebo, making it difficult to evaluate

IPT's stand-alone efficacy given the expectations about treatment that may be functioning when patients are unknowingly taking a pill-placebo. The generalizability of IPT research is also limited because it has been evaluated primarily in healthy, ambulatory, white patients with major depression.

Major Depression

IPT PLUS PILL-PLACEBO VERSUS WAIT-LIST OR PLACEBO. Few studies have compared IPT with placebo or a wait-list control. In a study of treatment for chronic/recurrent major depression in late life, IPT plus pill-placebo were found to be better than pill-placebo in preventing the recurrence of major depression (Reynolds et al 1999b). In another study, acute treatment with a combination of nortriptyline and IPT in ambulatory older adults with a bereavement-related major depressive episode was associated with the highest rate of remission when compared with rates associated with nortriptyline treatment alone, pill-placebo alone, or pill-placebo in combination with IPT (Reynolds et al 1999a). The results from these two studies suggest that IPT combined with pill-placebo or medication may be more efficacious than pill-placebo alone in treating major depression.

IPT VERSUS MEDICATIONS. Although a few small studies initially found IPT to be as good as antidepressant medication in the treatment of late life depression (Schneider et al 1986; Sloane et al 1985), one more recent study suggests that IPT plus pill-placebo may not be as effective as IPT plus antidepressant medication either acutely or in the long run when treating older adults with major depression secondary to grief (Reynolds et al 1999a).

LONG-TERM OUTCOMES. Most of the IPT studies have focused on the longer-term outcomes of IPT and medication. In all studies, participants are treated with IPT and antidepressant medication for acute treatment. Once remission is achieved, participants are then randomized to receive IPT plus antidepressant medication or IPT plus pill-placebo. According to these studies, combined treatment with IPT and antidepressant medication may produce the best relapse prevention during the maintenance phase following acute treatment, whereas IPT plus pill-placebo produces the worst rates (Reynolds et al 1999b). Interpersonal psychotherapy may be most effective as a maintenance treatment when it is administered in combination with an antidepressant medication for more severely depressed older adults. Taylor et al (1999) found that more severely depressed older adults relapsed when they were receiving IPT maintenance therapy without adjunctive antidepressant medication when compared with older adults who were receiving pill-placebo, nortriptyline alone, or a combination treatment. Hence, IPT plus pill-

placebo may be most useful for the maintenance of depression remission among elderly patients whose initial depression is milder and who achieve remission during acute treatment with IPT and antidepressant medication.

Interpersonal psychotherapy plus pill-placebo cannot be considered equivalent to IPT alone. Patients may have different expectations about being treated with or without medication that could affect their ultimate outcome. The long-term efficacy of IPT as a stand-alone therapy is difficult to judge based on extant studies.

Dysthymia and Minor Depression

Only one study has evaluated the efficacy of IPT for minor depression in older adults. Mossey et al (1996) randomized 76 medically ill older adults with dysthymia (GDS > 11, no current diagnosis of dysthymia or major depression) who had recently been discharged from acute hospital care to interpersonal counseling (IPC), a modified shortened version of IPT, or usual care. At 6 months following treatment initiation, IPC was superior to usual care in reducing depressive symptoms. Thus far, no studies have looked at IPT for dysthymia.

Summary and Limitations

Interpersonal psychotherapy has not yet garnered support as a stand-alone intervention in the treatment of late life depression. Although a few small studies indicate that IPT could potentially be a useful stand-alone intervention for milder depression, the data from larger clinical trials support a combined approach to treating late life depression, particularly in chronic and recurrent types. As stated previously, the data are limited in that IPT is typically evaluated in combination with pill-placebo and not as a stand-alone intervention. In addition, only one research group has completed large-scale studies. As is true for CBT, the generalizability of the IPT literature is somewhat limited by the fact that existing studies have tended to include small numbers of minority elderly, and most participants are healthy and ambulatory.

Brief Dynamic and Reminiscence Therapy

The research on BDT and RT has been reviewed in part in other sections of this article. Most of the research suggests that BDT is an efficacious intervention for treating major depression in older adults (i.e., Gallagher and Thompson 1982), although other forms of psychotherapy may produce greater reduction in symptoms (Areán et al 1993). Reminiscence therapy also has some support. All of the research in this area has focused on the treatment of major depression only. Because this work has been reviewed in the CBT section, we briefly summarize the findings here.

Brief Dynamic Therapy

As discussed previously in the review of CBT, BDT has been found to be an effective intervention for treating major depression in older adults (Thompson et al 1987). Studies have found that BDT is better than no treatment (Thompson et al 1987). Outcomes for major depression seem to be maintained over a 1-year period. Moreover, although this intervention is an efficacious mode of treatment, it does not seem to be more efficacious than CBT (Gallagher-Thompson and Steffen 1994; Steuer et al 1984). Brief dynamic therapy has not been compared with antidepressant medication in the elderly.

Reminiscence Therapy

Life review and reminiscence, therapies that are derived and based on eriksonian developmental theory, were specifically developed for older adults. Although there are several open trials of RT in the treatment of late life depression, few randomized trials exist. Controlled trials of life review therapies suffer from small sample sizes, insufficient power, and a lack of formal diagnostic testing. Only a few published studies report the effects of these therapies on reducing depressive symptoms. Most study results suggest that life review therapies may be useful in reducing depressive symptoms among older community-dwelling and residential cognitively impaired older adults with milder levels of depressive symptoms.

Among older ambulatory community-based adults with a “high level of depression,” structured and unstructured life review were effective interventions when compared with a no treatment control condition (Fry 1983). In another study that measured posttreatment and 3-month follow-up changes in depressive symptoms among community-dwelling older adults with major depressive disorder, RT was effective, although less effective than PST, in reducing depressive symptoms when compared with a wait-list control group (Areán et al 1993). Dhooper et al (1993) found that an intervention consisting of life review and a problem-solving component resulted in a significant decrease in depressive symptoms among 16 elderly nursing home residents when compared with the reductions in a group of eight no treatment control participants; however, Haight (1992) found that reductions in depressive symptoms were not evident at posttreatment, nor were they reduced at 1-year follow-up among a group of homebound elderly.

Summary and Limitations

To date, a small body of research supports BDT as an efficacious intervention for late life major depression in healthy and ambulatory elderly adults. More research is

needed to compare BDT with antidepressant medication. Other research groups should do this work before we can recommend this intervention as an evidence-based psychotherapy for late life depression. The research on RT as an efficacious intervention remains inconclusive but suggests that it is potentially useful.

Combined Antidepressant Medication and Psychotherapy

There has been a limited amount of research on the combined effects of antidepressant medication and psychotherapy. The largest body of evidence has investigated the combined effects of IPT with medication (CAMP-IPT), and two studies have looked at the combination of CBT and medication (CAMP-CBT). Some preliminary data suggest that, for certain populations of older adults, CAMP is better than monotherapies in the treatment of late life major depression. There is no research on CAMP for dysthymia or minor depression.

Acute Treatment of Major Depression

Much of the research on CAMP-IPT has been described in detail in the section on IPT. Antidepressant medication combined with IPT has been found to be most efficacious in treating major depression in ambulatory older adults with chronic/recurrent depression (Miller et al 1998; Reynolds et al 1994; Reynolds et al 1999b). It is also an effective acute treatment in ambulatory older adults with a bereavement-related major depressive episode (Reynolds et al 1999a). Antidepressant medication combined with IPT tends to yield positive outcomes, and the results seem to be as good in older adults as in younger adults (Reynolds et al 1996).

The data on CAMP-CBT are mixed. Although the study by Beutler et al (1987) investigated the efficacy of CBT plus alprazolam, we do not include the results from this study herein because alprazolam is not an antidepressant medication. Only two studies have looked at the efficacy of CAMP-CBT. Blanchard et al (1995, 1999) compared CAMP-CBT with medication alone in 103 older community-dwelling adults. They found that CAMP-CBT not only resulted in better acute outcomes for older adults with major depression but that the outcomes were maintained during 1 year. Thompson et al (2001) found that CAMP-CBT was more efficacious than antidepressants alone, but, in contrast to the studies by Blanchard et al (1995, 1999), the findings did not demonstrate any added benefit of CAMP-CBT over CBT alone.

Summary and Limitations

The evidence for CAMP in the treatment of late life depression is still preliminary. Good support exists for

CAMP-IPT as a means for preventing relapse and recurrence of major depression in older adults, particularly older adults with recurrent major depression. The evidence for CAMP-CBT is mixed; one study finds the combination to be more beneficial than either treatment alone, whereas another study finds no added benefit. Although promising, CAMP-IPT suffers from the same set of limitations seen in the IPT literature; only one research group has studied this approach with adequately powered study designs, and the generalizability of these findings is unclear.

Special Populations and Settings

Although limited, a few small studies have investigated the efficacy of psychotherapy for late life depression in special populations and samples. In particular, the research on cognitively impaired patients, medically ill patients, primary care settings, rural settings, and minority populations is promising.

Medical Patients

According to Areán and Miranda (1996), older adults seeking help for depression in primary care respond well to CBT. Kunik et al (2001) also found that a one-session CBT intervention was effective in alleviating depressive symptoms in older adults with chronic obstructive pulmonary disease, although no longer-term follow-up was conducted in this study. Williams et al (2000) found that PST was not as efficacious as antidepressant medication in the treatment of dysthymia and minor depression in older medical patients. Although there are preliminary data on the efficacy of CBT for older medical patients, more research is needed. Interpersonal psychotherapy may also prove useful for treating depressive symptoms among the medically ill elderly. A modified form of IPT known as IPC was developed by Weissman and Klerman (1993) for use in treating depressive symptoms in the medically ill elderly. As previously discussed, Mossey et al (1996) found that IPC was superior to usual care in reducing depressive symptoms 6 months following treatment initiation.

Currently, two multisite trials on the treatment of late life depression in older primary care patients are underway and have included psychotherapy as a treatment option (Reynolds et al; Unützer et al 2001). Because neither study randomly assigns participants to psychotherapy, the information on efficacy or effectiveness will be limited; however, these studies promise to shed light on the responsiveness of older primary care patients to psychotherapy.

Rural/Homebound Elderly

Several studies have focused on increasing access to CBT to elderly adults who are hard to reach and unlikely to

attend regular psychotherapy visits, either because of distance or disability. These studies have used minimal contact bibliotherapy, which involves a preliminary orientation meeting with the depressed patient to review the rationale for treatment, reading assignments, and periodic and regular check-ups over the phone or in occasional face-to-face meetings. Two recent studies found that CBT delivered in this fashion was superior to usual care in rural elderly (Landreville and Bissonnette 1997) and homebound elderly adults (Landreville 1998). Psychotherapy can be adapted to circumvent access barriers and potentially retain its therapeutic effect.

Cognitively Impaired Elderly

There has also been limited research on the efficacy of behavioral and CBT interventions for treating depression in older adults with cognitive impairment. To the extent that psychosocial interventions may improve cognition as well as depression and perhaps retard further cognitive decline, reductions in hippocampal volume, and other morphologic changes associated with depression (Sapolsky 2000), intervention research among older adults with comorbid depression and cognitive impairment is an essential focus. Preliminary research suggests that BT seems to produce significant improvements in depressive symptoms among demented older adults and their caregivers (Teri et al 1997). No studies have attempted to replicate this finding.

Reminiscence therapy may also be useful for treating depression in confused or demented older adults living in residential facilities, particularly among adults who receive an intervention that increases orientation to time and space before the initiation of RT (Baines et al 1987). Among demented elderly nursing home residents, RT participants reported fewer symptoms of depression when compared with participants undergoing supportive therapy and a no treatment control group (Goldwasser et al 1987).

Minority Elderly

Although CBT has been studied to a limited degree in older medical patients, patients with dementia, and hard-to-reach populations, it has not been evaluated rigorously in minority elderly. Although the proportion of ethnic minorities in older age groups is smaller than the proportion found in younger age groups, it is expected by the year 2050 that the proportion of minority older adults will double, and the number of older Hispanic adults with quadruple. Only one study to date has looked at the efficacy of CBT in older minorities. That study found positive results but was not a randomized trial (Areán and Miranda 1996).

Summary and Future Directions

Based on our review, the following conclusions and recommendations are made. First, CBT, PST, and CAMP-IPT are acutely efficacious in treating major depression in ambulatory older adults. Nevertheless, more research is needed to determine long-term outcomes, the impact on functional outcomes (not just symptoms), and the impact of these interventions on patients with medical or psychiatric comorbid conditions. We recommend that these interventions be evaluated using larger samples from multiple geographic sites so that their effectiveness in the typical older person with major depression can be appropriately evaluated. Single-site randomized trials on selected participants are no longer required. Second, more controlled trials are needed to test the efficacy of BDT, IPT (without placebo), and the combined effects of CBT, PST, and BDT with antidepressant medication. We anticipate that only a few more controlled trials are needed to clarify conflicting information from disparate studies. For instance, one additional trial of BDT for treating late life major depression by another research group would meet the efficacy requirements set out by Chambless and Hollon (1998). Third, more research is needed on the efficacy of any psychotherapeutic intervention in the treatment of dysthymia and minor depression and in special populations such as frail elderly and older adults from minority groups. Because older adults are typically coping with more than depressive symptoms, that is, illness and quality of life issues, outcomes should focus more broadly on other functional domains, such as quality of life, activity of daily living, and better management of illness, and not just on decrements in depressive symptoms.

Continued work in the area of psychotherapy for older adults is needed. There is a clear disparity in the number of geriatric psychotherapy trials and medication trials to date (700 medication trials vs. nine psychotherapy trials published in the last 5 years). Numerous studies documenting mental health treatment preferences consistently show that psychotherapy is considered by older adults to be a viable option and, in some studies, is preferred to antidepressant medication (Landreville et al 2001; Rokke and Scogin 1995; Speer et al 1991). There are far fewer studies on the effects of psychotherapy in late life depression than there are medication studies. The disparity is due to fewer resources for this line of research. Unlike pharmaceutical research, psychotherapy has no industry to draw upon to help finance research and development, and few foundations have invested funds in the development and study of psychotherapy in late life. Psychotherapy researchers tend to rely on the National Institute of Mental Health (NIMH) as their sole source of support. We call

upon foundations to consider investing in the development and study of psychotherapy for late life depression and request that the pharmaceutical industry broaden their portfolios to include research into the combination of medication and psychotherapy for late life depression. Because of the limited support for research in late life psychotherapy, few mental health professionals enter the psychotherapy field. To date, only a handful of senior researchers are actively involved in evaluating psychotherapy for late life depression. This trend does seem to be changing. According to data from the NIMH/AAGP Summer Research Institute in Geriatric Psychiatry, the number of junior level researchers pursuing this area of research has grown from 3% (1 in 38 attendees) to 17% (4 in 28 attendees) (Halpain et al 2001, personal communication). More outreach and support from organizations such as the APA is needed to support career development initiatives pioneered by the AAGP and NIMH. A greater awareness of the need for this research by advocates, policy makers, funders, and researchers is necessary. Given the results from preference studies and the fact that Medicare, the largest insurer of geriatric mental health, covers psychotherapy services rather than medication, older adults may be accessing mental health treatment that has not been adequately studied. The elderly have the right to receive optimal, evidence-based mental health care, and psychotherapy is clearly an important aspect of that care in terms of scientific evidence and preference.

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