Using Interpersonal Psychotherapy (IPT) in a Combined Psychotherapy/ Medication Research Protocol With Depressed Elders

A Descriptive Report With Case Vignettes

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One hundred eighty subjects at least 60 years of age with recurrent unipolar major depression were recruited to participate in a depression treatment protocol. All patients received drug therapy with nortriptyline (NT) and interpersonal psychotherapy (IPT) with an experienced clinician. Acutely, 81% of subjects showed a full response to combined treatment. In the initial 127 subjects, the most common problem areas in therapy were role transition (41%), interpersonal disputes (34.5%), and grief (23%). Case vignettes are presented and discussed. The combination of IPT and NT showed a powerful antidepressant effect. IPT was readily adaptable to the needs of depressed elders.

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The National Institutes of Health Consensus Conference on Geriatric Depression concluded that the current system of care delivery for depressed geriatric patients was "inadequate, fragmented, and passive" and argued for more research endeavors to refine promising psychosocial treatments, such as interpersonal psychotherapy, for geriatric depression.[1]

Although Sigmund Freud was pessimistic about using psychoanalysis with the aged,[2] many subsequent practitioners refuted that view and proceeded to publish case descrip-

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tions of geriatric cases with successful outcomes. The literature prior to the 1980s is primarily composed of such case reports, often richly descriptive but limited to the experience of single practitioners.[3–14] Recently, research efforts in psychotherapy have focused on the use of manual-based psychotherapies such as cognitive-behavioral therapy[15] (CBT) or interpersonal psychotherapy[16] (IPT) in order to standardize treatments by different practitioners and allow for meaningful comparison between groups of patients receiving different treatments.

In this article, we describe our collective experience treating 180 depressed elderly patients over the past 7 years in a controlled treatment trial, the Maintenance Therapies in Late-Life Depression (MTLLD) study. We begin with a brief background of the development of IPT and a description of the protocol within which it was used. Preliminary cross-sectional data are presented along with case vignettes to illustrate each IPT problem area.

Interpersonal psychotherapy of depression was developed about 25 years ago by Gerald Klerman, Myrna Weissman, and their colleagues in the New Haven–Boston Collaborative Depression Research Project. It was described by the authors as "a focused, short-term, time-limited therapy that emphasizes the current interpersonal relations of the depressed patient" (p. 5).[16] The focus of IPT is jointly agreed upon by patient and clinician and is broadly contained in one of four problem areas: abnormal grief, role transition, role dispute, or interpersonal deficit. The techniques of IPT are based on a long tradition of interpersonal psychotherapy, primarily developed in the Baltimore-Washington area, and on many empirical studies related to attachment bonds and significant life events.[17] Karasu[18] has published a comparison of IPT with other psychotherapies for depression, describing the major features, advantages, and limitations of the psychodynamic, cognitive, and interpersonal approaches.

The rationale for using IPT was initially described in a treatment manual and was subsequently published as a textbook,[16] which has been used to train clinicians in a variety of clinical and research settings. Over the years, IPT has been modified for use with specific populations, such as those with recurrent depression or depression in late life or adolescence.[19] IPT has been demonstrated empirically to be an effective form of treatment for acute and maintenance treatment of adults ages 18 to 60.[15,20]

METHODS

Description of the MTLLD Study

The Maintenance Therapies in Late-Life Depression study was conceived to attempt to reduce the high recurrence rate observed in geriatric depression by comparing the efficacy of the antidepressant nortriptyline (NT) with interpersonal psychotherapy and their combination as maintenance treatments under placebo-controlled, double-blind, random-assignment conditions. IPT was chosen because it was anticipated to be readily adaptable to the problems facing elders, particularly grief and role transitions. Furthermore, IPT is a manual-based psychotherapy that can be standardized and verified.

The MTLLD study enrolls elderly individuals with a history of recurrent depression during a current episode of major depression. Patients were excluded if they were bipolar, dementing, psychotic, diagnosed with neurodegenerative disease, or medically unable to be tried on NT or to travel for weekly visits. Since the goal of the study is to compare the efficacy of maintenance treatment, the first task is to maximally treat the current episode. All patients in the acute phase of the study therefore receive combined IPT and NT. All patients are seen weekly for 50 minutes of IPT for a minimum of 12 sessions. After achieving stable remission for 16 weeks, patients are then randomized for 3 years of maintenance follow-up on either NT or placebo in combination with either monthly IPT or a 15-minute medication check. For a

more detailed description of the MTLLD protocol, see Reynolds et al.[21] A report on the differential efficacy of these maintenance assignments will be available once the ongoing study is complete.

Teaching IPT to Protocol Psychotherapists

Teaching of the principles of IPT was carried out under the direction of senior clinicians, all of whom were highly experienced in its use from previous studies through direct collaboration with the developers of IPT. All therapists completed a 6-month didactic course (1½ hours per week) on the principles of IPT, including videotaped case vignettes. Each therapist was assigned two pilot cases, working with an individual supervisor on a weekly basis as well as alternately presenting videotapes for weekly group discussion and supervision. As the study progressed, the weekly case conference also served as an opportunity for ad hoc validation of the most appropriate focus of therapy. The pilot experience of Sholomskas et al.[22] recommended that therapists maintain an active stance, that they be prepared to help patients with practical problems such as finances or transportation, and that they maintain an awareness that options for change may be limited among elderly patients.

We expected our elderly subjects as a group to be struggling more frequently than younger subjects with issues of grief and loss and with role transitions such as retirement and relocation. Regarding role disputes, we tried to remain cognizant of the writings of Sholomskas and colleagues, who warned that elderly individuals may see themselves as having fewer options to make changes in role disputes than younger persons. Finally, we expected to find a disproportionate number of subjects in an elderly cohort confronting issues of aging, illness, and the perception of impending death.

RESULTS

Introducing IPT to Elderly Subjects

Many of our geriatric patients had little experience or understanding of psychotherapy prior to enrolling in the MTLLD study. They voiced their willingness to do anything to feel better but did not always come asking for psychotherapy in particular. Because IPT was a requirement of protocol participation, every effort was made to educate patients about the process and potential benefits of IPT. The vast majority of patients were able to learn and use the psychoeducational aspects of IPT and to use the time in therapy fruitfully.

The majority of patients worked very hard in therapy and reported reviewing sessions on their own and sometimes keeping notes. They voiced appreciation for the opportunity to have the psychotherapy sessions, since they often had no other confidant.

Overall, MTLLD therapists found fewer differences in applying IPT to elderly patients than anticipated. There was a range of psychological mindedness among our patients that was very similar to our experience with younger populations. On the whole, carrying out IPT was not more difficult with elders. A few patients could not tolerate full 50-minute sessions when acutely depressed, but most were easily engaged and very reliable about keeping appointments. Because few patients were still working, schedules were flexible and time was less restricted than with younger patients.

Dependency issues did arise infrequently when the maintenance phase approached and patients anticipated a 50% chance of no longer receiving psychotherapy. We were careful to handle termination according to the IPT principles of beginning discussion of these issues well in advance of transition times and by confronting them openly.

Cross-Sectional Data

Thus far, the combined use of IPT and NT has been shown to be a powerful treatment for

depression in elderly subjects, with a full response rate of 81% (defined as a score ≤ 10 for 3 consecutive weeks on the Hamilton Rating Scale for Depression[23] [Ham-D]). Mean pre/post Ham-D scores among responders were 21.9 (SD = 4.2) and 4.9 (SD = 2.8), respectively. Detailed reports of other preliminary outcome variables have been published elsewhere.[21,24,25]

The four major problem areas that serve as foci in IPT are 1) abnormal grief, 2) role transitions, 3) role disputes, and 4) interpersonal deficits. A detailed analysis of the first 127 patients showed a primary psychotherapy focus on role transition in 41%; a focus on grief in 23%; a focus on role disputes in 34.5%; and a focus on interpersonal deficits in 2 subjects. The role transitions that were associated with depression in our elderly patients, in descending rank order of frequency, are aging issues, retirement, declining health, "empty nest," loneliness, widowhood, relocation, ill significant other, marital change, work-related role transition, and dating. A secondary focus of role transition was identified in 57% of patients (in 41% of those with grief as a primary focus and in 32% of those with interpersonal dispute as a primary focus). The breakdown of losses precipitating grief, in rank order, was as follows: spouse, adult child, parent, sibling, close friend, nephew, and multiple family members. The problematic relationship in the 44 subjects with a primary focus on role disputes was most frequently with a spouse, followed by interaction with children, multiple family members, and, in one case each, a sibling and a close friend. For a detailed account of clinical and demographic correlates of IPT foci, see Wolfson et al.[23]

Case Vignettes

Role transition, illustrated in the following vignette, was the most frequent problem we encountered. As the role transition crisis abated in the early phase of treatment, the focus of IPT changed to role dispute.

The tasks of the IPT therapist in a role transition are to 1) elucidate the lost role, 2) facilitate the expression of emotion surrounding it, 3) encourage the development of social skills suitable for the new role, and 4) seek social supports to help maintain the new role.

Case 1: Role Transition/Role Dispute. Mr. A., a 61-year-old white, married professional, presented in his third episode of major depression. He reported previously seeing a psychiatrist for "advice" during a midlife crisis but not finding it very helpful.

Mr. A. described how his professional practice partner had recently retired, leaving him with an office he could not afford. Gradually, a picture came into focus of a man with deep ambivalence about his chosen profession and a pattern of financial negligence in paying debts and collecting fees that was nearly bankrupting him. Mr. A. explicitly stated that his ambivalence toward starting again with another practice versus taking up other employment or choosing retirement was particularly depressing to him. A focus on role transition seemed most appropriate at the outset.

After several sessions exploring various options and providing him an opportunity to ventilate his feelings about his work-related ambivalence, Mr. A. finally decided to invest in a new office, found a young partner, and opened a new practice. His goal was to retire in 5 years. His depression gradually improved over the ensuing 3 months.

During his IPT treatment, Mr. A.'s wife was diagnosed with cancer. She was successfully treated with chemotherapy and achieved a rapid remission, but her tolerance for her husband's behavior was diminishing. She became more confrontational regarding his pattern of "forgetting" to fulfill his responsibilities, which now seemed more pronounced since her treatment had left her greatly weakened and more of the day-to-day responsibility of running their affairs fell into Mr. A.'s hands. She once telephoned out of desperation, complaining about his behavior in light of their dire financial circumstances. Gradually, a pattern of passive deferral or passive aggression toward his wife became clear, and a shift in the focus of IPT to role dispute seemed appropriate. A few conjoint sessions were deemed necessary to deal with the crisis of his wife's cancer diagnosis. During these sessions, Mrs. A.'s accusations of a

long-standing pattern of passive aggressive behavior and convenient forgetfulness were not denied by Mr. A. Their relationship had developed a homeostasis that rested upon Mrs. A.'s ability to continually rescue her husband when his negligence caught up with him. The inclusion of his wife in these conjoint sessions helped to reveal more fully the patient's lifelong character pathology. His "forgetfulness" became so problematic that Mr. A. and his wife requested neuropsychological testing because she was afraid he might be showing early signs of dementia. The test results were negative for significant cognitive impairment.

Since IPT does not seek to change personality structure per se, his IPT therapist continued to focus in very practical ways on the day-to-day tasks as they related to role disputes with his wife. On review with Mr. A. of the list of his day-to-day responsibilities, he appeared to be more forthcoming about his long-standing pattern of avoiding responsibilities. With continued review of these issues, Mr. A. began to take more responsibility for the running of the household. He became more attentive to his wife's needs and more honest with her about what he was willing and able to do. Mr. A.'s wife confirmed that he seemed better at "hearing her" and she now felt she was receiving more of the support she sorely needed to cope with her cancer.

The vignette of Mr. A. illustrates a case of shifting focus from role transition (work transition) to role dispute (marital conflict). The long-standing character traits of passivity and passive aggression were acknowledged by the IPT therapist but addressed only through persistent reevaluation of here-and-now themes. The crisis of his wife's diagnosis of cancer caused Mr. A. to more fully confront his long-standing, maladaptive behavior patterns. His IPT therapist was able to help him see the relationship of these behaviors to the role dispute with his wife and to seek alternative strategies that were more appropriate.

Role disputes that were ameliorated by work, child care, or independent activity often proved to be more difficult when one spouse became ill or dependent or if retirement or children leaving home required a couple to spend more time together, as the following case vignette illustrates.

Case 2: Role Transition/Role Dispute/Abnormal Grief. Mrs. B., a white, married 64-year-old, presented in her fourth episode of major depression, never having had any previous experience in psychotherapy. She had recently retired from her position as a health care provider. She was extremely anxious and guarded at the onset of therapy and reported an almost complete remission of depressive symptoms in the first week. The clinical staff was intuitively skeptical of this "flight into health" and was able to convince her to stay in the program. Within several weeks, her symptoms returned and her Ham-D score was as high as it had been initially. She was extremely anxious and had a difficult time engaging actively in therapy. After a cautious start, the educational component of IPT began to pay off and she began to engage more actively. Gradually, she began talking about her difficulties in adjusting to retirement. These included difficulties in time management, learning to manage money, and setting boundaries on her availability for baby-sitting her grandchildren. The first 5 to 8 sessions focused on these role transition issues.

Once Mrs. B. began to feel somewhat better and a therapeutic bond formed, she began to reveal deep-seated resentments toward her husband. She requested that we shift our focus away from her problems with retirement and onto her role disputes with her husband. Each situation that Mrs. B. brought to therapy manifested an underlying imbalance of power and control. Mrs. B. described her husband as a benign dictator. Her IPT therapist explored specific instances of the power imbalances she described and her usual response of failing to ask for what she wanted because she "knew" he would become upset if she disagreed with him. After exploring alternative strategies and the potential consequences of greater assertiveness, Mrs. B. vowed to attempt to speak up more and be more clear about her needs. The interpersonal disputes worsened with these initial attempts, as did her own internal dissonance. With continued confrontation and clarification of this pattern, Mrs. B. recognized her own responsibility in allowing her husband to "rule the roost" and the great difficulty she had in asserting herself. With the continuing support of her IPT therapist, Mrs. B. made persistent attempts to assert herself more clearly and was both surprised and delighted to find her husband

more willing than she had imagined to share in decision making. With practice, she eventually became more comfortable with her newly acquired role. Through her work in IPT, Mrs. B. was able to learn to be more aware of her role in her marital discord and to accept more personal responsibility for their joint problems. The net effect of these efforts led to improved marital communication.

As the interpersonal dispute with her husband improved, Mrs. B. revealed another dimension of her interpersonal life that related to her depression. Her sister, who was her primary confidant, had died several years earlier, and Mrs. B. felt that she had never properly grieved for her. This was due, in part, to complex dynamics in her family, such as family secrets that only she and her sister shared, as well as Mrs. B.'s unwillingness to allow herself to "let go" and really mourn, since her primary role in the family had always been to take care of others. With gentle encouragement Mrs. B. was able to step out of her role as caregiver and to express a great deal of her grief and pain. She chose to share some of the family "secrets" that had played a role in her buried grief for her sister. Her father was much older than her mother and developed Parkinson's disease while many of the children were still small. Since her father was unable to continue working, her parents took in boarders to generate income. Her revelation of the family secret that her mother had several love affairs with her male boarders was followed by extreme self-doubt and worry that she was being disloyal to her family for talking about this "secret."

Mrs. B. spoke of her difficulty trusting the confidence of her sister, who also knew of the "secret." Mrs. B. had wanted many times to discuss it with her sister but had never done so. The issue of trust was explored at length, and Mrs. B. expressed her appreciation for having the opportunity to discuss these issues in a "safe" forum where there were no ramifications in her personal life. The issues of trust, shame, embarrassment, and loyalty were each explored in turn, since they were key to unlocking her buried, incomplete grieving for her late sister.

Her IPT therapist was able to tie Mrs. B.'s feelings surrounding grief for her sister to her current situation (and thus return the focus to the present) by helping her to explore ways in which she might become more flexible in her roles with important people in her life now and learn to ask for support from others when she needed it.

The role of the IPT therapist is to explore problem interpersonal relationships and search for ways in which they might be handled better. Mrs. B.'s IPT therapist recognized her problem trusting others and encouraged her to learn to ask for more from others within her significant relationships.

Early in treatment, this patient demonstrated the "flight into health" phenomenon because of her anxiety about "opening up." Her IPT therapist, through patient and persistent psychoeducational efforts, convinced her of the safety of sharing her interpersonal difficulties as she saw them. Mrs. B.'s initial complaints indicated a role transition focus (retirement), followed by psychotherapeutic work centered on her role disputes in her marriage. After progress handling the first two problems, a third, more briefly explored focus on unresolved grief was made possible by her bolstered confidence that she could trust her therapist with her most deeply held secrets.

Issues arising from old traumas might be expected to surface more often in elderly patients because they have more years of accumulated experience. IPT does not set out to elucidate early life experiences or uncover traumas per se, as one might in psychodynamic or psychoanalytic therapies; however, when patients bring them up, it is appropriate in IPT to encourage the ventilation of feelings around the old trauma. Mrs. B. clearly needed to share the long-held family secret that was connected to her unresolved grief for her sister. After allowing her to express her feelings about the matter, her IPT therapist gently brought her back to the present and connected the issue to her current problems by posing questions to her about how she might learn to ask for more support and understanding from others instead of continuing a pattern of silent suffering.

We expected to encounter difficulty coping with grief and loss in our elderly subjects and frequently did so. We have previously written at length about our experiences using IPT for grief in elders.[26] The following vignette illus-

trates one presentation of abnormal grief.

Case 3: Abnormal Grief/Role Dispute. Mr. C., a white, single 64-year-old, reported a history of persistent depressive symptoms for 3 years prior to his admission to the MTLLD study. Mr. C. had never married but was very close to his siblings and their families. Mr. C. was a health care professional and, as such, regularly assumed the role of caregiver with his entire family's medical problems. He was particularly close to his 10 nephews, with whom he especially enjoyed playing golf.

Four years prior to his presenting for help, one of his nephews died of leukemia at age 37. A month afterward, another nephew, also in his thirties, died suddenly from a cerebral aneurysm. In 1988 one of his brothers died, and a year later a second brother died. Shortly after that, one of his great-nephews (age 25), died in a car accident. Mr. C. said, "I have been grieving for the last three years." To make matters worse, as a result of prostate cancer treatment, colon resection, and recent carpal tunnel surgery, he himself could not play golf for an entire season.

The IPT focus, abnormal grief, was complicated by several factors. In addition to being distressed by his own limiting illnesses, Mr. C. was resentful of being continually thrust into the role of liaison with various health care providers who were caring for his ill relatives, a role he found to be extremely stressful but to which he could never say no. Additionally, although other family members, especially the parents and spouses of the deceased, received support and acknowledgment of their losses, no one seemed to recognize the depth of his losses. He was "only the uncle," although it became clear that he shared a special bond with his nephews.

His IPT therapist offered a safe, supportive forum to express all of his feelings of sadness for his lost relatives, as well as his negative feelings that his grief was not being legitimized by other family members and that he was being taken for granted as a health care liaison despite his own medical problems and restrictions. With continued confrontation of his role in allowing the status quo to remain, he expressed a willingness to be more assertive in declining some of the expected obligations he no longer felt he could fulfill. The self-perception that he had to "give more" as "only an uncle" to feel worthy of inclusion in the family was challenged, resulting in the acknowledgment that his own problems were just as deserving of family attention and support.

By first acknowledging the legitimacy of his grief, IPT offered Mr. C. the opportunity to openly grieve, to talk about how he experienced his nephews' deaths not only as the "family nurse," but also as their beloved uncle. He also learned that he could relieve his resentment at being overburdened by his family's medical needs by being more assertive in his expectations that he be included as a full-fledged family member complete with his own problems, not just "the uncle."

DISCUSSION

In our experience, IPT in combination with nortriptyline shows a high degree of utility with depressed geriatric patients. We were impressed with the ability of our patients as a group to learn from the psychoeducational components of IPT, to become working partners in psychotherapy, often without prior experience, and to use IPT to modify interpersonal problems.

A shift of focus during IPT occurred in 57% of our subjects. In the case vignettes, Mr. A.'s job-related role transition and his wife's cancer diagnosis forced a confrontation with long-standing maladaptive behavior in his marital relationship. Mrs. B. revealed her long-standing resentments toward her husband only after exploring her difficulties adjusting to retirement. Mr. C. struggled with the grief of multiple losses through death before confronting his resentment toward various family members who assumed he would be their health care liaison. Perhaps a more crisis-oriented therapy with limited sessions would not have allowed for these secondary role disputes to emerge; however, in our view the secondary focus on role disputes is often the most important focus that is "saved for last"—after more temporary adjustments in coping have been made and after patients have developed the required rapport to approach more worrisome or deep-seated problems in their relationships. In other words, role transitions are easier to

handle if important relationships are viewed as working well, and vice versa.

Regarding spousal role disputes, perhaps we are seeing an age cohort effect, since divorce would have been more frowned upon in the earlier years of these couples' marriages than in recent times. Couples with severe marital strains may have found ways to cope, however tenuous, only to find their tried and true strategies were failing as the stresses of late life accumulated. One-third of the patients with a primary focus of role dispute showed a secondary focus of role transition. Perhaps an unavoidable role transition precipitated a shift of a tenuously balanced relationship into one with a serious role dispute. It is not difficult to imagine the stresses of a new medical illness or the approach of retirement precipitating more disputes between spouses.

The clinical impressions of the 5 participating IPT psychotherapists treating these 180 patients over the past 7 years were that IPT required no major modification and was no more difficult to carry out than IPT with younger patients. There were certainly instances when financial, legal, medical, transportation, or housing problems arose and required exploration and sometimes practical recommendations for appropriate assistance. These instances were seen somewhat more frequently than with younger patients, but they did not significantly interrupt or overshadow the focal work in IPT. The reader should bear in mind that elderly subjects with significant memory loss or dementia, who would be expected to require even more assistance, were excluded from the protocol.

In preparing to work with depressed elderly patients, we found a review of principles of gerontology highly useful to familiarize ourselves with and be able to anticipate common problems and needs of elderly patients in general. A background course in gerontology or a year or more of experience working with elders is highly recommended for clinicians interested in applying IPT to elderly patients.

Although the use of nortriptyline with IPT, in our experience, has been a powerful antidepressant combination for elders with recurrent depression, we cannot comment on the differential effects of these two treatments as acute treatments. Report of the comparative efficacy of IPT, nortriptyline, and their combination as maintenance treatments will follow upon completion of the MTLLD protocol.

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References

1. NIH Consensus Development Panel on Depression in Late Life: Diagnosis and treatment of depression in late life. JAMA 1992; 268:1018–1024
2. Freud S: On psychotherapy (1905), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, vol 7, translated and edited by Strachey J. London, Hogarth Press, 1953, pp 255–268
3. Lazarus L: Clinical Approaches to Psychotherapy With the Elderly. Washington DC, American Psychiatric Press, 1984
4. Kockott G: Psychotherapy in advanced age in psychogeriatrics: an international handbook, edited by Bergener M. New York, Springer Publishing, 1987
5. Miller M: Using psychoanalytically oriented psychotherapy with the elderly. Jefferson Journal of Psychiatry 1986; 4:13–21
6. Muslin CJ: The transference of the therapist of the elderly. J Am Acad Psychoanal 1988; 16:295–313
7. Miller M: Opportunities for psychotherapy in the management of dementia. J Ger Psychiatry Neurol 1989; 2:11–17
8. Berezin M: Psychodynamic considerations of aging and the aged. Am J Psychiatry 1972; 128:33–41
9. Kroetsch P, Shamoian CA: Psychotherapy for the elderly. Medical Aspects of Human Sexuality 1986; 20:123–127
10. Ursano RJ, Hales RE: A review of brief individual psychotherapies. Am J Psychiatry 1986; 143:1507–1517
11. Goldfarb AI, Turner H: Psychotherapy of aged persons, II: utilization and effectiveness of brief therapy.

Psychotherapy of Aged Persons 1953; 916–921
12. Wasylenki DA: Psychodynamics and aging. Can J Psychiatry 1982; 27:11–17
13. Meerloo J: Psychotherapy with elderly people. Geriatrics 1955; 10:583–587
14. Safirstein SL: Psychotherapy for geriatric patients. New York State Journal of Medicine 1972; 72:2743–2748
15. Elkin I, Shea T, Watkins JT, et al: National Institute of Mental Health Treatment of Depression Collaborative Research Program: general effectiveness of treatments. Arch Gen Psychiatry 1989; 46:971–982
16. Klerman GL, Weissman MM, Rounsaville BJ, et al: Interpersonal psychotherapy of depression. New York, Basic Books, 1984
17. Cornes CL: Interpersonal psychotherapy of depression (IPT), in Handbook of the Brief Psychotherapies, edited by Wells R, Giannetti V. New York, Plenum, 1990, pp 261–276
18. Karasu TB: Toward a clinical model of psychotherapy for depression, I: systematic comparison of three psychotherapies. Am J Psychiatry 1990; 147:133–147
19. Klerman G, Weissman MM (eds): New Applications of Interpersonal Psychotherapy. Washington, DC, American Psychiatric Press, 1993
20. Frank E, Kupfer DJ, Perel JM, et al: Three-year outcomes for maintenance therapies in recurrent depression. Arch Gen Psychiatry 1990; 47:1093–1099
21. Reynolds CF, Frank E, Perel JM, et al: Combined pharmacotherapy and psychotherapy in the acute and continuation treatment of elderly patients with recurrent major depression: a preliminary report. Am J Psychiatry 1992; 149:1687–1692
22. Sholomskas AJ, Chevron ES, Prusoff BA, et al: Short-term interpersonal psychotherapy (IPT) with the depressed elderly: case reports and discussion. Am J Psychotherapy 1983; 37:552–566
23. Hamilton M: A rating scale for depression. J Neurol Neurosurg Psychiatry 1960; 23:56–62
24. Wolfson L, Miller M, Houck P, et al: Foci of interpersonal psychotherapy (IPT) in depressed elders: clinical and outcome correlates in a combined IPT/nortriptyline protocol. Psychiatry Res 1997; 7:45–55
25. Miller MD, Silberman RL: Using interpersonal psychotherapy with depressed elders, in A Guide to Psychotherapy and Aging: Effective Clinical Interventions in a Life-stage Context, edited by Zarit SH, Knight B. Washington, DC, American Psychological Association, 1996, pp 83–99
26. Miller MD, Frank E, Cornes C, et al: Applying interpersonal psychotherapy to bereavement-related depression following loss of a spouse in late life. J Psychother Pract Res 1994; 3:150–162