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Psychotherapies for Late-Life Depression

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Availability of tolerated and relatively safe antidepressants increased the use of antidepressants in late-life depression. However, only one third of depressed older adults achieve remission with any single agent.[1] Treatment resistance to antidepressants prompted the development and investigation of effective psychotherapies for cognitively unimpaired, depressed older adults. Since late-life major depression is often accompanied by cognitive impairment, disability, and medical illnesses[1,2], novel psychotherapies for depressed patients with cognitive impairment, disability, chronic medical illnesses or acute medical events have also been developed. Thus, the selection and planning of psychotherapy depends on the patient's clinical state and requires a thorough assessment. Areas of assessment include not only the patient's depressive symptoms, acute and chronic stressors, interpersonal context, skills and behavioral deficits, but also the presence and degree of the patient's cognitive deficits, medical burden and disability. This article describes assessment procedures pertinent to psychosocial interventions and outlines psychosocial interventions for depressed older adults.

Assessment of Late-Life Depression in Older Adults

Depressive Symptoms

Most depressed older patients may benefit from psychotherapy. High quality psychotherapy is rarely available in clinical settings offering care to elders because of time, reimbursement constraints, and a limited, well-trained workforce. Nonetheless, psychotherapy should always be considered in patients who have failed adequate trials of antidepressants and patients whose depressive syndrome developed in the context of an acute stressor.[2] The clinical examination of depressed elders prior to referral for psychotherapy is similar to that of younger adults, although special attention needs to be given to history and presence of medical illnesses, cognitive dysfunction, and disability. Accordingly, the clinician should collect information about the nature and role of likely precipitants, the course of the current depressive episode, past history of depression and other psychiatric illnesses, current or past history of suicidal ideation and suicide attempts, family history of depression and suicide attempts, and medical history. In addition, the clinician should review the history of psychiatric and non-psychiatric medications (dosages, duration, and treatment response),

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prior attempts at psychotherapy (type and quality of treatment, frequency and duration, and response), and any other treatments (ECT, TMS, etc.).

Cognitive Impairment

Assessment of the cognitive limitations of depressed older adults and their expected course can help determine the selection of psychotherapy. Cognitive dysfunction may be a symptom of depression itself, be part of a coexisting cognitive disorder or both.[3] Non-demented, depressed older adults frequently have poor concentration, low processing speed and short-term memory, and executive dysfunction (including impaired organizing, planning, initiating, sequencing, and shifting).[4, 5] Some older adults with late-life depression may also exhibit a "reversible dementia" syndrome (i.e. a cognitive impairment that mimics dementia but diminishes upon remission of depression). A large percentage of these patients progress into irreversible dementia within 2–3 years.[6] Medical illnesses, including thyroid abnormalities, deficiency of vitamin B12, lymphomas and pancreatic cancer, and neurological disorders, such as vascular dementia, Alzheimer's disease and Parkinson's disease, may cause both depression and cognitive dysfunction.[3] Therefore, cognitive screening, and when indicated a comprehensive neuropsychological evaluation, along with a thorough medical history and neurological examination, may map the type of cognitive dysfunction and clarify its causes. However, in some cases, reliable diagnosis can only be made after long-term follow-up.

Medical Comorbidity

Understanding the impact of medical events on the behavior of depressed patients and members of their ecosystem is critical for identifying psychotherapy treatment targets and selecting interventions. Late-life depression often develops in patients with a chronic medical illness or an acute medical event. More than 75% of depressed older adults have a medical condition for which they receive treatment, 46% have two, and 25% have three or more. Lack of energy from chronic medical illness combined with the pessimism and helplessness of depression compromise adherence to create a "perfect storm", leading to abandonment of effective treatments. Acute medical events are followed by an upheaval in patients and their ecosystem and to dysfunctional behavior that undermines any treatment efforts. For these reasons, understanding the role of medical events and illnesses on patients' adaptation and their impact on their ecosystem can inform psychotherapeutic strategy.

Disability

Disability is a distinct dimension of health.[7] Although disability is related to severity of late-life depression, cognitive impairment, and medical burden, these relationships are rather weak. Depression promotes disability in medically healthy and medically ill older adults.[8] Disability can exacerbate depressive symptoms and cognitive impairment.[9] Improving functioning and reducing disability may ameliorate depressive symptoms and signs.[10] Therefore, the assessment of late-life depression should include an evaluation of the patient's physical and functional limitations and assess the interaction of depression, cognitive impairment and disability. Beyond diagnosis, clinicians need to determine whether the patient needs assistance on any instrumental (e.g., shopping for groceries, cooking meals, doing laundry, paying bills, performing housework, using the telephone, taking

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medication, walking a short distance) or basic activities of daily living (e.g., bathing, eating, combing hair, dressing) and devise a psychotherapy plan aimed at improving function or at remedying dysfunctions that are not likely to change.

The Role of Caregivers

Available and willing caregivers should be invited to participate in the assessment process. The caregiver may assist in identifying periods of depression, provide an accurate description of patient's behavior and overall functioning when depressed, and detail cognitive, physical, and functional limitations. If a patient refuses to involve his/her caregiver, the reasons for refusal should be explored and, when appropriate, targeted explanations may be offered on the importance of the caretaker's perspective in assessment and treatment. In addition to the patient's caregiver, collateral information from other sources, such as the patient's primary care physician, may be critical to establish a timeline of depressive symptoms and identify cognitive deficits and other clinical and social problems.

Suicide Ideation and Suicide Risk

Suicide risk increases with age, with Caucasian older men at highest risk.[11] Psychiatric illnesses, especially depression, are the most prominent risk factors whereas other risk factors include poor physical health, disability, recent loss, and lack of social connectedness.[11–13] As part of the assessment process, the clinician should assess the presence of suicide ideation, intent or plan, and identify any risk factors. A detailed history of past and/or recent suicide attempts as well as the exact suicide thoughts, severity and frequency that contributed to the attempt should be documented. Access to lethal means, including firearms, needs to be assessed. Finally, the clinician should explore protective factors, reasons for living, and any supports available to the patient.

Psychotherapies for Late-Life Depression

Problem Solving Approaches

Problem Solving Therapy (PST) has been shown to be efficacious in reducing depression and disability in cognitively unimpaired, depressed older adults and in older adults with mild cognitive deficits.[10, 14–16] Specifically, Problem Solving Therapy for Executive Dysfunction (PST-ED) teaches patients skills for improving their ability to cope with daily problems and life crises. Patients are instructed to identify problems, brainstorm different ways to solve these problems, create action plans, perform a cost-benefit analysis, and evaluate the effectiveness of potential solutions. PST-ED improves skills needed in interpersonal relationships, remedies communication deficits, and increases behavioral activation by enhancing exposure to pleasurable activities.

Problem Adaptive Therapy (PATH) is a home-delivered intervention designed to reduce depression and disability in depressed, disabled elders with significant cognitive impairment and mild dementia.[17, 18] This 12-week intervention targets the patient's ecosystem, which encompasses the patient, the caregiver, and the home environment. With PST as its basic therapeutic framework[19, 20], PATH utilizes environmental adaptations and encourages

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caregiver participation because older adults with significant cognitive impairment may be unable to follow treatment recommendations without assistance. Environmental adaptation tools (PATH tools) include notebooks, calendars, medication pill boxes, alarms, timers, checklists, and step-by-step breakdown of tasks that are specifically selected based on the patient's cognitive, physical and behavioral strengths and limitations. PATH also aims to reduce negative emotions triggered by functional and cognitive limitations. PATH's approach is consistent with the emotion regulation model, which assumes that emotion regulation is achieved through five approaches: situation selection, situation modification, attention deployment, cognitive change, and response modulation.[21]

Cognitive-Behavioral and Behavioral Activation Approaches

Cognitive Behavior Therapy has been found to be effective in cognitively unimpaired, depressed older adults.[22] Cognitive Behavior Therapy for Mild Dementia (CBT-Mild Dementia) is an active, directive, time-limited, structured approach with symptom reduction as the primary focus.[23] Composed of 16–20 sessions, CBT-Mild Dementia integrates neuropsychological data in order to understand and target the cognitive capabilities of the patient. In order to address behavioral deficits resulting from cognitive impairment, memory aids are used such as notepads and audiotaping of sessions. CBT-Mild Dementia also offers cognitive strategies such as examining the evidence, listing pros and cons of different situations, and experimenting with new attitudes or cognitions. To date, no efficacy data are available for CBT-Mild Dementia.

Behavioral treatments for depression in moderate to severe dementia teach caregivers behavioral strategies to alleviate patients' depression.[24] Behavior Therapy – Positive Events (BT-PE) teaches caregivers strategies to increase the patient's engagement in pleasant activities and positive interactions whereas Behavior Therapy – Problem-solving (BT-PS) focuses on providing problem-solving skills training to caregivers. Both treatments led to significant reductions in patients' depressive symptoms and these reductions were maintained at 6-month follow-up.[24]

Interpersonal Psychotherapy

Interpersonal Psychotherapy has been shown to be an efficacious evidence-based treatment for late-life depression in combination with antidepressants and on its own.[25] Interpersonal Psychotherapy for Mild Cognitive Impairment (IPT-CI) is a manual-based treatment (12–16 sessions) developed for depressed older adults with mild cognitive impairment.[26] The IPT model focuses on the interpersonal context in which depression is expressed regardless of the causes of depression. Accordingly, IPT focuses on complicated grief, role transitions, role dispute/interpersonal conflicts, and interpersonal deficits. In the initial phase, the clinician helps patients identify and gain insight into their problems in their own interpersonal context. Depending on the individual patient's problems, the second phase of IPT aims to facilitate the grief process, assist in dealing with role transition, explore interpersonal conflicts, and improve interpersonal skills. The third phase of IPT helps patients consolidate their gains and prepares them for implementing these coping strategies on their own. Modifications of IPT-CI include integration of the caregiver into the treatment process from the outset and the flexible addition of joint patient-caregiver sessions. The

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systematic incorporation of concerned caregivers into the psychotherapeutic process promotes understanding and communication. Furthermore, the IPT-CI approach to role transition not only helps patients accept their lost role, but reminds them of their intact abilities and aids them in fostering attachment to their caregivers.

Interventions for Chronically Medically Ill Elders

Chronic medical illnesses weaken and demoralize patients and compromise their ability to adhere to treatment requiring consistency and effort, even when such treatment could be valuable. Chronic obstructive pulmonary disease (COPD) exemplifies the health problems of aging adults living with chronic conditions. We developed the Personalized Adherence Intervention for Depression and COPD (PID-C).[27] PID-C drew from the Theory of Reasoned Action, according to which patients weigh risks and benefits of treatment aimed to shift the balance in favor of treatment engagement. PID-C is administered by trained care managers who work with each patient and the patient's treatment team. The care managers: 1) identify adherence barriers specific to each patient, and through education and support, help them adhere to their exercise regimens and to antidepressants; and 2) work with the patients' physicians to facilitate treatment adherence. We recently reported that PID-C led to higher remission rates of depression, reduction in depressive symptoms, and reduction in dyspnea-related disability than usual care in depressed older adults with severe COPD.[28]

Interventions for Acutely Medically Ill Elders

Acute medical illnesses create a psychosocial storm that disrupts patients and their ecosystems. Ecosystem Focused Therapy (EFT) may be used as a model treatment for depression developing in the context of acute medical events.[29] Specifically developed for patients with post-stroke depression, EFT targets five areas that arise from the patient's sudden disability and the change in the patient's needs and family's life. EFT's five integrated components include: 1) an action-oriented, "new perspective" about recovery and the new physical condition; 2) a treatment "adherence enhancement structure"; 3) a "problem solving structure" helping patients to focus on solvable problems; 4) a focus on assisting the family in "reengineering its goals, involvement, and plans" to accommodate the patient's disability and its impact on the family; 5) a coordination of care with specialized therapists to ensure patient engagement in treatment, rehabilitation, and utilization of community resources.[29] While all components can be helpful, EFT therapists give special attention to components pertinent to the individual patient and his/her ecosystem. Preliminary evidence has shown that EFT is feasible and efficacious in reducing depressive symptoms and signs and disability of post-stroke depression.[29]

Streamlined Psychotherapy for Broad Community Use

"Engage" is a psychotherapy for depressed older adults developed by our group and collaborators with the explicit goal to streamline and simplify its interventions so that it can be used broadly by clinicians practicing in the community.[30] "Engage" was based on our view that neurobiological knowledge has reached the point of providing biologically meaningful behavioral targets, thus guiding the development of effective, simplified psychotherapies. This view is supported by the Research Domain Criteria (RDoC) Project,

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which reflects the field's consensus and recognizes the readiness of neurobiology to guide research in treatment development.

"Engage" targets behavioral domains of late-life depression grounded on RDoC constructs using efficacious behavioral strategies selected for their simplicity. "Reward exposure" targeting the behavioral expression of positive valence systems' dysfunction is the principal therapeutic vehicle of "Engage." Facilitation of reward exposure utilizes a simplified problem-solving approach in which the patient selects a goal, develops a list of ideas to achieve this goal, selects one of these ideas, and develops an "action plan" with concrete steps to address obstacles to implementation. If patients repeatedly fail to complete their "action plans", therapists seek barriers in three behavioral domains i.e., "negativity bias" (negative valence system), "apathy" (arousal system), and "emotional dysregulation" (cognitive control system) and adds strategies targeting these domains. "Engage" is currently being tested for feasibility and efficacy in the community against other empirically supported treatments for depressed elders with cognitive impairment.

Conclusion

Pharmacotherapy leaves many depressed older adults depressed and suffering. A number of psychotherapies, including PST, CBT, IPT, and Behavior Therapy, have been found to be helpful in late-life depression. Novel psychotherapies have also been designed and are being tested in depressed elders with cognitive impairment (PST-ED and PATH) and acute (EFT) and chronic medical illnesses (PID-C). Despite evidence of efficacy, psychotherapies are underutilized in the community. To address this need, our group and our coworkers have developed "Engage", a psychotherapy streamlined to target biologically meaningful behavioral domains. Improving the efficacy and availability of effective, empirically-supported interventions for late-life depression may provide relief to a large group of depressed elders who are resistant to antidepressant medication.

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Table 1

Psychotherapies for Depressed Older Adults: A Guide to the Referring Physician.

Name of Psychotherapy	Target Population	Location of Delivery	Duration	Specific Techniques
Problem Solving Therapy for Executive Dysfunction (PST-ED)	Depressed, non- demented older adults with executive dysfunction	Outpatient setting	12 weekly sessions	Problem solving skills: Problem definition, goal setting, generation of alternative solutions, decision making, planning.
Problem Adaptive Therapy (PATH)	Depressed, disabled older adults with significant cognitive impairment	Patient's home	12 weekly sessions	Problem-solving skills, caregiver involvement, environmental adaptation tools (e.g., notebooks, calendars, pill boxes, alarms, timers, checklists, and step-by-step breakdown of tasks).
Cognitive Behavior Therapy for Mild Dementia (CBT-Mild Dementia)	Depressed older adults with mild dementia	Outpatient setting	16–20 weekly sessions	Cognitive strategies (e.g., examining the evidence, listing pros and cons, cognitive restructuring), behavioral activation, memory aids.
Behavior Therapy – Positive Events (BT-PE)	Depressed older adults with moderate to severe dementia and their caregivers	Outpatient setting	9 weekly sessions	Behavioral strategies (e.g., identifying, planning, and carrying out positive activities as well as identifying and eliminating obstacles).
Behavior Therapy – Problem-solving (BT-PS)	Depressed older adults with moderate to severe dementia and their caregivers	Outpatient setting	9 weekly sessions	Problem-solving skills training to caregivers; education, advice, and support to caregivers.
Interpersonal Psychotherapy for Mild Cognitive Impairment (IPT-CI)	Depressed older adults with mild cognitive impairment	Outpatient setting	12–16 weekly sessions	Interpersonal skills, joint caregiver-patient sessions.
Personalized Adherence Intervention for Depression and COPD (PID-C)	Depressed older adults with COPD	Outpatient setting	9 weekly sessions	Skills to target barriers to adherence (i.e. misconceptions, misunderstanding of recommendations, misattribution of symptoms, stigma, hopelessness, dissatisfaction with treatment experience, logistic barriers).
Ecosystem Focused Therapy (EFT)	Older adults with post- stroke depression	Patient's home	12 weekly sessions	New perspective, adherence enhancement structure, problem solving structure, re-engineering goals and plans of family, coordination of specialized therapists.
Engage	Depressed older adults	Outpatient setting	9 weekly sessions	Reward exposure (action planning to increase rewarding activities). Behavioral techniques targeting barriers (negativity bias, apathy, emotional dysregulation) to reward exposure.