



Because there are particular corollaries to the treatment of depression in older adults, which include contraindications to the use of antidepressant drugs in combination with many medications, there is a need to examine nonpharmacological forms of treatment. This paper is based on a review of the literature on nonpharmacological treatments for depression in older adults. Electroconvulsive therapy has a role in severely depressed older adults because of its rapid effectiveness in life-threatening situations while psychotherapy, either on its own or in combination with antidepressants, is effective in the treatment of mild to moderate depression.

Key words: older adults, psychotherapy, depression, electroconvulsive therapy

Nonpharmacological Treatments for Older Adults with Depression

Marie Crowe, RPN, PhD, Associate Professor, Department of Psychological Medicine, Christchurch School of Medicine and Health Sciences, Christchurch, New Zealand.

Sue Luty, FRANZCP, PhD, Associate Professor, Department of Psychological Medicine, Christchurch School of Medicine and Health Sciences, Christchurch, New Zealand.

The contribution of biology, psychology, and sociology to the genesis and amelioration of depression in older adults challenges both scientists and clinicians to think in complex ways about depression in late life.¹ Because there are particular corollaries to the treatment of depression in older adults, which include contraindications to the use of antidepressant drugs in combination with many medications that older patients may already be taking, there is a need to examine nonpharmacological forms of treatment for depression if possible. There is a fair degree of diversity in risk factors for, and presentation of, depression in late life,² including recurrence of a chronic disorder first experienced in young adulthood and first-time depression. The treatment of depression in late adulthood focuses on symptom reduction, facilitation of functional abilities, improvement in quality of life, and reduction in mortality. This paper is based on a review of the literature on nonpharmacological treatments including electroconvulsive therapy (ECT) and the commonly used psychotherapies. There is a particular emphasis on interpersonal psychotherapy for which there have been a number of promising studies.

Electroconvulsive Therapy

The effectiveness of ECT in treating severe mental illnesses is recognized by the American Psychiatric Association, the American Medical Association, the National Institute of Mental Health, the Food and Drug Administration, the U.S. Surgeon General's office, and similar

organizations in Canada, Great Britain, and many other countries. A course of treatment with ECT usually consists of six to 12 treatments, which are usually given three times a week for a month or less. It can be administered unilaterally or bilaterally. In older adults there is a greater risk of confusion, memory impairment, and delirium when electrodes are placed bilaterally. It is believed that ECT works through the stimulation of neurotransmitters.

Electroconvulsive therapy is generally used in cases of severely depressed patients where other forms of therapy—such as medications or psychotherapy—have not been effective. The definition of treatment resistance may apply to such cases where there has been no response to two to three adequate doses of treatment for at least four to six weeks, but this depends on the treating clinician, the severity of depression, and clinical state of the patient. ECT is also indicated when medication cannot be tolerated or (in life-threatening cases) when it will not help the patient quickly enough. As such, ECT is the most effective and most rapidly acting treatment available for severe major depression. Therefore, in the older adult, ECT is useful when certain medications are inadvisable due to side effects, even when there are significant comorbid medical conditions. It is also of benefit when time is of the essence: for example, in severely suicidal older adults or in those who have no interest in food and are literally starving to death. Indeed, the response to ECT can be seen as soon as after one session and on average within

two weeks of starting a course, which, when compared with that of three weeks for medication, could be the difference between life and death for many older patients.

In their extensive review of the literature on ECT in older adults, Salzman *et al.*³ concluded that ECT was, overall, efficacious and safe, with some indication that it was more therapeutic than pharmacological treatment. This particular review was not systematic but used data for the period 1995–2001. Data was obtained on 33,167 subjects of mean age 72 years. Of the studies included, 97 reported on antidepressants and 12 on ECT. The types of antidepressants were broadly grouped into tricyclics or SSRIs. Whilst this descriptive review is encouraging, a more recent systematic review from the Cochrane Collaboration tried to establish the place for ECT by searching for studies of real vs. sham ECT vs. antidepressants, but the authors were unable to draw clear conclusions. This suggests that this is an area which warrants further definitive research.³⁰ They suggested ECT may be the most rapid and efficacious treatment for the most severely ill patients. It was well tolerated, even in patients over 80 years, but side effects were identified including an increased risk of falls.³⁰

The major side effects of ECT are confusion and memory loss. Confusion and disorientation usually clear within an hour or so upon awakening after ECT. The memory problems are variable and are typically associated with bilateral placement of electrodes. This retrograde amnesia can extend as far back as six months prior to ECT and can lead to decreased ability to learn new information for about two months (i.e., anterograde amnesia). However, the degree of impairment can be variable across individuals. Cardiac arrhythmias can be particularly problematic in the older patient, but death is rare and, if it occurs, is unrelated to the ECT.³¹ Indeed, the mortality rate is only 0.2 to 0.4 per 10,000 treatments—no higher than that from a general anesthetic. The older patient should be carefully exam-

Table 1: Nonpharmacologic Therapy for Depression

Therapy	Function	Role
ECT	Rapid response	Suitable for severe depression Some cognitive side effects
CBT	Focus on negative cognitions	Suitable for mild-to-moderate depression
Psychodynamic	Focus on intrapsychic processes	
Life Review	Focus on reminiscence	No side effects identified
IPT	Focus on relationship issues	

ined for anesthetic risk with monitoring of pre- and postcardiac status. There are no absolute contraindications against the use of ECT in older patients, just relative, and ECT has been performed on older patients with a range of serious medical conditions.⁴ Flint and Gagnon⁴ also found that age does not increase the risk of cognitive side effects from ECT, but the risk is increased with age-associated neurological conditions such as Alzheimer’s dementia and cerebrovascular disease, and concomitant pharmacotherapy. They also found that relapse of depression after response to ECT remains a significant problem and can be as high as 50% during the first twelve months post ECT. There continues to be considerable debate in the literature with regard to post-ECT treatment such as gradual tapering of ECT doses, whether to consider ECT as a monthly maintenance treatment, or whether to continue treatment with an antidepressant.⁴

Psychotherapy

The duration of psychotherapy is dependent on the type; for example, psychodynamic psychotherapy can be open-ended, whereas interpersonal psychotherapy is usually provided over a few months. Similarly, there are different training and experience prerequisites for each psychotherapist, but it is usually provided by a registered health professional who has undertaken the requisite training.

There is growing evidence that psychotherapy on its own or in combination with medication is efficacious in the treatment of depression for the older

adult. For example, one meta-analysis of time-limited psychotherapy found response rates to be higher than those found in placebo-controlled antidepressant trials.⁵ Gum and Arean⁶ have described how it can be successfully provided in primary care settings, and that it shows potential in long-term care and in-home settings. However, Alvidrez and Arean⁷ have identified a reluctance from physicians to refer patients to psychotherapy despite its recommendation in depression treatment guidelines, and suggest that more information about the efficacy of psychotherapy for older adults may be helpful in promoting referrals.

The process of psychotherapy in older adults is the same as its application in younger age groups, but it may require adaptations and a particular understanding of their individual historical experiences, health problems or sensory deficits, cognitive changes, and family involvement. Compared to younger age groups, older adults often engage well with psychotherapy because they may be more introspective, have a more developed sense of their own values and beliefs, and have a lifetime of relationships and coping experiences to draw upon in tackling current problems.¹ Ageism has historically led to barriers in utilizing or offering psychotherapy to older adults, often because they were simply felt to be too slow at cognitive tasks to be able to tolerate the process of psychotherapy. The use and potential benefits of three psychotherapies in older adults—cognitive behavioural therapy (CBT), psychodynamic therapy, and life review thera-

py—will be briefly described, followed by a more in-depth discussion of interpersonal psychotherapy (IPT).

Cognitive Behavioural Therapy

CBT for depression is based on a conceptualization of depression as related to systematic errors in thinking that maintain negative thoughts about oneself, one's experiences, and one's future, and that result in negative moods and behaviours.⁸ As a psychotherapy, it helps patients identify, challenge, and replace automatic depressive thoughts with more realistic thoughts. While CBT has acknowledged efficacy in general applications for depression, it has also been found to be an effective treatment for depression in older adults.^{9–11} Meta-analyses have shown CBT to be more effective than placebo, wait list, or non-treatment control conditions.^{1,5} A number of specific adaptations may be helpful such as an early challenge of the dysfunctional cognitions (i.e., "I am too old to change"), an emphasis on activity scheduling, and themes which relate to aging. CBT is usually regarded as providing skills for long-term efficacy, but maintenance sessions can be provided for symptom re-emergence.

Psychodynamic Psychotherapy

Psychodynamic psychotherapy includes a range of therapies that view depression as a consequence of developmental problems that result in poor coping skills. They emphasize intrapsychic processes as integral to symptom development and amelioration. Emotional insight, often gained through exploration of the relationship between the patient and the therapist, is viewed as the primary means for psychotherapeutic change.¹ Erickson¹³ specifically described the developmental task of old age as needing to negotiate ego-integrity and ego-despair. The most common theme in psychodynamic work with older patients is loss, both actual and anticipated, but this does not exclude older adults from working on gaining new strengths. Literature on psychodynamic therapy in older adults is limited to a few studies.^{14,15}

Life Review Therapy

This psychotherapy was developed specifically for use in older adults and focuses on reminiscence, which is regarded as a normative experience in later life. It is described as a psychological process that facilitates resolution about how one has lived one's life¹ and uses creative reminiscing. Methods used to facilitate the process of remembering one's life include writing or taping autobiographies, making pilgrimages to important places, attending reunions, constructing genealogies, reviewing scrapbooks, photo albums, or old letters, writing or verbalising summaries of one's life work, and preserving ethnic identity.¹⁶ There have been several studies exploring the effects of this therapy with older adults^{17–20} and these have shown an improvement in depressive symptoms which is comparable to that of CBT, and also an improvement in cognitive functioning.

Interpersonal Psychotherapy

IPT is a brief period of psychotherapy that focuses specifically on interpersonal issues.²¹ IPT is usually delivered over 12–15 sessions by a qualified IPT therapist. It is primarily concerned with symptom functions that are presumed to have biological and psychological precipitants. In addition, it focuses on social and interpersonal relations, particularly interactions in social roles with other persons derived from learning based on childhood experiences, concurrent social reinforcement, and personal mastery and competence.²² The emphasis is on current disputes, frustrations, anxieties, and wishes as defined in the interpersonal context and aims to help people to change rather than to simply understand and accept their current life situation. IPT focuses on four problem areas: interpersonal role disputes, role transitions, grief, and interpersonal deficits.

Frank *et al.*²³ propose that the active stance of the IPT therapist and the problem-oriented focus of the interventions are appealing to older persons who may require, at least initially, direct help in problem resolution and who view work

towards short-term goals as consistent with the limited time they may see remaining in which to change their lives. They note that older adults are at high risk of suffering delayed grief and mourning following multiple deaths of loved ones, friends, and acquaintances, and may have severe problems with loneliness secondary to these losses. Role transitions can include changes related to deteriorating health, wealth, and status; decreasing support systems and reduced contact with friends and family; retirement or loss of job; changing family roles (including empty nest syndrome) and the transition to being grandparents or even great-grandparents; and medical disorders, pain, and disabilities that lead to decreased activities and withdrawal from constructive and formerly satisfying activities. Interpersonal conflicts in the lives of the older adult may be related to increased dependency on others, decisions about where to live, changes in financial situation, chronic unresolved grievances, or general preparation for an end period of life. Interpersonal deficits are often connected to long-standing patterns of isolation and loneliness, or to decreased energy and motivation to make new friends.

The evidence for the use of IPT alone or in combination with antidepressant medications for the acute and maintenance treatment of depression in older adults is increasing.^{24–28} Miller *et al.*²⁹ have noted that minimal changes were required to adapt IPT for use in older adults. In their experience of conducting large scale studies of IPT with older adults they found that the vast majority of subjects were willing participants despite a lack of prior experience with psychotherapy, and that they were able to engage, establish a focus, work through problems, and try new approaches to solving problems.

Conclusion

The nonpharmacological treatments described above all have a role to play in the treatment of depression in older adults. Electroconvulsive therapy has a role in severely depressed older adults

because of its rapid effectiveness in life-threatening situations. Psychotherapy, either on its own or in combination with antidepressants, is effective in the treatment of mild to moderate depression in older adults. There is a range of psychotherapies available, although interpersonal psychotherapy appears to be particularly effective, relevant, and acceptable to older adults. Its effectiveness as a short-term and maintenance therapy has been demonstrated in a number of studies. A barrier to its general utilization as a preferred treatment is the availability of appropriately trained therapists and resources to provide it. ♦

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