Best Practices

Psychosocial Treatments for Major Depression and Dysthymia in Older Adults: A Review of the Research Literature

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Older adults represent a growing segment of the population with the highest suicide rate and an increasing need of counseling services for major depression and dysthymia. The present study examined the literature with the purpose of identifying research addressing psychosocial treatments of depression in later life. A summary of treatments currently supported by research as being efficacious when treating older individuals experiencing depression or dysthymia is presented. Limitations of the findings are discussed.

Individuals over the age of 65 constitute a fast growing segment of the population, and recent studies suggest that their rate of depression is a significant issue (Myers & Harper, 2004; Powers, Thompson, Futterman, & Gallagher-Thompson, 2002). The population of older adults in the United States is growing at a fast pace and will continue to do so in the years to come (Administration on Aging, 2001). The Administration on Aging indicates that 1 in every 8 Americans is 65 years and older. Over the last 100 years, the population of older adults has more than tripled in percentage, from 4.1% to 12.4%, and projections indicate that this number will continue to grow to as much as 20% by the year 2030 (Administration on Aging, 2001). As the number of individuals age 65 and older continues to grow, counselors will increasingly be faced with meeting the needs of older adults and their families (Myers & Harper, 2004; Schwiebert, Myers, & Dice, 2000).

The health care costs of depressive disorders are significant. Depression is prominent within the mental disorders condition; it is 1 of the top 15 conditions that account for almost half of the growth in spending in health care since 1987 (Thorpe, Florence, & Joski, 2004). Depression costs about the same as coronary heart disease in direct and indirect costs in the United States: $43 billion annually (Birrer & Vemuri, 2004). Major depression is widely distributed in the population and is usually associated with substantial symptom severity and role impairment (Kessler et al., 2003). Kessler et al. reported that major depression affects 13 to 14 million American adults, or approximately 6.5% of the population, in a given year. Depression continues to be a significant public health problem for older adults (Lebowitz et al., 1997; Serby & Yu, 2003), with statistics indicating that 1% to 2% of older adults in the community (i.e., not living in nursing homes or other institutions) experience depression (Johnson, Weissmann, & Klerman, 1992) and as many as 50% of older adults in nursing homes display depressive symptoms (Koenig & Blazer, 1996). Similar findings were reported by Zisook and Downs (1998), who found that 2% of the older adults living in the community experience a major depressive episode, 2% experience dysthymia, and 0.2% experience bipolar disorders. These estimates may be conservative because some individuals have the misconception that it is normal for older adults to feel depressed and dismiss the symptoms as a normal part of aging (Myers & Harper, 2004; Nelson, 2001).

Depression is often undiagnosed and untreated in older adults (Birrer & Vemuri, 2004; Crystal, Sambamoorthi, Walkup, & Akincigil, 2003; Reynolds, Alexopoulos, & Katz, 2002). However, when a diagnosis of depression is warranted, treatment with medication and/or psychosocial therapy will help the person with depression return to a happier, more fulfilling life (Anderson, 2001). A great body of data exists to support the notion that treatment of depression can shorten the time to recovery; such data justify the use of antidepressant medication and several psychosocial therapies (Gotlib &

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Hammen, 2002). Efficacy studies show that late-life depression can be treated with psychosocial therapy (Lebowitz et al., 1997).

Undiagnosed and untreated depression in older adults causes needless suffering for the family and for the individual who could otherwise live a fruitful life. Research has shown that longstanding depression predicts mortality, whereas recovery from depression does not (Pulska, Pahkala, Laippala, & Kivelä, 1999). Suicide risk is significantly elevated among individuals with mood disorders (Rivas-Vazquez, Johnson, Rey, Blais, & Rivas-Vazquez, 2002). Suicidality is a significant risk factor for older adults (Barnow & Linden, 2000). Barnow and Linden reported that "suicidality is of high importance in very old age" (p. 177) and thoughts of suicide indicate the likely presence of depression. Compared with all age groups, older adult clients have the highest suicide rate (Szanto et al., 2001). Finally, comorbidity of depression with physical illnesses and disability are also unique factors to consider when treating older individuals (Katz, 1996; Rovner, Zisselman, & Shmuely, 1996), and adaptations may be necessary when working with older adults because of these comorbid issues (Knight, 1999).

Counselors and other mental health professionals provide *psychosocial treatments*, defined for the purposes of this article as any treatment that does not involve the use of medication or medical procedures. Pinquart and Sörensen (2001) suggested that providing psychosocial therapy to older adults is valuable because it decreases depression and promotes general psychological well-being. Treating mood disorders has also been shown to decrease suicide risk (Rivas-Vazquez et al., 2002; Szanto, Mulsant, Houck, Dew, & Reynolds, 2003). The National Institutes of Health's (NIH) Consensus Panel on Diagnosis and Treatment of Depression in Late Life (1992) found that there are many different treatments of depression in older adults that have been shown to be safe and efficacious. Many studies have been completed that suggest the efficacy of some available psychosocial therapies when applied to treatment of late life depression. These studies have been incorporated into meta-analysis studies, evidence-based studies, best practices models, and comparison studies (Areán & Cook, 2002; Chambless et al., 1998; Gatz et al., 1998; Orb, Davis, Wynaden, & Davey, 2001; Pinquart & Sörensen, 2001).

Older adults need and will continue to need counseling services for major depression and dysthymia, and counselors need to be informed about current treatments for these disorders (Myers & Harper, 2004). Thus, our first interest in depression in the older adult involves a practical issue of recognizing and serving the needs of a large and growing population. Our second interest was to identify best practices for treating major depression and dysthymia in older adults. The concept of evidence-based or best practice has gained friends and foes among counselors. However, as indicated by Marotta (2000),

> Both critics and advocates of guideline development understand that the time is long past when practicing without guidelines is acceptable to both the public who use services and the professionals who provide such services. In addition, accountability in service provision is one way for a profession to grow in recognition. It is especially appropriate for professional counseling to be able to show the public and public policymakers that its practices are effective, efficient, and ethical. We do that in part by being knowledgeable about standards of care used by other mental health professionals and by staying abreast of evolving trends. (p. 494)

As the population of older adults continues to increase, counselors of all specialties will need this information. For example, school counselors may be approached by a student and his or her family asking for information about treatment for a grandparent experiencing a depressive reaction. Career counselors may be asked to provide a referral to an older worker experiencing depressive symptomatology, and a mental health counselor may encounter an older client reporting depressive symptoms. These professionals would benefit from knowing which are the current psychosocial treatments that are best supported by outcome research.

In this article, we review the research literature on psychosocial treatments for major depression and dysthymic disorder and summarize those treatments currently supported by research as being efficacious when treating older individuals experiencing these mood disorders. For each psychosocial treatment, we provide a description of the treatment, suggested applications, adaptations that maximize success of therapy in older adults, and studies supporting treatment efficacy.

Method

Studies that addressed psychosocial treatments of the older adult population were identified through a literature search. Two electronic databases, PsycINFO and MEDLINE, were used in this study. Search terms used were the following: *aged, older adult, elderly, psychosocial treatment, geriatric, treatment, counseling, depression, evidence-based*, and *best practice.* Criteria for inclusion in this review were (a) age of the population studied is over 55 years; (b) article is either a research comparison, meta-analysis, or outcome review article from a peer reviewed journal; and (c) focus on psychosocial treatments of depression with the older adult population. The review produced 26 articles. An effort was made to include only evidence-based treatments or therapies. Criteria and discussion on best practices are provided by a variety of sources, including Banerjee and Dickinson, (1997), Chambless et al. (1998), and Orb et al. (2001). Outcome research available to support the psychosocial treatment was the main criterion used in our review. We used Gatz et al.'s (1998) definition of well-established or prob-

ably efficacious treatment: "Demonstrated efficacy compared to waiting list control groups qualifies an intervention as probably efficacious, whereas being categorized as well established requires superiority to a psychological placebo group or control treatment (or equivalence to another well-established treatment)" (p. 11).

The criteria used for diagnosing depression are derived from the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR;* American Psychiatric Association [APA], 2000). The criteria in the *DSM-IV-TR* do not generally distinguish between adults and older adults, although symptoms may manifest or demonstrate themselves in slightly different ways according to age, from children to the older adult (APA, 2000, see pp. 349–354).

Major depressive disorder generally refers to a series of symptoms that mainly include a sad, depressed, hopeless or "down" mood with a noticeable loss of interest or pleasure in previously enjoyable activities. It is diagnosed when an individual presents with a single major depressive episode, which is not better explained by a thought disorder, and the individual has never experienced a manic episode (APA, 2000). A major depressive episode is diagnosed when, during the same 2-week period, at least five symptoms are present, including depressed mood most of the day; markedly diminished interest or pleasure in activities for most of the day; significant weight loss/gain or decrease/increase in appetite; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive guilt; diminished ability to think or concentrate; recurrent thoughts of death; or suicidal thoughts/attempts (APA, 2000). *Dysthymic disorder* is a form of depression that persists for years with no more than moderate intensity. The disorder is not better explained by major depression; it does not occur only during the course of a psychotic disorder; and there has never been a manic episode, a mixed episode, a hypomanic episode, or a cyclothymic disorder. Dysthymic disorder is diagnosed when depressed mood is present nearly every day for 2 years and at least two additional criteria are present including poor appetite, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration, or feelings of hopelessness (APA, 2000).

Overview of Therapies

The research literature review identified and found support for four specific individual therapies when treating older adult depression. These therapies are cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), brief dynamic therapy (BDT), and reminiscence therapy (RT). Additional therapies that received some support from research are group therapy and family therapy because they apply to older adults. Finally, maintenance therapy is briefly addressed. All of these therapies are reviewed in this section.

CBT

Cognitive therapy has been defined as a structured therapy that is both time limited and directive, with emphasis on changing thoughts and belief systems (Beck, 1967/1972; Beck, Rush, Shaw, & Emery, 1979). Klausner and Alexopoulos (1999) stated that "the goals of cognitive-behavioral therapy are to change thoughts, improve skills, and modify emotional states that contribute to psychopathology" (p. 1198). Cognitive therapy can be applied in multiple ways using techniques from Beck's (Beck, 1976; Beck et al., 1979) cognitive therapy model, Ellis's (Ellis, 1973; Ellis & Grieger, 1986; Ellis & Whiteley, 1979) rational emotive behavioral therapy model, or Meichenbaum's (1977) cognitive behavioral modification program, all of whom are major contributors to the field of CBT. CBT is indicated to treat clients who present with persistent distorted perceptions and beliefs that lead them to see themselves as deficient, incapable, or unlovable; to see their current environment as unsupportive and overpowering; and to see their future as hopeless (Beck, 1976). The goal of CBT therapists is to help their client examine and modify negative thoughts, excessive self-criticism, lack of motivation, and the client's tendency to view problems as insurmountable. Some techniques used in CBT include challenging irrational or self-destructive thoughts, changing the way in which individuals process information, self-monitoring exercises, communication skills, problem-solving initiatives, increasing positive self-statements and experiences, and countering mistaken belief systems (Areán & Cook, 2002; Pinquart & Sörensen, 2001). Behavioral techniques, such as problem solving and communication skills, can also be incorporated into the therapy (Areán & Cook, 2002). The intended effect of this therapy is to alleviate depression by developing reinforcing and rewarding experiences and perceptions (Kennedy & Tanenbaum, 2000).

When used with older adults, CBT may need to be adapted to meet their needs (Knight & Satre, 1999). These adaptations include the assessment of client's knowledge, attitude, and misconceptions. The goal of the clinician is to identify those who may have difficulties in assuming an active participation in the treatment and/or in accepting therapeutic suggestions. Also, clinicians can evaluate a client's limitations, especially cognitive or sensory impairments, in order to identify those who may have difficulties understanding treatment. On the basis of these assessments, clinicians could conduct an in-depth orientation to treatment to facilitate clients' participation. In addition, Kennedy and Tanenbaum (2000) suggested using "recorded sessions for playback at home, written instructions to accompany homework assignments and a review of past material prior to progressing to the next assignment" (p. 389). The establishment of moderate treatment goals may be needed for older adults with limited resources and challenging life circumstances (Gallagher & Thompson, 1982). Extended treatment may be necessary to help older clients with long-term problems.

Finally, clients should be allowed to return to therapy if their problems reoccur or if new problems arise (Kennedy & Tanenbaum, 2000).

In the literature, a significant number of studies have researched the efficacy of CBT with older individuals, and it has generally been shown to be efficacious as a treatment intervention with older adults (Pinquart & Sörensen, 2001). Scogin and McElreath (1994) analyzed posttreatment scores of experimental and control groups to determine the effects of CBT in a meta-analysis of seven studies and reported an effect size of $d = .85$. Also, there is evidence that CBT combined with desipramine results in greater improvement than desipramine alone, especially with more severely depressed clients (Thompson, Coon, Gallagher-Thompson, Sommer, & Koin, 2001). Additional studies found that CBT was superior to usual care for depression (Campbell, 1992), wait list control (Rokke, Tomhave, & Jocic, 2000), pill placebo (Jarvik, Mintz, & Steuer, 1982), and no treatment (Viney, Benjamin, & Preston, 1989). The findings of Areán and Cook (2002) and Gatz et al. (1998) support the position that cognitive therapy and CBT are "probably efficacious" treatments for depression in older adults.

IPT

IPT has generally been described as exploratory with focus on interpersonal roles and conflicts (Kennedy & Tanenbaum, 2000). It was initially outlined and defined by Klerman, Weissmann, Rounsaville, and Chevron (1984), and their theory continues to be applicable in its original form. IPT typically emphasizes specific areas such as grief issues, role transitions and disputes, and interpersonal shortfalls (Gatz et al., 1998). Hinrichsen (1999) provided an excellent review of IPT, describing three phases of treatment that focus on two of four main problem areas: grief, interpersonal disputes, role transition, and interpersonal deficits. During the first phase of treatment, a review of the individual's presenting symptoms is completed, diagnoses are assigned, and one or two problem areas are defined with goals established for continuation of therapy. The second phase of therapy involves working on achieving the established goals of treatment. Techniques used during this phase include reflection, exploration, encouragement, clarification, verbal and nonverbal communication, providing psychoeducation and suggestions, and the relationship between the therapist and client. In the final phase of therapy, focus is generally on termination of therapy and processing the difficulties involved in ending therapy. Treatment goals are reviewed and changes that have been made are discussed, including problems that may arise after termination of therapy in anticipation for better preparation to solve them (Hinrichsen, 1999). IPT is indicated for older adults who need to change their behavior in current interpersonal relationships. This therapy is not intended to alter personality traits or delusional symptomatology (Kennedy & Tanenbaum, 2000). In working with older clients, the IPT therapist works toward establishing rapport, educates the client about how the treatment works, assumes an active role in addressing the client's issues and focusing on pragmatic solutions, and acknowledges that he or she is a resource for advice and information (Miller & Silberman, 1996). According to Kennedy and Tanenbaum, the IPT therapist addresses in a practical manner the client's dependency needs, chronic pathologies, and the effects of significant losses; is flexible regarding length of sessions, telephone consultations, and missed appointments (due to transportation, health, or financial difficulties); and keeps goals at a modest level while providing reassurance and support. Older adults who have limited options to engage in new interpersonal relationships may be encouraged to tolerate problematic relationships while working in therapy to find acceptable alternatives.

Several studies have been completed that address efficacy of IPT for older adults with depression, and the results are mixed (Areán & Cook, 2002; Gatz et al., 1998). Most studies evaluated the efficacy of IPT compared with medication therapy or pill placebo, thus limiting the ability to evaluate IPT as a stand alone therapy (Areán & Cook, 2002). Gatz et al. (1998) reported that the "evidence with respect to interpersonal therapy is incomplete" (p. 16). Some studies do support the efficacy of IPT. One study in particular reported that "elderly persons treated with IPT . . . show significant improvements in their symptoms when treated with or without concurrent psychiatric medication" (Hinrichsen, 1999, p. 952).

BDT

BDT is often used with older adults to address issues such as adjustment and traumatic stress disorders, grief issues, and self-concept during aging, using a time-limited and focused approach (Kennedy & Tanenbaum, 2000). Techniques typically used in BDT include exploration of unconscious processes, processing of lifetime developmental issues, and facilitating client insight with regard to making life changes; transference and countertransference are important factors to be aware of when using BDT (Gatz et al., 1998). The main goals of BDT are to increase awareness and insight into the unconscious processes leading an individual to repeat past experiences and to institute corrective experiences through the interaction between client and therapist (Nordhus & Nielsen, 1999). BDT is indicated for clients who have adjustment disorders, grief, and traumatic stress disorders (Kennedy & Tanenbaum, 2000). An essential adaptation of BDT for working with older adults includes helping the client regain self-mastery and a positive self-perception while preventing the development of dependency. Limiting the number of sessions to 15 allows many clients to successfully complete treatment and reduces the development of unhealthy dependency (Kennedy & Tanenbaum, 2000).

Most studies that evaluated the use of BDT as a viable therapy have shown it to be an efficacious treatment of depression in older adults (Areán & Cook, 2002; Gallagher &

Thompson, 1982, 1983; Gallagher-Thompson, Hanley-Peterson, & Thompson, 1990; Gallagher-Thompson & Steffen, 1994). Gatz et al. (1998) also concluded that "brief psychodynamic therapy is a probably efficacious treatment for late life depression" (p. 16). Areán and Cook found that "a small body of research supports BDT as an efficacious intervention for late life major depression in healthy and ambulatory elderly adults [and] more research is needed to compare BDT with antidepressant medication" (p. 299).

RT

RT was developed to be used with older adults as they reflect on their lives in positive and negative ways (Butler, 1974). RT is based on Erikson's (1950) theory of psychosocial development, and use of this therapy is seen as a way of regaining balance in an older adult struggling with his or her search for meaning, mastery over life, and self-esteem (Kettell, 2001). Life review (LR) is the main focus of RT as individuals work on resolving past issues in order to find meaning in the present and promote ego integrity (Gatz et al., 1998; Kennedy & Tanenbaum, 2000; Pinquart & Sörensen, 2001). RT specifically tends to be less structured compared with life review therapies in general (Gatz et al., 1998). LR therapy is indicated for older clients coping with stressful life events or the realization of their own mortality (Butler, 1974). Techniques that are used in RT and LR therapies are homework assignments that involve finding mementos, photos, journals, autobiographies, and other memorabilia from one's life to share with the therapist in an effort to resolve past issues and gain tolerance of present conflicts (Kennedy & Tanenbaum, 2000). In working with older adults, especially those who are survivors of traumatizing life events (e.g., Vietnam War's prisoners), LR therapists demonstrate a commitment to listen and understand what the client is experiencing while reviewing their past. During this process clients experience myriad emotions including rage, resentment, or distrust, all of which may affect their engagement in treatment. The therapist's listening attitude and the development of a meaningful degree of understanding between both parties seems to play a critical role in the client's coping response to current life threatening illnesses, losses, or nursing home placement; all of which may trigger memories of catastrophic events (Kennedy & Tanenbaum, 2000).

LR and RT studies "suggest that life review therapies may be useful in reducing depressive symptoms among older community and residential cognitively impaired older adults with milder levels of depressive symptoms" (Areán & Cook, 2002, p. 299). In their meta-analysis of seven therapy outcome studies, Scogin and McElreath (1994) found an effect size of $d = 1.05$ for LR therapy. Gatz et al. (1998) also found results to suggest that structured LR is probably efficacious in treating older adults with depressive symptoms, although a word of caution was voiced regarding size of studies, comparison results, and maintenance beyond the conclusion of therapy. In conclusion, Areán and Cook maintained that "the research on RT as an efficacious intervention remains inconclusive but suggests that it is potentially useful" (p. 299).

Family and Group Therapy

Six articles in this review discussed family and group therapy for the older adult (Baker, 1985; Ong, Martineau, Lloyd, & Robbins, 1987; Pinquart & Sörensen, 2001; Qualls, 1999, 2000; Tisher & Dean, 2000). Family and group therapy for the older adult currently is considered a supportive treatment with their main focus on social functioning (Pinquart & Sörensen, 2001). These therapies have not, however, been studied enough to be considered a best practice and have been suggested to be less efficacious than individual therapies (Pinquart & Sörensen, 2001). Baker (1985) suggested that "personal interaction available in group therapy may stimulate growth and life satisfaction for participating elders" (p. 24). Qualls (1999) indicated that many of the issues brought to individual sessions involve family members, suggesting that a family systems approach may be indicated when working with individuals. "A family therapy framework will aid almost all clinicians working with older adults because it provides guidance for what to ask, where to look, how to investigate family factors in elder well-being, and how to intervene" (Qualls, 1999, p. 978). Tisher and Dean (2000) also found that a systems family approach was "very appropriate in understanding and working with the individual and family experience of the elderly stage of the life cycle" (p. 100). More research is needed to determine the efficacy of both of these treatments for the older adult (Pinquart & Sörensen, 2001).

Maintenance Therapies

The goal of maintenance therapies is to prevent a relapse of depression. There are limited studies on ways to maintain recovery from depression after initial treatments are completed. Four studies have evaluated effective maintenance treatments. It has been suggested that maintenance depends on the client's initial response to treatment (Dew et al., 2001). Group support has been shown to be effective in maintaining initial treatment recovery (Ong et al., 1987). Combined therapy (nortriptyline and IPT) seems to be most effective for maintenance of mood after initial treatment (Miller et al., 2001; Reynolds et al., 1999). Treatment of late life depression with nortriptyline and ITP has been shown to help clients maintain social adjustment more than treatment with either treatment alone, suggesting that combination therapy improves not only duration but also quality of wellness (Lenze et al., 2002).

Additional Issues in Counseling the Older Adult

Additional stressors for the older adult include a high incidence of poverty and limited access to health care (Administration on Aging, 2001). Morgan (2001) discussed tailoring

treatment to the older adult client who presents with group-specific challenges, including multiple-loss issues, struggles with side effects of multiple medications, apprehension to see a therapist due to fear of being labeled insane or crazy, significant age differences between client and counselor, and specific cognitive and sensory impairments. It has ultimately been found that "because therapists with special gerontological/geriatric training were more effective than other therapists, the improvement of gerontological and geriatric training for psychotherapists and other persons who work with older adults is recommended" (Pinquart & Sörensen, 2001, p. 230). Additional education is needed, not only for counselors but also for physicians, due to suggestions that referrals for psychosocial therapy services by physicians tend to be low (Alvidrez & Areán, 2002; Barnow & Linden, 2000).

Limitations of This Review

The psychosocial treatments presented in the summary are those that have been evaluated empirically. It is important to be aware of the standards that best practice models promote in terms of efficacy. However, there may be limitations to using strict best practice models. The stringent criteria that are required for therapies to be considered a best practice may preclude many valuable therapies from ever being suggested as a viable option for treatment. As a result, many therapies may be neglected. Niederehe, Street, and Lebowitz (1999) reported that

> the demonstration of efficacy represents simply the first step in a more extended treatment development process, rather than the end point, . . . [and] research will likely deal with demonstrating efficacy for newly developed treatments (where a need for novel approaches is evident) or for the application of existing treatments to alternate indications and under-researched populations. (E. "Is There Still a Commitment to Support of Efficacy Studies?" ¶ 1)

Psychosocial treatments for major depression and dysthymia disorders continue to be evaluated (Gotlib & Hammen, 2002). Many therapies were not included in this study but may be helpful in counseling older adult depression. It is important for counselors to be aware of both best practices and additional therapies offered for treating older adults with depression. Also, there is a high percentage of older adults with depression who experience depression produced by a general medical condition, by substance abuse, or by other comorbid disorders (e.g., anxiety disorder; Leon et al., 2003). Although these conditions were not part of the scope of this article, counselors should gain knowledge about these disorders and consider adapting the available therapies to accommodate for comorbid disorders. Many older adults may not respond positively to the therapies reviewed in this article, and they may require the implementation of therapies that have not been researched in the same way as the psychosocial treatments listed here.

Discussion

Our review of the research literature clearly suggests that older adults who have major depression and dysthymia can benefit from psychosocial treatments. A summary of our findings regarding psychosocial treatments for major depression and dysthymia in older adults is presented in Table 1. The research reviewed in this article clearly shows that CBT is the most researched of all the psychosocial treatments for depression in the older adult. The outcome studies reviewed suggest that CBT is probably efficacious as a treatment for depression in older clients who are cognitively intact and are not suicidal. A similar conclusion was reached by Gatz et al. (1998), observing that there is a lack of research with sufficiently large samples demonstrating superiority of CBT to psychological placebo and that studies demonstrating superiority to another treatment are scarce. A similar conclusion can be reached for BDT. The research available suggests that this treatment is probably efficacious for treating major depression in older adults. RT also seems to be potentially useful/helpful for treating older adults with major depression. Issues of small samples and comparisons favoring alternative treatments support this conservative conclusion

TABLE 1

Psychosocial Treatments for Major Depression and Dysthymia in Older Adults

Therapy	Major Depression	Dysthymia	Maintenance
CBT	Probably efficacious	Potentially useful/helpful	Has been researched with incomplete evidence
IPT	Has been researched with incomplete evidence	Potentially useful/helpful	Useful when combined with medications
BDT	Probably efficacious	ND	ND
RT	Potentially useful/helpful	ND	ND
Family	Has been researched with incomplete evidence	Has been researched with incomplete evidence	Has been researched with incomplete evidence
Group	Has been researched with incomplete evidence	Has been researched with incomplete evidence	Has been researched with incomplete evidence

Note. CBT = cognitive-behavioral therapy; IPT = interpersonal therapy; BDT = brief dynamic therapy; RT = reminiscence therapy; ND = no data found in the research.

(Gatz et al., 1998). IPT has been researched but needs additional support as a useful or efficacious treatment of depression for this population.

Family and group therapy have also been researched with incomplete evidence to support usefulness or efficacy when treating older adult depression. These results are different from those of Gatz et al. (1998). The differences may be explained by the fact that in Gatz et al.'s report, they "combined individual and group therapies that were based on the same treatment approach" (p. 37), whereas we analyzed them separately.

For dysthymia, only CBT and IPT have been shown as potentially useful/helpful treatments with older adults. All other therapies should be researched to determine their usefulness for treating dysthymia in older adults. Finally, as a maintenance therapy, IPT combined with medication appears to be probably efficacious in helping older clients maintain their mood improvements after the initial treatment. Current research for the use of CBT and group therapy as maintenance therapies does not fully support their usefulness or efficacy, and further research is needed.

The research also suggests that necessary adjustments for providing therapy for older clients are needed disregarding the type of psychosocial treatment used. Therapists should be flexible to accommodate for any sensory and cognitive impairment, for the participation of family members and caregivers, as well as for accepting improved function and symptom reduction as valuable therapeutic goals (Kennedy & Tanenbaum, 2000).

According to Mechanic and Bilder (2004), treatments for people affected by mental disorders have improved or become more accepted during the past decade. The rate of outpatient treatment for depression increased from 0.73 per 100 persons in 1987 to 2.33 in 1997 (Olfson et al., 2002). Despite these changes, many people who need treatment for depression still do not receive it, and most treatment fails to meet reasonable evidence-based standards of care. According to a recent national survey, more than half of all people with major depression now seek treatment for the disorder, but only 1 in 5 people with depression receives adequate medication and psychotherapy (Kessler et al., 2003). According to Kessler et al., the fact that only 20% of people with major depression receive adequate treatment reinforces the need for access to mental health services and for equal (parity) insurance coverage for mental as well as physical ailments. Men, African Americans, Latinos, and those who preferred counseling to antidepressant medications reported significantly lower rates of depression care (Unützer et al., 2003). In research of more than 20,966 Medicare claims between 1992 and 1998 (Stephen, Sambamoorthi, Walkup, & Akincigil, 2003), it was found that those age 75 or older, those with Hispanic ethnicity, and those without additional coverage to supplement Medicare received significantly less treatment; furthermore, if treated, these groups were less likely to receive psychotherapy. In fact, people living in poverty were nearly 4 times as likely to experience chronic depression as affluent people (Kessler et al., 2003). These disparities suggest that increased efforts are needed to ensure access to appropriate treatment for all groups of older clients and to remove economic barriers to treatment (Crystal et al., 2003). *Evidence-based treatments* appear to be effective in minority women if they are given support to overcome barriers to care. It is likely that outreach programs, transportation, and child care for the intervention groups enhanced access to *treatment;* without this support, women were unlikely to use resources that were available to them (Wellbery, 2004).

Current research of psychosocial interventions for treating depression in older adults falls short of meeting the country's demographic characteristics and needs. Our review reveals the same limitation observed by Karel and Hinrichsen (2000): that most studies have been conducted with relatively healthy White older adults. Studies of the efficacy of psychosocial therapeutic interventions for treating depression in minority and frail older adults are needed (Karel & Hinrichsen, 2000).

The emerging demographic trends in the United States make the study of the effect of psychosocial treatments for major depression and dysthymic disorders in older adults of critical interest. The older adult population will be in greater need of mental health services in the near future. As counselors, we cannot ignore these statistics and are responsible for learning as much as possible about the unique needs and challenges of older adults. We will see older adult clients in our practices and, as with other groups, need to become educated on the best way to provide treatment services to them. With additional knowledge, we can offer effective treatments and advocacy on their behalf. This is particularly important given the fact that many older adults prefer psychosocial interventions over pharmacological interventions. Unützer et al. (2003), on the basis of the results of one of the largest and most diverse cohorts of older adults with depression to date, reported that "most participants indicated a preference for counseling or psychotherapy over antidepressant medications, but only 8% had received such treatment in the past 3 months, and only 1% reported four or more sessions of counseling" (p. 505).

With knowledge, we counselors can question why mental health providers appear to ignore the use of psychosocial therapy when older consumers are themselves asking for these treatments and when there is evidence that they are useful in treating late life depression (Evans, 2000; Unützer et al., 2003). As stated by Myers and Harper (2004), "Given the current lack of counseling services to older persons, combined with a paucity of outcome research with this population, counselors are encouraged to conduct both quantitative and qualitative studies of intervention effectiveness" (p. 217).

Future research of depressive disorders in older adults will need to focus on the following areas. First, controlled trials comparing psychosocial treatments, medication, and their combination are needed to determine which treatments are more effective and whether combined treatment provides an additive benefit in symptom reduction. Second, analyses of treatments' components are needed to identify the relative contributions of specific therapeutic components to symptom reduction and maintenance of improvements. Third, follow-up studies with adequate control groups are needed to evaluate the long-term benefit of specific treatments, including examining whether maintenance sessions reduce relapse rates. Fourth, studies of the use of psychosocial interventions in a preventative fashion are needed to reduce the chances of developing depression in later life. Fifth, studies with diverse older adult populations are needed to evaluate the effectiveness of current psychosocial treatments with these populations. Finally, studies directed to determine effective ways of removing barriers and increase treatment acceptability in diverse groups are needed. The outcome of these studies will help us as counselors enhance the services we provide to older clients. Ultimately, improved recognition and treatment of depression in late life will make those years more enjoyable and fulfilling for older persons with depression, their families, and caretakers.

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