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Editorial

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Evidence Based Psychotherapies for Late Life Depression

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Late life depression is a term used to describe depression occurring in people older than 65 years of age who have not had a previous history of mood disorder [1]. Late life occurs in approximately 1% to 2% of all community-dwelling elders [2,3]. In acute care hospitals its prevalence rises to approximately 10% to 12% [4]. Among all nursing home residents, 12% to 14% meet the criteria for a major depressive episode (MDD) [1]. Depressive symptoms are much more prevalent in late life with prevalence rates between 30% and 45% [2,5]. Higher frequency of depressive symptoms in late life can explained by factors associated with aging, such as a higher proportion of women, greater physical disability, more cognitive impairment and lower socioeconomic status [1,2].

Available evidence indicates that patients with late life depression can be treated with psychotherapy, pharmacotherapy, electroconvulsive therapy (ECT) or a combination of these different treatment modalities [1,6,7]. A consensus guideline developed by geriatric psychiatrists supports the use of medication in combination with psychotherapy as the most widely accepted first-line treatment for severe late life depression [7]. The use of antidepressants as a stand-alone treatment was considered an alternative first-line treatment for these patients. Electroconvulsive therapy was considered an appropriate alternate treatment for severe depression when treatment with two medication trials have failed or patients had acute suicide risk or medical comorbidities made treatment with medications unsafe. Psychotherapies that were rated as being first-line included Cognitive Behavioral Therapy (CBT), Supportive Psychotherapy (SP), Interpersonal Therapy (IPT) and Problem-Solving Therapy (PST). For late life psychotic depression, the use an antidepressant in combination with an antipsychotic medication was rated as first-line treatment. An ECT trial was recommended in patients who do not respond adequately to pharmacotherapy. For minor depressive episodes, pharmacotherapy in combination with psychotherapy was regarded as the first-line treatment strategy. Treatment with either pharmacotherapy or psychotherapy alone was considered as an acceptable alternative. A 4 to 7 weeks trial on the maximally tolerated dose of one medication was recommended prior to a switch to another medication. This guideline suggested a treatment-duration of 6-months for the first depressive episode with longer-term treatment being recommended for subsequent episodes [7].

The evidence for using psychotherapies for the treatment of late life depression is growing. In a review by Makin and Arean, the investigators concluded that Cognitive Behavioral Therapy (CBT), Reminiscence Therapy (RT), Brief Dynamic Therapy (BDT) and the combination of medication and Interpersonal Psychotherapy (IPT) are acutely efficacious in the treatment of late life depression [8]. The meta-analysis by Cuijpers et al. found that psychological treatments had moderate to large effects on late life depression with a standardized mean effect size of 0.72 [9]. There was no difference between individual, group or bibliotherapy formats. In addition, there was no difference between Cognitive Behavioral Therapy and other types of psychological treatment. The effects were comparable in studies where depression was defined according to a diagnostic criteria compared to those studies where depression was measured with self-rating questionnaires.

Pinquart et al. in their meta-analysis found that the effect sizes were large for cognitive behavioral therapy (CBT) and reminiscence therapy [10]. Effect size was medium for Psychodynamic Therapy, Psychoeducation, Physical Exercise and Supportive Interventions. Weaker effects were found in studies that used an active control group and in studies of physically ill or cognitively impaired patients. Studies comprising exclusively of patients suffering from major depression when compared to other mood disorders yielded weaker intervention effects. On average, 19% of participants did not complete the intervention with higher dropout rates reported in group interventions and in longer term interventions. Wilson et al in their meta-analysis found that cognitive behavioral therapy was more effective than waiting list controls for late life depression [11]. No significant difference in treatment effects was noted between psychodynamic therapy and CBT. Cognitive Behavioral Therapy was found to be superior to active control interventions when using the Hamilton Depression Rating Scale (HAM-D) but equivalent when using the Geriatric Depression Scale (GDS).

Kiosses et al. found that Problem Solving Therapy (PST), Cognitive Behavioral Therapy (CBT) and Treatment Initiation and Participation Program (TIP) program are probably efficacious for the acute treatment of late life depression [12]. The investigators reported that increased baseline anxiety and stress level, personality disorder, endogenous depression, and reduced self-rated health are associated with worse depression outcomes. Baseline depression severity moderated the effects of CBT versus CBT plus medication and the effects of Interpersonal Psychotherapy versus Usual Care (UC).

Pinquart et al. completed a meta-analysis integrating the results of eighty nine controlled studies for the treatment of late life depression [13]. The investigators discovered that for currently available treatments for late life depression, the effect size were moderate to large. There was greater improvement in clinician-rated depression scores among control subjects participating in medication studies when compared to those in psychotherapeutic studies. The investigators concluded that the results of comparisons between psychotherapy and pharmacotherapy must be interpreted with caution because in part medication studies are more likely to use a credible active placebo which may lead to smaller adjusted effect sizes in medication studies. The investigators concluded that as psychotherapy and pharmacotherapy did not show strong differences in effect sizes, the treatment choice should be based on other criteria such as contraindications, treatment access or patient preferences.

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Conclusion

In conclusion, it can be stated that available evidence indicates that pharmacotherapy and psychotherapy are both effective in the treatment of late life depression. Current data indicates that combination of these two treatment modalities is norm for the treatment of late life depression. Among the psychotherapies, Cognitive Behavioral Therapy (CBT), Supportive Psychotherapy (SP), Interpersonal Therapy (IPT) and problem-solving therapy (PST) are rated as first-line treatments. Presently, there is no clear difference in efficacy or tolerability between these psychotherapeutic modalities for the treatment of late life depression. For clinicians treating patients with late life depression the final treatment choice is usually based on patient preferences, treatment access and contraindications to a particular treatment.

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