

## Psychosocial Interventions for Late-Life Depression

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## Support

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- Wright Center for Aging Research and Clinical Care
- Mental Health Initiative Foundation

## Focus of Presentation

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- Types and prevalence of late-life depression
- How do we recognize depression in older adults?
- Why is late-life depression underdiagnosed and undertreated?
- Which psychotherapies are evidence-based treatments for late-life major depression?
- New treatments and future directions

## Why focus on late-life depression?

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- 2000-2030: 100% increase of people 85 years and older (4.2 - 8.9 million)
- WHO: by 2020, depression second cause of disability and premature death
- Increases medical burden and medical costs
- Interferes with treatment adherence of medical conditions
- Is associated with mortality and suicide

## Types of Depression

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- Different types depending on duration and severity
- Major Depression: Severe and usually acute (2 weeks of severe symptoms)
- Dysthymia: Less severe but chronic (at least 2 years of mild symptoms)
- Adjustment Disorder with Depressed Mood
- Minor Depression: Less severe than Major Depression (1 week of mild symptoms)

## Prevalence of Depression in Late-life

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- Major Depression
- 1% in the community
  - 2% dysthymia
  - 4% adjustment disorder
- 6-12% in primary care
- 14% in home care

## Symptoms of Depression

- **TWO CARDINAL SYMPTOMS:** Depressed mood or loss of interest or pleasure
- **SLEEP:** Difficulty falling asleep, interrupted sleep, early morning awakening
- **PHYSICAL SYMPTOMS:** Fatigue, appetite and weight loss
- **THINKING:** Thoughts of worthlessness, hopelessness, suicide, and concentration difficulties
- **BEHAVIOR:** Agitation, retardation
- **PATIENTS' WORDS:** *I feel discouraged, exhausted, can't get out of bed, don't have motivation, don't enjoy life*

## Suicide in Late-life

- Risk and protective factors (Conwell et al., 2011)
  - Psychiatric illness (present in 70-98%), mostly MDD
  - Physical ill health and functional impairment
  - Stressful life events as predisposing factors
  - Social connectedness reduces risk
- Higher risk of suicide: white elderly males, poor social support, pronounced disability (Conwell et al., 2002)
- Use of immediately lethal means, decreased chances of rescue, greater frailty (Conwell et al., 2011)

## Late-life Depression is Underdiagnosed

- Difficulty diagnosing depression
  - Not necessarily depressed mood
  - Depression vs. Medical Conditions: Fatigue, low energy, weight loss, sleep and appetite disturbances
  - Depression vs. Dementia: Crying spells, emotional lability, insomnia, weight loss
- Stigma
- Aging stereotypes (“older age is associated with lack of pleasure”)

## Late-life Depression is Undertreated

- Stigma may prevent depressed older adults to seek appropriate psychiatric treatment
- Most are treated by internist or primary care physicians who are dealing with many medical conditions
- Most common scenario: patient is on low dosage of antidepressant medication but still depressed
- 75% of suicide victims had visited their primary care physician a month before their suicide

## Effective Treatments Are Available

- No matter what the causes of depression are, depression needs to be treated
- Goals of treatment:
  - Recover from current episode
  - Prevent relapses or recurrences
- Effective treatments include: psychotherapy, antidepressant medication, ECT

## Why Are Psychosocial Interventions Important in Late-Life Depression?

- Older adults may have multiple medical conditions and take many medications
- Antidepressants may have limited efficacy in depressed elders with cognitive impairment, especially with executive dysfunction (Sneed et al., 2007; Alexopoulos et al., 2005)
- Psychosocial interventions may reduce the effects of life stressors and losses

## Review of Psychosocial Interventions

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- Overall effective in older adults with depression (effect size=0.72-0.93) (Cuijpers et al., 2006; Pinquart, 2007)
- Psychosocial interventions for depressed elders
  - Cognitive Behavioral Therapy (CBT)
  - Problem Solving Therapy (PST)
  - Supportive Psychotherapy
  - Reminiscence Therapy
  - Interpersonal Psychotherapy (IPT)
  - Dialectical Behavioral Therapy (DBT)
  - Psychodynamic Psychotherapy

## Efficacy of Psychosocial Treatments for Late-life Depression

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- Most randomized clinical trials have been conducted in “young-old”, mostly “Caucasian”, educated samples
- Depending on the severity of depression and the criteria for efficacy, a variety of psychosocial interventions have been categorized as “efficacious”
- Cognitive Behavioral Therapy (CBT) and Problem Solving Therapy (PST) have been consistently categorized as “efficacious” treatments in late-life depression (including major depression)

## Cognitive Behavioral Therapy (CBT)

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- Cognitive Therapy and Behavioral Techniques
- Cognitive Model of Depression by Aaron Beck
  - Genetic predisposition and/or early experiences lead to cognitive vulnerability and to formation of core beliefs
  - Cognitive vulnerability plus environmental stressors may lead to depression
  - Treatment focuses on modifying automatic negative thoughts, dysfunctional assumptions and core beliefs

## Cognitive Behavioral Therapy (CBT)

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- Automatic negative thoughts appear on the surface, while core beliefs are deep (Beck et al, 2011)
  - Automatic negative thought: My wife doesn't want to spend time with me
  - Core belief: I am unlikeable
  - Automatic negative thought: I should have total control of my life
  - Core belief: I am helpless
- Three types of core beliefs: unlovable, helpless, and worthless (Beck et al, 2011)

## Cognitive Behavioral Therapy (CBT)

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- Identify and confront cognitive distortions
  - All-or-none thinking
  - Catastrophizing
  - Disqualifying or discounting the positive
  - Selective abstraction
  - Emotional reasoning
  - Labeling
  - Mind reading

## Problem Solving Therapy (PST)

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### THEORETICAL ASSUMPTIONS

- Problems in everyday life may contribute to or exacerbate depression.
- Depressed patients have difficulty in solving their problems:
  - Negative thinking and concentration difficulties may affect the accurate evaluation of the problem
  - Hopelessness may make the problem seem unsolvable
  - Lack of motivation may interfere with the implementation of a solution

### **Psychosocial Interventions to Improve Adherence**

- **Treatment Initiation and Participation Program (TIP)** (Sirey et al., 2010, 2011)
  - Designed to improve adherence to antidepressants
- **Adherence Enhancement Intervention (AE) for Chronic Obstructive Pulmonary Disease (COPD) and major depression** (Alexopoulos et al, under review)
  - Designed to improve adherence to medical and rehabilitation regimen, exercise, and antidepressant medication treatment

### **Treatment Initiation and Participation Program (TIP)**

- 12-week individualized intervention in primary care (3 in-person sessions and 2 phone follow-ups)
- Identifies barriers (including psychological barriers, stigma and fear of antidepressants) and utilizes techniques to address these barriers
- At 12-week follow-up, TIP vs. Treatment as Usual:
  - Greater reduction in depression, better adherence (82 vs. 43%)

### **Adherence Enhancement Intervention (AE) for COPD and Major Depression**

- Two sessions in inpatient rehabilitation program, 4 home-delivered sessions at weeks 3, 4, 8, 12, 16, 20, 24, and 28 (from entry to the study)
- Initial visit focused on development of alliance and evaluation of risks to poor treatment adherence
- Subsequent visits consisted of a review of clinical state, treatment adherence and barriers and reinforcement of the plans to address them

### **Adherence Enhancement Intervention (AE) for COPD and Major Depression**

- Compared to Usual Care, AE led to greater reduction in both depression and dyspnea over a period of 28 weeks.
- The intervention's advantage over usual care on dyspnea was retained six months after the last intervention session.

### **Need for a New Intervention**

- Despite the need for psychotherapeutic treatment for depressed, cognitively impaired elders, most randomized controlled trials focus:
  - on cognitively intact, “young - old” depressed elders (average age=65-70) with limited disability (Kiosses et al., 2011) or
  - on demented patients with significant disability (Teri et al., 1997)
- PST for mild executive dysfunction reduces depression and disability in depressed elders (Arean et al., 2010; Alexopoulos et al., 2010)

### **PATH: Problem Adaptation Therapy for Depressed, Cognitively Impaired Elders**

- To meet the needs of this population, we developed PATH:
  - Targeting the patient's “ecosystem”: patient, caregiver, home environment
  - home-delivered
  - using Problem Solving Therapy (PST) as the therapeutic framework
  - integrating a “tool kit” of environmental adaptations / compensatory strategies
    - to bypass functional and physical limitations
  - utilizing the assistance of family member/caregiver

## **PATH: Problem Adaptation Therapy**

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- Home-delivered intervention
  - the assessment of problems is more accurate
  - the treatment strategies target the most important problems in the patient's natural environment
  - depression, cognitive impairment, and disability may prevent many elders to seek outpatient treatment

## **PATH: Problem Adaptation Therapy**

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- Environmental adaptations / compensatory strategies
  - signs, calendars, timers, clocks, alarms, voice reminders, customized audiotapes, etc.
  - based on Cognitive Adaptation Training (Velligan et al., 2000)
  - other tools to provide structure: step-by-step division of a task, notebooks, written goals.

## **PATH: Problem Adaptation Therapy**

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- Involvement of Family Member/Caregiver
  - depends on the patient's needs
  - caregiver's participation increases caregiver's self-efficacy and decreases their distress (Gitlin et al., 2001)
  - caregiver's techniques to improve care recipient's depression by increasing pleasure events (Teri et al., 1997)
  - caution to avoid additional burden

## **Pilot Study**

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- PATH vs. home-delivered Supportive Psychotherapy
- Recruited through Home-Delivered Meals Programs of 3 agencies and our geriatric outpatient clinic
- 12 sessions in 12 weeks
- N=63 intent-to-treat; PATH=31 vs. Supportive=32
- 27% Males
- 17% African-American, 5% Hispanic
- Cognitive impairment: mild cognitive deficits to mild to moderate dementia

## **Inclusion Criteria**

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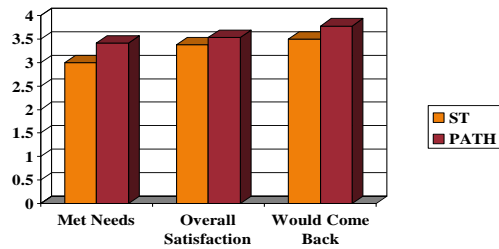
- Age: 65 years and older
- Diagnosis: Unipolar Major Depression
- Disability: At least 1 impairment in Instrumental Activities of Daily Living but the average subject had impairment in 6 out of 9 IADLs
- Evidence of cognitive impairment
- Off antidepressants, cholinesterase inhibitors, or memantine or on a stable dosage for at least 6 weeks

## **Exclusion Criteria**

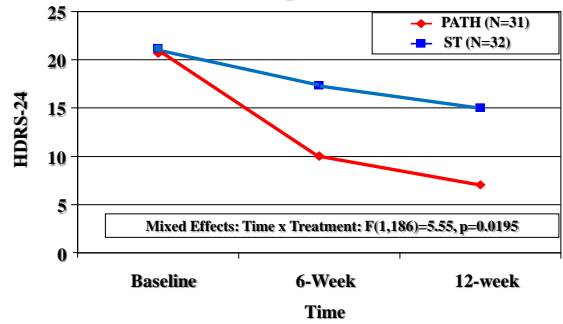
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- High suicide risk, i.e., intent or plan to attempt suicide in near future
- Moderate to severe dementia
- Current involvement in psychotherapy
- Aphasia, sensory problems, and inability to speak English

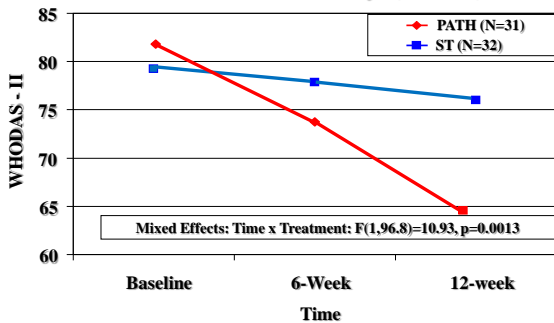
### Client Satisfaction Questionnaire



### Effect on Depression (N=63)



### Effect on Disability (N=63)



### Summary

- Late-life depression is underdiagnosed and undertreated
- Psychosocial interventions are important in the treatment of late-life depression
- Cognitive Behavioral Therapy (CBT) and Problem Solving Therapy (PST) have consistently shown evidence of efficacy
- Psychosocial interventions may reduce depression by improving treatment adherence

### Summary

- Treatment for depressed older adults with cognitive impairment may need to incorporate caregiver participation and environmental adaptations
- Future research may focus on:
  - participants older than 80 years old
  - ethnic minorities
  - older adults with low education
  - advanced cognitive impairment

Thank you