

Evidence-Based Psychotherapeutic Interventions for Geriatric Depression

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In 1991, the National Institutes of Health consensus statement on the treatment of late-life depression ranked psychotherapy as third in a line of treatment options, with antidepressant medication first and electroconvulsive therapy second, indicating that there was insufficient evidence to recommend psychotherapy as a first-line treatment for depression in older adults [1]. Since that time, numerous articles have been written reviewing the evidence base for psychotherapy research in older adults and four meta-analyses of existing trials have been conducted (Table 1) [2–26]. In addition, several randomized clinical trials meeting guideline recommendations for evidence-based interventions [27] have evaluated the efficacy of psychotherapy as a treatment for late-life depression (Table 2) [28–43]. Most of these studies have focused on the evaluation of cognitive-behavioral therapy (CBT), brief dynamic therapy (BDT), interpersonal psychotherapy (IPT), reminiscence therapy (RT), and the combination of these interventions with medication management. This review systematically evaluates the evidence base for psychotherapy as an empirically supported treatment of late-life depression and is an update of the present authors' recent review of the literature [23].

Methods

Studies were selected through literature searches of MEDLINE (1966–2005) and PsychINFO (1840–2005) using the keywords psychotherapy, cognitive-behavioral therapy, interpersonal psychotherapy, reminiscence therapy, life review therapy, brief dynamic therapy, psychoeducation, depression, late-life depression, older adults, elderly, and geriatric depression. In addition, the studies used in earlier meta-analyses [7,12,21,26] were

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Table 1
Literature reviews of psychotherapies for late-life depression

Study	Type of review	Therapies reviewed	Conclusions
Charatan [2] 1985	Summary	Antidepressants, ECT, psychotherapies	All modalities useful
Morris and Morris [3] 1991	Literature	CBT, RT, PST, skills training	Therapies efficacious; cognitive impairment special consideration
Reynolds [4] 1992	Literature	Antidepressants, IPT, CBT, combined treatment	Individual and combined treatments
Areán et al [5] 1993	Literature	CBT	Efficacious treatment
Clark and Vorst [6] 1994	Summary	Group	Need more research on group therapy with depressed elderly
Scogin and McElreath [7] 1994	Meta-analysis	BT, CT, psychodynamic RT, eclectic	Moderately or highly efficacious
Reynolds et al [8] 1995	Literature	Antidepressants, IPT	Both efficacious for long-term maintenance; review challenges in maintenance research
Koder et al [9] 1996	Literature	CT	Efficacious, insufficient evidence as to efficacy of adaptations
Thompson [10] 1996	Literature	CBT	CBT efficacious, minor adaptations for older adults
Lebowitz et al [11] 1997	Literature	CBT, IPT, PST	Efficacious
Engels et al [12] 1997	Meta-analysis	CBT, BT, RT	Efficacious
Zeiss and Breckenridge [13] 1997	Literature	CT, BT, IPT, BDT	CT and BT most cost effective
Gatz et al [14] 1998	Literature	CBT, IPT, BDT	CT, CBT, BDT probably efficacious; IPT promising
Niederehe and Schneider [15] 1998	Literature	Antidepressants, ECT, psychosocial	Efficacious
Klausner and Alexopoulos [16] 1999	Literature	CBT, PST, IPT, psychodynamic, RT	Acute treatment efficacious; probably efficacious for continuation, maintenance
Knight and Satre [17] 1999	Literature	CBT	Efficacious with suggested adaptations
Pachana [18] 1999	Literature	CBT, antidepressants, family, relaxation, combined	Efficacious; need more research on combined treatments, family, and substance abuse treatment

Table 1 (continued)

Study	Type of review	Therapies reviewed	Conclusions
Draper [19] 2000	Literature	Antidepressants, CT, CBT psychodynamic, exercise, music, ECT	Few studies; insufficient empirical evidence for efficacy of psychotherapies with medically ill elderly
Karel and Hinrichsen [20] 2000	Literature	CBT, IPT, psychodynamic, life review, group, family	CBT, IPT most empirical support; combined therapy and medications best for more severely depressed elderly
Pinquart and Sorensen [21] 2001	Meta-analysis	CBT, RT, BDT, ST, IPT	CBT produces above average effects on depression; individual more effective than group; weaker effects for older participants
Areán et al [22] 2001	Literature	CBT-PC, PST-PC, IPT-PC	All feasible and effectively adapted to primary care settings
Areán and Cook [23] 2002	Literature	CBT, PST, BDT, IPT, RT, CAMP	CBT, PST, CAMP-IPT effective; more research needed for BDT, IPT
Bartels et al [24] 2002	Literature	CBT, PST, BDT, IPT, CAMP	Empirical evidence supports psychosocial interventions for geriatric depression
Bartels et al [25] 2003	Literature	CBT, PST, BDT, IPT, CAMP	CT, BT, and CBT effective for tx of geriatric MDD
Bohlmeijer et al [26] 2003	Meta-analysis	RT, LR, CT, PST	RT and LR highly efficacious

Abbreviations: BDT, brief dynamic therapy; BT, behavioral therapy; CAMP, Combined antidepressant medication + psychotherapy; CBT, cognitive-behavioral therapy; CT, combined therapy; IPT, interpersonal psychotherapy; PST, problem-solving therapy; RT, reminiscence therapy; tx, treatment.

obtained. Studies were also included that pertain to the efficacy of psychotherapy and its combination with medication in the treatment of late-life depression (in individuals over the age of 60). Only those studies that used samples of sufficient size (25 or more participants per experimental condition) and compared the therapy against a wait-list or placebo control or the gold standard treatment at the time of the study were included in this review, to be consistent with previously published guidelines on defining empirically supported therapies [27].

More than 100 studies pertaining to the psychotherapeutic treatment of late-life depression were identified. Most studies were excluded based on the application of the Chambless and Hollon [27] criteria. Only 17 studies met the minimum sample size criteria. Four studies compared active

Table 2
Treatment outcome research: psychotherapies for late-life depression

Study	Number of subjects	Age (y)	Populations	Experimental conditions	Control condition	Outcome
Fry [28] 1983	162	65–82; mean = 68.5	MDD; community-dwelling,	Structured RT; unstructured RT	No treatment	Both treatments efficacious; structured RT more effective than unstructured RT
Fry [29] 1984	75	67–80	MDD; community-dwelling	Immediate vs delayed CBT Treatment package	NA	CBT efficacious in immediate and delayed treatment subjects
Thompson et al [30] 1987	91	60+; mean 67.1	MDD; outpatient	CT, BT, BDT	Wait list	All three therapies efficacious
Gallagher-Thompson et al [31] 1990	91	60+	MDD; outpatient, diagnosed patients 2-y follow-up	CT, BT, CT, or psychodynamic, BDT	NA	No difference in maintenance of gains by psychotherapy modality; All efficacious
Campbell [32] 1992	103	64–82	MDD; community dwelling	CBT	No treatment	CBT efficacious in reducing depression
Areán et al [5] 1993	75	55+	MDD; community dwelling	PST, RT	Wait list	PST and RT effective; PST showed greater benefit
Gallagher-Thompson and Steffen [33] 1994	66	Mean 62	MDD; depressed family caregivers	CBT, BDT	NA	BDT better for “new” caregivers; CBT better for “seasoned” caregivers
Blanchard et al [34] 1995	96	Mean 78.2	MDD; community screening	CT nurse intervention	Primary care control	Nurse CT intervention effective

Areán and Miranda [35] 1996	182	60+	Medically ill outpatients	Individual and group CBT	NA	Psychotherapies effective in medically ill elderly
Mossey et al [36] 1996	76	60+	Minor depression; recently released hospitalized elderly	IPC	Usual care	IPC more efficacious at 6-mo follow-up
Reynolds et al [37] 1999	187	Mean 67	Community elders with recurrent MDD	NT, NT + IPT, IPT + pill-placebo	Pill-placebo	NT + IPT most efficacious
Blanchard et al [38] 1999	64	Mean 78.2	MDD	Comprehensive intervention or medications + therapy	No treatment	Psychotherapeutic interventions effective for maintenance
Williams et al [39] 2000	415	Mean 71	Primary care patients with minor depression or dysthymia	Paroxetine, PST	Pill-placebo	Paroxetine moderately efficacious, PST more variable in efficacy
Thompson et al [40] 2001	102	60+	Veterans with MDD; VA outpatients	Desipramine alone, CBT alone, CBT plus desipramine	NA	All effective; combined therapy resulted in greater improvement; most effective for most severe depression
Unützer et al [41] 2002	1801	60+	Primary care patients with MDD	IMPACT intervention (PST, meds, or both)	Usual care	IMPACT collaborative care significantly more effective than usual care
Ciechanowski et al [42] 2004	138	60+	Minor depression dysthymia	PEARLS intervention (PST, meds, or both)	Usual care	PEARLS program significantly more effective than usual care
Wang [43] 2005	94	65	Tawainese elderly with depressive symptoms	RT	No treatment	RT more effective than control

Abbreviations: BDT, brief dynamic therapy; CBT, cognitive-behavioral therapy; CT, cognitive therapy; IMPACT, Improving Mood Promoting Access to Collaborative Treatment; IPT, interpersonal psychotherapy; MDD, major depressive disorder; NT, nortriptylene; PEARLS, Program to Encourage Active, Rewarding, Lives for Seniors; PST, problem-solving therapy; RT, reminiscence therapy; VA, Veterans Affairs.

treatments without a control group, two studies compared psychotherapy to a waiting list control, two studies compared psychotherapy to pill placebo, eight studies compared psychotherapy to usual care or no treatment, and one study was a 2-year follow-up. Two studies compared the effectiveness of psychotherapy to medication. Twelve studies focused on major depression, and five studies evaluated minor depression or dysthymia. Twelve studies evaluated CBT therapies, two evaluated IPT, three evaluated BDT, and three evaluated RT; several studies evaluated more than one treatment modality.

Results

Behavioral and cognitive-behavioral therapies

Behavioral therapy (BT) and CBT have received the most research attention of any psychotherapeutic interventions for late-life depression. These therapies conceptualize depression as the result of an inability to cope with life stressors, poor affect regulation skills, social isolation, and difficulty solving problems. Thus, cognitive-behavioral therapies treat depression by teaching patients methods for regulating their affect, remaining engaged in pleasant activities as a means of warding off depression, and changing depressogenic choices and behaviors through a problem-solving process [44]. Eleven randomized clinical trials or follow-up studies of cognitive or cognitive-behavioral interventions for the treatment of late-life depression meeting the criteria described previously have been published from seven different research centers. These studies have been conducted with individuals who have major depression, identified in clinical settings or through community screening, as well as with individuals who have minor depression or dysthymia. Three of these studies used comparisons with usual care, two used a wait-list control, two used a no-treatment control condition, and one study used a placebo-treatment condition. Some studies have included 1- to 2-year follow-up periods to determine the permanence of treatment outcome.

Major depression

Comparison with placebo or wait-list controls

Six randomized trials have compared CBT with usual care or wait-list control for individuals with major depression. All of the studies found that CBT was superior to usual care for depression [41], wait-list control [5,30], pill-placebo [39], and no treatment [32,34]. There is also evidence to suggest that these treatment gains persist over long periods of time. For instance, Gallagher-Thompson and colleagues [31] found that cognitive and behavioral interventions along with brief dynamic therapy maintained significant improvement of depressive symptoms over a 2-year period in comparison with a wait-list control condition. Overall, this research base suggests that CBT interventions are better than no treatment or usual care of late-life depression.

Comparisons with other psychotherapies

Research comparing CBT with other psychologic interventions has yielded mixed results. Studies comparing cognitive therapy, behavioral therapy, and brief dynamic therapy have found that all three treatments were efficacious, with no significant differences in treatment outcome [30,31, 33,45]. Only one other study has compared treatment modalities studies, and that study found that problem-solving therapy (PST) is more effective in reducing depressive symptoms than reminiscence therapy [5].

Comparison with antidepressant medication

Only one study has compared CBT with antidepressant medication in the treatment of major depression in older adults [40]. In this study, CBT was compared with the use of desipramine and a combination of CBT and desipramine in 100 older adults who had major depression. Results indicated that CBT and the combination of CBT and desipramine were more efficacious in treating depression symptoms than was desipramine alone [40]. However, to date, no geriatric research has compared CBT with the newer antidepressant medications (eg, selective serotonin reuptake inhibitors) for major depression.

Long-term effects and relapse prevention

Several studies by the same research group demonstrate that CBT along with cognitive therapy and brief dynamic therapy has positive effects 1 [30,45] and 2 years after treatment [31]. No other research groups have published long-term outcome results.

Dysthymia and minor depression

The literature on the efficacy of CBT for treating dysthymia or minor depression is emerging. These studies are important because these disorders are far more prominent in older adults than major depression. To date, two studies have investigated the effect of CBT on dysthymia or minor depression [39,42]. Williams and colleagues [39] used an abbreviated version of PST designed for primary care (PST-PC) medicine [46] that was compared with the administration of paroxetine and pill-placebo for the treatment of minor depression and dysthymia in older and younger adults in a primary care setting. The study found that both active treatments were effective in decreasing depressive symptoms and improving functioning; however, PST-PC was not as effective as paroxetine, had a slower onset of treatment effect, and was affected by the degree of therapist training in learning-based strategies [47]. A limitation of this study was that PST-PC is an abbreviated PST (four to six 30-minute sessions delivered over 8 weeks) and is much shorter in length than the traditional PST, which may not have been ideal for older adults [48]. Geropsychologists generally recognize that interventions should be modified for older adults by slowing the pace at which material is presented, emphasizing a repeated review of material

and relying on multiple modes of information transmission to ensure that adequate exposure is achieved. These adaptations would, therefore, result in more treatment time with the patient than is needed with younger patients. Therefore, it is likely that participants in this study did not have adequate exposure to PST [39]. In a more recent study [42], a modified PST emphasizing social and physical activation over a longer time period (eight sessions over the course of 19 weeks) was shown to be more effective in reducing depressive symptoms, promoting remission of depression, and improving quality of life compared with usual care practices.

Summary and limitations

Research on the efficacy of CBT is compelling and suggests that these treatments are viable therapeutic treatment options for older adults suffering from major depression and, to a lesser degree, dysthymia and minor depression. The methodological strengths of this literature include the variety of investigators who have evaluated CBT, the sound implementation of the studies (use of Research Diagnostic Criteria or Diagnostic Statistical Manual Criteria, the use of manuals and therapist supervision, and control comparisons), and the use of long-term follow-up. Nevertheless, there are insufficient data on the efficacy of CBT for minority elderly, frail elderly, and older adults with mild cognitive impairment.

Interpersonal psychotherapy

Although IPT is considered generally to be commensurate with CBT as a psychotherapeutic intervention for depression in younger adults, there are fewer studies investigating the efficacy of IPT as a stand-alone therapy for older adults with depression. Interpersonal psychotherapy [49] consists of elements of psychodynamic-oriented therapies (exploration and clarification of affect) and CBT (behavior change techniques and reality testing of perceptions) that are used to address four areas of conflict: (1) unresolved grief; (2) role transitions; (3) interpersonal role disputes; and (4) interpersonal deficits. A major limitation of the IPT literature is that most research has studied IPT in conjunction with medication or pill-placebo, making it difficult to evaluate the stand-alone efficacy of the intervention. The generalizability of IPT research is further limited in that it has been evaluated primarily in healthy, ambulatory, white patients with major depression.

Major depression

Interpersonal psychotherapy plus pill-placebo versus wait list or placebo

Few studies have compared IPT with placebo or a wait-list control. However, in one study evaluating the treatment effects for chronic or recurrent major depression in late life, IPT plus pill-placebo was found to be better

than pill-placebo in preventing the recurrence of major depression [37]. Findings from this study suggest that the combined treatment with IPT and antidepressant medication may produce the best relapse prevention during the maintenance phase after acute treatment, whereas IPT plus pill-placebo produces the worst rates [37]. Therefore, IPT may be most effective as a maintenance treatment for severely depressed older adults when it is administered in combination with an antidepressant medication.

Dysthymia and minor depression

Only one study has evaluated the efficacy of IPT for minor depression in older adults. Mossey and colleagues [36] randomized 76 medically ill older adults with subdysthymia (Geriatric Depression Scale ≥ 10 and no current diagnosis of dysthymia or major depression) who had recently been discharged from acute hospital care to interpersonal counseling (IPC), a modified, shortened version of IPT, or usual care. Six months after treatment initiation, IPC was found to be superior to usual care in reducing depressive symptoms. Thus far, no studies have examined IPT for the treatment of individuals meeting the criteria for dysthymic disorder.

Summary and limitations

Interpersonal psychotherapy has not yet garnered support as a stand-alone intervention in the treatment of late-life depression. Although one study suggests that IPT could potentially be a useful stand-alone intervention for milder depression, the data from a larger clinical trial support a combined approach to treating late-life depression, particularly in chronic and recurrent types. As is also true for CBT, the generalizability of the IPT literature is somewhat limited by the fact that existing studies have tended to include small numbers of minority elderly, and most participants are healthy and ambulatory.

Brief psychodynamic therapy

The research support for BDT exists largely because of the research on CBT; this intervention has often been used as the comparison arm in these randomized trials. It has only been studied as an intervention for major depression, and as such, the present review is limited to that disorder. From a brief dynamic perspective, depression is often conceptualized from a psychodynamic perspective as being the result of unresolved, unconscious conflicts, usually stemming from childhood. The goal of this type of therapy is for the patient to understand and cope better with these feelings. As such, brief psychodynamic therapies focus on the reflection of past experiences, clarification of affect, the therapeutic relationship, and the confrontation of maladaptive interpersonal patterns, wishes, or conflicts [50,51].

As discussed previously in the review of CBT, BDT has been found to be an effective intervention for treating major depression in older adults [30,33]. In these studies, the BDT intervention was not manualized, but it did follow an outline to account for patient progress. There were no significant differences shown in the outcomes of brief dynamic therapy compared with other treatment modalities [30], and outcomes for major depression were maintained over 1- [30,45] and 2-year [31] periods.

Summary and limitations

BDT has a small evidence base as an efficacious intervention for late-life major depression. However, more research is needed to clarify its true efficacy because only one research group has conducted these trials. Brief dynamic therapy has not yet been compared with antidepressant medication in the elderly and also has not been investigated in individuals with minor depression or dysthymia. Future research is needed in these areas.

Reminiscence therapy

Like BDT, life review and reminiscence therapies are beginning to develop an evidence base. These interventions were studied decades ago as treatments for depression in nursing home patients but have not been studied rigorously for a number of years. More recently, there have been a number of reports evaluating their efficacy as a depression intervention; however, few meet the Chambless and Hollon standards for adding to the evidence base. Life review and reminiscence therapies are derived from Eriksonian developmental theory and have been developed specifically for older adults. Reminiscence therapies typically promote patients' recall of past events during the intervention, which can also include the use of photographs, music, and objects from the patient's past.

Reminiscence therapy has been proposed to counteract learned helplessness by promoting an individual's feeling of control over past and present life events [52]. Although several small open trials of RT in the treatment of late-life depression have been conducted, few larger randomized trials exist [5,28,43].

Both structured and unstructured life review therapies have been found to be effective interventions compared with a no-treatment control condition among older ambulatory community-based adults who have depression [28]. Similarly, findings reported by Wang and colleagues [43] have shown that an intervention consisting of a life review intervention resulted in a significant decrease in a report of selected depressive symptoms among elderly nursing home residents in Taiwan, compared with no-treatment control participants. In a third study that measured post-treatment and 3-month follow-up changes in depressive symptoms among community-dwelling older adults who had major depressive disorder, RT was found to be effective, although

less effective than PST, in reducing depressive symptoms compared with a wait-list control group [5].

Summary and limitations

The research on RT suggests that it is a potentially useful intervention for the treatment of late-life depression; however, more research is needed to replicate these findings to evaluate the relative efficacy of this intervention compared with other therapies and to determine the efficacy of the intervention for minor depression and dysthymia. In addition, the prospects for using this type of intervention among minority elderly, frail elderly, and older adults who have mild cognitive impairment should be explored.

Combined antidepressant medication and psychotherapy

There has been a limited amount of research on the combined effects of antidepressant medication and psychotherapy compared with monotherapies for the treatment of late-life depression. Some preliminary data suggest that, for certain populations of older adults, combined treatments are better than monotherapies in the treatment of late-life major depression; however, these results are not equivocal. There is no research on combined treatments for dysthymia or minor depression.

Acute treatment of major depression

The research on combined medication and IPT has been described previously in detail. Antidepressant medication combined with IPT has been found to be most efficacious in treating major depression in ambulatory older adults who have chronic or recurrent depression [37], and the results seem to be as good in older adults as in younger adults [53]. In another study, Thompson and colleagues [40] investigated the efficacy of desipramine alone, CBT, and a combination of the two and found that all three conditions showed substantial improvement. The combined group showed greater improvement than desipramine alone, but there was little difference between CBT alone and the combined condition.

Summary and limitations

The evidence for combined treatments for late-life depression is still preliminary. Good support exists for the combination of medication and IPT as a means for preventing relapse and recurrence of major depression in older adults, particularly older adults who have recurrent major depression. Although promising, the research on medication with IPT suffers from the same set of limitations seen in the IPT literature; only one research group has studied this approach with adequately powered study designs, and as such, the generalizability of these findings is unclear. Similarly, with regard

to CBT trials, in the one studied reviewed here, the finding that few differences between the CBT alone and a combined CBT and medication condition indicates that further research is necessary to evaluate the efficacy of combined interventions compared with specific monotherapies to determine the overall efficacy of these approaches.

Directions for future research

Although there have been studies of psychotherapy in specialized settings and with special populations, these studies did not meet the Chambless and Hollon evidence-based criteria. In particular, studies on the use of psychotherapy for people who have mild cognitive impairments, people living in rural areas, disabled elderly, and low-income minorities are either too small to provide any definitive information or are nonexistent.

Of particular importance for future study is the focus on older, depressed adults who have mild cognitive impairments (MCI). The majority of research on late-life depression has found a strong association with executive dysfunction [54–56] as well as memory deficits, slowed information processing speed, and visuospatial disturbances [56,57]. Although some of the variability in cognitive deficits associated with late-life depression may be attributed to the severity of depressive symptoms [58], much of the remaining variability is likely caused by comorbid neuropathologic conditions and their neuropsychologic sequelae. Furthermore, studies have shown that deficits in executive functions are associated with a poor and unstable response to antidepressant medications [59]. Given this, one alternative is to develop a more complex medication regime to address nonresponse in MCI individuals, and another alternative is to develop psychosocial interventions that address depression in individuals who have identified mild cognitive impairments. A small pilot study of PST [60] has shown that this latter alternative may be a viable one.

Another important area of study is increasing the access to psychotherapy for older people who cannot access this treatment, either because of disability or unavailability (eg, those living in rural areas). There is promising research on the efficacy of telephone-based psychotherapy for disabled adults [61] and bibliotherapy for distressed older patients living in rural areas [62]. More research of this nature should be conducted. Finally, research on the effects of psychotherapy for low-income minorities is also important to explore. Recent research on younger, poverty-level minorities has been mixed; some findings show psychotherapy to be very effective [63] and other findings show medications to be better than psychotherapy [64].

Based on the present review, the following conclusions and recommendations are made. First, CBT, RT, BDT, and the combination of medication and IPT are acutely efficacious in treating major depression in ambulatory older adults. More research is needed to determine long-term outcomes, the impact on functional outcomes (not just depressive symptoms), and

the impact of these interventions on patients who have medical or psychiatric comorbid conditions. The present authors recommend that these interventions be evaluated using larger samples from multiple geographic sites so that their effectiveness in the typical older person with major depression can be evaluated appropriately. Single-site randomized trials on selected participants are no longer required.

Second, more controlled trials are needed to test the efficacy of BDT, IPT (without placebo), and the combined effects of CBT, PST, and BDT with antidepressant medication. It is anticipated that only a few more controlled trials are needed to clarify conflicting information from disparate studies. For instance, one additional trial of BDT for treating late-life major depression by another research group would meet the efficacy requirements set out by Chambless and Hollon [27]. Third, more research is needed on the efficacy of any psychotherapeutic intervention in the treatment of dysthymia and minor depression and in special populations such as frail elderly, cognitively impaired elderly, and older adults from minority groups. Additionally, because older adults are typically coping with more than depressive symptoms, that is, illness and quality of life issues, outcomes should focus more broadly on other functional domains such as quality of life, activity of daily living, and better management of illness, and not just on decrements in depressive symptoms.

Continued work in the area of psychotherapy for older adults is needed. There is a clear disparity in the number of geriatric psychotherapy and medication trials to date. Numerous studies documenting mental health treatment preferences show consistently that psychotherapy is considered by older adults to be a viable option and, in some studies, is preferred to antidepressant medication [65–67]. Given the results from preference studies, older adults may be accessing mental health treatments that have not been studied adequately. The elderly have the right to receive optimal, evidence-based mental health care, and psychotherapy is clearly an important aspect of that care in terms of scientific evidence and preference.

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