

Late-life depression: Focused IPT eases loss and role changes

Interpersonal psychotherapy focuses on here and now



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Mrs. E, age 74, has been distraught for 6 months since the death of her husband of 45 years. She is brought for evaluation by her daughter, who is exasperated and worried about her mother's sad mood, frequent tearfulness, weight loss (11 pounds), and social isolation.

Mrs. E says she feels lost and paralyzed, that she "sticks out like a sore thumb" when among couples "that still have each other." She refuses to go to church, though she attended regularly in the past.

Unresolved grief appears to be linked to the onset and persistence of Mrs. E's depressive symptoms. After a thorough evaluation confirms major depression, the psychiatrist explains the diagnosis to Mrs. E. She agrees to begin an antidepressant and interpersonal psychotherapy (IPT).

IPT is easy to use and well-suited to address abnormal grieving, role transitions, and role disputes in depressed older patients. In controlled

trials, IPT has been shown effective as acute¹ and maintenance treatment^{2,3} of depression. This article describes how IPT can work effectively for depressed older adults and their clinicians.

IPT AND ELDER DEPRESSION

New-onset or recurrent depression is common in older patients experiencing retirement, relocation, disabilities, or loss of important persons in their lives (*Box 1*).⁴ IPT recognizes that depression, regardless of psychosocial stress or biologic vulnerability, is expressed in an interpersonal environment (*Box 2, page 42*).^{5,6} The environment may have contributed to the depression, but it also can be a platform for intervention.

Depressed older adults who are verbal, nondemented, and engageable are candidates for IPT, with or without adjunctive antidepressant therapy. Psychotherapy is not indicated for patients with severe dementia, but this article will describe how IPT is being adapted for those with early dementia or mild cognitive impairment.

CASE CONTINUED: 'HE MADE ALL THE DECISIONS'

At Mrs. E's first IPT session, the therapist assigns her the "sick role." They contract to meet 12 to 16 weeks, and Mrs. E's daughter agrees to drive her to sessions.

In the next few weeks, the therapist explains depression's biopsychosocial model and explores dual strategies with Mrs. E: to ease her mourning and explore new interests or relationships. The therapist encourages her to express her feelings and seeks to understand the dynamics of her marriage.

Mrs. E said she was raised by nurturing parents and married soon after high school. She depended

Box 1

Depression causes specific to later life

Biologic insults. Any brain injury that is more common in late life or that accumulates with age (such as cerebrovascular, Alzheimer's, or Parkinson's disease) increases the risk of damage to the neural circuitry that maintains mood.⁴ Common metabolic abnormalities such as hypothyroidism and vitamin B12 deficiency also can contribute to late-life depression, which is why routine blood screening is recommended.

Older patients often take multiple medications, increasing the risk for interactions and adverse events. Drugs with depression as a potential side effect include antipsychotics, antihypertensives, and corticosteroids.

Losses in later life can include bereavement for departed family and friends; changes in ego support and financial security with retirement; lack of transportation to sustain hobbies and interests; and declining vision, hearing, and physical function such as urinary continence or ambulation.

Role disputes and interpersonal conflicts. Marriages may be strained by role changes related to retirement or to caring for a physically frail or cognitively impaired partner. Problems of adult children or grandchildren—illnesses, substance abuse, unemployment—can burden elders, especially if families expect financial support, child-care help, or cohabitation. Elder abuse or neglect may also add to late-life stress.

Death and dying issues. Older persons may worry about dying, experiencing pain, being a burden to their families, and whether their lives have been meaningful. Moving to a long-term care facility can demoralize those who view this transition as "the last abode before the grave."

on her husband for almost every decision, including their social calendar. She describes their relationship as mutually loving. As part of an interpersonal inventory, her therapist encourages her to describe in detail all the ways she misses him.

The 'sick role.' The therapist assigned Mrs. E the "sick role" to emphasize that major depression



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Box 2

IPT targets depression's themes, such as losses and role changes

Klerman et al⁵ developed interpersonal psychotherapy (IPT) in the 1970s while working with depressed adults. These authors adopted an empiric approach, reviewing the literature for evidence-based outcomes from various schools of thought to pull together elements that proved to be effective in treating depression.

Social workers on the team reported that interpersonal themes—such as family disputes, life changes, and grief reactions—seemed to trigger or perpetuate many patients' depressions. Using these observations and the literature review, the group developed IPT as a practical psychotherapy to address depression in an interpersonal environment. IPT's case discussions and guidelines are designed to help health professionals learn the approach quickly, use it with broad populations, and complete therapy within weeks rather than years.^{5,6}

can be a severe illness. A therapist might say: "If you had pneumonia, you wouldn't think of trying to rake leaves. You would rest and take care of yourself to speed the healing. Persons with major depression should do the same."

The contract. The therapist also explained to Mrs. E that contracting to meet weekly for 12 to 16 weeks is part of the treatment. A contract:

- encourages patients to commit to an IPT trial for a reasonable time
- presses patients to achieve adequate progress by the deadline
- discourages digression, avoidance of painful subjects, and dependence on the therapist.

IPT's framework. IPT sees clinical depression as having three components: a symptom function, social and interpersonal relations, and personality and character problems (*Table 1, page 47*).^{5,6}

Because IPT is brief, its interventions focus on the first two components. The third may be addressed indirectly, such as when a patient with a depressogenic personality style learns new social skills, compensates better, and improves his or her symptoms.

IPT begins with a complete psychiatric evaluation, including the patient's past, family, and social histories; alcohol and drug use; medical comorbidities; mental status exam; and sometimes blood screening to rule out metabolic abnormalities. Antidepressants are prescribed as needed to relieve vegetative symptoms and are used during IPT when indicated.

Interpersonal inventory. Each of the patient's interpersonal relationships is then systematically reviewed. This inventory sets the stage for exploring relationships that may be linked to the depressive symptoms or offer opportunities for trying alternate coping strategies, such as learning to seek social support (*Table 2, page 47*).

IPT'S FOUR FOCI

IPT's goal is to relieve depressive symptoms by identifying and focusing on problems that may have caused or are perpetuating those symptoms. Most of the reasons depressed patients give for seeking help fall into four foci: unresolved grief, role transition, role dispute, and interpersonal deficit (*Table 3, page 48*).^{5,6} The therapist uses clarification, interpretation, confrontation, and testing of perceptions and performance to address each focus, as detailed in the IPT manual.⁶

The therapist acts as the patient's advocate, and focuses treatment on interpersonal relationships in the "here and now," not past traumas, childhood conflicts, cognitive-behavioral interventions, or intrapsychic themes. No attempt is made to restructure personality.

Progress in relieving depressive symptoms is reviewed regularly, and treatment ends within the

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contract's time limits in many cases. Older patients may need additional sessions because they often take longer to respond to antidepressant trials (6 to 8 weeks, compared with 3 to 4 weeks for younger adults). We allow older patients to "catch up" with additional sessions if illness, lack of transportation, or other problems prevent them from receiving the "full dose" of IPT.

IPT does not work for all patients. Consider other types of treatment if a patient shows no discernable benefit.

CASE CONTINUED: STALLED IN GRIEF

As the weeks pass, Mrs. E improves but remains hypoactive and reclusive. She seems afraid to take any action without her late husband's approval. Thinking about making independent decisions overwhelms her, and she withdraws to her couch to hide.

Her therapist discerns that Mrs. E needs more-active confrontation to accept that her new life requires her to make choices, even though decision-making is difficult for her. They develop a game, chronicling all decisions Mrs. E has made for the first time, such as calling a repairman and planting the summer vegetable garden by herself.

The therapist applauds these "firsts" and points out that Mrs. E's depressive symptoms have improved as her list of completed decisions has grown. Mrs. E holds the power to make decisions, the therapist stresses, and bears the consequences of not taking action.

Table 1

IPT's understanding of depression comprises 3 component processes

Component	Description
Symptom function	Biological or psychological causes may trigger neurovegetative signs and symptoms
Interpersonal and social relations	Influenced by childhood learning, social reinforcement, personal mastery, and competence
Personality and character problems	Enduring traits such as excess anger, guilt, impaired communication, or low self-esteem may impair patient's ability to maintain satisfying interpersonal relationships

Source: References 5 and 6

Table 2

'How-to' checklist of IPT procedures

- Complete** thorough biopsychosocial evaluation
- Diagnose** depression
- Provide** psychoeducation
- Assign** patient the 'sick role'
- Determine** if antidepressant medication is indicated
- Explore** 'interpersonal inventory' in detail
- Relate** depressive symptoms to an interpersonal context in 'here and now'
- Establish** treatment contract (12 to 16 weekly sessions)
- Establish** IPT focus or problem area
- Use** specific interventions for each IPT focus
- Regularly view** depressive symptoms and progress toward change
- Terminate treatment** as per IPT contract, while teaching techniques to help patient cope independently after IPT

continued



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Table 3

IPT's 4 foci, specific to late-life depression

Focus	Description
Unresolved grief	Emotional reactions to the death of another person (not the loss of a job or one's health)
Role transition	Difficulty adjusting to life change (such as retirement, ceasing to drive, or moving to an apartment)
Role dispute	Nonreciprocal expectations between two or more persons that predispose or perpetuate depressive symptoms
Interpersonal deficit	History of social impoverishment or inadequate or nonsustaining interpersonal relationships

Source: References 5 and 6

APPLYING IPT TO LATE-LIFE DEPRESSION

Our group has used IPT in research protocols for 15 years. We and others⁷⁻¹¹ have found that IPT is well-suited for treating late-life depression because:

- Older patients without psychotherapy experience or psychological sophistication can easily participate.
- Persons with limited education can understand IPT's informal explanations of depression.
- Two foci of IPT—grief and role transition—address common themes of aging, such as spousal role disputes after retirement or caregiver stress when one partner becomes ill or shows signs of dementia.

In this research, median time to recurrence of major depression was 69 weeks in IPT-treated patients compared with 16 weeks in similar patients treated with monthly clinical management. Age, depression severity, or medical burden did not determine whether a patient got well with IPT plus nortriptyline.

Only minor IPT adaptations were required for older patients, such as:

- shorter sessions for those who reported physical discomfort
- accommodating for hearing loss, arranging transportation, and conducting sessions by telephone when patients were ill or shut in by inclement weather.

CASE CONTINUED: MORE 'FIRSTS' BUILD CONFIDENCE

Mrs. E makes slow, sometimes painful, but steady progress. Her therapist encourages her to keep trying more "firsts," such as going back to church and attending her first social event alone, and to review her emotional reactions.

Mrs. E's depressive symptoms wane as her confidence builds, and she readjusts her self-image to that of a widow who enjoyed a good marriage with a benevolent but overprotective husband. Her therapist links her progress to her string of successful "firsts" and to the contributing benefit of antidepressant medication.

IPT AS MAINTENANCE THERAPY

In the Maintenance Therapies for Late Life Depression (MTLLD) study—a randomized, double-blind, placebo-controlled trial¹²—we showed IPT to be effective as maintenance therapy for recurrent depression in patients age 60 and older. The 187 patients (mean age 67, one-third age ≥ 70) with nonpsychotic unipolar major depression were first treated to remission with IPT plus nortriptyline (80 to 120 ng/mL).

We then randomly assigned the 107 who achieved recovery to one of four maintenance therapies. After 3 years of monthly follow-up, relapse rates were:

- 20% with nortriptyline plus maintenance IPT

- 43% with nortriptyline plus medication clinic visits
- 64% with maintenance IPT plus placebo
- 90% with medication clinic plus placebo.

Combination therapy. Patients in all active-treatment groups, including those receiving IPT plus placebo, did statistically better than those receiving medication clinic visits plus placebo, indicating that IPT had a protective effect (though not as robust as that of medication). Based on these results, combined antidepressant/IPT therapy appears to be the optimal clinical strategy for maintaining recovery with IPT.

Further analysis showed that patients age ≥ 70 required combined treatment with nortriptyline and IPT to stay well, whereas those ages 60 to 69 stayed well with drug therapy alone. Patients age ≥ 70 also had a higher and more rapid relapse rate.

Recurrence by therapy focus. In patients who received placebo instead of nortriptyline:

- Time without a new depressive episode was similar for patients with a focus on grief or role transition, whether they received IPT or medication checkups.
- Recurrence rates were clearly lower in patients whose initial focus was role dispute if they received monthly maintenance IPT sessions instead of medication check visits.

We suspect the reason for this difference may be that patients more or less resolved grief and role transition issues during acute treatment, before randomization. Those with role disputes who achieved remission probably drifted back to maladaptive behaviors across 3 years. They became depressed again without monthly IPT refresher sessions to reinforce the new skills and insights they had learned.⁹

CASE CONTINUED: LOOKING AHEAD

As the 12- to 16-week contracted period winds down, Mrs. E admits she still longs for her hus-

band's protection. She said she would gladly give up her independence to have that "safe" feeling back.

The therapist acknowledges that feeling but gently reminds her that she has the tools to face her new life realistically. During therapy, Mrs. E has shown she can assess life's many decisions, make rational choices, and live with the consequences.

Their final discussion touches on the notion that Mrs. E could imagine having some kind of friendship with another man in the future.

Wrapping up. The last IPT sessions focus on reviewing any decline in depressive symptoms that may be linked to having learned new coping skills. With successful IPT, patients learn to appraise their strengths and remaining vulnerabilities and gain skills, self-confidence, and understanding to confront remaining obstacles after therapy ends.

ADAPTING IPT FOR SPECIAL POPULATIONS

Resistant depression. Researchers at the University of Pittsburgh are investigating whether adding IPT can achieve remission in depressed older patients who show partial response to a 6-week trial of escitalopram, 10 mg/d. In this ongoing trial, patients with Hamilton Depression Rating Scale scores of 11 to 14 after 6 weeks receive an increased escitalopram dosage (20 mg/d) and are randomly assigned to medication alone or medication plus 16 weeks of IPT.

Cognitive impairment. An unpublished follow-up to the MTLDD study enrolled 116 patients aged ≥ 70 and used a similar design, except that:

- patients were not required to have had recurrent depressive episodes
- paroxetine was used instead of nortriptyline
- patients with cognitive impairment (Mini-Mental Status Examination scores $\geq 18/30$) were included.

Results are being analyzed, but preliminary findings do not show a protective effect for IPT compared with paroxetine.

continued



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Cognitive impairment may have interfered with patients' ability to benefit from traditional IPT. Thus, to improve the quality of life of depressed, cognitively-impaired elders, researchers are involving caregivers (usually a spouse or adult child) in modified forms of IPT couples therapy.^{6,13-18} A team at the University of Pittsburgh is developing a flexible approach that includes meetings with the patient, the caregiver, or both. Two papers on IPT-CI (for cognitive impairment) are under review.

References

1. Elkin I, Shea MT, Watkins JT, et al. National Institute of Mental Health treatment of depression collaborative research program: general effectiveness of treatments. *Arch Gen Psychiatry* 1989;46:971-82.
2. Frank E, Kupfer DJ, Perel JM, et al. Three-year outcomes for maintenance therapies in recurrent depression. *Arch Gen Psychiatry* 1990;47:1093-9.
3. Kupfer DJ, Frank E, Perel JM, et al. Five-year outcomes for maintenance therapies in recurrent depression. *Arch Gen Psychiatry* 1992;49:769-73.
4. Miller MD, Reynolds CF. *Living longer depression free: A family guide to the recognition, treatment and prevention of depression in later life*. Baltimore: Johns Hopkins University Press; 2002.
5. Klerman GL, Weissman MM, Rounsaville BJ, Chevron E. *Interpersonal psychotherapy of depression*. New York: Academic Press; 1984.
6. Weissman M, Markowitz JC, Klerman GL. *Comprehensive guide to interpersonal psychotherapy*. New York: Basic Books; 2000.
7. Miller MD, Cornes C, Frank E, et al. Interpersonal psychotherapy for late-life depression: Past, present and future. *J Psychother Pract Res* 2001;10(4):231-8.
8. Wolfson LK, Miller M, Houck PR, et al. Foci of interpersonal psychotherapy (IPT) in depressed elders: clinical and outcome correlates in a combined IPT/nortriptyline protocol. *Psychother Res* 1997;7(1):45-55.
9. Miller MD, Frank E, Cornes C, et al. Value of maintenance Interpersonal Psychotherapy (IPT) in elder adults with different IPT foci. *Am J Geriatr Psychiatry* 2003;11(1):97-102.
10. Joiner T, Coyne JC. *The interactional nature of depression: advances in interpersonal approaches*. Washington, DC: American Psychological Association; 1999.
11. Sherrill JT, Frank E, Geary M, et al. An extension of psychoeducational family workshops to elderly patients with recurrent major depression: Description and evaluation. *Psychiatr Serv* 1997; 48(1):76-81.
12. Reynolds CF, Frank E, Perel JM, et al. Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent major depression: a randomized controlled trial in patients older than 59 years. *JAMA* 1999;281(1):39-45.
13. Alexopoulos GS, Meyers BS, Young RC, et al. Executive dysfunction and long-term outcomes of geriatric depression. *Arch Gen Psychiatry* 2000;57(3):285-90.

Related resources

- ▶ International Society for Interpersonal Psychotherapy. Accreditation, training, and research information. www.interpersonalpsychotherapy.org.
- ▶ Stuart S, Robertson M. *Interpersonal psychotherapy: a clinician's guide*. London: Edward Arnold Ltd.; 2002.
- ▶ Miller MD, Reynolds CF. Interpersonal psychotherapy. In: Hepple J, Pierce J, Wilkinson P (eds). *Psychological therapies with older people*. East Sussex, UK: Brunner-Routledge; 2002:103-27.
- ▶ Miller MD, Reynolds CF. *Living longer depression-free: a family guide to the recognition, treatment and prevention of depression in later life*. Baltimore: Johns Hopkins University Press; 2002.

DRUG BRAND NAMES

Escitalopram • Lexapro
Nortriptyline • Pamelor

Paroxetine • Paxil

DISCLOSURES

Dr. Miller is a consultant to Forest Laboratories and GlaxoSmithKline and is a speaker for Forest Laboratories, GlaxoSmithKline, and Wyeth Pharmaceuticals.

14. Bozoki A, Giordani B, Heidebrink JL, et al. Mild cognitive impairments predict dementia in nondemented elderly patients with memory loss. *Arch Neurol* 2001;58(3):411-6.
15. Hinrichsen GA, Zweig R. Family issues in late-life depression. *J Long Term Home Health Care* 1994;13:4-15.
16. Reischies FM, Neu P. Comorbidity of mild cognitive disorder and depression—a neuropsychological analysis. *Eur Arch Psychiatry Clin Neurosci* 2000;250(4):186-93.
17. Teri L. Behavior and caregiver burden: behavioral problems in patients with Alzheimer disease and its association with caregiver distress. *Alzheimer Dis Assoc Disord* 1997;11(suppl 4):S35-S38.
18. Wright LK, Clipp EC, George LK. Health consequences of caregiver stress. *Medicine, Exercise, Nutrition, and Health* 1993;2:181-95.

With its focus on abnormal grief and role transitions, interpersonal psychotherapy can be useful for depressed older patients. It is usually brief (12 to 16 weekly sessions) and has shown efficacy with or without adjunctive antidepressant trials. Monthly IPT maintenance sessions may help prevent recurrent depression in patients with role conflicts.

BottomLine