COMMENTARY

An Impressive Step in Identifying Evidence-Based Psychotherapies for Geriatric Depression

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The substantive contribution identifying six evidence-based psychotherapies for geriatric depression by Scogin, Welsh, Hanson, Stump, and Coates is laudable. Their analysis of studies from the 1980s to the present, which recognizes treatments with clear research support, will likely prove valuable to clinicians, researchers, and political advocates. However, their efforts are an initial step. The scope and depth of the findings are limited as a result of the decision to exclude studies of depression with comorbid medical conditions, particularly field research done in primary-care settings, as well as those that use both medication and psychological strategies. Included in this commentary are some caveats regarding the pragmatics of financial reimbursement for the identified EBTs.

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The review article in this issue by Scogin, Welsh, Hanson, Stump, and Coates identifies six evidence-based psychological treatments rated as beneficial for treating geriatric depression, a significant but preliminary step toward potentially shaping practitioner behavior as well as guiding future research efforts and political advocacy in geropsychology. The following psychological therapies passed muster according to the criteria elaborated in the coding manual developed by a Task Force of the Committee on Science and Practice of the Society of Clinical Psychology in 1998: behavioral, cognitive-behavioral, cognitive bibliotherapy, problem-solving approaches, brief psychodynamic, and reminiscence. The authors reviewed initially several hundred studies from the 1980s through the present time, and by eliminating protocols with methodological problems, narrowed their pool of studies down to 20 that provided relevant information for evidence-based treatment status. From the 20 studies the review team found a total of six treatments that met the criteria of "beneficial" to depressed older adults.

By ferreting out these psychological treatment modalities for depression with scientific evidence of benefit to elders, the authors have done a substantial service for the large numbers of generalist psychologists who may scratch their proverbial heads when faced with growing numbers of older depressed patients. This review will prove of value to other groups such as specialty geriatric mental health professionals and newly licensed psychologists and social workers working in long-term care settings. Although the article does not help the reader differentiate which treatments best fit clientele in differing treatment settings, it does guide the clinician to articles about EBTs found to be of utility with institutionalized or dementing elderly patients (Hussian & Lawrence, 1981; Dhooper, Green, Huff, & Austin-Murphy, 1989; Matteson, 1982; Teri, 1994; Teri &

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Logsdon, 1991; Teri, Logsdon, Uomoto, & McCurry, 1997).

It should be noted, however, that those seeking extensive descriptions of the six EBTs will not find them here. Instead, the article has an extensive reference list that can guide the clinician and researcher to detailed descriptions of the treatment strategies. By studying this review, the conscientious therapist, either seasoned or a newcomer to the field, can become more confident in his/her approach with depressed elderly patients by considering these techniques as an appropriate foundation for treatment. As well, this review provides content ideas that should prove useful in planning continuing education programs that demonstrate the nuts and bolts of EBT strategies.

The limitations of this important review article can be made on a pragmatic micro level and a much broader macro level. On the micro level, four of the EBTs described (behavioral, cognitive-behavioral, problem-solving, and brief psychodynamic) are generally recognized as psychotherapeutic techniques reimbursable through third-party payment systems such as Medicare. However, the clinician should be cautioned that many regional fiscal intermediaries—such as the insurance companies that contract with the Centers for Medicare and Medicaid Services (CMS)—are not likely to reimburse for reminiscence therapy or cognitive bibliotherapy, despite the fact that those practices meet the criteria of evidence-based treatments. Policies governing reimbursement can change following periodic reviews that encourage comments by provider groups, but this author strongly suggests that the therapist check with the policies of his/her fiscal intermediary before billing for either of these services (Hartman-Stein, 1999, 2002).

Before the reader takes umbrage with insurance companies and Medicare regulations, consideration should be given to the reasons for skepticism by third-party payers in accepting these treatment modalities as psychotherapy. Scogin et al. describe reminiscence therapy as a process designed "to help resolve conflicts and to help participants accept both the successes and failures of their lives." Inherent in this process is reframing negative cognitions and changing self-deprecating thoughts, core elements of cognitive therapy. Clinicians using reminiscence techniques are advised to document these purported mechanisms of change in order to demonstrate how the therapy is more than simply eliciting memories of the past. Otherwise, clinicians are at risk of being questioned by auditors about whether the intervention meets the criteria for psychotherapy. Moreover, there are potential opportunities for fraudulent billing practices if reminiscence techniques are used with severely demented older adults. (See Teri, McKenzie, & LaFazia, in this issue for a review of EBTs for depressed older adults with dementia, as well as the accompanying commentary by Niederehe.)

Another micro-level consideration is related to the fact that cognitive bibliotherapy has been found to be an effective technique for mitigating depressive symptoms without direct face-to-face therapeutic contact (Scogin, 1998). Under Medicare regulations, however, reimbursable therapy is provided face to face, except for family therapy without the patient present, which is primarily for the benefit of the patient. Therefore bibliotherapy used alone without direct patient contact does not qualify as reimbursable as individual therapy. Nevertheless, cognitive bibliotherapy appears to be a very reasonable method of treatment when working with older adults in a healthcare delivery system not governed under the rules and regulations of fee-for-service treatment.

From a broader, macro-level perspective, it is important that the authors of the review acknowledge the limitation that the EBT protocols deemed to be of benefit have been conducted primarily within academic settings. Most treatment of geriatric depression is actually conducted in the primary-care setting (U.S. Department of Health and Human Services, 1999), and the field needs more research conducted in this important setting. (See Areán & Ayalon in this issue for a review of psychotherapy studies conducted in primary-care settings.) During a recent interview, Cummings noted that the problem with most EBT research is that it is usually directed at systems that are easy to quantify, and not at the need in the field (Hartman-Stein, 2004).

Additionally, the number of depressed older adults who actually seek the services of specialty mental health practitioner is quite small. Fewer than 3% of older adults report receiving treatment from mental health professionals (Lebowitz et al., 1997). In order to make a significant impact on decreasing misery, increasing function of depressed older adults, and getting the attention of

our political decision makers, we need to develop and promulgate depression protocols that can be delivered by professionals other than doctoral-level clinicians (with the doctoral-level therapist in a supervisory capacity) that can be implemented with large numbers of patients.

Another serious concern with the current state of EBT research on treatments for geriatric depression is the omission of studies of patients with comorbid medical conditions. Cummings (2003) posits that depression is not a unitary condition and that it often accompanies comorbid conditions of chronic illness. In her description of how to implement a primary-care depression clinical pathway, Robinson (2003) lists four conditions (diabetes, heart disease, arthritis, and asthma) that are common in older adults and can best be managed in combined depression treatment and self-management skill training. This is the direction for meaningful future research—treating depression as a comorbid condition within geriatric healthcare.

One final limitation of the Scogin et al. review is that the criteria for study inclusion (developed by the taskforce of the Society of Clinical Psychology Committee on Science and Practice in creating the coding manual) result in the exclusion of some important large-scale population-based interventions. An example is that of a 14-session group psycho-educational bereavement program for newly widowed older adults conducted within a managed healthcare plan (Cummings, 1998). In this prospective study of approximately 600 enrollees of Humana Health Plan, the outcome measure was medical care utilization following the loss of a spouse rather than traditional paper and pencil depression outcome measures. In this time of ever-shrinking financial resources, it makes good sense that behavioral research efforts and clinical programming concentrate on outcomes related to depression such as overutilization of medical services due to somatization of mood disorders. Although these types of outcomes have traditionally been the domain of "services research," failure to include them in studies of EBTs means that we risk losing a great deal of important information that could 'fuel' political advocacy by demonstrating cutting of medical costs.

Although Scogin and his associates mention the IMPACT intervention, a very impressive study of 1800 patients aged 60 years or older with major depression or dysthymic disorder, they do not include it in their description of the EBTs. This intervention consisted of education, care management, and support of antidepressant management or brief problem solving psychotherapy within a primary-care setting (Unutzer, et al., 2002). By design, the coding manual on EBTs developed by the taskforce of the Society of Clinical Psychology excludes all studies that used a combination of pharmacotherapy and psychotherapy for depressed older adults because the specific effects of psychotherapy cannot be readily identified. For a preliminary summary of EBTs for geriatric depression, this approach is justified. However, medical guidelines for treatment of clinical depression usually include medication management as the first line of treatment for adults of all ages. Whether or not we as psychologists agree with this treatment approach, it is vital to investigate the type and frequency of psychological treatments that work well with older adults who are also receiving medication management for their depressive symptoms.

In summary, this identification and review of evidence-based psychological therapies found to be beneficial for depression of older adults is an important and commendable step in the ongoing effort to identify evidence-based treatments for late-life depression. The authors provide a succinct summary of the EBT movement as this pertains to older adults and provide the reader with a wealth of informative references. However, the studies included in the review may be limited in terms of generalizability to real-world settings where most depressed older adults receive care. The next wave of evidence-based protocols need to be developed and tested in the context of primary medical care and possibly other settings in the community where older adults live and frequent.

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