Curr Treat Options Psych (2019) 6:452–460
DOI 10.1007/s40501-019-00195-7

Geriatric Disorders (K Zdanys, Section Editor)

Group Psychotherapy for Late-Life Depression

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Published online: 5 December 2019

This article is part of the Topical Collection on *Geriatric Disorders*

Keywords Group psychotherapy · Geriatric psychotherapy · Psychotherapy with older adults · Reminiscence therapy · Cognitive behavioral therapy

Abstract

Purpose of review Depression is a common and disabling diagnosis in the elderly. Psychotherapy, both individual and group, has emerged as an important adjunctive treatment for late-life depression along with medications and neurostimulation therapies. This review seeks to summarize recent literature on group psychotherapy for late-life depression, define the type of therapies commonly used, and discuss both the theory and practice of group psychotherapy.
Recent findings Studies show that various group-based psychotherapies are effective for late-life depression, and there is increasing support for an integrated approach. Accommodations must be made to make therapy accessible and useful for the older adult. Our experience leading a geriatric psychotherapy group at University of Connecticut Medical Center is shared with the reader. Recent evidence-based clinical practice guidelines and other measures, published by the American Group Psychotherapy Association to assist the therapist, are briefly described as well.
Summary Group psychotherapy, in particular utilizing cognitive behavioral therapy and reminiscence therapy, is an effective intervention for late-life depression.

Introduction

Depression is one of the most pervasive diagnoses among the elderly, with significant impact on quality of life. There has been an increasing focus on diagnosis and management of late-life depression with the increase in the older population, and it seems likely that this trend will continue. In accordance with the Freudian dictum of futility of psychotherapy in the elderly, medications and neurostimulation therapies have been the frontrunners in management of late-life depression [1]. This has changed in recent years, with an explosion of

studies showing that psychotherapy, both individual and group, is an effective treatment for late-life depression. In this review, we evaluate recent literature on group psychotherapy, highlighting significant findings and discussing our personal experience with group psychotherapy for late-life depression.

Late-life depression

Symptoms of late-life depression span the spectrum from subsyndromal depressive symptoms to severe major depressive disorder. Late-life depression is often diagnosed using either rating scales or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria for depression [2]. Some researchers have argued that depression in the elderly presents differently than in younger adults [3], and, therefore, studies using these criteria tend to underestimate the incidence and prevalence of depression. Others have argued towards adopting a dimensional rather than categorical approach when diagnosing depression in the elderly, since subthreshold depressive symptoms tend to be at least as common, if not more, as major depression.

In a large population-based study in the USA, the prevalence of major depressive disorder in 10,409 adults over the age of 55 was 13.7%, and an additional 13.8% met the criteria for subsyndromal depression [4]. Prevalence tends to be lower in community settings and highest in long-term care settings. Risk factors included female gender, medical burden, disability, and poor social support. Subthreshold depression is associated with increased disability, health care utilization, and suicidal ideation [5].

The theory of group psychotherapy

Simply put, any therapy in which a small number of people meet together under the guidance of a professionally trained therapist to help themselves and one another can be considered group psychotherapy. In *The Theory and Practice of Group Psychotherapy*, Yalom and Leszcz divide the therapeutic experience of group psychotherapy into eleven primary factors: 1. Instillation of hope, 2. Universality, 3. Imparting information, 4. Altruism, 5. The corrective recapitulation of the primary family group, 6. Development of socializing techniques, 7. Imitative behavior, 8. Interpersonal learning, 9. Group cohesiveness, 10. Catharsis, and 11. Existential factors [6••].

Of these, arguably the most important factors are interpersonal learning and cohesiveness. The process of interpersonal learning is based upon the supposition that disturbed interpersonal relationships are often at the root of psychological symptoms. The therapy group forms a microcosm of each member's social environment, and significant patterns of their interpersonal behavior are highlighted through member-member, member-leader, and member-group interactions. As the group members become aware of these patterns, they are encouraged to try new ways of being and relating to others, eventually setting in motion an adaptive spiral that enhances their ability to form more functional interpersonal relationships [6••].

"Cohesion" describes the therapeutic relationships in group psychotherapy. Cohesion may indicate the direction of the relationship—*member-member*,

Table 1. The AGPA practice guidelines for group psychotherapy

Section	Example
Creating successful therapy groups	Client referrals and administrative collaboration
Therapeutic factors and therapeutic mechanisms	Understanding mechanisms of change, including cohesion, and its relationship to other therapeutic factors
Selection of clients	Inclusion and exclusion criteria, and group composition
Preparation and pre-group training	Objectives, methods and procedures, and impact
Group development	Models of group development and developmental stages—forming, norming, storming, performing, and adjourning
Group process	The group as a whole, splits, and subgroups
Therapist interventions	Basic therapist functions (executive function, caring, emotional stimulation, and meaning-attribution), fostering client self-awareness and establishing group norms
Reducing adverse outcomes and the ethical practice of group psychotherapy	Professional ethics, record keeping, confidentiality, and preventing adverse outcomes
Concurrent therapies	Combining with individual and other therapies
Termination of group psychotherapy	Time limited vs open-ended groups, ending rituals, and therapist departures

Adapted from Barlow, S., Burlingame, G.M., Greene, L.R., Joyce, A., Kaklauskas, F., Kinley, J., Klein, R.H., Kobos, J.C., Leszcz, M., MacNair-Semands, R., Paquin, J.D., Tasca, G.A., Whittingham, M., and Feirman, D. (2015). Evidence-based practice in group psychotherapy [American Group Psychotherapy Association Science to Service Task Force web document]. Retrieved from http://www.agpa.org/home/practice-resources/evidence-based-practice-in-group-psychotherapy

member-therapist, member-group—or the quality of the relationship—*positive or negative* [7•]. In a cohesive group, members are accepting and supportive of each other. This allows them to express themselves freely, to connect with others, and not shy away from exploring negative aspects of self and others. Cohesive groups have better attendance and tend to remain more stable, allowing the group process to endure and eventual learning to be generalized outside the group. In a meta-analysis of 55 studies and 3323 patients, cohesion had a statistically significant effect on the success of group psychotherapy. This correlation was found across different settings and different diagnostic classifications [8].

Author experience: In our geriatric psychotherapy group, members will frequently progress from feeling out of place and lonely to feeling validated and supported. As one member said, "I feel that they get me; I did not think this was likely to happen at this stage of life. For this alone the group has been worth the travel for me."

There have been other attempts over the years to describe various therapeutic factors that explain patient improvement in group treatment. Burlingame et al. defined 5 sources that can affect group outcomes—formal change theory, small group process, group structure, the patient, and the group leader [8]. Formal change theory refers to the theoretical inclination of the group therapist—whether it be interpersonal therapy, cognitive behavioral therapy, reminiscence therapy, or psychodynamic therapy. As the practice of group psychotherapy evolves from a diagnosis-centric approach to a patient-centric

approach, these approaches are being increasingly integrated and applied innovatively to address non-traditional diagnostic targets. Likewise, more studies are investigating outcomes of diagnostically mixed groups [9, 10].

The practice of group psychotherapy

In 2015, the Science to Service Task Force of the American Group Psychotherapy Association (AGPA) published its clinical practice guidelines for group psychotherapy, with a goal to support group psychotherapy practitioners in establishing an evidence-based practice. The guidelines describe ten essential group therapy domains, starting from the screening and referral process, therapeutic factors that influence group process, the five stage model of group development, the therapist's role in the group process, and finally addressing group termination.

The task force recommends a patient-based focus, applying clinical expertise to the situation within the context of client characteristics, culture, and preferences, as opposed to a disease-based approach [11] (Table 1).

The process begins with screening and referral, often from the patient population of the therapist's greater milieu. It is imperative for a therapist to foster and grow a reliable pool of educated referral sources. The referral sources, which may include colleagues in the field of mental health but often includes other specialties, should be educated about the goals and process of the group, inclusion and exclusion criteria, and other information that may be necessary to generate reasonable referrals. In our practice, we find it useful and simple to generate a flyer with this information that can be widely circulated. This is followed by an initial screening by the group leader, selecting members whose who are physically, cognitively, and psychologically able to participate in the group. One or more individual visits with the group leader are useful in the screening and preparation process. Some attrition is to be expected and should be accounted for when selecting group members—it is usually wise to start with a slightly larger group than one hopes to finish with.

Understanding and maintaining therapeutic factors and mechanisms is important to the success of all group therapy. Cohesion must be actively maintained, nurtured, and tracked using empirical measures. Changes to the group structure or process might influence cohesion requiring therapist intervention to restore the group relationships and engagement.

Author experience: In our depression psychotherapy group, we typically find that transitions- new members joining, old members leaving, appearance of a new therapist/co-leader- are all moments requiring attention and often an intervention to re-establish cohesion.

In 1965, Bruce Tuckman proposed the famous multistage model of group development—forming, storming, norming, performing, and adjourning—that has since been widely supported by research [12, 13]. Group development in older adult groups tends to proceed in a similar fashion, and the therapist must always remain vigilant to the group process, establishing group norms, providing emotional stimulation, as well as meaning attribution, fostering self-awareness, and using self-disclosure as needed [6••].

Author experience: We find that there is a stronger focus on executive role of the therapist, communication and positive caring, and more frequent use of

self-disclosure in a group for older adults than would be warranted in a group of younger adults. As always, the therapists must remain aware of local privacy and confidentiality laws, and maintain boundaries and safety.

While termination of group therapy is a fraught process in which many emotions are likely to come up, groups frequently develop termination rituals as a coping mechanism. In our group, we tend to encourage these rituals, followed by processing member reactions to the termination.

Along with the Clinical Practice Guidelines, another useful tool provided by the AGPA is the revised CORE (Clinical Outcome Results Standardized Measures) Battery, which allows group psychotherapists to measure the effectiveness of their groups using selection, process, and outcome measures [14]. The first section, designed to help with group selection and preparation, includes handouts for members, as well as two questionnaires focused on group therapy and group selection. The second section includes tools to measure group process such as the Working alliance inventory, Empathy scale, the Group Climate questionnaire-short form, and the Therapeutic factors inventory cohesiveness scale. The third section on outcome measures includes primary assessment tools such as the Outcome questionnaire-45 and secondary assessment tools such as the Group evaluation scale [15•] (Table 2).

Types of therapy amenable to group setting

Cognitive behavioral therapy

Multiple studies have established the efficacy of group cognitive behavioral therapy (CBT) for depression. CBT is based upon identifying dysfunctional attitudes and cognitive distortions that lead to depression, questioning these beliefs, and ultimately replacing them with more accurate and adaptive thoughts and behaviors. Behavioral approaches may also utilize roleplaying, modeling, and feedback from the group. Evidence suggests that group CBT is an effective treatment for depression in the elderly [16, 17].

Reminiscence Therapy

Reminiscence therapy (RT), based upon Erikson's stage of ego integrity vs despair, assists older adults in systematically reviewing their past with the goal of resolution of late-life developmental issues [18]. Multiple studies

Table 2. Materials and methods of CORE-R

Section	Materials and methods—examples
Group selection and pre-group preparation	Handouts for group leaders and members, including information and confidentiality agreements, questionnaires for group selection
Process measures	Assessment tools such as the Working Alliance Inventory (WAI) and Cohesion to the therapist scale (CTS)
Outcome measures	Outcome questionnaires and evaluation Scales such as the Group Evaluation Scale (GES)

Adapted from Strauss B, Burlingame GM, Bormann B. Using the CORE-R battery in group psychotherapy. Journal of Clinical Psychology. 2008 Nov;64(11):1225-37

have shown RT to be effective in the treatment of depression in older adults [19, 20]. Some authors have indicated that RT may be more effective for old older adults compared to young older adults and for those with more severe depression [21]. Reviews have also suggested that RT may be helpful in older adults with dementia and depression, but more high-quality studies with larger numbers are needed [22].

Psychodynamically based group therapy

Psychodynamic group therapy is based upon the premise that depression results from an individual's failure to successfully negotiate narcissistic injuries. In a cohesive group, these injuries are addressed through provision of relationships—whether between members, between member-therapist, or maybe even between the member and the group—that serve the needed self-object functions [23].

Interpersonal psychotherapy

Interpersonal psychotherapy (IPT) focuses on interpersonal relationships in four broad areas: abnormal grief, role transition, role dispute, and interpersonal deficits. The therapist uses techniques of exploration, clarification, encouragement of affect, communication analysis, and encouragement to help the group members develop alternative coping strategies [24]. In their seminal work, *The Theory and Practice of Group Psychotherapy*, Yalom and Leszcz emphasized the "here and now" experience of the group—"The group lives in the here-and-now, and it also doubles back on itself; it performs a self-reflective loop and examines the here-and-now behavior that has just occurred" [6••].

Author experience: It may be helpful to think of these various approaches as being broadly developmental-dynamically based or cognitive-behaviorally based. That said, our practice has evolved into an integrated/eclectic approach, first discussed by Leszcz in 1990 [23].

The success of an integrated approach has since been borne out by research, such as a recent study showing significant improvement in dropout rates when patients were treated with medications and integrated group therapy as compared to patients treated with medications and group cognitive behavioral therapy. The integrated therapy in the study included elements of CBT, dialectical behavioral therapy, psychoanalysis, Buddhism, Chinese Taoism, as well as elements from the local culture [25].

Evidence for efficacy of group psychotherapy

It had been well established that psychotherapy, whether individual or group, is equally effective for younger and older adults [26]. Group psychotherapy, especially cognitive-behavioral group psychotherapy, is also well recognized as an effective treatment for mood disorders in younger adults [9]. Certain authors have suggested that it is components of the group process itself, rather

than the therapy process, that impact treatment efficacy [26, 27].

Group therapy for late-life depression has not been studied as extensively. An early meta-analytic review exploring the efficacy of psychodynamic therapy and CBT concluded that while group therapy was effective in late-life depression, most of this effect was attributable to non-specific intervention variables [28]. In 1998, Klausner et al. studied two forms of group psychotherapy—goal-focused group psychotherapy (GFGP) and reminiscence psychotherapy—in a group of adults > 55 years with major depression. Both groups showed improvement in depression and disability with the GFGP group showing greater improvement [29]. A systematic review including this and 5 other studies concluded that group psychotherapies based on cognitive-behavioral therapy are effective for depression in older adults, with an overall modest effect size [30]. The authors noted that the studies included were of mixed quality. A more recent systematic review of nine studies confirmed that reminiscence therapy and cognitive-behavioral therapy are viable group interventions for geriatric depression, significantly superior to most controls [31•].

Lastly, a meta-analysis of 8 studies exploring the efficacy of group CBT interventions for older patients with sub-threshold depression showed a significant effect on depressive symptoms at post treatment, but not at follow-up [32].

Conclusions: Issues unique to geriatric groups

We have established that group psychotherapy appears to be just as effective in older adults and in younger adults. However, modifications of group therapy techniques may be needed for older adults. Accommodations are often made for problems in mobility, hearing, and other disabilities. First and foremost in our practice is the issue of physical accessibility; finding a space that is accessible by wheelchair and walker, and is within "geriatric reach" (as described by one of our group members) of the parking lot. After trying a larger conference room with large rectangular tables, we have found a smaller clinic room to be better suited, allowing people to sit in a circle and hear better. A checking in with the status of hearing and other assistive devices is often needed at the beginning of the group.

The therapist's approach varies as well—while pairing off into subgroups/socializing outside groups is often discouraged in younger groups, it may be acceptable, even useful, in a group of older adults, as long as the relationships are not kept secret from the group. Boundaries are often more flexible and humor is frequently utilized. Death and disability are frequent topics of discussion, promoting both a sense of universality and group cohesion. The therapist must be careful to not let the group become too "medically" focused, by making sure that members' medical needs are being actively met outside the group.

Cognitive impairment plays a unique role in older adult groups. The group may be modified with an emphasis on structure and cuing, apathetic individuals may need to be gently drawn in, and impaired members may need help getting reoriented and redirected into the group process [33]. If handled skillfully, coping with cognitive impairment may become fodder for the group process and members may notice improvement in the ability to express themselves and in establishing interpersonal connections [33].

In summary, group psychotherapy offers older adults a unique environment in which they can express themselves, feel acknowledged, and get support and feedback from peers who are dealing with similar age-specific issues of loss, grief, role transitions, disability, and the imminence of death. A successful group often results in greater acceptance, normalization of life's challenges and allows members to restore their sense of self-worth, competency, and mastery.

Compliance with ethical standards

Conflict of interest
The author declares that there is no conflict of interest.

Human and animal rights
This article does not contain any studies with human or animal subjects.

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