

Interpersonal Psychotherapy as a Treatment for Depression in Later Life

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You are a psychologist in independent practice who begins to see an increasing number of depressed older adults. Without formal training in clinical geropsychology, you wonder which psychotherapies might be best to treat this clinical population. In this article, the author discusses a time-limited, empirically supported treatment, interpersonal psychotherapy (IPT), that seems well-suited to the kind of clinical problems often evident in depressed older people. The general structure of IPT, its suitability for older adults, relevant research, and a clinical case are briefly reviewed. In addition, our clinical experience with conducting IPT with older adults, a description of a program for teaching IPT to psychology trainees, and suggestions on how to acquire IPT skills are discussed.

Keywords: interpersonal psychotherapy, depression, older adults, empirically supported treatment

Is there a baby boomer in your future? In only 4 years, the first members of the 75 million baby-boomer generation—those born between 1946 and 1964—will reach age 65 years. By the year 2030, fully 20% of the United States population will be 65 years of age or older. Ready or not, here they come—and most psychologists in practice in the next 20 years will be seeing older adults in clinical practice. The fact is that almost 70% of practicing psychologists currently see at least a few older adults in clinical practice, although only a tiny 3% view older adults as their primary professional practice group (Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002). There will not be enough trained geriatric mental health care providers to serve the needs of the soon-to-balloon population of older adults, and generalist practitioners will almost certainly be responsible for most care of older people (Jeste, Alexopoulos, Bartels, Cummings, Gallo, et al., 1999). Psychologists who provide services to older adults are urged to become familiar with gerontology and geropsychology in a manner that maximizes their effectiveness in assessing and treating late-life psychological difficulties (American Psychological Association, 2004).

For those who conduct or will conduct psychotherapy with older adults, what therapeutic options are available? The good news is that most psychotherapies developed for younger adults appear useful for older adults when applied in an age-informed, age-sensitive manner (Knight, 2004; Scogin, Welsh, Hanson, Stump, & Coates, 2005). In the early 1990s, after 10 years of clinical practice with older adults, I was interested in finding a psychotherapeutic modality that seemed well-suited to the clinical problems of de-

pressed older adults, that was consistent with general recommendations for doing psychotherapy with older people, for which there was some evidence for its efficacy, and that was consonant with my own collaborative style of doing psychotherapy. I found that interpersonal psychotherapy (IPT) fit the bill and subsequently obtained formal training. For almost 15 years, I have conducted IPT and trained students in how to conduct IPT with older adults. I have found IPT an especially useful modality in the treatment of late-life depression and believe that many practitioners will similarly find IPT professionally appealing, consistent with their own clinical style, and effective.

What Is an Older Adult?

A starting point for providing psychological services to any group is understanding the basic parameters of their lives. A recurring question from professional and nonprofessional audiences to whom I speak about aging is “Who do you consider old?” Sixty-five years of age is the usual demarcation of “old age,” “older adulthood,” “senior citizenship,” and myriad names that are assigned to the older population. The simple question about who is an older adult attests that 65 years of age is arbitrary, and many older persons do not consider themselves “old.” In part, the question of who is old also reflects the reluctance of older adults to be included in a named category that some gerontologists have suggested prejudicially portrays older people as “doddering but dear” (Cuddy & Fiske, 2002). Gerontologists recognized early that older adulthood is not a unitary phenomenon. Being 65 years old is usually quite different from being 85 years old. Further, each generation or cohort of older adults has unique generational experiences that shape their experiences and views of old age. Issues that often concern older adults are their own health and that of family and friends, possible need to move from their homes if health deteriorates (i.e., to residences that provide health-related care such as a nursing home), how to maneuver a complex and not well-integrated health care system, dementia, financial resources that may not last to the end of their lives or those of surviving spouses or partners, and other issues (Knight, 2004). Numerous research studies attest to the adaptability and resilience of older

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people as evident from the fact that the vast majority of them have viable social ties to family and friends, have meaningful activities in which they engage, contribute to their families and communities, evidence lower levels of psychiatric disorders than younger adults, and are generally content with their lives (APA Working Group on the Older Adult, 1998). As is evident from this discussion, although gerontologists make broad generalizations about what is usual and normative about older adults (in research studies indexed as means, medians, and modes), there is considerable diversity among older adults (as statistically evident in standard deviations). Some have argued that as people get older they are more diverse. The experience of aging is often sharply different for members of racial and ethnic minorities than for majority older adults. For example, 26% of older African Americans live in poverty in contrast to 8% of older white Americans—and over half of divorced older African American women live in poverty. Although 84% of the current cohort of older adults is white, by 2050 only 64% will be (Federal Interagency Forum on Aging-Related Statistics, 2000). The answer to the question, “What is an older adult?” is a complex and evolving one.

What Is IPT?

IPT was originally developed as a time-limited psychotherapy for major depression by Gerald Klerman, Myrna Weissman, and their colleagues in the 1970s (Klerman, Weissman, Rounsaville, & Chevron, 1984). In one of their early studies, IPT was found to be as useful as antidepressant medication in the treatment of depression in younger adults (DiMascio et al., 1979; Weissman et al., 1979). There are now numerous studies of IPT in the treatment of depression and other mental disorders (for review of studies, see Weissman, Markowitz, & Klerman, 2000). Theoretically, Klerman and colleagues nested IPT in the interpersonal school of psychiatry best known through the work of Harry Stack Sullivan (1953), which emphasized the importance of relationships in the genesis and amelioration of mental health problems. Klerman and colleagues also drew on then-existing research findings that interpersonally relevant problems increased risk for depression, whereas close human bonds protected against depression (Klerman et al., 1984). A subsequent generation of research has continued to demonstrate that interpersonally relevant problems increase risk for depression, depression damages interpersonal relationships, and interpersonal relationships play an important role in the clinical course of depression (Hinrichsen & Emery, 2005).

IPT is typically delivered weekly, for a duration of 16 weeks, in three phases of treatment: initial sessions, intermediate sessions, and termination (see Weissman et al., 2000, for current IPT treatment manual and associated readings). The focus of IPT is on one or two of four interpersonally relevant problem areas: grief (complicated bereavement), interpersonal role disputes (conflict with a significant other), role transitions (life change), and interpersonal deficits (problems in initiating and sustaining relationships). In the initial sessions (Weeks 1–3), the therapist diagnoses depression, educates the client about depression, reviews current and past significant relationships (“the interpersonal inventory”), determines the problem area(s) that will be the focus of treatment, and outlines therapy goals. Commonly a depression-rating scale is administered in the initial sessions, in the termination phase of therapy, and sometimes during the course of treatment. In the

intermediate sessions (Weeks 4–13), the therapist implements strategies associated with each of the four problem areas as well as uses different therapeutic techniques to achieve IPT problem-specific goals in tandem with reduction in depressive symptoms. In the termination phase (Weeks 14–16), the end of treatment is discussed, feelings the client has about ending are explored, treatment progress (or lack of progress) is reviewed, and the possible need for additional treatment is ascertained. Distinguishing features of IPT include focus on current interpersonally relevant problems; collaborative, supportive, and optimistic stance of the therapist; psychoeducation about depression; and a regular review of options that the client has to deal with life problems. IPT’s therapeutic mantras are: “That’s your depression speaking” (i.e., clients feel, think, and act differently when they are depressed but are not always cognizant of the pervasive effects of the disorder) and “There are always options” (i.e., depression is disempowering and limits perspective on options to deal with life problems related to the depression). Clinically, IPT clients may be treated with psychotherapy alone or in combination with antidepressant medication. In contrast to psychodynamic psychotherapy, IPT focuses primarily on current issues and much less on posited historical or developmental issues tied to depression. In contrast to cognitive-behavioral therapy, the focus of IPT is not on changing maladaptive cognitions coexistent with depression but on improving interpersonal behaviors associated with the current episode of depression.

Why Does IPT Seem Especially Useful for Older Adults?

Concern about the emotional and social well-being of older adults has been evident since the beginning of the field of gerontology. Sociologists wondered about the social impact of loss of social roles in later life, notably the loss of roles of parent and worker (Rosow, 1967). More recently, there has been concern about the emotional impact of late-life social role acquisition—notably caregiving roles—on older adults (Schulz, O’Brien, Bookwala, & Fleissner, 1995). Others wondered about how older adults contend with the individual and collective loss of family and friends as they age. Several generations of academic research have demonstrated that most older adults contend well with the many challenges of later life and do not become depressed (APA Working Group on the Older Adult, 1998). However, a minority of older adults do become depressed as a result of interpersonally relevant life changes and can potentially benefit from psychotherapy (Scogin et al., 2005).

I find that IPT problem areas nicely dovetail with the issues that I have seen in outpatient clinical practice with older adults. The most common problem area among older adults treated with IPT is role transitions (Hinrichsen & Clougherty, 2006; Reynolds et al., 1999). The modal late-life role transition is acquisition of responsibility for care of a spouse with physical health problems and/or dementia. Other late-life role transitions include onset of health problems (i.e., transition into the patient role), residential move (e.g., to new community, assisted living, long-term care), retirement or late-life job loss, and care for a grandchild (i.e., acquisition of parenting role). The other problem area most commonly encountered is interpersonal role disputes. Among older adults, disputes typically involve spouse/partner and adult children. Others involve siblings and friends. Usually, grief is a problem area for

older adults who have lost a spouse/partner but sometimes an adult child, grandchild, or close friend. I find that IPT's interpersonal deficits is a problem area that is rarely used with older adults in outpatient clinical practice. I suspect the reason for this is because most older adults come for mental health services at the urging of family or close friends. Persons with interpersonal deficits lack relationships that could serve to facilitate access to treatment.

Research Support for IPT in the Treatment of Depression in Younger and Older Adults

For younger adults, IPT is frequently cited as an empirically supported treatment for depression and other disorders because solid evidence attests to its efficacy. Two studies found that IPT was useful in the treatment of acute depression (DiMascio et al., 1979; Elkin et al., 1989; Weissman et al., 1979). Acute treatment studies have examined how well a psychotherapy, medication, or combination do in significantly reducing symptoms of depression during the current episode. Two studies have found that monthly "maintenance" IPT is useful in reducing the likelihood of recurrence of depression (an episode of depression is successfully treated and the client then has another, separate episode of depression; Frank et al., 1990; Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974; Kupfer et al., 1992). It is worth noting that a large body of research on the treatment of mood disorders has generally found that IPT is useful among different age groups (i.e., adolescents, adults), in different formats (i.e., individual, group, dyadic, a brief form of IPT called interpersonal counseling), with varied clinical foci (i.e., depressed persons contending with medical problems, ante- and postpartum pregnancy, marital difficulties), and in other cultures (i.e., Europe, South America, Africa; Weissman et al., 2000). IPT has also been found to be useful in the treatment of nonmood disorders, including eating disorders and anxiety disorders (Weissman et al., 2000).

There is a smaller body of research that has examined the efficacy of IPT in the treatment of depression in older adults. Two small pilot studies of IPT for acute depression in older adults ($N = 18$ and $N = 55$, respectively) have suggested that IPT may be useful (Rothblum, Sholomskas, Berry, & Prusoff, 1982; Sloane, Staples, & Schneider, 1985). Two continuation/maintenance studies of IPT with older adults have been conducted at the University of Pittsburgh (Reynolds et al., 1999, 2006). Both studies demonstrated that weekly IPT in combination with antidepressant medication is associated with a significant reduction in depressive symptoms in almost three quarters of older adults. The first study found that monthly IPT and antidepressant medication significantly reduced the likelihood of recurrence of depression among a large group of older adults ($N = 180$, mean age = late 60s) with recurrent major depression (Reynolds et al., 1999). In the second study, only antidepressant medication (and not monthly IPT) significantly reduced the likelihood of depression recurrence among another large group of older adults ($N = 151$, mean age = late 70s), the majority of whom had a first episode of depression in later life. Researchers have suggested that once-a-month IPT was not useful in the second study because subjects were more likely to have had cognitive problems than those in the first because late-onset depression is associated with risk for dementia (Alexopoulos et al., 1997). Finally, one study found that a brief form of IPT, interpersonal counseling, was effective in reducing depressive

symptoms in older adults ($N = 76$) who had initially been hospitalized with medical problems and then were followed on an outpatient basis (Mossey, Knott, Higgins, & Talerico, 1996).

Our Clinical Experience in Conducting IPT With Older Adults

My colleagues, psychology trainees, and I have conducted IPT with older adults in a multidisciplinary, outpatient geriatric mental health program of a large medical center since the mid-1990s. Referrals for IPT were made for clients who were depressed (i.e., major depressive episode, adjustment disorder with depressed mood, depressive disorder, NOS), had a problem(s) that was relevant to at least one of the four IPT problem areas, were cognitively intact, and had at least some degree of initial interest in taking part in psychotherapy. Some older clients were on antidepressant medication, and some were not. Most older clients showed a reduction in depressive symptoms during the course of IPT. Clinically it appeared that older clients without psychiatric medication did as well as those on medication. However, clients on medication often had more severe symptoms of depression than did those clients not on medication as determined by treating psychiatrists (Hinrichsen, 2004). These are clinical observations (in contrast to randomized, controlled clinical studies), but they do reflect outcomes generally consistent with research studies with depressed older adults treated with both antidepressant medication and weekly IPT (Reynolds et al., 1999). I used the Hamilton Rating Scale for Depression (Hamilton, 1960) as an index of depression severity. Other ratings scales such as the Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979) or the Geriatric Depression Scale (Yesavage et al., 1983) could also be used. Role transitions and interpersonal role disputes were the most common IPT problem areas for older adults. Grief as a problem area was seen less frequently, and as noted earlier, interpersonal deficits were rarely seen as an IPT problem area. We did not find that IPT had to be adapted for older adults. However, IPT was delivered to older clients in a way that was informed by general guidelines for providing psychological services to older adults (American Psychological Association, 2004). Most of the older adults treated with IPT found appealing the time-limited, problem-focused, psychoeducational, collaborative ethos of the psychotherapy. We rarely had treatment dropouts from IPT. At the end of acute treatment with IPT (i.e., 16 weeks), some older adults continued to be seen in less frequent ("maintenance") IPT. It is my experience that older adults with anxiety disorders are better treated with cognitive-behavioral therapy than IPT. Also, older adults with notable personality disorders (e.g., borderline personality disorder) are better treated with other modalities including long-term psychodynamic psychotherapy or dialectical behavior therapy.

A Clinical Example of IPT in the Treatment of Late-Life Depression Associated With Role Transitions

Mrs. Johnson was a 75-year-old married white woman who sought psychotherapy because of the onset of symptoms of depression that appeared to have been triggered by increasing responsibilities for care of her husband with Parkinson's disease. [Note: Name is fictitious, and details of the case have been

changed to disguise client identity.] She was also concerned about problems in functioning since she became depressed. "In the morning, just pulling a wash cloth over my face seems overwhelming." Mrs. Johnson had two sons who lived considerable distance from her. She had had an episode of major depression when she was a young woman that was associated with a suicide attempt. On the whole, she had functioned well in her life and had worked in competitive employment.

The Initial Sessions (Weeks 1–3)

In the initial sessions, the therapist reviewed with Mrs. Johnson current depressive symptoms and administered a depression severity rating scale. She had symptoms consistent with the DSM diagnosis, major depressive disorder, recurrent. On the basis of the depression severity rating scale, her depression was characterized as "moderate–severe." She denied suicidal ideation. The therapist discussed with the client her diagnosis and the score on the depression rating scale, and explained that it was understandable that she found it difficult to function since difficulty functioning is one of the key symptoms of depression. He encouraged her, if possible, to at least temporarily reduce some of her daily responsibilities until she was feeling less depressed. The onset of depression was clearly tied to deterioration in her husband's condition—he began to have a series of falls that required medical attention, and he became more cognitively impaired. "I began to wonder, is this the beginning of the end? Can I handle this?" Although she maintained social contact with some friends, she felt increasingly isolated. "I look at that telephone answering machine and see '0 messages' and feel lonely." A review of current and past significant relationships (i.e., "the interpersonal inventory") revealed that her mother had died when the client was a child and she was subsequently raised in an orphanage. "Those early years were terrible." She had experienced a generally good marriage to her husband, had been providing care to him for about 4 years, and found caregiving increasingly stressful as his condition deteriorated. She said she had a "good relationship" with her two sons but was disappointed that they did not call or visit more often. Mrs. Johnson had a history of establishing and maintaining friendships and had several close relationships that were emotionally sustaining to her. When asked what she hoped to get from psychotherapy, she said, "I want to be less depressed, and I think I need some help to care for my husband." When asked what kind of help she wanted, she said she was not sure.

At the end of the initial sessions, the therapist reviewed with Mrs. Johnson that she had a major depressive episode that appeared tied to sharply increased demands in her role as caregiver to her husband. That is, she was transitioning from the role of a person who was providing care to a husband who needed some assistance to providing care to someone who required much more assistance. Now that she was in the middle of a major depression, it became even more difficult for her to provide care to her husband. The therapist indicated that he was optimistic that her depression would improve and that another therapeutic option, in addition to IPT, was antidepressant medication. Mrs. Johnson said that she did not want to take antidepressant medication but would if psychotherapy was not successful in improving her mood. On the basis of problems discussed with the client in the prior sessions, the therapist summarized, "There are two chief goals of the

therapy. First, at the end of therapy you will be significantly less depressed. Second, you will feel like you are in a better position to provide care to your husband." Mrs. Johnson said she concurred with these goals, which were congruent with the general reasons for which she sought psychotherapeutic help. The therapist reminded her that 13 weekly sessions remained and that the chief focus of therapy would be current problems related to care of her husband. The therapist also encouraged her to discuss any concerns she had about how therapy was proceeding.

The Intermediate Sessions (Weeks 3–14)

Mrs. Johnson continued to experience significant depressive symptoms and pushed herself throughout the day to provide care to her husband. She said she felt discouraged and wondered if things would improve. "That's your depression talking. Depression makes you feel like things can't change. There are always options to deal with life problems. Let's start thinking about some of the options you have to deal with your problems." The therapist encouraged her to think about ways in which she could get more help with the care of her husband. After several sessions, she decided to get a home health aide twice a week to help her husband so that she could attend an exercise class and see friends. She continued to comment that too often her answering machine registered "0 messages." "From whom did you want a call?" asked the therapist. She responded, "The truth is, I wish I heard from my sons more." Her sons phoned every few weeks and visited a few times a year. At first it was difficult for her to admit how disappointed she was with her sons' frequency of contact and perceived concern about her. After review of different options to potentially increase contact with her sons, she decided to call each of them and discuss the issue. One of her sons expressed surprise that she wanted more contact and readily agreed to telephone her each week and visit more often. Her other son was less committal but promised to call more often. Mrs. Johnson expressed relief that her sons would make more effort to be in touch with her. She said that she had previously minimized caregiving problems to her sons. During the eighth session, the therapist readministered the depression rating scale. Symptoms were half of what they had been at the beginning of therapy. The therapist discussed this fact with the patient who concurred that she was improving.

By the 10th session, Mrs. Johnson began to discuss life with her husband before he became ill. She expressed sadness over the loss of relationship as her husband became more physically and cognitively impaired from Parkinson's disease. She discussed their courtship and early marriage. Notably, she reviewed in more detail the reasons for the onset of depression and suicide attempt earlier in her life: "I was a young mother. I felt overwhelmed with responsibilities. I didn't know what to do." She admitted that her husband was confused about why she had made the attempt although he tried to be supportive of her. The therapist noted the parallel between depression and care for children in earlier life and her current episode of depression and care for her husband. She acknowledged this connection and also discussed feelings she had had as a child following her mother's death and life in the orphanage. "I felt so isolated and that there was nobody I could depend on." The therapist pointed out that providing care for a husband with medical problems was stressful for most women. Given her earlier life experience, it was especially important for her to feel

that she was supported and cared for—and that was why an answering machine that registered “0 messages” was so troubling to her. The connection between Mrs. Johnson’s improved mood and increased social involvement with others as well as more frequent phone calls from her sons was underscored by the therapist. Toward the end of psychotherapy, Mrs. Johnson’s sons came to her home for a birthday party. During the visit, they had an opportunity to see how much more physically and cognitively impaired their father was compared with earlier visits. They affirmed that they would do more to help. Mrs. Johnson felt deeply satisfied by the visit.

Termination

The therapist asked Mrs. Johnson to talk about any feelings related to the end of therapy. She expressed appreciation for the help provided by the therapist and said she was sad to end therapy. The therapist emphasized the active efforts she had made to get more practical help and emotional support and that these efforts were tied to improvement in mood. The therapist readministered the depression rating scale. She had relatively few depressive symptoms. The therapist also noted that she no longer met the criteria for major depression. Therapist and client discussed likely stresses she would encounter in future months, and she frankly acknowledged that at some point her husband would likely need to enter a nursing home. Mrs. Johnson asked if it would be possible to continue psychotherapy. The therapist reemphasized that she had done very well in therapy and wondered why she wanted to continue. “Because I know that the coming months will bring more problems and I need the support.” The therapist agreed to see her monthly. Eventually she joined a support group for relatives of persons with Parkinson’s disease and ended the monthly sessions. She remained depression free.

The IPT Training Program

I developed a program for teaching IPT to psychology externs and interns with a year-long placement in the geriatric mental health clinic as well as for geropsychology postdoctoral fellows. Concurrent with the IPT training program was a year-long seminar in geropsychology in which trainees became broadly familiar with gerontology and geropsychology (Hinrichsen & McMeniman, 2002). First, trainees were required to read *Comprehensive Guide to Interpersonal Psychotherapy* (Weissman et al., 2000), which is the contemporary training manual for IPT in the treatment of depression. Trainees were also encouraged to read *Interpersonal Psychotherapy for Depressed Older Adults* (Hinrichsen & Clougherty, 2006), which discusses how IPT is used in the treatment of late-life depression. Second, trainees were given the equivalent of an 8-hr workshop in which the goals and structure of IPT were reviewed, and audio- and videotapes of actual IPT sessions with older adults were shown and discussed. Third, a depressed older adult was assigned as a psychotherapy case to the trainee. An effort was made to assign an IPT case as early in the training year as possible, although this was not always possible. All patient sessions were audiotaped, and the supervisor reviewed all taped sessions in advance of individual supervision. Fourth, trainees took part in a weekly IPT seminar/group supervision during which selected audiotaped material from trainees was discussed. IPT

research studies have typically required that research therapists successfully complete three IPT cases (i.e., 16 sessions per case) under close supervision before treating study subjects. However, the issue of how much training is required for persons to achieve “proficiency” in the conduct of IPT (including the number of supervised cases) continues to be debated within the International Society for Interpersonal Psychotherapy. Most of our trainees completed one case and occasionally two. I found that most psychology trainees developed fairly solid skills in conducting IPT with older adults and appeared to have reasonably good clinical outcomes and no more treatment dropouts than staff.

How to Learn IPT

A larger problem for empirically supported psychological treatments is their dissemination. Many empirically supported treatments have been developed in research or academic centers and only slowly move into clinical practice (Weissman & Sanderson, 2002). Further, there are problems with how postgraduate practicing psychologists can acquire new therapeutic skill sets (Qualls et al., 2002). Nonetheless, here are some practical suggestions on how an interested psychologist can develop skills in IPT.

1. Acquire knowledge of aging. Those individuals with no background in provision of psychological services to older adults should acquire knowledge of gerontology and geropsychology. The American Psychological Association’s (2004) *Guidelines for Psychological Practice with Older Adults* are a good starting point. Many excellent books are available on adult development and aging, clinical geropsychology, and psychotherapy with older adults. APA’s Division of Adult Development and Aging (Division 20), Society for Clinical Geropsychology (Division 12, Section II), and Office on Aging websites include bibliographic and other resources. See the Appendix for relevant website addresses.

2. Become familiar with IPT. As noted, Weissman et al.’s (2000) *Comprehensive Guide to Interpersonal Psychotherapy* is the primary IPT text to read. Those individuals who are specifically interested in the use of IPT with older people might consider *Interpersonal Psychotherapy for Depressed Older Adults* (Hinrichsen & Clougherty, 2006). APA also has a psychotherapy videotaped series with videos on how to conduct psychotherapy with older adults, including one on IPT in the treatment of late-life depression.

3. Obtain training in IPT. Introductory workshops (and occasionally advanced workshops) on IPT are offered several times a year. Sometimes these are offered in conjunction with professional meetings or in other venues. The International Society for Interpersonal Psychotherapy website has listings of upcoming IPT training workshops. Web searches will also likely reveal the availability of IPT workshops.

4. Obtain supervision in IPT. There are at least two major challenges to obtaining IPT supervision. The availability of IPT trainers is limited, and training can be expensive. Psychologists living in certain metropolitan areas might be able to find an IPT trainer to provide in-person supervision. Supervision typically involves audio- or videotaping sessions that are reviewed by the supervisor and followed by in-person meetings with the supervisor. However, IPT supervision can often be provided at a distance. Recorded IPT sessions are mailed to the supervisor in advance (or, increasingly, digitally taped sessions can be sent via Internet), and phone supervision is provided. The International Society for In-

terpersonal Psychotherapy is a resource for potentially locating an IPT supervisor. As noted, three (16-week) IPT cases are often required for formal training.

Conclusion

With the aging of the baby-boomer population, many psychologists will see older adults in clinical practice. Fortunately, many psychotherapies developed for younger individuals have also been found useful for older adults. Most older adults confront a number of stresses in later life, many of them involving life transitions, losses, and interpersonal stresses. Although most older adults contend well with these stresses, a minority become depressed. In an outpatient geriatric mental health clinic, my colleagues and I have found that IPT is well suited to problems tied to late-life depression. We think that IPT is a psychotherapy that psychologists who see older adults in clinical practice may want to consider.

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Appendix

Websites With Resources in Psychotherapy With Older Adults and Interpersonal Psychotherapy

American Psychological Association (APA) Division of Adult Development and Aging (Division 20): www.apadiv20.phhp.ufl.edu

APA Office on Aging: www.apa.org/pi/aging

APA Society of Clinical Geropsychology (Division 12, Section II): www.geropsych.org

APA Videos: www.apa.org/videos

International Society for Interpersonal Psychotherapy: www.interpersonalpsychotherapy.org

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