Counselling older people: **a systematic review**

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Contents

Summary

Objective
Systematically to locate, appraise and synthesise evidence from scientific studies in order to obtain a reliable overview of the effectiveness, appropriateness and feasibility of counselling with older people.

Methods
- searches of six electronic databases
- hand-searches of 10 journals
- Internet searches and citation tracking to identify 47 studies relevant to the review criteria
- critical appraisal of each paper by two independent reviewers to produce a summary of each study (graded as poor, fair, good or excellent)
- organisation of studies into a summary table to allow analysis and presentation of themes in a narrative report.

Conclusions
- Counselling is efficacious with older people, particularly in the treatment of anxiety, depression and in improving subjective wellbeing.
- Outcomes are consistent with those found in younger populations suggesting that old age is not a barrier to being able to benefit from counselling.
- Of the various counselling approaches CBT has the strongest evidence base and is efficacious with older people in the treatment of anxiety and depression.
- There is a lack of research into a number of counselling approaches which are commonly used in routine practice, particularly interpersonal, psychodynamic, client-centred, validation, goal-focused and gestalt therapies.
- When different therapeutic approaches are tested against each other with this population, outcomes are not significantly different, indicating an absence of superiority of any one particular type of counselling.
- Evidence as to the efficacy of reminiscence therapy and life review in the treatment of dementia and cognitive decline is weak, but consideration should be given to the chronic and debilitating nature of these conditions as compared with more treatable disorders such as anxiety and depression.
- Evidence indicates that individual, as opposed to group counselling, is the psychological treatment of choice among the community-dwelling elderly and that this may be the more effective modality with this population.
- Although not necessarily reflecting older people's preferences, group counselling for nursing home residents and home-based individual counselling for community-dwelling older people are both feasible modes of service delivery.
- A proactive approach to the identification of psychological problems among residential and community-dwelling older people is necessary to ensure problems are not left untreated.
- Training counsellors to treat older people is feasible and some studies report that good outcomes are associated with highly-qualified therapists who have undergone specialised training in working with older people.
- There is an urgent need for counsellors to research UK older populations, UK health and social care settings and the routine counselling approaches used in the UK.
- Future research should generate practice-based evidence that assesses the effects of counselling with older people in routine practice and in naturalistic settings.

Introduction

The ageing of the UK population is well documented. In 2002, based on mid-year estimates, from a total population of 59,229,000, 18.4 per cent were over pensionable age:

6,927,000 were women aged 60 and over (of whom 5,452,000 were aged 65 and over)
3,977,000 were men aged 65 and over
9,429,000 were people aged 65 and over
4,464,000 were people aged 75 and over
1,124,000 were people aged 85 and over. (Age Concern, 2003)

In England alone, since the early 1930s, the number of people aged over 65 has more than doubled. Between 1995 and 2025 the number of people over the age of 80 is set to increase by almost a half and the number of people over 90 will double (Department of Health, 2001). The inexorability of these trends is underlined by continuous and incremental increases in life expectancy. In England average life expectancy at birth is rising at about 0.25 years per year for males and 0.16 years per year for females. National life expectancy has increased over the last 10 years by an average of 2.4 months per year. Average life expectancy for males in England is currently 75.6 years and for females, 80.5 years (Association of Public Health Observatories, 2003).

The Government's National Service Framework for older people has been developed in response to these demographic trends and the consequential urgent need to expand health and social care services for older people. An extra £1.4 billion per year has been committed to health and social care for older people. This includes an extra 2,500 therapists and other professionals to provide person-centred care, which meets individual needs, supports independence and sustains older people within the community (Department of Health, 2001).

The importance of mental health care for older people as an area of public policy has also been recognised by government, the under-detection of mental illness in older people having been identified as a key issue. Depression in people aged 65 and over is especially under-diagnosed particularly among residents in care homes, perhaps indicative of a general tendency for mental health problems in older people to be perceived as an inevitable consequence of ageing, rather than health problems which are treatable (Department of Health, 1999). The Audit Commission (2000) advocates early detection of mental health issues in older people in order to initiate the appropriate treatment and services as early in the illness trajectory as possible.

The National Service Framework calls for mental health treatment for older people to be multi-disciplinary, community-orientated and evidence-based. If counselling is to play a key role in this area of service provision it is important to demonstrate that it meets these criteria. The expansion of counselling services in primary care during the last decade is testimony to how counsellors can engage in multi-disciplinary work, complementing the efforts of doctors, psychiatrists and clinical psychologists. The values and ethics of counselling, with their emphasis on meeting individual needs and promoting autonomy in the client (BACP, 2002), are congruent with the principles of person-centred and community-based care. However, to date, the evidence base to demonstrate the effects of counselling with this client group has not been established. This report aims to address this deficiency by presenting the results of a systematic review of the literature in this area.

Scope of the review

Counselling
Counselling is defined using terms developed by the British Association for Counselling and Psychotherapy in its *Ethical Framework* (BACP, 2002) and by McLeod (2001). The latter emphasises the choice of the client in voluntarily entering into a counselling relationship. This is not simply a matter of giving informed consent as, unlike other forms of healthcare treatment, counselling demands a high degree of active participation in order to be effective. Hence a level of motivation is required above and beyond a passive consent to treatment. Counselling is also distinctive in its responsiveness to individual needs, requiring both an understanding of the client on the part of the counsellor and a flexibility of response. The intended outcome is to bring about change in psychological and behavioural functioning. In its *Ethical Framework* BACP offers further clarification of the purpose of counselling using three differing perspectives. First, a disease model is suggested by the notion of alleviating personal distress and suffering. Second, a growth model is suggested by the aim of fostering a sense of self that is meaningful to the client. Third, a social functioning model is implicit in how counselling aims to increase personal effectiveness. Such definitions are particularly important when researching counselling outcomes.

These definitions of counselling are applicable to both group and individual interventions and so both modalities have been included in the review. Interventions termed psychotherapy have also been included as both counselling and psychotherapy are regarded as sharing a common therapeutic process and comparable relational qualities, regardless of differences in the setting where the activity takes place and the training backgrounds of therapists. Studies which evaluate a treatment package which includes counselling have been excluded from the review where the effects of counselling alone cannot be isolated. Similarly, psychosocial interventions which are primarily educative, advisory or directed at treatment adherence have been excluded as they do not fall within our definition of counselling. Examples of these would be psycho-educational classes or psychological interventions directed at smoking cessation, weight-loss or exercise. Throughout the review counselling is used as a generic term that embraces both psychotherapy and those psychological/psychosocial interventions that fall within the above definition.

Older people
While for the purposes of this review a definition of older people is required in terms of age limit, the authors do not seek to define old age in any wider sense. Hence an iterative approach has been taken to the fraught question, 'when does old age begin?' The review has been guided by terms used by researchers in their individual studies in order to find a consensual age limit. The starting point was to search for the use of terms such as old age, late life, geriatric, senior citizen and then to identify the age limits used in the various studies to define such terms. A large number of studies use 60 years as a definition. But a significant number of studies use the lower limit of 55 years and a small number define old age as 50 years and above. Therefore in order to include as much relevant research as possible, studies with an age limit of 50 years and over have been included in the review.

A three-dimensional focus
In evaluating the use of counselling with older people the review has three central dimensions as proposed by Evans (2003). First is the issue of effectiveness, which addresses whether counselling works with older people in the way that is intended. Second is the issue of appropriateness, which concerns the impact of counselling on older people and whether they find it acceptable as a treatment. Hence whether counselling has any negative side-effects and older people's treatment preferences are relevant considerations here. The third dimension is that of feasibility which is primarily concerned with the provision of counselling to this section of the population. Issues relating to resourcing service-delivery, the training needs of counsellors and the impact of carrying out this type of work on individual counsellors and organisations are all pertinent. The underlying premise is that for counselling to be considered a successful intervention for older people then not only must it be effective but also it should be acceptable to older people and have no significant barriers to its delivery.

The multi-dimensional focus of the review has implications for the types of study included and the hierarchy of evidence adopted. Systematic reviews and well-conducted randomised controlled trials are viewed as providing the best evidence of efficacy. But as appropriateness is primarily concerned with the client's perspective then good evidence can be provided by a variety of study types, such as qualitative studies which investigate the client's experience of counselling and descriptive studies such as surveys which are an effective method of discerning people's opinions. Descriptive and qualitative approaches can prove similarly valuable when investigating the feasibility of counselling as an intervention with older people. Therefore, this review seeks not only systematically to locate, appraise and synthesise evidence from scientific studies in order to obtain a reliable overview, as defined by the NHS Centre for Reviews and Dissemination (1996) but also, as with other systematic reviews that focus on social rather than clinical interventions (Long et al, 2002), to adopt an inclusive approach to study type and include quantitative, qualitative and mixed-method designs. The rationale is to locate as much relevant research as possible and to include a variety of perspectives. However, to merit inclusion studies needed to have a clearly-articulated and replicable study design, consisting of a systematic collection of data and a rigorous method of analysis.

Review methods

A systematic review of quantitative and qualitative research studies was undertaken, utilising the approach recommended by Long et al (2002).

Locating the evidence

A number of methods were used to ensure that a comprehensive set of studies were located for potential inclusion in the review. Scoping searches were carried out to identify relevant search terms and key words in relation to counselling and older people. Comprehensive searches were then undertaken on the following six databases:

- MEDLINE (biomedical information)
- CINAHL (nursing and allied health)
- Cochrane Library (Cochrane Database of Systematic Reviews and Database of Abstracts of Reviews of Effects (DARE))
- PsycINFO (psychological literature)
- Caredata (social work and social care literature)
- Counsel Lit (counselling literature).

(The search strategies used can be found in Appendix A.)

These databases were selected as they cover a range of perspectives and so were likely to produce a comprehensive set of studies on the topic area. Searches were undertaken from 1985 onwards and restricted to papers written in the English language due to resource limitations. Electronic database searching was supplemented by the hand-searching of 10 journals (listed in Appendix B), an extensive call for grey literature (details in Appendix B) and a search of relevant Internet sites (listed in Appendix B). This located a potential 2,646 studies for inclusion in the study. Finally citation tracking was undertaken on the papers selected for inclusion in the review. References from each paper identified for inclusion in the review were checked and any that appeared potentially relevant were cross-checked against the original searches. This process identified 60 additional references for possible inclusion in the review. All references identified were loaded onto an Endnote database. This database was used to track and maintain an audit trail of all studies as they passed through the review process. The titles and abstracts of all references were scanned by one of two reviewers (A Brettle or A Hill) to determine their relevance to the review. Full papers were obtained for those that appeared to be relevant. These papers were checked against the inclusion criteria (see below) and those meeting the criteria were critically appraised (see below). This process is illustrated in Figure 1 (p7).

Inclusion/exclusion criteria

A set of inclusion/exclusion criteria was identified from the aims of the study and the initial scoping of the literature. This was discussed and agreed by members of the project team and BACP.

Inclusion criteria

To be included in the review studies had to:

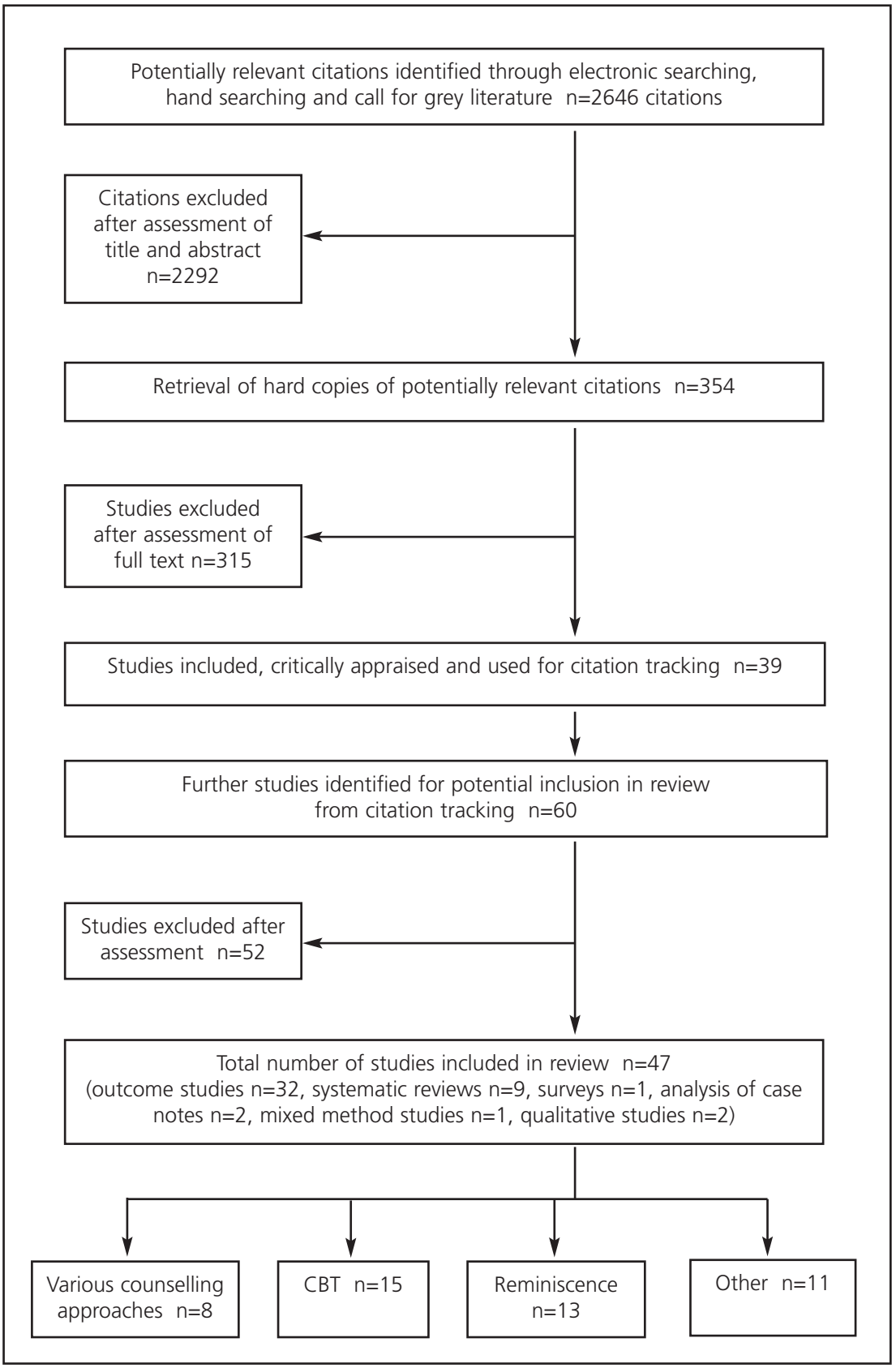
- address at least one of three dimensions relating to the delivery of counselling (effectiveness, appropriateness or feasibility)
- test interventions which fall within the BACP definition of counselling
- draw samples from populations which were clearly 50 years of age or above.

Exclusion criteria

Studies were excluded from the review if they met at least one of the following criteria:

- the report was a book chapter – unless clearly reporting the findings from a research study or a review of research studies
- where counselling was combined with other interventions (eg counselling and medication) and it was not possible to isolate the effects of counselling alone
- where the intervention was unclear
- where the intervention was clearly directive, educational, advice-giving or aimed at treatment

Figure 1: Overview of literature search and retrieval



adherence
- where a study design could not be identified from the abstract (eg a discussion of counselling older people)
- where the age group was ambiguous or included participants who were under 50
- counselling/psychotherapy with carers of the elderly, unless the carers were clearly over 50
- descriptive articles on attitudes to counselling older people
- discussions of methodological issues rather than studies
- discussions of counsellor training
- studies of psychosocial support.

Evaluating and synthesising the evidence

A total of 47 studies met these criteria and were independently critically appraised by two reviewers from of a team of nine, using a set of quality checklists (for quantitative, qualitative and mixed method studies) developed by the Health Care Practice R&D Unit (2003) (Appendix C). The final summary review of each paper was agreed by both reviewers, including the quality assessment, any discrepancies having been resolved by discussion.

Quality of papers

Because of limited resources papers reporting the results of systematic reviews were appraised as studies in their own right rather than utilised as sources of primary studies for individual review. In recognition of the higher level of evidence provided by systematic reviews, extra weight has been placed upon their findings. Trials included in these reviews were in some instances included and appraised in their own right if they contributed to the central dimensions of this review.

The quality of papers was graded using the following terms: excellent, good, fair, poor.

The checklists (Appendix C) provided the criteria by which quality was judged. In order to verify the inter-rater reliability of the grading scheme, one paper was reviewed by all nine members of the review team and a high level of convergence attained among reviewers' evaluations.

The individual reviews were categorised by intervention and the quality-grading of the paper and compiled into a summary table (Appendix D). This includes papers classified excellent to poor. The table was subsequently used to discern which of the three dimensions (effectiveness, appropriateness and feasibility) was being addressed by each paper and to draw together the findings and conclusions. These are presented in the following sections and on the whole are derived from the papers classified as excellent or good.

Review of evidence

This section reports on the evidence arising from the papers included in the review. Before reporting the findings, contextual issues such as the topic areas and quality of the papers and the setting are highlighted and discussed. The review findings are then presented in terms of interventions, and the effectiveness, appropriateness and feasibility of undertaking counselling with older people.

(Note: References to studies that are not included in the review have been *italicised*.)

Contextual issues

The studies included in the review identified a number of psychological problems prevalent in this age group and therefore of key concern to both practitioners and service providers. These are highlighted in Table 1 (p10). In the majority of studies such problems are clearly foregrounded as the target of the interventions being tested. The effectiveness of treatment for the various target problems is mostly discussed in the section entitled 'Interventions'. Along with a wide variety of therapeutic interventions, both group and individual, many studies also address issues relating to the setting where older people reside and receive treatment. This often has a direct influence on how counselling services should be delivered to maximise effectiveness. The findings are discussed in terms of effectiveness, appropriateness and feasibility. While it is important to assess the efficacy of counselling, the acceptability of counselling to older people is a key test of likely usage of counselling services and the issue of feasibility is important in addressing the physical, practical, psychological and ethical problems associated with service-delivery.

There is evidence that as a group older people experience lower rates of most mental health disorders than do younger adults (*Bourdon et al, 1992*). For example, 15 per cent of adults are reported as having a common mental disorder, whereas a prevalence of just 10 per cent has been estimated for those between 60 and 74 years. Similarly, 16 per cent of adults are thought to suffer from neurotic disorders compared with 12 per cent of those aged 60-74 years (*Evans et al, 2003*). However, such problems in older populations have often been attributed to the inevitable consequences of the ageing process and therefore left untreated (*Butler et al, 1998*). In terms of disorders, almost half of the studies (n=21) feature depression as the main target problem, highlighting this condition as being of key concern. Less frequently investigated are the problems of dementia and cognitive decline (n=7), followed by anxiety (n=5). Just two studies evaluate the effect of counselling on depressive symptoms combined with some of the chronic, disabling, physical illnesses prevalent in late life. A further 12 studies do not target a single condition but rather address either multiple problems associated with old age or general levels of wellbeing in older people. Such studies often aim to investigate the role of counselling in maintaining and enhancing older people's quality of life.

Depression

Estimates of the prevalence of depression in older people vary, many researchers and clinicians holding that it is the most common functional psychiatric condition of late life (*Blazer and Busse, 1996; Jenike, 1996*). In UK older populations between 10 and 15 per cent are thought to be depressed (Mental Health Foundation, 2004a). In a large retrospective self-reported study of primary care patients *Barry et al (1998)* discovered 17.8 per cent of females and 9.4 per cent of males over the age of 60 had a diagnosis of depression. It has been found to be particularly common in females, people who are single, those suffering bereavement and other stressful life events and in those lacking an adequate social and emotional support network (*Zisook and Schucter, 1994*). Although diagnosable mood disorders such as major depressive disorder and dysthymia are relatively less frequent among older versus younger adults, depressive symptoms and adjustment disorders with depressed mood are prevalent (*Koenig and Blazer, 1992*). The prevalence of clinically-significant depression ranges from three per cent to 10 per cent among community-dwelling older adults (*Mulsant and Ganguli, 1999; Reynolds and Kupfer, 1999; Steffens, Skoog and Norton, 2000*). Depression is a spectrum disorder ranging from low mood

Table 1: Studies included in the review, categorised by target problems

Depression	Anxiety	Dementia and cognitive decline	Physical illnesses	Other
Abraham et al (1992)	Barrowclough et al (2001)	Baines et al (1987)	Kemp et al (1992)	Arean et al (2002)
Brand and Clingempeel (1992)	Doubleday et al (2002)	Goldwasser et al (1987)	Kunik et al (2001)	Berghorn and Schafer (1986)
Cuijpers (1998)	Harp Scates et al (1985-6)	Morton and Bleathman (1991)		Blankenship et al (1996)
Engels and Vermey (1997)	Stanley et al (1996)	Neal and Briggs (2003)		Gatz et al (1998)
Gallagher-Thompson et al (1990)	Stanley et al (2003)	Orten et al (1989)		Haight (1988)
Gorey and Cryns (1991)		Spector et al (2003)		Kaufman et al (2000)
Hseih and Wang (2003)		Toseland et al (1997)		Mosher Ashley (1994)
Klausner et al (1998)				O'Leary and Nieuwstraten (2001)
Lenze et al (2002)				O'Leary et al (2003)
Lynch et al (2003)				Pinquart and Sorensen (2001)
McDougall et al (1997)				Rattenbury and Stones (1989)
Miller et al (2003)				Young and Reed (1995)
Mossey et al (1996)				
Parsons (1986)				
Scogin and McElreath (1994)				
Thompson et al (2001)				
Thompson (2001)				
Thompson et al (1987)				
Watt and Cappeliez (2000)				
Youssef (1990)				
Zerhusen (1991)				

resulting from a loss (older people being prone to such losses: retirement, status, bereavement, independence) to a chronic, debilitating and life-threatening condition. Prevalence rates have been estimated at about three per cent for major depression and 10-15 per cent for mild to moderate depression (*Cole and Yaffe, 1996*). Further studies have estimated a range of 13-27 per cent for mild to moderate depression (*Judd et al, 1994*) and a prevalence rate of what may be termed elevated depressive symptoms of between 20-50 per cent in medically-ill older people (*Koenig et al, 1988*), symptoms that are associated with delayed recovery in this latter population (*Mossey et al, 1990*). Even in the absence of a physical illness, older adults with depressive symptoms are more likely than older adults without depressive symptoms to perceive their physical health as poor and consequently make significantly higher use of health services (*Callahan et al, 1995*).

Blazer (1987) noted that the majority of depressed older adults have symptoms associated with physical illness and adjustment to life stresses. Therefore, among those dwelling in nursing homes, with their multiple illnesses and functional disabilities, prevalence is high *(Mozley et al, 2000)*. One study *(Parmalee et al, 1989)* found that 26.5 per cent of nursing home residents suffered from diagnosable major or minor depression. In this setting, depression with its associated apathy, decreased attention span and diminished concentration, may contribute to cognitive dysfunction, even in those without dementia (*Blazer, 1989*). It has long been recognised that depression can lead to impairments in functional abilities such as social adjustment (*Weissman et al, 1974*). Furthermore, a decline in physical functioning in the depressed elderly has been observed (*Pennix et al, 2000*) and suicide rates, two-thirds of which are thought to be depression-related (*Blixen et al, 1997*), are higher among elderly persons than any other age-group (*McIntosh, 1992*). In almost all cultures, the suicide rate rises with age, the highest rates in the UK being among those over 75 (*Mental Health Foundation, 2004b*). As regards treatment, only 10 per cent of elderly persons in need of psychiatric help actually receive it (*Friedhoff, 1994*). There may be a variety of reasons for this, such as poor service provision for the elderly or denial by the older person of the condition, perhaps arising from the fear of stigmatisation which often accompanies a psychiatric diagnosis. An additional complication in the treatment of depression relates to poly-pharmacy, where anti-depressants may interact with other medications regularly prescribed to older people, producing undesirable side-effects.

Anxiety

Estimates of the prevalence of anxiety disorders in older adults range from four per cent (*Bland et al, 1988*) to six per cent (*Reiger et al, 1988*). There is some evidence that rates are lower for older adults than for younger people (*Fuentes and Cox, 1997*), although they represent a significant proportion of mental health problems in old age (*Beck and Stanley, 1997*). Use of medication is common in the treatment of late-life anxiety (*Pearson, 1998*). Indeed evidence indicates that older adults with emotional problems are prescribed drugs at a disproportionately higher rate than is the case with younger people with similar diagnoses (*Hersen and Van Hasselt, 1992*). As with the use of anti-depressants, coexistent medical illnesses with their concomitant medications make drug treatment for anxiety problematic. Anxiety can be non-specific as in the case of generalised anxiety disorder or specific as in phobia, obsessive compulsive disorder and panic disorder. Estimates of the prevalence of symptoms rather than disorders (sub-clinical anxiety) in the community range from 10 to 20 per cent (*Fuentes and Cox, 1997*).

Dementia and cognitive decline

The Alzheimer's Society estimates that there are currently over 750,000 people in the UK with dementia, of which only 18,500 are aged under 65. The chances of having the condition rises sharply with age: one in 20 people aged 65 and over, and one in five people aged 80 and over will develop dementia (*Age Concern, 2003*). The death rate from this condition and related dementias is increasing significantly. In people aged 65 and over in England and Wales between 1979 and 1996 there were 171,590 deaths from dementias and neurodegenerative disorders, with the number of deaths per year increasing from 3,021 in 1979 to 10,415 in 1996. Age-standardised death rates for all diagnoses combined increased from 39 to 96 per 100,000 for men and from 45 to 101 for women between 1979 and 1996. The most dramatic

increase was seen in death rates from Alzheimer's disease which increased from less than one per 100,000 in 1979 to 19 for men and 21 for women in 1996 (*Kirby et al 1998*).

Feil (1982) classified individuals with cognitive impairment as having one of four stages on a continuum of dementia: malorientation, time confusion, repetitive motion and vegetation. Prevalence of dementia among nursing home residents is high, estimated at between 40 and 70 per cent (*Rovner et al, 1990; Rovner and Katz, 1993*). Cognitive impairment, mostly due to Alzheimer's disease and related dementias, affects over 60 per cent of nursing home residents and 15 per cent suffer from cognitive impairment with co-morbid depression (*Parmelee et al, 1989*). Many older people suffering from dementia have difficulties with communication and exhibit disturbances in behaviour which at times may be aggressive. Nursing home environments that lack stimulation may further the process of cognitive decline.

Physical illnesses

Older people often suffer from physical illnesses, sometimes with co-morbid anxiety and depression. Only two papers included in the review investigate this area, one *(*Kunik et al, 2001*)* making particular reference to chronic obstructive pulmonary disease (COPD). Chronic obstructive pulmonary disease is a life-threatening illness which in the United States is prevalent in approximately 3.5 per cent of people over the age of 64 years, almost three times higher than those 45 to 64 years of age (*National Center for Health Statistics, 1982-1995*). It is difficult to ascertain the prevalence of this disease in the UK, but it may be widespread (*Bandolier, 2003*). Such an illness has a significant negative impact on emotional and social, as well as the physical quality of life *(Anderson, 1995)*. About 40 per cent of COPD patients in general medical practice have depressive disorders, compared with 13 per cent of all patients in general practice (*Yohannes et al, 1998*). There is evidence to indicate the prevalence of panic (20 per cent) and generalised anxiety (30 per cent) disorders in this population is greater than that in the general population (three per cent and 15 per cent, respectively) (*Wingate and Hansen-Flaschen, 1997*). The second paper *(*Kemp et al, 1992*)* highlights disabling physical illnesses more generally (rheumatoid arthritis, stroke, osteoporosis, heart disease and pulmonary disease), reporting how major depression among older persons with disabling illnesses is thought to be between 10 per cent (*Blazer and Williams, 1980*) and 50 per cent (*Robinson and Price, 1982*). The prevalence of non-major, but clinically significant depression in this population is reported to be approximately 30 per cent (*Gallagher, 1987*).

Non-clinical populations

A number of studies use non-clinical samples, focusing on counselling's effect on the general wellbeing and quality of life of older people, rather than targeting specific disorders. In such studies the notion of wellbeing is operationalised in terms of life-satisfaction, psychological wellbeing, activities of daily living and absence of depressive symptoms. The various outcome measures available for these variables are then used to produce an index of general wellbeing. Studies of this type often use developmental theory as a rationale, investigating how counselling can support and enhance the naturally occurring maturation processes relevant to late life (*O'Leary, 1996*).

Methodological and quality issues

It is noteworthy that the vast majority of potentially relevant papers located in the search process were a mixture of author opinion, unsystematic literature review and case vignette. The lack of rigorous study design in such papers led to their exclusion from the review. The search of the 'grey' literature was disappointing as it produced very few papers, none of which met the inclusion criteria, perhaps indicating that counselling older people is a subject rarely investigated by postgraduate research students.

Twenty of the studies included in the review are randomised controlled trials, making this the most commonly-used study design. A further 12 are outcome studies which lack either a control condition or randomised allocation to groups, or, in the case of six of these 12 studies, both of

these characteristics. Additionally, there are nine systematic reviews, one survey, one mixed-method study, one statistical analysis of case notes and just three qualitative studies. The preponderance of randomised controlled trials and systematic reviews indicates that, on the whole, the research evidence is of a high standard. In the appraisal of individual studies independent reviewers rated three as excellent, 22 as good, 17 as fair and five as poor, indicating that over 50 per cent of studies were either excellent or good in quality.

Randomised controlled trials (RCTs)

While RCTs can produce a very high standard of evidence, there are a variety of issues facing triallists. In some studies the samples are very small, at times fewer than 10 participants. Add to this the tendency for samples to be taken from various local communities, not necessarily representative of larger populations, and the results of studies become difficult to generalise, thus reducing external validity. Attrition rates tend to be high in studies of older people, largely due to illness and death. Not only does this factor undermine the results of the study but also such losses are likely to have an impact on measures of depression and wellbeing, especially when participants have formed affiliations with each other as often happens when people are treated in a group.

As regards interventions, the wide variety of counselling approaches renders problematical judgments about the effectiveness of counselling, a state of affairs compounded by the tendency for some researchers to devise and test their own bespoke interventions, thus adding to the plethora of interventions. The RCT study design frequently uses manualisation of interventions to facilitate replication by other researchers and faithful implementation in clinical settings for best results. The tendency for different counsellors to implement the same therapeutic approach in idiosyncratic ways is a confounding factor in this type of study, but a fact of life in routine counselling practice. The demand for manualisation in research settings means that the interventions tested are increasingly set apart from routine counselling practice, which tends to be generalist, flexible, self-correcting and responsive to the needs of individual clients. This, in turn, increases the gap between research and practice. There is a distinction between effectiveness and efficacy *(Hemmings, 2000)*. Efficacy research, invariably involving RCTs, is carried out in strictly-controlled environments, frequently with manualised interventions and participants selected according to clinical diagnosis who are then randomly assigned to treatment or control conditions. Once a treatment has proved to be efficacious in laboratory-type conditions then the next stage is to test whether it is effective in the real world of clinical practice where strict controls are often not feasible. Hence the efficacy of an intervention established by this type of study should not be taken to signify that similar interventions will work in routine practice, as this has to be established by further research: efficacy and effectiveness should not be confused.

Although frequently using manualised treatments, many of the RCTs included in the review are conducted in naturalistic settings such as nursing homes, hospitals, primary care medical centres or in older people's own homes, as opposed to the more carefully-controlled environment of a research clinic. This increases the external validity of the studies, as clinical conditions approximate real-world routine practice. However, such gains are often at the expense of internal validity, as the control of confounding variables and the blinding of participants to the condition they are receiving (whether treatment, comparison or placebo) become more difficult. It is generally the case in the field of counselling research that participants are often able to judge whether they are receiving an active intervention or a no-treatment control condition. Additionally, the everyday interaction of people who live and socialise together in a residential setting can lead to the effects of the treatment having an impact on others in the home who may not be directly receiving the treatment. Hence members of control groups may be affected indirectly by the intervention. Other events and social activities which are part of nursing home life may also have a confounding effect on therapeutic outcomes. To attempt to control for all such variables would be too disruptive of nursing home life to merit consideration.

In the majority of cases the outcome measures used in the studies are reliable and well-validated. Findings based on the results of non-validated outcome measures designed purely for the purpose of the individual study must be treated with caution as, to a lesser degree, must findings based

on the use of a single outcome measure rather than a broad range of measures. Self-report measures completed by research participants are the most frequently used in the studies. However, when researching older people with dementia this type of measure is often not feasible and observational measures completed by researchers or clinical staff need to be employed. Whether a study uses self-report or observational measures is of some significance in the light of Pinquart and Sorensen's (2001) findings that clinician-rated measures yield greater effect sizes than self-rated measures.

There are a number of ethical issues highlighted in outcome studies involving older people. First, the general issue of withholding treatment from clinical samples in order to create control conditions is of concern. This is addressed in some studies by the use of a cross-over design where participants in the control group receive the intervention following the initial period of treatment. Second, the culture and hierarchy of residential settings may produce a tendency for participants to comply with researchers and clinical staff, introducing bias to therapeutic outcomes. Third, the task of obtaining informed consent to participate in research from older people with dementia or cognitive decline is extremely difficult. Researchers often circumvent the problem by obtaining consent from close relatives, but this does not obviate the fact that such older people may be resistant to participation and unable to understand the process in which they are taking part. Ethical issues in relation to dementia research are discussed further by Dewing (2002).

Systematic reviews

This type of study is associated with the highest level of evidence as the aggregation of results from large, multi-centre samples and the selection of high-quality studies produces findings which are valid, reliable and generalisable. The systematic reviews included in this study vary in their approach, some being broad-based and inclusive, others narrowly-focused and exclusive. For example, Pinquart and Sorensen (2001) included 122 studies, whereas Spector et al (2003) include just two studies. The number of studies included is an indication of the scope of the review. For example, *Empirically validated psychological treatments for older people* (Gatz et al, 1998) is a much wider-ranging area of research than *Reminiscence therapy for dementia* (Spector et al, 2003). Systematic reviewers also adopt a variety of approaches to quality and hierarchies of evidence. Cochrane reviews seek to include a relatively small number of rigorously-conducted randomised controlled trials, whereas inclusive reviews take a more pluralistic approach to study-type and seek to locate as much relevant research as possible, acknowledging it will be of varying quality. Perhaps inevitably, there is a trend for inclusive reviews to support the effectiveness of counselling with older people while the exclusive reviews fail to draw firm conclusions on the grounds of a lack of evidence.

Reviews can be broadly quantitative or qualitative in approach, the former using a statistical meta-analysis on which to base the findings and the latter adopting a narrative or thematic strategy. The majority of reviews included in this study take a quantitative approach and aggregate the results of the included studies using a calculation of effect size. The effect size of each individual study is used to produce an overall mean effect size which is an index of efficacy based upon a large, multi-centre sample of participants.

Effect size statistics are a method of standardising outcomes across different studies, which may use different outcome measurements. Although there are a number of different effect sizes, the most common describes the impact of treatments in relation to the overall variability in the client sample. As a simple rule of thumb, effect sizes of 0.2 are considered small, 0.5 as medium and 0.8 or over as large. Some authorities consider effect sizes of 0.5 or greater as clinically significant.

Tests of clinical significance seek to determine whether the outcomes of a psychological therapy are important in a clinical sense. There are a number of ways of doing this. For example, a treatment may be described as having clinically significant effects if it returns a high proportion of clients to a state similar to that of a non-clinical sample (such as the general population). It is possible for a study to demonstrate statistically significant effect, which has little clinical

significance *(Harris and Pattison, 2004)*. In synthesising data in systematic reviews, studies which may otherwise be useful may have to be excluded if they lack the statistics necessary for a calculation of effect size, samples may be too heterogeneous in terms of socio-demographic variables or clinical conditions and the outcome measures employed in the individual studies may be too disparate. In such cases a more qualitative approach may be useful.

In all types of systematic review there are general issues on how to control for the levels of bias in each individual study and how to account for publication bias resulting from the tendency for studies with positive results to be published and those with negative or equivocal results to be left unpublished. Those reviews which search the 'grey' or unpublished literature are often most successful in dealing with this type of bias.

Surveys

Just one included study uses a survey method to ascertain older people's preferences for psychological services (Arean, 2002). This is a suitable method to gather information on people's opinions. However, the authors acknowledge that the selection of preferred services as part of the survey may be different from the real choices older people may make when faced with an urgent need to access services. Hence some caution should be exercised when interpreting results.

Analysis of case notes

Two studies (McDougall et al, 1997; Mosher-Ashley, 1994) use an analysis of case notes to investigate aspects of counselling with older people. Mosher-Ashley (1994) takes a quantitative approach, using frequency calculations to discern patterns of drop-out from therapy. McDougall et al (1997) take a qualitative approach identifying themes in the notes that are associated with positive therapeutic outcomes; for example a lessening of depressive symptoms. A major source of bias in these studies is the subjectivity of the counsellors who made the case notes which form the raw data of the analysis. As counsellors' perceptions may not always coincide with those of clients there is a need for case notes to be triangulated with the views of clients in order to reduce such bias.

Qualitative research

There is a paucity of qualitative research into counselling older people, with just three studies (McDougall, 1997; O'Leary and Niewstraten, 2001; Young and Reed, 1995) adopting this approach. Young and Reed (1995) use one-hour, open-ended interviews to investigate clients' perceptions of group psychotherapy. Transcripts of the interviews are then subjected to a thematic textual analysis. Although the findings are not generalisable beyond the sample of the study the approach does produce a detailed insight into the process of psychotherapy as experienced by the participants. A similar approach is adopted by O'Leary and Nieuwstraten (2001) who utilise discourse analysis to investigate psychotherapeutic process. The value of this type of research is its ability to shed light on how counselling works, complementing quantitative research which tends to focus on whether it does work.

Settings

Overview

The term setting refers to both the environment where older people reside and the location where the counselling intervention is delivered, in most studies the two being synonymous. Settings and target problems are often connected; for example, dementia being more prevalent in nursing homes than among community-dwelling older adults. Similarly, hospitalised older adults in the included studies invariably suffer from either physical or psychiatric illnesses. In the majority of studies (n=24) which make up the review participants are community-dwelling and receive counselling in that setting (ie in their own homes or in a local primary care medical centre). A breakdown of studies in relation to the settings in which they take place can be found in Table 2 (p16). In 14 studies participants are residents of nursing homes and in three studies participants are hospitalised. In six studies, most of which are systematic reviews, participants are drawn from all types of setting. The significance of setting is that it can have

Table 2: Studies included in the review, categorised by setting

Community	Nursing homes	Hospitals	Other
Arean et al (2002)	Abraham et al (1992)	Blankenship et al (1996)	Engels and Vermey (1997)
Barrowclough et al (2001)	Baines et al (1987)	Brand and Clingempeel (1992)	Gatz et al (1998)
Cuijpers (1998)	Berghorn and Schafer (1987)	Mossey et al (1996)	Gorey and Cryns (1991)
Doubleday et al (2002)	Goldwasser et al (1987)		Mosher Ashley (1994)
Gallagher-Thompson et al (1990)	Hseih and Wang (2003)		Pinquart and Sorensen (2001)
Haight (1988)	Morton and Bleathman (1991)		Scogin and McElreath (1994)
Harp Scates et al (1985-6)	Neal and Briggs (2003)		
Kaufman et al (2000)	O'Leary and Nieuwstraten (2001)		
Kemp et al (1992)	Orten et al (1989)		
Klausner et al (1998)	Rattenbury and Stones (1989)		
Kunik et al (2001)	Spector et al (2003)		
Lenze et al (2002)	Toseland et al (1997)		
Lynch et al (2003)	Youssef (1990)		
McDougall et al (1997)	Zerhusen et al (1991)		
Miller et al (2003)			
O'Leary et al (2003)			
Parsons (1986)			
Stanley et al (1996)			
Stanley et al (2003)			
Thompson et al (2001)			
Thompson (2001)			
Thompson et al (1987)			
Watt and Cappeliez (2000)			
Young and Reed (1995)			

an effect on the efficacy and feasibility of counselling and so is a significant factor both in practice and in research.

Community

Evidence indicates that community-dwelling older people with mental health needs are underserved (*Black et al, 1997*) and that those who do seek help tend to access their primary care provider (*Callahan et al, 1995*). In the US in 1994, of nearly 2 million people who received home health care services, 72 per cent were 65 years or older, mostly female, widowed and the majority being between the ages of 75 and 84 (*National Center for Health Statistics, 1997*). In England, between 1 April 2001 and 31 March 2002, 501,000 clients over the age of 65 received home help or home care services, 151,000 received day care and 205,000 received meals (*Age Concern, 2003*). There tends to be a high concentration of older people in rural areas: in the US 25 per cent of people of 65 years and above live in rural areas (*US Bureau of the Census, 1992*). This group is at risk of experiencing mental health problems and also living in areas where mental health services are scarce. Factors associated with an increased risk of emotional disturbance among older community-residing adults include poor physical health, social isolation, problems managing a household and difficulties in performing the activities necessary for daily living (*Gatz et al, 1996*). Researchers have considered it important to investigate counselling with older people who are homebound (Haight, 1988; Kaufman et al, 2000; McDougall et al, 1997). Such people are often disabled and dependent on at-home services in order to live independently in the community. There are older people without disabilities but who are likewise homebound and dependent on at-home services as a result of being a caregiver to someone with a disability. In England and Wales, in 2001, it was estimated that 342,032 people aged 65 and over provided 50 hours or more of unpaid care per week (*Age Concern, 2003*). *Wehry (1995)* cites research estimating that as many as 50 to 70 per cent of older home health care recipients suffer from behavioural, emotional and/or psychological disorders. One of the roles counselling may perform in this setting is to help older people live independently in the community, thus avoiding a nursing home placement.

Certain studies (Barrowclough et al, 2001; Cuijpers, 1998; Haight, 1988; Kaufman, 2000; McDougal et al, 1997; Mosher-Ashley,1994) focus on the delivery of counselling services in clients' own homes and the need to take a proactive approach to the identification and treatment of late-life psychological problems in the community. Cuijpers (1988) has noted the under-utilisation of psychiatric services by depressed elderly people and concluded that programmes which seek actively to identify and treat mental health problems among the community-dwelling elderly are needed to address this trend. Using the term 'outreach' to describe this mode of delivery, Cuijpers (1988) found a large mean effect size when comparing groups that participated in such programmes with those that did not. Researchers have also tested the effects of counselling older people in their own homes, a mode of service delivery which merits serious consideration in light of the physical disabilities and difficulties with transportation often experienced by older people. Mosher-Ashley (1994) found that the delivery of counselling in people's own homes is associated with persistence (low early drop-out rates) in therapy. Barrowclough et al (2001) found that treatments offered in this setting were effective. Focusing on rural-dwelling older people, Kaufman et al (2000) concluded that home-delivered counselling may have an important role to play in treating mental health problems. The use of home-based counselling to improve the quality of life of those who are home-bound is investigated by Haight (1988) who found that life-satisfaction and psychological wellbeing were significantly affected by the intervention. Maintaining the recovery of home-bound older people following discharge from psychiatric hospital is the focus of a study by McDougall et al (1997) who likewise found positive results.

Nursing and care homes

Approximately six per cent of the older adult population in the US reside in nursing home facilities (Youssef, 1990). In the UK in 2001, four per cent of people aged 65-69, seven per cent of people aged 70-74, 10 per cent of people aged 75-79, 13 per cent of people aged 80-84 and 19 per cent of people aged 85 and over lived in sheltered accommodation (*Age Concern, 2003*). In April 2003, in the United Kingdom, there were an estimated 13,385

registered care homes for older people and an estimated 501,900 places for the nursing, residential and long-stay hospital care of older, chronically ill and physically disabled people (*Age Concern, 2003*). Nursing homes are a major source of social care when family caregivers are overburdened or family resources are exhausted (*Rovner et al, 1986*). Consequently, nursing home residence is associated with high rates of cognitive impairment and dementia, some estimates as high as 60 per cent of residents being affected (*Parmelee et al, 1989*). Other estimates are more conservative and put the figure at around one-third (*Evans et al, 1981*). It has been suggested that in some nursing homes a lack of stimulation and fatalistic attitudes to improving the lot of those with dementia are commonplace (Abraham, 1992). These factors may combine to hasten the decline of residents (Orten et al, 1989). Other authors discuss the negative effects of the physical and social isolation experienced by residents, who spend the majority of time in their rooms (*Brent et al, 1984*). This sense of isolation is no doubt compounded by the fact that residents are also isolated from their families. There may be a tendency for such residents to be withdrawn and take little part in activities provided by the home (Baines et al, 1987). There is evidence that nursing homes have tended to focus on providing good-quality physical care (Baines et al, 1987) and effective management of difficult behaviour (Orten et al, 1989), rather than psychotherapeutic intervention, which in turn may lead to the development of rigid routines demanding little initiative from residents. An additional isolating factor may be that rates of staff turnover tend to be high (between 25.0 and 66.7 per cent) (Toseland et al, 1997) suggesting that relationships between caregivers and residents may be transient.

Hospitals

Research into counselling older people in hospitals is scant, tending to focus on two groups of inpatient; those with a psychiatric disorder, such as depression or dementia, and those with physical illnesses and co-morbid psychological symptoms. The high prevalence of elevated depressive symptoms in the latter group of inpatients highlights the need for psychological as well as medical treatment in this setting. Researchers often seek to ascertain whether counselling can not only reduce depressive symptoms but also assist in the process of physical recovery, thus reducing the length of stay in hospital.

Interventions and their effects

Overview

The studies included in the review cover a range of therapeutic interventions, 17 different types of therapy in all. Summaries of all included studies categorised by intervention can be found in Appendix D. The most-commonly researched therapies are reminiscence therapy (RT) (n=11) and cognitive-behavioural therapy (CBT) (n=9). There were also a number of studies (n=8), predominantly systematic reviews, which investigate multiple counselling approaches. In order to discuss with some clarity and simplicity the effects of a plethora of counselling approaches, therapies that are theoretically and technically similar have been grouped together. Hence CBT has been aggregated with behaviour therapy, cognitive therapy and dialectical behavioural therapy to form the most frequently researched group of interventions (n=15). Reminiscence therapy has been combined with life review therapy to become the second most frequently researched group of interventions (n=14). There remains a large number of less frequently researched interventions: interpersonal therapy (IPT) combined with interpersonal counselling (n=3), supportive counselling (n=3), psychodynamic therapy (n=2), validation therapy (n=3), task-centred combined with goal-focused therapy (n=2), gestalt therapy (n=2) and group psychotherapy based on the work of *Yalom (1985)* (n=1). In addition, some interventions are offered as group therapy and others as individual treatments. The modality of the intervention (whether group or individual) is likely to be a significant factor when considering outcomes. The findings reported in the remainder of this section are mainly based on the summaries of the papers classified as excellent or good. Studies classified as fair or poor are listed in Appendix D, but unless stated are not used to draw any conclusions.

Various counselling approaches

In reviewing the effectiveness of psychological treatments for older people, Gatz et al (1998)

uses the American Psychological Association's classification for empirically validated treatments. The highest classification is 'well-established' and the second is 'probably efficacious' each being defined by a set of quality criteria relating to levels of evidence (*Chambless et al, 1996*). This review of 77 studies found that psychological treatments met the criteria for 'probably efficacious'. From their statistical meta-analysis of 122 studies, Pinquart and Sorensen (2001) conclude that psychotherapy promotes improvements in depression and psychological wellbeing and that the effect size of psychotherapeutic interventions is moderate to large. In this study psychotherapeutic interventions changed self-rated depression and other measures of psychological wellbeing by about one half standard deviation, which can be interpreted as a moderate effect, and clinician-rated depression by more than one standard deviation, a large effect. Similarly, Engels and Vermey (1997*)* in their meta-analysis of 17 studies found that the mean treated client with depression was better off than 74 per cent of participants in control conditions. Scogin and McElreath (1994) found that psychological interventions are at least moderately and, more likely, highly effective in the treatment of depression in older people. Their statistical meta-analysis of 17 studies found an overall mean effect size of .78, comparing favourably with the figure of .73 obtained by *Robinson et al (1990)* in their review of psychotherapy for depression across all adult ages. Hence the authors conclude that effects are comparable with the results of studies with younger age groups. This is supported by Gallagher-Thompson et al (1990) and Thompson et al (1987) who, in their studies of depression, found that despite older people being likely to experience a high frequency of physical and psychological stressors in their lives, therapeutic outcomes are consistent with results reported for younger patients treated with similar types of counselling.

When the effectiveness of different counselling approaches is compared several studies conclude that outcomes are not significantly different. Scogin and McElreath (1994) found no clear superiority for any one system of psychotherapy in the treatment of old-age depression. Comparing cognitive, behavioural and psychodynamic therapy, Gallagher-Thompson et al (1990) discovered no differences in patient outcomes for the three types of treatment. Likewise, Gorey and Cryns (1991) in their meta-analysis of 19 studies found all types of group therapy equally effective in the treatment of depression in later life. They also found that the age of participants had no impact on the effectiveness of the intervention.

Cognitive-behavioural and related therapies

Cognitive-behavioural therapy is the most widely researched intervention and so, of all the therapeutic approaches, is supported by the greatest weight of evidence. A review by Cuijpers (1998) noted that there is a non-significant trend that cognitive behavioural therapy may be more effective than other therapies in the treatment of depression. This is supported by Pinquart and Sorensen's review (2001) which concludes that cognitive behavioural therapy is especially recommended to improve the subjective wellbeing of older adults. Engels and Vermey (1997) found that behaviour therapy and cognitive therapy as separate interventions were more effective than other forms of therapy and better than the two in combination (ie CBT). Zerhusen et al (1991) found that a group cognitive therapy intervention resulted in a statistically significant improvement in ratings for depression for nursing home residents with moderate to severe depression. In the treatment of elderly outpatients, in combination with the antidepressant desipramine, Thompson et al (2001) found that CBT produced significantly greater improvements than drug treatment alone. A study by Lynch et al (2003) which combined antidepressant medication with dialectical behaviour therapy in the treatment of depressed older adults produced similar results.

Studies report that CBT has produced beneficial effects in the treatment of late-life anxiety. Stanley et al (2003) found improvements not only post-treatment but at one year follow-up, results which are supported by Barrowclough et al (2001), who found that at 12 month follow-up 71 per cent of patients showed a good treatment response with regard to anxiety symptoms. In this latter study CBT was also found to be more effective than supportive counselling. Two studies found CBT effective when treating older people with physical illnesses. Using measures of both anxiety and depression, Kunik et al (2001) discovered beneficial effects from a brief group CBT intervention among a group of older people suffering from chronic

obstructive pulmonary disease. Similarly, when comparing the effects of CBT on two groups of depressed older people, one with disabling physical illnesses and one without, Kemp et al (1992) found substantial and equivalent decreases in depression in both groups, suggesting that the existence of co-morbid physical illness does not decrease the effectiveness of the intervention. A number of studies found CBT to be as effective as other interventions. For example, Thompson et al (1987) found cognitive and behavioural interventions as effective in the treatment of depression as psychodynamic psychotherapy. Stanley et al (1996) found both CBT and supportive counselling equally effective in the treatment of generalised anxiety disorder. A small number of studies found little evidence for the effectiveness of CBT. Abraham et al (1992) found no significant changes in depression, hopelessness or life-satisfaction resulting from group CBT with nursing home residents and studies by Harp Scates (1985) and Brand and Clingempeel (1992) are similarly inconclusive.

Reminiscence therapy and life review

Reminiscence and life review therapies have been developed specifically for the treatment of older people, setting them apart from other types of therapy which tend to be used with all age groups. It is also often the case that these treatments are used with those older adults who are suffering from chronic disorders such as dementia and with nursing home residents who have low levels of functioning. These factors need to be taken into account when considering the effectiveness of the therapies. Spector et al, in a recent Cochrane review (2000), conclude that as a treatment for dementia there are insufficient data to reach firm conclusions about the effectiveness of reminiscence therapy, but the authors acknowledge there is some evidence of efficacy which needs to be confirmed by further research. Likewise, Orten et al (1989) found little evidence that reminiscence groups could produce improvements in social behaviour among confused nursing home residents.

Targeting a different problem Goldwasser et al (1987) found that levels of depression in a similar population were positively affected by group reminiscence therapy but that these gains were not maintained at five week follow-up. As a result, the authors concluded that reminiscence therapy should be offered continuously to maintain improvements in the quality of life of such a population. More positive effects were discerned by Baines et al (1987) who found that to treat confused elderly people firstly with reality orientation and subsequently with reminiscence therapy led to significant improvements on measures of cognition, communication and behaviour even at four weeks post-treatment. In several studies reminiscence therapy has been used as a treatment for depression with varying effects. As a treatment for depression Hseih and Wang (2003), in their systematic review, fail to draw firm conclusions about its effectiveness. In a randomised controlled study Youssef (1990) discovered a significant reduction in depression in people aged 65-74, but not in older participants aged 74 and over). However, Watt and Cappeliez (2000), having developed two types of reminiscence therapy which integrate cognitive approaches, found that the interventions led to significant improvements among depressed older adults and moderate to high effect sizes were maintained at three months follow-up. Likewise Parsons (1986) found statistically significant improvements in depressive symptoms following a reminiscence therapy intervention. Using a qualitative study design, McDougall et al (1997) discerned a lessening of depressive symptoms among homebound adults discharged from psychiatric hospitals resulting from individual life review therapy. Also using homebound elderly participants, Haight (1988) found that individual life review therapy led to significant improvements in life satisfaction and psychological wellbeing but that treatment had no impact on depression and activities of daily living measures. Rattenbury and Stones (1989) found that group reminiscence therapy was associated with improved psychological wellbeing but the intervention was no more effective than a current topics discussion group. By way of a summary, in their systematic review, Gatz et al (1998) conclude that reminiscence therapy as a treatment for cognitive impairment is not supported by research evidence but that life review and reminiscence are probably efficacious in ameliorating symptoms of depression or improving feelings of life satisfaction, for both cognitively intact older adults and populations suffering from dementia.

Other therapies
There are a number of counselling approaches for which there is little research evidence but which are noteworthy as they are commonly used in practice.

Interpersonal therapy (IPT)
There is only a small amount of research into IPT, a fact emphasised by Gatz et al (1998) whose systematic review concluded that evidence in relation to interpersonal therapy is incomplete. However, a small number of studies have found positive outcomes; for example Mossey et al (1996) treated a large sample of medically ill, hospitalised patients suffering from sub-clinical depression with brief interpersonal counselling and found significant improvements at six months from the commencement of the intervention. Two studies (Lenze et al, 2002; Miller et al 2003;) have investigated the use of IPT in maintaining recovery from major depression. The former found that a combination of IPT and the anti-depressant nortriptyline was a more effective form of maintenance therapy than either the medication or the psychotherapy alone. The latter found that IPT was superior to medication alone in preventing a recurrence of depression in those patients experiencing role conflict, suggesting that IPT may be particularly effective with this type of problem.

Psychodynamic therapy
In their systematic review Pinquart and Sorensen (2001) note that there are very few published studies on the effects of psychodynamic interventions. The evidence available suggests that psychodynamic therapy is as effective as cognitive or behavioural approaches in the treatment of depression (Thompson et al, 1987; Gallagher-Thompson et al, 1990).

Supportive counselling
As with psychodynamic therapy, Pinquart and Sorensen (2001) note the need for more research into supportive or client-centred counselling. Having compared CBT with supportive counselling in the treatment of anxiety, Barrowclough et al (2001) conclude that both CBT and supportive counselling provided effective treatment. In a similar study Stanley et al (1996) found both supportive counselling and CBT produced large effect sizes and no significant differences in outcomes between the two interventions could be discerned.

Validation therapy
Developed by Naomi Feil (1982), like reminiscence and life review therapy, validation therapy is an approach designed for older people, particularly those with dementia. In their Cochrane review, although noting that observational studies suggest there may be some positive effects, Neal and Briggs (2003) located only two studies of sufficient quality and so found insufficient evidence to draw any firm conclusions as to the efficacy of validation therapy for older people with dementia or cognitive impairment. One of the two studies reviewed by Neal and Briggs (Toseland et al, 1997) is in itself inconclusive, stating that although the nursing staff caring for the clients noted improvements in the behaviour of those treated with the intervention, these findings were not supported by independent observers.

Task-centred and goal-focused therapy
Investigating a brief, task-centred intervention Kaufman et al (2000) found that clients reported improvements in their emotional wellbeing and indicated significant reduction in severity of the problems targeted by the intervention. When compared with a reminiscence therapy group, Klausner et al (1998) found that a goal-focused group intervention showed the greater improvements in depressive symptoms. Improvements were also discerned in the areas of hope, anxiety and social functioning.

Gestalt therapy
O'Leary et al (2001) concluded that gestalt group therapy increased the expression of anger, left clients less hostile, clearer-headed and less confused. O'Leary and Nieuwstraten (2003) in their qualitative study found that gestalt reminiscence therapy elicited certain types of memory that were posited as being therapeutic.

Modality

Just over half of the studies are of group interventions, the remainder being investigations of either individual therapy or a mixture of group and individual. Some of the systematic reviews consider both group and individual treatments (Gatz et al, 1998; Pinquart and Sorenson, 2001; Scogin and McElreath, 1994) and compare the relative effects of the two modalities. Two studies (Pinquart and Sorensen, 2001; Engels and Vermey, 1997) assert that individual interventions were more effective than interventions in groups. In a systematic review investigating the effects of group therapy with depressed older people, Gorey and Cryns (1991) found significant improvements as a result of the intervention but no difference in effect sizes across the various theoretical orientations. They state that group therapy accounted for a 42 per cent positive change in clients' affective states but that 87 per cent of this improvement appears to be attributable to non-specific variables extraneous to the therapeutic technique applied. These findings are supported by other studies. Abraham et al (1992) found no significant difference in outcomes between CBT, focused visual imagery and education-discussion groups in the treatment of depression. Rattenbury and Stones (1989) found equivalent outcomes for a reminiscence and a current topic discussion group. Toseland et al (1997), in comparing group validation therapy with a social contact control group found that in some areas of functioning (reduction in verbally aggressive behaviour) the control group had better outcomes than the treatment group. The implication here is summarised by Neal and Briggs (2003) that the benefits of group therapy may be a result of group activity per se or the attention received by an individual, rather than the application of a therapeutic technique. This position is partly supported by Young and Reed (1995) who conclude that group activity which is reflective and interpersonal leads to positive psychological development in participants.

The three dimensions

Effectiveness

The vast majority of studies (n=43) (91 per cent) address the effectiveness of counselling with older people in terms of either symptom reduction or enhancement of levels of wellbeing, as already discussed. Twenty-five of the 47 papers reported positive effects that were statistically significant (Baines et al, 1987; Barrowclough et al, 2001; Cuijpers, 1998; Engels and Verney, 1997; Gallagher-Thompson et al,1990; Gorey, 1991; Haight,1988; Kaufman et al, 2000; Kemp et al, 1992; Klausner et al, 1998; Lenze et al, 2002; Lynch et al, 2003; Mossey et al, 1996; Parsons, 1986; Pinquart and Sorenson, 2001; Rattenbury and Stones, 1989; Scogin and McElreath, 1994; Stanley et al, 1996; Stanley et al, 2003; Thompson LW, 2001; Thompson SBN, 2001; Thompson et al, 1987; Watt and Cappeliez, 2000; Youssef, 1990; Zerhusen et al, 1991) providing good evidence of the effectiveness of counselling with older people. Almost a third of studies found either a lack of effect or effects that were not statistically significant (Abraham, 1992; Berghorn and Schafer, 1986; Blankenship et al, 1996; Brand and Clingempeel, 1992; Gatz et al, 1998; Goldwasser et al, 1987; Harp Scates et al, 1985; Hseih and Wang, 2003; Miller et al, 2003; Morton, 1991; Neal and Briggs, 2003; O'Leary, 2001; Orten et al, 1989; Spector et al,2000; Toseland et al, 1997).

Appropriateness

A small number of studies (Arean et al, 2002; Mosher Ashley, 1994; Young, 1995*)* have appropriateness as a single concern and another four (Baines, 1987; Barrowclough et al, 2001; Cuijpers, 1998; Zerhusen, 1991*)* address a combination of effectiveness, appropriateness and feasibility. The former investigate how far such treatments are acceptable to older people and what would be their preferences given a choice of interventions. Arean et al (2002) in examining older people's preferences for psychological services in primary care found that a large majority (79 per cent) of older people would use psychological services. While 34 per cent said they would attend group psychotherapy, 71 per cent indicated they would use individual counselling, this being the most popular form of psychological service. Preferences were not affected by the degree of psychological distress, indicating that these would be the services of choice for those with either mild or severe psychological problems. The authors conclude that psychological services, particularly individual counselling is acceptable to older primary care patients.

The apparent lack of popularity of group psychotherapy among older people is supported by other studies. Barrowclough et al (2001), having evaluated the effectiveness of CBT and supportive counselling with older people residing in the community, suggested that it is more appropriate to deliver therapeutic interventions on an individual rather than a group basis with this population. Cuijpers (1998), also investigating the treatment of community-dwelling older people, found that dropout rates were high in group treatments, and that other significant predictors of dropout appeared to be cognitive behavioural interventions, the higher the percentage of female participants and the greater the number of sessions. It may be that group interventions are more popular in residential settings such as hospitals and nursing homes. This position is supported by Baines et al (1987) who observed that therapy groups were liked by residents and staff alike. Zerhusen et al (1991) also found that group treatments were acceptable to older nursing home residents. Mosher-Ashley (1994) found dropout rates from individual counselling to be high. Only 59 per cent completed at least 16 sessions. However, the percentage of subjects who dropped out of therapy by the fourth session was substantially lower than the dropout rate found for the general adult population. Persistence in treatment was associated with nursing home residence, having religious beliefs and receiving counselling at home.

Feasibility

Two studies conclude that it is relatively easy to train nursing and associated staff to deliver counselling interventions. Mossey et al (1996) noted how interpersonal counselling can be provided by psychiatric nurse specialists and Zerhusen et al (1991) concluded that group cognitive therapy can be effectively provided by two nurses and a social worker after 300 hours of training. In contrast Pinquart and Sorensen (2001) found that high qualification and specialised training in working with older people are associated with above average effects. The ability of older people to benefit from counselling is addressed by Doubleday et al (2002) with particular reference to fluid intelligence. This term is defined as the ability to problem-solve and has been found to decline with age (*Hayslip and Sterns, 1979)*. The study concludes that older adults with higher fluid intelligence scores derived most benefit from supportive counselling, there being no association between fluid intelligence and the ability to benefit from CBT. Hence CBT may be more effective for those older adults with declining fluid intelligence.

All the studies conducted in nursing homes are of group counselling, indicating a preference among researchers and clinicians for this modality in this setting and suggesting that group treatments are both an effective use of resources and facilitative of greater levels of social interaction in these residential settings. Conversely, when providing counselling to those in the community there is a trend towards individual rather than group counselling and in some cases home-delivered services (Haight, 1988; Kaufman, 2000; McDougall, 1997). There is evidence to conclude that where older people are disabled and housebound to offer treatment in their own homes is the most feasible mode of service delivery.

Conclusions and implications for research and practice

The efficacy of counselling with older people

The number of systematic reviews and good-quality RCTs included in this review provide strong evidence that counselling is efficacious with older people, particularly in the treatment of anxiety, depression and in improving subjective wellbeing. The fact that outcomes are consistent with those found in younger populations indicates that age is not a factor in being able to benefit from counselling. Of the various counselling approaches CBT is most researched and thus has the strongest evidence base, being efficacious with older people in the treatment of anxiety and depression. Evidence as to the efficacy of reminiscence therapy and life review in the treatment of dementia and cognitive decline is weak, but consideration should be given to the chronic and debilitating nature of these conditions as compared with more treatable disorders such as anxiety and depression. Inevitably, the growth in numbers of older people in the UK population will lead to an increase in cases of dementia and cognitive decline, which in turn drives the need for early intervention and effective treatments. Future research in this area should attempt to address the ethical issues relating to informed consent and the empirical problems surrounding the measurement of outcomes. Additionally, rather than exclusively targeting the symptoms of dementia, researchers should investigate to what extent counselling can improve the quality of life for this group of older people. More generally, future research should focus on those counselling approaches which, although commonly-used in practice, are almost absent in the research literature, for example IPT, psychodynamic, client-centred, validation, goal-focused and gestalt therapies. The potential value of all of these approaches is underlined by the fact that when different therapeutic approaches are tested against each other with this population, outcomes are equivalent, indicating an absence of superiority of any one particular type of counselling.

Older people's preferences with regard to therapeutic modality

The evidence available indicates that individual counselling, as opposed to group therapy, is the psychological treatment of choice among the community-dwelling elderly and that this may be the more effective modality with this population. As these findings are based on a small number of studies further investigation of these trends is required. The fact that the majority of studies were of group, rather than individual, interventions may indicate that researchers find it more convenient to treat participants in groups, rather than this being a reflection of older people's preferences. It will be valuable for future research to give more attention to individual interventions with this population. There is some evidence that group therapy may be popular with older people in residential settings but again, this needs to be confirmed by further research. To date, investigations of group therapy have tended to see therapeutic elements in group interaction which are extraneous to therapeutic technique as potential confounding variables. A change in perspective allowing these variables to become the focus of research studies would greatly enhance our understanding of this therapeutic modality.

The delivery of counselling services for older people

Available evidence indicates that offering group counselling to nursing home residents and counselling community-dwelling older people individually in their homes are both feasible modes of service delivery. There was lack of studies regarding individual counselling for older people in residential settings; this would be a valuable area for further research. A proactive approach to the identification of psychological problems among older people in all settings is necessary to ensure problems are not left untreated. The training of counsellors to treat this population is also feasible, good outcomes being associated with therapists who have high qualifications and have undergone specialised training in therapeutic work with older people. Further research into these trends would be valuable.

The need for UK research

The majority of studies included in this review have been conducted in North America. Of the

47 included papers only seven (Baines et al, 1987; Barrowclough et al, 2001; Doubleday et al, 2002; Morton et al, 1991; Neal and Briggs, 2003; Spector et al, 2000; Thompson SBN, 2001) were studies carried out in the UK. Although social and cultural similarities between the two countries may justify the relevance of these research findings to UK populations, demographic and economic differences, along with a radically different structure of health care delivery could suggest otherwise. Even though the findings presented here represent the best evidence currently available, there is an urgent need for future research to focus on UK populations, UK health and social care settings and the counselling approaches used by UK counsellors.

The need for 'counselling' research

Of the research reviewed, few studies use the term 'counselling' and few interventions are carried out by professionals who call themselves counsellors. Instead the majority of the research investigates counselling interventions delivered by psychiatrists, psychologists, social workers and mental health nurses. For the future, research into the effects of counselling provided by counsellors is a priority.

Practice-based evidence

Having established a level of efficacy, it is important for future research to assess the effectiveness of counselling with older people in routine practice and in naturalistic settings. This will necessitate the use of pragmatic RCTs along with additional designs which meet the demands of counselling in naturalistic settings. As a consequence, systematic reviews which have to date used the RCT as a gold standard for good evidence will need to take a more pluralistic and inclusive approach to evidence in order to locate and appraise evidence of effectiveness. The paucity of well-conducted qualitative research located in this review suggests that such methods are under-recognised and require more attention from researchers, particularly when therapeutic processes and the experiences of older people in therapy are the focus of investigation.

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A list of excluded studies has been compiled. This is available from the authors on request.

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Appendix A

Search strategies for electronic databases

CAREDATA

1. counsel*
2. psychotherapy
3. 1 or 2
4. older people
5. dementia
6. alzheimers disease
7. ageing
8. 4 or 5 or 6 or 7
9. 3 and 8

NB: Searched via the electronic Library for Social Care (eLSC)
* = truncation symbol
Used Caredata keywords

Cinahl

1. exp Counseling/
2. exp Psychotherapy/
3. 1 or 2
4. Aged/
5. Aging/
6. Gerontologic Care/ or Gerontologic Nursing/ or GERIATRICS/
7. exp Dementia
8. 4 or 5 or 6 or 7
9. 3 and 8
10. limit 9 to (research and yr=1985-2003 and clinical trial or 'questionnaires/scales' or research or research instrument or review or systematic review) and English)
11. psychotherapy/
12. behaviour therapy/
13. cognitive therapy/
14. psychotherapy, group/
15. family therapy/
16. Transactional Analysis/
17. Validation Therapy/
18. Psychotherapeutic Processes/
19. 'transference (psychology)'/ or 'countertransference (psychology)'/
20. 1 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19
21. 8 and 20
22. limit 21 to (research and yr=1985-2003 and clinical trial or 'questionnaires/scales' or research or research instrument or review or systematic review) and English)
23. health behaviour/
24. nutrition education/
25. health education/
26. nicotine replacement therapy/
27. smoking cessation$.sh.
28. diet records/
29. blood glucose$.sh.
30. glycemic control$.sh.
31. mammography/
32. health promotion/
33. alcohol abuse/
34. incontinence$.sh.
35. 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34

36. counsel$.mp.
37. 35 and 36
38. 22 not 37
39. limit 38 to yr=1985-2003

NB: performed on OVID software
$ = truncation symbol
/= subject heading search
.mp. = title, abstract and subject heading field search
exp = explode function

Cochrane Library (Cochrane Database of Systematic Reviews and DARE)
1. counselling
2. counseling
3. psychotherap*
4. (group next counsel*)
5. group-counsel*
6. (group next psychotherapy*)
7. group-psychotherap*
8. (psychological next therapy)
9. (psychological next intervention*)
10. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9
11. aging
12. ageing
13. (older next people)
14. (old next age)
15. elderly
16. geriatric*
17. gerontol*
18. aged
19. (late next life)
20. senile
21. (older next adult)
22. #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21
23. #10 and #22

Counsel Lit
1. elderly people
2. geriatrics
3. old age
4. 1 or 2 or 3

NB: All counsel Lit key words

Medline
1. Counseling/
2. psychotherapy/ or art therapy/ or behaviour therapy/ or 'biofeedback(psychology)'/ or crisis intervention/ or gestalt therapy/ or 'imagery(psychotherapy)'/ or nondirective therapy/ or exp psychoanalytic therapy/ or exp psychotherapeutic processes/ or psychotherapy, brief/ or psychotherapy, multiple/ or psychotherapy, rational-emotive/ or reality therapy/ or socioenvironmental therapy/
3. counsel$.mp.
4. psychotherapy$.mp.
5. socioenvironmental therapy/ or therapeutic community/ or exp psychotherapy, group/
6. 1 or 2 or 3 or 4 or 5
7. GERIATRICS/
8. exp Aged/

9. exp Dementia
10. ageing.mp.
11. aging.mp.
12. elderly
13. late life.mp.
14. geriatric$.mp.
15. gerontology$.mp.
16. 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15
17. 6 and 16
18. limit 17 to (English language and yr=1985-2003)
19. research/or exp empirical research/or feasibility studies/or peer review, research/or pilot projects/ or reproducibility of result/ or exp research design/
20. 18 and 19
21. limit 18 to (clinical trial or clinical trial, phase I or clinical trial, phase II or clinical trial, phaseIII, or clinical trial, phase IV or controlled clinical trial or evaluation studies or meta analysis or multicenter study or randomized controlled trial or review, academic or review, multicase or review, tutorial or review literature)
22. 20 or 21
23. smoking$.mp.
24. tocacco$.mp.
25. obes$.mp.
26. nutrition$.mp.
27. health promotion/
28. health behaviour/
29. attitude to health/
30. health behaviour$.mp.
31. cardiovas$.mp.
32. exercise$.mp.
33. diet$.mp.
34. diabet$.mp.
35. urinary$.mp.
36. pelvic$.mp.
37. incontin$.mp.
38. prostate$.mp.
39. patient compliance/
40. or 23-29
41. counsel$.mp.
42. behaviour therapy.mp.
43. behavior therapy.mp.
44. biofeedback.mp.
45. or/ 41-44
46. 40 and 45
47. 22 not 46

NB: performed on OVID software
$ = truncation symbol
/= subject heading search
.mp. = title, abstract and subject heading field search
exp = explode function

PsycINFO
1. Gerontology in DE
2. Geriatric-Patients in DE
3. Geriatric-Psychotherapy in DE
4. Geriatrics in DE
5. Aging in DE
6. explode Dementia in DE

7. 1 or 2 or 3 or 4 or 5 or i6
8. Brief-Psychotherapy in DE
9. Geriatric-Psychotherapy in DE
10. Group-Psychotherapy in DE
11. Individual-Psychotherapy in DE
12. Psychotherapy in DE
13. Counseling in DE
14. Counseling-Psychologists in DE
15. Counseling Psychology in DE
16. Family-Therapy in DE
17. Group-Counseling in DE
18. Psychotherapeutic Counseling in DE
19. Rehabilitation Counseling in DE
20. 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19
21. 7 and 20
22. Limit 21 to PY=1985-2003, LA: English

NB: Searched using Silverplatter Webspirs software via BIDS
DE = Descriptor field

Note
The AgeInfo Database is a relevant source for this subject area. At the time of the study, the authors did not have access to this database. Test searches were undertaken and the volume of citations relating to counselling and psychotherapy appeared to be low and therefore not warrant taking out a subscription within the resources allocated to the project. During 2004 AgeInfo was made available free of charge via the Electronic Library for Social Care, and would be a relevant and accessible source in any subsequent studies relating to older people.

Appendix B

List of resources searched in compiling the review

Electronic Databases
CAREDATA
CINAHL
Cochrane Library (Cochrane Database of Systematic Reviews and Database of Abstracts of Reviews of Effects)
Counsel Lit
MEDLINE
PsychINFO

Note: AgeInfo is a potentially relevant resource in this topic area, however the University of Salford does not have access to this and the project budget was insufficient to take out a subscription. A check of the limited freely available version on the Internet suggested that the number of articles on this topic area was not worthwhile investing in a subscription for the purposes of this project.

Hand searches
American Journal of Psychiatry
International Journal of Geriatric Psychiatry
Aging and Mental Health
Counselling and Psychotherapy Research
Counselling Psychology Quarterly
Journal of Counselling Psychology
British Journal of Guidance and Counselling
Psychotherapy Research
Counseling Psychologist
The Gerontologist

Websites
Centre for Policy on Aging
Research into Ageing
Sheffield Institute for Studies on Ageing
OMNI (gateway to quality assured medical/health resources on the Internet)
British Association of Counselling and Psychotherapy

Call for grey literature

Letters/emails to directors of relevant MSc and doctorate programmes
University of Abertay Dundee
University of Birmingham
University of Bristol
University of Edinburgh
Keele University
Leeds University
University of Leicester
University of Manchester
University College of Ripon and York St John
University of Strathclyde
University of East Anglia
University of York

Email discussion lists
Narra-uk (jiscmail)
Psych-couns (jiscmail)

Professional networks
Allied Health Professions Conference, University of Liverpool
BACP research network
BPS Counselling-Psychology Group
BPS group PSIGE: special interest group for the elderly
Cochrane Dementia and Cognitive Improvement Group
Elderly Care 2003 Conference

Subject experts
Jane Hazell: consultant clinical psychologist, clinical and counselling service, Wolverhampton
John McLeod: professor of counselling, Tayside Institute of Health Studies
Chris Phillipson: president British Society of Gerontology, University of Keele
Professor Ken Wilson: professor of old age psychiatry, University of Liverpool

Journals
Counselling and Psychotherapy Journal (Noticeboard pages)
Counselling Review (flyer inserted)

Appendix C

Quality checklists used for critical appraisal

Quantitative study

Review area	Key questions
1. Study evaluative overview	
Bibliographic details	■ Author, title, source (publisher and place of publication), year
Purpose	■ What are the aims of this paper? ■ If the paper is part of a wider study, what are its aims?
Key findings	■ What are the key findings?
Evaluative summary	■ What are the strengths and weaknesses of the study and theory, policy and practice implications?

Review area	Key questions
2. Study, setting and sample	
The study	■ What type of study is this? ■ What was the intervention? ■ What was the comparison intervention? ■ Is there sufficient detail given of the nature of the intervention and the comparison intervention? ■ What is the relationship of the study to the area of the topic review?
Setting	■ Within what geographical and care setting was the study carried out?
Sample	■ What was the source population? ■ What were the inclusion criteria? ■ What were the exclusion criteria? ■ How was the sample selected? ■ If more than one group of subjects, how many groups were there, and how many people were in each group? ■ How were subjects allocated to the groups? ■ What was the size of the study sample, and of any separate groups? ■ Is the achieved sample size sufficient for the study aims and to warrant the conclusions drawn? ■ Is information provided on loss to follow up? ■ Is the sample appropriate to the aims of the study? ■ What are the key sample characteristics, in relation to the topic area being reviewed?

Review area	Key questions
3. Ethics	
Ethics	■ Was ethical committee approval obtained? ■ Was informed consent obtained from participants of the study? ■ How have ethical issues been adequately addressed?

Review area	Key questions
4. Group comparability and outcome measurement	
Comparable groups	■ If more than one group was analysed, were the groups comparable before the intervention? In what respects were they comparable and in what were they not? ■ How were important confounding variables controlled (eg matching, randomisation, in the analysis stage)? ■ Was this control adequate to justify the author's conclusions? ■ Were there other important confounding variables controlled for in the study design or analyses and what were they? ■ Did the authors take these into account in their interpretation of the findings?
Outcome measurement	■ What were the outcome criteria? ■ What outcome measures were used? ■ Are the measures appropriate, given the outcome criteria? ■ What other (eg process, cost) measures are used? ■ Are the measures well validated? ■ Are the measures known to be responsive to change? ■ Whose perspective do the outcome measures address (professional, service, user, carer)? ■ Is there a sufficient breadth of perspective? ■ Are the outcome criteria useful/appropriate within routine practice? ■ Are the outcome measures useful/appropriate within routine practice?
Timescale of measurement	■ What was the length of follow-up, and at what time points was outcome measurement made? ■ Is this period of follow-up sufficient to see the desired effects?

Review area	Key questions
5. Policy and practice implications	
Implications	■ To what setting are the study findings generalisable? (For example, is the setting typical or representative of care settings and in what respects?) ■ To what population are the study's findings generalisable? ■ Is the conclusion justified given the conduct of the study? (For example, sampling procedure; measures of outcome used and results achieved) ■ What are the implications for policy? ■ What are the implications for service practice?

Review area	Key questions
6. Other comments	
Other comments	■ What was the total number of references used in the study? ■ Are there any other noteworthy features of the study? ■ List other study references
Reviewer	■ Name of reviewer ■ Review date

Qualitative study

Review area	Key questions
1. Phenomenon studied and context	
Phenomena under study	■ What is being studied? ■ Is sufficient detail given of the nature of the phenomena under study?
Context I: Theoretical framework	■ What theoretical framework guides or informs the study? ■ In what ways is the framework reflected in the way the study was done? ■ How do the authors locate the study within the existing knowledge base?
Context II: Setting	■ Within what geographical and care setting is the study carried out? ■ What is the rationale for choosing this setting? ■ Is the setting appropriate and/or sufficiently specific for examination of the research question? ■ Is sufficient detail given about the setting? ■ Over what time period is the study conducted?
Context III: Sample (events, persons, times and settings)	■ How is the sample (events, persons, times and settings) selected? (For example, theoretically informed, purposive, convenience, chosen to explore contrasts) ■ Is the sample (informants, settings and events) appropriate to the aims of the study? ■ Is the sample appropriate in terms of depth (intensity of data collection – individuals, settings and events) and width across time, settings and events (For example, to capture key persons and events, and to explore the detail of inter-relationships)? ■ What are the key characteristics of the sample (events, persons, times and settings)?
Context IV: Outcomes	■ What outcome criteria are used in the study? ■ Whose perspectives are addressed (professional, service, user, carer)? ■ Is there sufficient breadth (eg contrast of two or more perspectives) and depth (eg insight into a single perspective)?

Review area	Key questions
2. Ethics	
Ethics	■ Was ethical committee approval obtained? ■ Was informed consent obtained from participants of the study? ■ How have ethical issues been adequately addressed?

Review area	Key questions
3. Data collection, analysis and potential researcher bias	
Data collection	■ What data collection methods are used to obtain and record the data? (For example, provide insight into data collected, appropriateness and availability for independent analysis) ■ Is the information collected with sufficient detail and depth to provide insight into the meaning and perceptions of informants? ■ Is the process of fieldwork adequately described? (For example, account of how data was elicited; type and range of questions; interview guide; length and timing of observation work; note taking) ■ What role does the researcher adopt within the setting? ■ Is there evidence of reflexivity, that is, providing insight into the relationship between the researcher, setting, data production and analysis?
Data analysis	■ How is the data analysed? ■ How adequate is the description of the data analysis? (For example, to allow reproduction; steps taken to guard against selectivity) ■ Is adequate evidence provided to support the analysis? (For example: includes original/raw data extracts; evidence of iterative analysis; representative evidence presented; efforts to establish validity such as searching for negative evidence, use of multiple sources, data triangulation; reliability/consistency over researchers, time and settings; checking back with informants over interpretation) ■ Are the findings interpreted within the context of other studies and theory?
Researcher's potential bias	■ Are the researcher's own position, assumptions and possible biases outlined? (Indicate how these could affect the study, in particular the analysis and interpretation of the data)

Review area	Key questions
4. Policy and practice implications	
Implications	■ To what setting are the study findings generalisable? (For example, is the setting typical or representative of care settings and in what respects? If the setting is atypical, will this present a stronger or weaker test of the hypothesis?) ■ To what population are the study's findings generalisable? ■ Is the conclusion justified given the conduct of the study (For example, sampling procedure; measures of outcome used and results achieved?) ■ What are the implications for policy? And for service practice?

Review area	Key questions
Study overview	
Bibliographic details	■ Author, title, source (publisher and place of publication), year
Purpose	■ What are the aims of this paper? ■ If the paper is part of a wider study, what are its aims?
Key findings	■ What are the key findings?
Evaluative summary	■ What are the strengths and weaknesses of the study and theory, policy and practice implications?

Mixed method study

Review area	Key questions
1. Study evaluative overview	
Bibliographic details	■ Author, title, source (publisher and place of publication), year
Purpose	■ What are the aims of this paper? ■ If the paper is part of a wider study, what are its aims?
Key findings	■ What are the key findings?
Evaluative summary	■ What are the strengths and weaknesses of the study and theory, policy and practice implications?

Review area	Key questions
2. Study and context (setting, sample and outcome measurement)	
The study	■ What type of study is this? ■ What was the intervention? ■ What was the comparison intervention? ■ Is there sufficient detail given of the nature of the intervention and the comparison intervention? ■ What is the relationship of the study to the area of the topic review?
Context I: Setting	■ Within what geographical and care setting was the study carried out? What is the rationale for choosing this setting? ■ Is the setting appropriate and/or sufficiently specific for examination of the research question? ■ Is sufficient detail given about the setting? ■ Over what time period is the study conducted?
Context II: Sample	■ What was the source population? ■ What were the inclusion criteria? ■ What were the exclusion criteria? ■ How was the sample (events, persons, times and settings) selected? (For example, theoretically informed, purposive, convenience, chosen to explore contrasts) ■ Is the sample (informants, settings and events) appropriate to the aims of the study? ■ If more than one group of subjects, how many groups were there, and how many people were in each group? ■ Is the achieved sample size sufficient for the study aims and to warrant the conclusions drawn? ■ What are the key characteristics of the sample? (events, persons, times and settings)
Context III: Outcome measurement	■ What outcome criteria were used in the study? ■ Whose perspectives are addressed? (professional, service, user, carer) ■ Is there sufficient breadth (eg contrast of two or more perspectives) and depth (eg insight into a single perspective)?

Review area	Key questions
3. Ethics	
Ethics	■ Was ethical committee approval obtained? ■ Was informed consent obtained from participants of the study? ■ How have ethical issues been adequately addressed?

Review area	Key questions
4. Group comparability	
Comparable groups	■ If more than one group was analysed, were the groups comparable before the intervention? In what respects were they comparable and in what were they not? ■ How were important confounding variables controlled (eg matching, randomisation, in the analysis stage)? ■ Was this control adequate to justify the author's conclusions? ■ Were there other important confounding variables controlled for in the study design or analyses and what were they? ■ Did the authors take these into account in their interpretation of the findings?

Review area	Key questions
5. Qualitative data collection and analysis	
Data collection methods	■ What data collection methods are used in the study? (Provide insight into data collected, appropriateness and availability for independent analysis) ■ Is the process of fieldwork adequately described? (For example, account of how data was elicited; type and range of questions; interview guide; length and timing of observation work; note taking)
Data analysis	■ How was the data analysed? ■ How adequate is the description of the data analysis? (For example, to allow reproduction; steps taken to guard against selectivity) ■ Is adequate evidence provided to support the analysis? (For example: includes original/raw data extracts; evidence of iterative analysis; representative evidence presented; efforts to establish validity such as searching for negative evidence, use of multiple sources, data triangulation; reliability/consistency over researchers, time and settings; checking back with informants over interpretation) ■ Are the findings interpreted within the context of other studies and theory?
Researcher's potential bias	■ What was the researcher's role? (For example, interviewer, participant, observer) ■ Are the researcher's own position, assumptions and possible biases outlined? (Indicate how these could affect the study, in particular the analysis and interpretation of the data)

Review area	Key questions
6. Policy and practice implications	
Implications	■ To what setting are the study findings generalisable? (For example, is the setting typical or representative of care settings and in what respects? If the setting is atypical, will this present a stronger or weaker test of the hypothesis?) ■ To what population are the study's findings generalisable? ■ Is the conclusion justified given the conduct of the study (For example, sampling procedure; measures of outcome used and results achieved?) ■ What are the implications for policy? ■ What are the implications for service practice?

Review area	Key questions
7. Other comments	
Other comments	■ What was the total number of references used in the study? ■ Are there any other noteworthy features of the study? ■ List other study references
Reviewer	■ Name of reviewer ■ Review date

These checklists were developed as part of the following Department of Health funded study: Long AF, Godfrey M, Randall T, Brettle A and Grant M (2002) Developing evidence-based social care policy and practice: part three: Feasibility of undertaking systematic reviews in social care. Leeds: University of Leeds, Nuffield Institute for Health

They can be found at www.fhsc.salford.ac.uk/hcprdu/assessment

Appendix D

Summaries of included studies categorised by intervention

Various counselling approaches			
Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Arean PA, Alvidrez J, Barrera A, Robinson GS, Hicks S **Title:** Would older medical patients use psychological services? **Source:** The Gerontologist 42(3):392-8 **Year:** 2002 **Study type:** Survey by interview	To examine the preferences of older patients for psychological services, including the types of services they would be interested in and who should provide them	A majority of participants (79%) said they would use a psychological service (at least one of those specified in the survey). Most respondents (72%) preferred to talk to their primary care provider and 46% indicated that they would also speak with a mental health worker or nurse about their problems. Few older people (34%) said they would attend group psychotherapy, but 69% said they would attend psycho-educational classes. Individual therapy was the most popular form of psychological service with 71% indicating they would opt for this kind of treatment. The authors conclude that psychological services, particularly individual counselling would be acceptable to older primary care patients. The degree of psychological distress did not affect the preference for psychological treatment.	This is a good study, well conducted and clearly reported, with sufficient detail for the reader to draw firm conclusions. It uses data from a larger study on the prevalence of mental health problems in low-income older medical patients. Frequency calculations are used to identify the most preferred services. Within the sample (n=183) no significant differences were found between distressed and non-distressed sub-groups. The study concludes that, compared with earlier research the acceptability of psychological services among this cohort is increasing and that psychological services in primary care may have to grow to meet increasing demand. Some caution should be exercised in interpreting the findings because of the unrepresentative nature of the sample. Participants came from an urban setting in west coast North America, were mainly from ethnic minority groups, mostly male and of low socio-economic status. Also the authors acknowledge that the reporting of preferences as part of the survey may be different if participants were faced with real choices about accessing services. However the study provides good evidence as to the acceptability of psychological services, particularly of individual counselling, among older people with varying degrees of psychological distress.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Author: Cuijpers P **Title:** Psychological outreach programmes for the depressed elderly: a meta-analysis of effects and dropout **Source:** International Journal of Geriatric Psychiatry 13:41-8 **Year:** 1998 **Study type:** Systematic review with meta-analysis	To evaluate the effectiveness of psychological outreach treatment offered to depressed older people in the community	Fourteen studies were identified for inclusion in the review. A meta-analytic method was used to estimate the effects of the outreach programmes. The authors found a large mean effect size when comparing groups that participated in outreach programmes with those that didn't. For controlled studies there was a small non-significant difference between effect sizes. There was also a non-significant trend that cognitive behavioural therapy was more effective than other therapies. On the basis of a small number of studies, the author demonstrated that effects of treatment remain stable for one to six months. Multiple regression analysis demonstrated that the effects of cognitive behavioural interventions are larger than other therapies. Dropout rates were high, significant predictors of this being group treatments, cognitive behavioural interventions, the percentage of female participants and the number of sessions. The author notes that these results are comparable to meta-analyses in younger age groups.	This is a good study that identifies evidence that psychological therapies may be effective when offered on an outreach basis to depressed older people. The literature search to identify studies for inclusion appears to be systematic and fairly comprehensive but is described only briefly. Selective characteristics of each study are presented in a tabular format. The quality of the studies is briefly discussed and all were judged to be of adequate quality and their limitations described. The author provides a sound explanation of the meta-analytic methods used and the significance of the resulting effect sizes. The limitations of the meta-analysis are described including the methods of selection of the studies for inclusion and the small sample sizes of most of the included studies. The study acknowledges that volunteers for research projects differ from normal users of community mental health services. To control for this only studies that use active recruitment to enlist more typical and representative participants have been included in the review. The mean effect size for all studies was calculated as 0.77, which is large. Test for homogeneity among studies was carried out and indicated a high level of convergence. A number of areas for further research are suggested, namely whether outreach programmes are effective in helping people who wouldn't otherwise have sought treatment and the effect such programmes may have on dropout rates.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Engels GI, Vermey M **Title:** Efficacy of non-medical treatments of depression in elders: a quantitative analysis **Source:** Journal of Clinical Geropsych-ology 3(1): 17-35 **Year:** 1997 **Study type:** Systematic review with statistical meta-analysis	To assess the efficacy of psychological treatments for depression in the elderly	Psychological treatments were more effective than placebo or no treatment control conditions in the treatment of elderly depression. The mean treated client was better off than 74% of the clients in the control conditions. Effects were equal for mild and severe depression and proved to be maintained over time. Behaviour therapy and cognitive therapy separately produced larger effect sizes than the two in combination (ie cognitive-behaviour therapy), reminiscing therapy and anger expression. Individual therapy produced better results than group therapy.	This good-quality systematic review includes 17 studies and uses a calculation of effect size to produce a statistical meta-analysis. The review limits itself to the searching of one database (Psychlit) over the period 1974-1992, supplemented by hand searching the bibliographies of relevant reviews. Hence the search methods are far from comprehensive. Only studies that provide the statistics necessary for the calculation of effect sizes were included in the review. The 17 studies included 28 different psychological treatments and an aggregated sample of 732 participants. Results indicate the superiority of cognitive therapy and behaviour therapy as separate interventions and the minimal efficacy of reminiscence therapy. The review is well conducted and provides good evidence for the efficacy of counselling interventions. The quality of the included studies is analysed in some detail and the relationship between a number of variables (eg outcome measures, control conditions, age and sex of participants, diagnosis of target problem) and associated effect sizes is thoughtfully assessed.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Gorey KM, Cryns AG **Title:** Group work as interventive modality with the older depressed client: a meta-analytic review **Source:** Journal of Gerontological Social Work 16(1/2): 137-57 **Year:** 1991 **Study type:** Systematic review with statistical meta-analysis	To evaluate the effectiveness of group work with depressed older clients (65 years and older)	Group work with depressed older people was found to be clinically and statistically significant, accounting for 42% positive change in client affective states. However 87% of this improvement appears to be attributable to non-specific variables rather than the intended intervention. Group work is optimally effective for clients who live alone and are moderately to severely depressed. The age of clients had no impact on effectiveness and the most effective format consisted of small client groups and short interventions.	This good-quality systematic review includes 19 studies and uses a statistical meta-analysis on which to base its findings. Four databases were searched for the period 1967-1988, supplemented by hand searching. For inclusion studies had to have the necessary statistics for a calculation of effect size. The types of group interventions included in the review were cognitive-behavioural, psycho-dynamic, supportive, re-motivation and reminiscence therapy. Generalisability of the findings is limited by the over-representation in the sample of people with high educational attainment, those living alone and those living in institutional settings, as compared with the general population. Group size varied among the studies from four members to 14. Length of intervention varied between 10 and 160 hours. Client attrition rates were quite high at 23.1% and only four studies measured outcomes at follow-up. Convergence on the type of outcome measures used in the different studies was high. There was no significant difference in effect sizes across the different theoretical orientations. Neither was there a significant difference between brief and more extended interventions. Setting (ie whether community or institutional) and demographic factors were also non-significant variables. The need for further research to isolate the non-specific therapeutic factors in group work is highlighted.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Author: Mosher-Ashley PM **Title:** Therapy termination and persist-ence patterns of elderly clients in a community mental health center **Source:** The Gerontologist 34(2):180-9 **Year:** 1994 **Study type:** Statistical analysis of case notes	To identify factors associated with persistence in therapy and dropout patterns among elderly clients in a community mental health centre	Very few (less than 12%) terminated therapy appropriately (as judged by the therapist), about 59% completed at least 16 sessions and a majority of the community residents themselves initiated termination. Persistence in treatment was associated with nursing home residence, religious beliefs and receiving the therapy at home. Persistence was not associated with self-referral, type of diagnosis, age or gender. The percentage of subjects who drop out of therapy by the fourth session is substantially lower than the drop-out rate found for the general adult population.	This is a good study attempting to discover factors that may lead elderly patients to drop out of counselling/psychotherapy. The study explores how far counselling/psychotherapy is an appropriate and acceptable treatment for the elderly and how services should be organised to maximise usage. It is suggested that to offer counselling/psychotherapy either in older people's own homes or in nursing home settings would improve persistence (reduce early drop-out rates) and that those patients with religious beliefs persist longer in therapy. Interestingly, some of the factors associated with high dropout rates in younger adult populations (ie gender, type of referral, diagnosis, level of education) prove to be neutral in their effect with this sample of older people, suggesting that for the elderly there may be fewer barriers to persistence in therapy than with other adult populations. The limitations of the study are that generalisability beyond the locality where the study took place (Franklin County, Massachusetts) is questionable and that the subjectivity of the therapists who recorded the case notes that provide the raw data for the study will inevitably be a source of bias. Other weaknesses are a paucity of socio-demographic data relating to the sample and a lack of detail concerning the type of treatment offered, above and beyond the statement that 88.3% of the sample received individual counselling.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Pinquart M, Sorensen S **Title:** How effective are psycho-therapeutic interventions and other psychosocial interventions with older adults? A meta-analysis **Source:** Journal of Mental Health and Aging, 7(2):207-43 **Year:** 2001 **Study type:** Systematic review with meta-analysis	To present the results of a meta-analysis undertaken to determine whether the effects of psychosocial and psycho-therapeutic interventions with older adults are statistically significant. To determine whether the magnitude of the intervention effect is dependent on the age of the participants	Psychotherapy promotes improvements in depression and an increase in psychological wellbeing. Cognitive behavioural therapy is especially recommended to improve the subjective wellbeing of older adults. More research into family therapy and client-centred therapy is needed. Individual interventions were more effective than interventions in groups, as were interventions with depressed compared to non-depressed seniors. High qualification and specialised training in working with older people are associated with above-average effects. Effects on depression are weaker for older than younger individuals but still significant. The effect size of psychotherapeutic interventions is reported as moderate to large and no difference in outcomes is reported between community-dwelling and nursing home resident older people. Longer interventions promote above average change in depression. Hence interventions of less than 10 sessions may not be effective with older adults.	This is a good-quality study that uses a calculation of effect size for each study on which to base a meta-analysis. One hundred and twenty-two studies were included, some of which were excluded from this review as they do not fall within our definition of counselling. For some interventions (eg psychodynamic therapy) there were only a small number of studies and so further research is recommended. The meta-analysis may overestimate the effects of interventions as studies with non-significant results tend not be published. The literature review process is briefly described and although a large number of studies were located, the process may not necessarily have been comprehensive. Inclusion criteria are well described and the qualities of the included studies are discussed as a whole. The methods of performing the meta-analysis are also well described and limitations of previous meta-analyses in this area are highlighted. Details and descriptions of individual studies are lacking, even in tabular form. The disproportionate number of studies using CBT inevitably skews results. Useful conclusions about the use of outcome measures are drawn. Clinician-rated measures yielded greater effect sizes than self-report measures. On self-rated measures psychotherapeutic interventions were more likely to lead to change than psychosocial interventions. The results appear to support the conclusions drawn. This is a rigorous study supporting the effectiveness of psychotherapy with older people.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Scogin F, McElreath L **Title:** Efficacy of psychosocial treatments for geriatric depression: a quantitative review **Source:** Journal of Consulting and Clinical Psychology 62(1):69-74 **Year:** 1994 **Study type:** Systematic review	To undertake a meta-analysis to determine whether psychological treatments for geriatric depression are effective and to compare the effects of these treatments in older populations with those of other age groups	The authors suggest that psychosocial interventions for older adults experiencing depressive symptoms are quite effective for both severe and sub-clinical varieties of depression. Both cognitive and reminiscence therapy demonstrated impressive treatment effect sizes but no clear superiority for any one system of psychotherapy in the treatment of geriatric depression was discerned. The authors conclude that psychosocial interventions are effective for geriatric depression and that these findings are comparable with reviews of studies with other age groups. The authors indicate that more research is needed to isolate the therapeutic elements within the various treatments.	This good-quality meta-analysis incorporates 17 studies, involving approximately 765 participants. The interventions studied included behavioural, cognitive, psycho-dynamic, reminiscence and eclectic therapies. The search and reporting criteria are described but all sources are not listed. The period for the electronic searches was 1975-90 and in addition 10 journals were hand-searched for the period 1970-88. Individual studies were rated in terms of quality but this is not reported in the paper, nor is the general quality of the studies. The main features of the studies are summarised in a table and descriptive characteristics of all the studies are discussed. The effect sizes for two studies were estimated as the relevant statistics were not available. This may to a degree undermine the reliability of the overall findings. The conclusions are general rather than specific and slightly equivocal, claiming that psychosocial treatments for late-life depression are at least moderately and, more likely, highly effective.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Gatz M, Fiske A, Kaskie B, Kasl-Godley JE, McCallum TJ, Wetherell JL **Title:** Empirically validated psychological treatments for older adults **Source:** Journal of Mental Health and Aging 4(1):9-46 **Year:** 1998 **Study type:** Systematic review	To review the literature for outcomes of psychological treatments with older adults by applying criteria for empirically-validated treatments established by the American Psychological Association	Cognitive, behavioural and brief psychodynamic therapy are probably efficacious treatments for depressed community-residing older adults who are cognitively intact. Evidence in relation to interpersonal therapy is incomplete. There are insufficient evaluations of treatment to make recommendations for the treatment of geriatric anxiety. Reminiscence as a treatment for cognitive impairment is not supported by research evidence. Life review and reminiscence are probably efficacious with respect to ameliorating symptoms of depression or improving feelings of life satisfaction, for both cognitively intact older adults and populations suffering from dementia.	This is an inclusive but not exhaustive review encompassing treatments for depression and anxiety disorders with elderly people. Not all treatments covered in this systematic review fall within our definition of counselling and so some aspects of the study have been excluded. Therapies covered that are considered relevant include cognitive behavioural therapy, behavioural therapy, interpersonal therapy and brief dynamic therapy. This review is of fair quality and uses a narrative style, summarising key studies in a way that is useful to practitioners and policy-makers. The inclusion criteria are well-documented and the studies (but not their quality) are well described. The studies are assessed in terms of how well they meet criteria established by the American Psychological Association. These classify treatments into two categories: 'well established' and 'probably efficacious'. Findings should be treated with caution as key aspects of the review methodology are not reported, particularly search methods and review procedures. General empirical problems in this field of research are discussed.

Cognitive-behavioural and related therapies			
Quality rating: Excellent			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Stanley MA, Beck JG, Novy DM, Averill PM, Swann AC, Diefenbach GJ, Hopko DR **Title:** Cognitive-behavioural treatment of late-life generalized anxiety disorder **Source:** Journal of Consulting and Clinical Psychology 71(2):309-19 **Year:** 2003 **Study type:** RCT	To examine the efficacy of cognitive-behavioural therapy (CBT) compared to a minimal contact control condition (MCC) in relation to anxiety, depression and quality of life. Also to examine the durability of treatment over a one-year follow-up interval	CBT produced beneficial effects on moderately-severe generalised anxiety disorder compared with MCC. As regards worry, anxiety, depressive symptoms and quality of life, CBT also produced improvements at post-treatment assessment. At one-year follow-up, health gains according to most measures were maintained or enhanced.	This fulsome article reports on an excellent-quality randomised controlled trial. The authors show how the project is informed by previous research. The overall original sample size is 80 with 39 and 41 respondents allocated to the CBT and MCC groups respectively. Hence the size of the sub-groups is satisfactory. Although a small number of respondents drop out of the project the reasons are accounted for and inform the authors' discussion. Appropriate screening of respondents takes place and the social and demographic characteristics (including ethnicity) are taken into account. Tests used to measure worry, anxiety, depressive symptoms and quality of life are well validated and use both self-report and independent clinician ratings of symptom severity. Confounders are addressed. There is a good discussion of the findings and recommendations are made for future policy and practice. The authors note limits to the generalisability of the research. In particular, attention is drawn to the fact that the research took place in an academic clinical setting, which is very different to 'real-world' settings where older adults might seek help. Furthermore, given the sample characteristics, findings are most relevant to older adults who are relatively young, white, well educated and physically healthy.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Barrowclough C, King P, Colville J, Russell E, Burns A, Tarrier N **Title:** A randomized trial of the effectiveness of cognitive-behavioural therapy and supportive counseling for anxiety symptoms in older adults **Source:** Journal of Consulting and Clinical Psychology 65(5):756-62 **Year:** 2001 **Study type:** Randomised trial	To compare the effectiveness of cognitive-behavioural therapy (CBT) and supportive counselling (SC) in treating older adults with anxiety symptoms	After 12 months follow-up 71% of CBT patients showed a good treatment response in relation to anxiety symptoms. After 12 months follow-up 39% of the SC patients showed a good treatment response in relation to anxiety symptoms. In conclusion, both CBT and SC provided effective treatment for anxiety disorders in older adults, however CBT was significantly more effective than SC. Both CBT and SC showed a good treatment response for depression with no significant difference in the results. End-state functioning from CBT was also reasonably good for both anxiety (41%) and depression (59%) although not significantly better than the SC group. The results suggest that CBT in particular may be an effective treatment for anxiety in old age. The authors also suggest it is more appropriate to deliver therapeutic interventions on an individual rather than a group basis with this population.	This article reports on a good-quality randomised trial. Research participants over the age of 55 were recruited from primary care and community services as well as by newspaper advert. Respondents were allocated to either CBT or SC treatment schedules. Treatment took place on an individual basis in the respondent's own home or a clinic if preferred. In sampling or group allocation there is little mention of gender, ethnicity or other socio-demographic variables, although participants were carefully screened in terms of their clinical condition. The authors state that the study population was representative of community-dwelling, anxious older adults. The original sample size was relatively small and attrition rates quite high. Fifty-five participants commenced the study, hence each sub-group was relatively small. Furthermore, 12 patients dropped out before the project was complete leaving only 19 patients in the CBT group and 24 in the SC group. By the time of the last follow-up test only 40 respondents were available. Follow-up took place at three, six and 12 months. Researchers made good efforts to ensure treatment fidelity, although the CBT was delivered by two therapists and the SC only one. The authors acknowledge that the qualities of the individual therapists may be confounding factors. Treatment of participants in a naturalistic setting (in most cases their own homes) and the lack of a control group increases the possible influence of confounding variables. However, the study is generally well-conducted and the conclusions seem justified.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Kemp BJ, Corgiat M, Gill C **Title:** Effects of brief cognitive-behavioral group psycho-therapy on older persons with and without disabling illness **Source:** Behavior, Health and Aging 2(1):21-8 **Year:** 1992 **Study type:** Outcome study comparing two different populations	To test the effects of brief group psychotherapy on older persons with chronic disabling illness compared with older depressed persons without disabling conditions	Results indicated substantial and equivalent decreases in depression for both groups as well as increases in functional ability. Hence the presence of a disability did not make psychotherapy less effective.	This is a good-quality study of a brief, 12-week, cognitive-behavioural group intervention, tested on a sample of 51 participants all with a diagnosis of major depression. The attrition rate was high, 10 of the 51 not completing the study. The resulting sample is quite small making generalisability problematical. Both the intervention and the sample are described in sufficient detail and attempts made to match the groups in terms of levels of depression and social factors. A range of well-validated measures for both depression and activities of daily living were administered prior to treatment, at six and 12 weeks during treatment and at six and 12 months post-treatment. On average participants moved from a classification of 'severely' to 'mildly' depressed over the period of the study. On the Geriatric Depression Scale the non-disabled group continued to improve for up to six months following therapy, whereas the disabled group score levelled off. This leads authors to conclude that more continuous psychotherapy may be indicated for patients with disabilities. The increases in activities of daily living scores for both groups support the conclusion that depression in this age group may be associated with decrements in functional ability.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Kunik ME, Braun U, Stanley MA, Wristers K, Molinari V, Stoebner D, Orengo CA **Title:** One session cognitive-behavioural therapy for elderly patients with chronic obstructive pulmonary disease **Source:** Psychological Medicine 31:717-23 **Year:** 2001 **Study type:** Single-blind RCT	To compare the efficacy of a single two-hour session of group cognitive behavioural therapy (CBT) with an educational intervention in reducing anxiety and depression and improving physical and mental functioning, so leading to a better quality of life and greater satisfaction with treatment in older patients with chronic obstructive pulmonary disease (COPD)	When compared with a group that received an educational intervention about COPD, the two-hour CBT group showed decreased depression and anxiety. However there was no improvement in the physical functioning of patients. Both groups were similarly satisfied with their respective treatments.	This is a good-quality study and very relevant because (as stated by the authors) up to 40% of those with COPD suffer significant psychological symptoms. Results are based on a sample of 48 patients all with a diagnosis of COPD but not necessarily suffering from any depressive or anxious symptoms. Well-validated tools were used to measure outcomes across a range of functioning. Allocation of participants to groups was randomised and groups tested for heterogeneity. No significant differences were found. The authors' conclusions are justified by the study's findings and the failure of the intervention to have any effect on physical functioning is discussed and analysed. The authors acknowledge the weaknesses of the study with regard to generalisability and the fact that results may be quite different with participants who have a clinical diagnosis of depression or anxiety. The study provides some evidence that brief CBT is an acceptable form of treatment for such a population.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Lynch TR, Morse JQ, Mendelson T, Robins CJ **Title:** Dialectical behavior therapy for depressed older adults **Source:** American Journal of Geriatric Psychiatry 11(1):33-45 **Year:** 2003 **Study type:** RCT	To assess the efficacy of augmenting antidepressant medication (MED) with group dialectic behaviour therapy (DBT) in treatment of late-life depression	Participants treated with a combination of MED and DBT showed significant decreases on self-reported depression scores. The study suggests that DBT skills training and telephone coaching may effectively augment the effects of anti-depressant medication in depressed older adults.	This is a good-quality, well-conducted and comprehensively reported study. It addresses how psychological therapy can augment the effects of antidepressant medication. Good attention is paid to ensuring treatment fidelity and a range of well-validated outcome measures are utilised pre- and post-treatment and at six-month follow-up. As with CBT, the treatment (DBT) targets maladaptive thoughts and behaviours and teaches new coping skills. Thirty-four participants, all with a diagnosis of major depressive disorder were randomly allocated to 28 weeks of MED alone or MED with DBT. Limitations of the study, acknowledged by the authors, are its small sample and the preponderance of female participants. The paper's conclusion that DBT augments the effects of antidepressant medication with the elderly depressed is justified by the results although generalisability is questionable.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Stanley MA, Beck JG, Glassco JD **Title:** Treatment of generalized anxiety in older adults: a preliminary comparison of cognitive-behavioral and supportive approaches **Source:** Behavior Therapy 27:565-81 **Year:** 1996 **Study type:** Randomised trial	To compare the efficacy of cognitive-behaviour therapy and non-directive psychotherapy in older adults with a diagnosis of generalised anxiety disorder	Significant improvements were discerned in both treatment conditions. Effect sizes were large and treatment gains were maintained or improved over the six-month follow-up phase. There were no significant differences between the groups in terms of end-state functioning.	This is a good-quality study weakened by a high attrition rate and a lack of clarity surrounding the supportive counselling condition. The sample is described in detail and initially consists of 48 adults aged 55 years and above who met the DSM-III-R criteria for generalised anxiety disorder. Well-validated outcome measures were used in the domains of worry, anxiety, depression and associated fears. Both conditions were delivered by four therapists in small groups comprising four to six members, meeting for 14 weekly one and a half hour sessions. Adequate monitoring procedures were in place to ensure treatment fidelity. The CBT condition is described adequately but supportive counselling is not. Participants were randomly allocated to the two groups. Two participants dropped out prior to commencement of treatment and subsequently 33% of the remaining 46 participants dropped out of the study. However, drop-out rates for both groups were similar. There is some ambiguity in the reporting of the study relating to whether the supportive counselling group was intended as a comparison or a control condition. If the latter were the case then it could be concluded that CBT had no superiority over the control condition and hence there was no evidence of efficacy. The authors seem to emphasise the former definition which then justifies the conclusion that both treatments were equally effective.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Thompson LW, Coon DW, Gallagher-Thompson D, Sommer BR, Koin D **Title:** Comparison of desipramine and cognitive-behavioural therapy in the treatment of elderly outpatients with mild to moderate depression **Source:** American Journal of Geriatric Psychiatry 9(3):225-40 **Year:** 2001 **Study type:** Randomised trial	To evaluate the efficacy of desipramine alone, cognitive-behavioural therapy (CBT) alone and a combination of the two (desipramine and CBT) in the treatment of mild to moderate major depressive disorder (MDD) in older adult outpatients	All three treatments resulted in significant improvements. The combined treatment resulted in significantly greater improvements than the desipramine-alone condition. There was little difference between CBT-alone and the combined treatment. However, CBT-alone was less efficacious than the combined treatment with the most severely depressed patients who were receiving high levels of medication. Psychotherapy can be an effective treatment for older adult outpatients with moderate levels of depression and is effective when combined with desipramine. The efficacy of CBT is of particular importance where drug treatment is contra-indicated because of medical problems for older people or where there is non-compliance with drug treatment because of disturbing side effects.	This good-quality study was conducted at the Veterans Affairs Palo Alto Health Care System and Stanford University School of Medicine, USA, in a clinic specialising in the treatment of older adults with affective disorders. There is evidence of much rigour in the careful screening of participants, the use of well-validated outcome measures and the inclusion in the analysis of data available for those who dropped out of the study prior to post-testing. Quality control procedures are implemented to control for treatment fidelity. The study has certain limitations. The sample (n=102) recruited from the local community was at the low end of the geriatric age range (mid to late 60s) and consisted of relatively high-functioning, psychologically minded, older adults experiencing mild to moderate major depressive disorder. The sample was mostly female (2:1) and quite homogeneous with respect to socio-demographic characteristics. Hence it is difficult to generalise the study's findings to more diverse populations. The original sample size is reasonable but attrition rate is high: 69 completers and 33 dropouts. The therapy followed a CBT programme developed by Beck but with specific modifications to make it more suitable for older people. Dose levels of desipramine, for many individuals in the study, were below the recommended therapeutic level. Patients in the trial resisted increasing their medication due to side effects. Clinical judgment had to be made as to the regimen that would be of maximum benefit without raising side effects to the level such that patients would discontinue treatment.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Thompson LW, Gallagher D, Steinmetz-Breckenridge J **Title:** Comparative effectiveness of psycho-therapies for depressed elders **Source:** Journal of Consulting and Clinical Psychology 55(3):385-90 **Year:** 1987 **Study type:** RCT comparing three different therapies	To compare outcome measures for elderly subjects with major depressive disorder (MDD) following individual therapy using cognitive, behavioural or brief psycho-dynamic approaches	All three interventions were found to be equally effective when compared to the control group. The response of people of 60 years compared favourably to younger samples, indicating that psychotherapy is effective in the treatment of depression in this population. The findings suggest that psycho-therapy may be worth-while with older people who tend to be reluctant to seek psychotherapy. The lack of evidence of spontaneous remission in the control group lends further support to the effectiveness of the treatments.	This paper reports on a good-quality randomised controlled trial comparing three different therapeutic interventions. The study design makes use of a six week delayed treatment control condition. Appropriate quality control procedures are employed to ensure treatment fidelity and a good range of well-validated outcome measures were employed. Participants were tested prior to therapy, six weeks into therapy and at the end of the treatment. There was no longer-term follow-up and so conclusions about effects over time cannot be drawn. The sample was of a reasonable size (n=91 at post-test) and socio-demographic factors were taken into account. No significant differences between the groups were discerned prior to treatment. Eighteen participants dropped out of the study prior to completion of the treatment and data relating to these are analysed. Seventy per cent of participants responded well to psychotherapy and no statistically significant differences in outcomes could be discerned between the three types of therapy. These results compare favourably with psychotherapy outcomes measured in younger populations.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Zerhusen JD, Boyle K, Wilson W **Title:** Out of the darkness: group cognitive therapy for depressed elderly **Source:** Journal of Psychosocial Nursing 29(9):16-21 **Year:** 1991 **Study type:** RCT	To determine if nursing home personnel could become effective cognitive therapy group leaders and if nursing home residents would be receptive to such a programme	A 10-week group cognitive therapy intervention delivered by two registered nurses and one social worker, following 300 hours of training, resulted in a statistically significant improvement in ratings for depression for nursing home residents with moderate to severe depression. The average gain on the Beck Depression Inventory (BDI) in the experimental group was 12.37, compared to a music therapy group gain of 1.53 and a loss of 2.63 for a usual care control group. There was no significant difference in gains between experimental groups. Group cognitive therapy is feasible, appropriate and effective in this setting.	This paper provides a useful level of detail on a good-quality study that has certain limitations. The sample (n=60) is of reasonable size but was recruited from a particular private intermediate care nursing home in the USA, making general-isation difficult. Socio-demographic information is supplied. Participants were randomly allocated to one of three group conditions; cognitive therapy (sub-divided into three therapy groups), music therapy or usual care (control condition). The intervention is described with a good level of detail. Just one outcome measure is used (BDI) administered pre- and post-treatment without longer-term follow-up. Although a variety of other data are gathered to monitor treatment fidelity and acceptability of the treatment from the participants' perspective. The attrition rate is low as only one participant dropped out of the study. There is little discussion as to why music therapy was selected as a comparison condition, leaving it unclear as to the possible confounding variables controlled for by this condition. Anecdotal observations are provided to supplement the quantitative data and conclusions that cognitive group therapy can be effective in the short-term as a treatment for depression, can be feasibly-delivered in this setting and is acceptable to patients are supported by the findings.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Abraham IL, Neundorfer MM, Currie LJ **Title:** Effects of group interventions on cognition and depression in nursing home residents **Source:** Nursing Research 41(4):196-202 **Year:** 1992 **Study type:** Controlled trial	To compare the effects of cognitive behavioural group therapy (CBT), focused visual imagery group therapy (FVIT) and education-discussion groups on cognition, depression, hopelessness and dissatis-faction with life, among depressed nursing home residents	There were no significant changes in depression, hopelessness or life-satisfaction scores for any of the three conditions. Participants in the CBT and FVIT groups showed a significant improvement beginning eight weeks after treatment initiation on cognitive scores. These two group treatments may reduce cognitive impairment in depressed nursing home residents with mild to moderate cognitive decline. The hypothesis that improvements in cognitive functioning would occur primarily as a result of reducing depression was not supported, as there was no reduction in levels of depression in the CBT or the FVIT groups when compared to the education-discussion group.	This study is fair in quality comparing two forms of group therapy (CBT and FVIT) with an education-discussion group as a control. The sample size is moderate (n=76) but the attrition rate high (only 55 per cent of those entering completed the study). Participants received a 24-week intervention with testing at eight and 20 weeks and a post-test four weeks after treatment ended. Four well-validated outcome measures were used: geriatric depression scale; modified mini-mental status examination; hopelessness scale; life satisfaction scale. A total of eight groups were studied with participants recruited from seven nursing homes. There is no reporting of how or whether participants were allocated to groups randomly and a paucity of detail as to how treatment fidelity was assured across different groups. However researchers were blind to the treatment subjects had received. The fact that the study took place in a naturalistic setting where subjects live together and interact outside the treatment groups makes the control of possible confounders difficult. However despite such limitations the researchers' conclusions seem justified.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Brand E, Clingempeel WG **Title:** Group behavioural therapy with depressed geriatric inpatients: an assessment of incremental efficacy **Source:** Behavior Therapy 23:475-82 **Year:** 1992 **Study type:** Single-blind controlled trial (random-isation was not possible due to hospital policies in relation to group psy-chotherapy)	To compare outcomes of depressed elderly inpatients who participated in group behavioural therapy in addition to standard hospital care with elderly inpatients receiving standard hospital care only	Both groups improved on Beck Depression Inventory (BDI) scores and the Hamilton Rating Scale for Depression (HRSD) ratings but improvements were not statistically significant. However a greater percentage of ptients in the behavioural therapy group exhibited normal BDI scores and HRSD ratings at post-test. These patients also exhibited a higher rate of compliance with individualised homework assignments that involved the practice of social skills outside the group.	This is a fair-quality study conducted in a private hospital in the USA. Methodological weaknesses were acknowledged by the researchers with respect to the absence of a control group. This had an impact on the conclusions drawn as it was difficult to discern whether the success of the treatment was related to the specific character-istics of behaviour therapy or other therapeutic activities offered by the hospital. The groups could not start at the same time, so the experimental group and the comparison group were consecutive and not concurrent. The sample is of modest size (n=53) and drawn from a particular locality, making generalisation difficult and the lack of randomisation is also a weakness. Treatment compliance was associated with positive outcomes as patients who completed homework assignments involving the practice of social skills outside the group showed improvement to normative levels on BDI and HRSD. The lack of statistically significant differences between treatment and comparison groups renders the study inconclusive but in many ways the paper illustrates some of the methodological problems inherent in carrying out controlled trials in naturalistic settings.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Doubleday KE, King P, Papgeorgiou C **Title:** Relationship between fluid intelligence and ability to benefit from cognitive-behavioural therapy in older adults: a preliminary investigation **Source:** British Journal of Clinical Psychology 41:423-8 **Year:** 2002 **Study type:** Follow-up to previously reported RCT	To ascertain whether there is a correlation between older adults' fluid intelligence and their ability to benefit from either cognitive-behavioural therapy (CBT) or non-directive supportive counselling (SC)	Older adults with anxiety disorders who had higher fluid intelligence scores, derived most benefit from SC. However there was no association between fluid intelligence and the ability to derive benefit from CBT among such older adults.	This brief article reports on a preliminary investigation, fair in quality, into fluid intelligence and an anxious older individual's ability to benefit from CBT or SC. Older people who had taken part in Barraclough et al's (2001) research into the efficacy of SC and CBT were invited to participate in this smaller project. Thirty-two community-dwelling individuals were recruited, meaning that each sub-group of 16 participants was relatively small. These two groups were matched according to level of symptoms and disorder as well as a number of social and demographic criteria. Comparability of the groups was checked by t test. Applying a statistical analysis to pre-therapy data, post-therapy data and scores for fluid intelligence, the researchers reached the above conclusions. In the light of previous research, these conclusions were unexpected. The results of this study should be treated with caution because of the small sample size. However findings suggest that outcomes in therapy can be maximised by matching clients to therapies according to the client's characteristics/abilities.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Gallagher-Thompson D, Hanley-Peterson P, Thompson LW **Title:** Maintenance of gains versus relapse following brief psycho-therapy for depression **Source:** Journal of Counselling and Clinical Psychology 58(3):371-4 **Year:** 1990 **Study type:** Two-year follow-up to a previously reported RCT	To conduct a two-year follow-up of a randomised controlled trial comparing the effective-ness of brief cognitive, behavioural and psycho-dynamic psycho-therapies for depressed older people	There were no differences in patient outcomes for the three types of treat-ment. Improvements were maintained over the two years for a substantial proportion of the sample (52 per cent) who were depression-free at post-treatment testing. Despite the fact that older people are likely to experience a high frequency of physical and psychological stressors in their lives, findings are consistent with results reported for younger depressed patients treated with similar types of brief psychotherapy.	This study is fair in quality, building upon results provided by an earlier study (Thompson, Gallagher and Steinmetz Breckenridge, 1987). The authors' conclusions that all three treatments were equally effective and that therapeutic gains were largely maintained over a two-year follow-up period seem justified. However other conclusions relating to the therapeutic factors that produce positive outcomes are not justified as such factors have not been subjected to any form of analysis. Weaknesses in the study relate to the fact that even though authors report a plethora of statistics there is no analysis of the possible effects of the attrition rate on the results (at the two-year follow-up 17/91 participants refused to take part in testing). Also during the two-year follow-up period participants suffering a relapse of symptoms were offered further psychotherapeutic treatment. The introduction of such interventions during the follow-up period will inevitably skew the results and raise questions about the exact nature of the treatments being tested.

Quality rating: Poor			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Harp Scates SK, Randolph DL, Gutsch KU, Knight HV **Title:** Effects of cognitive-behavioural, reminiscence, and activity treatments on life satisfaction and anxiety in the elderly **Source:** International Journal of Aging and Human Development 22(2):142-6 **Year:** 1985-6 **Study type:** RCT	To find whether the participation of elderly people in either a cognitive-behavioural group, a reminiscence group or an activity group has an impact on their level of anxiety and life satisfaction. To compare the effects of these three group interventions	The life satisfaction of the elderly people concerned was not improved by participation in the cognitive-behavioural, the reminiscence or the activity group. However, at follow-up, the elderly people participating in the reminiscence group were significantly less anxious.	This article is a brief report of a poor-quality randomised controlled trial carried out in Mississippi, USA. Results are based on a sample of 50 participants who were divided equally into three groups (16, 17 and 17). Though the sample size for the project overall is reasonable for a small-scale study, the division into three groups makes each sub-group relatively small. Some screening of participants took place and note is made of gender and marital status. Life Satisfaction Index A and the State-Trait Anxiety Inventory were administered on initial contact, pre-test, post-test and at follow-up. There is no indication when the follow-up took place. No attention is given to possible confounders. A significant weakness is that pre-test scores were not used to match group membership so that, at the start of the experiment, there was already a trend for the reminiscence group members to be less anxious than members of the other groups. This undermines comparisons between the three groups. The researchers note this weakness in the study and also acknowledge that, as the respondents were not dissatisfied with their lives or particularly anxious at the start of the project, it might have been very difficult for the interventions to create change.

Quality rating: Poor			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Author: Thompson SBN **Title:** Cognitive therapy in cognitive rehabilitation: eight region study of older adults **Source:** The Journal of Cognitive Rehabilitation 19(4):4-7 **Year:** 2001 **Study type:** Clinical trial	To investigate the effective-ness of cognitive therapy (CT) in the treatment of depression in older adults	Symptoms of both anxiety and depression were reduced following cognitive therapy. No statistically significant correlation was discerned between the number of therapy sessions and the reduction of depressive symptoms.	This study is poor in quality and incompletely reported. The aims are not clearly stated and there is no control or comparison group. A small sample (n=16) was selected from a southern region of the UK. The participants (three male, 13 female) were treated with varying numbers of CT sessions (between two and 13). Only two outcome measures were used, Beck's Depression Inventory and the Hamilton Anxiety and Depression Scale, the latter measure only being used with nine of the 16 participants. Although the results indicated improvements in anxiety and depression scores, methodological weaknesses render the study's conclusions untrustworthy.

Reminiscence therapy and life review			
Quality rating: Excellent			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Spector A, Orrell M, Davies S, Woods RT **Title:** Reminiscence therapy for dementia **Source:** Cochrane Library, Issue 3, Oxford: Update Software **Year:** 2003 **Study type:** Systematic review (Cochrane)	To undertake a systematic review to assess the effectiveness of reminiscence therapy (RT) for dementia	Because of the limited data no firm conclusions could be reached about the effectiveness of RT. Other studies examined but not included in the review reported the positive benefits of RT. Therefore the authors suggest that it may be effective and could be incorporated into normal daily activities or treatment for those with dementia but more research is needed. They suggest that qualitative research might be useful in conjunction with RCTs to offer more insight into how RT can be most effective, perhaps focusing on therapist qualities, types of patient and how to deliver the intervention (how much and how frequently).	This paper reports on an excellent-quality, systematic review but with limited conclusions due to a small sample size, as just two trials were located for inclusion in the review. The search strategy is comprehensive and well described. The inclusion criteria are described and the quality of the studies discussed in some detail. Studies were assessed independently by two reviewers and data analysed for one study. The report concludes that results of these trials were statistically insignificant and so there is as yet insufficient evidence to support the effectiveness of RT. Useful areas for further research are suggested including the use of qualitative studies to clarify some of the questions raised but not answered by trials.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Baines S, Saxby P, Ehlert K **Title:** Reality orientation and reminiscence therapy, a controlled crossover study of elderly confused people **Source:** British Journal of Psychiatry 151:222-31 **Year:** 1987 **Study type:** Randomised controlled trial (RCT) with a crossover design for the two experimental groups.	To compare the effects on cognition, emotion and behaviour of two group therapies (Reality Orientation [RO] and Reminiscence Therapy [RT]) with confused, elderly, nursing home residents.	At follow-up the experimental group that received reality orientation followed by reminiscence therapy showed improvement on measures of cognition, communication and behaviour. These improvements were not found in the control or the other experimental group. This was interpreted as showing that it may be important to use reality orientation techniques with confused residents before involving them in reminiscence groups. Both types of therapy group led to staff members getting to know the residents in the therapy groups. Both types of therapy group were liked by residents and staff alike.	This is a good-quality study which uses a no-treatment control group and two treatment groups. Group A receives four weeks of RO and at the same time group B receives four weeks of RT. The groups then cross over, group A receiving four weeks of RT and group B four weeks of RO. The sample-size is small (n=15) and all participants are from the same nursing home making generalisation difficult. Good attention is paid to randomisation and ensuring the groups are matched. A good range of well-validated outcome measures were used, including one that measured participants enjoyment of the sessions. The lack of blinding of participants and researchers is likely to be a source of bias, but is perhaps inevitable in a naturalistic setting where participants are living together. However this is a useful study that points out not only the possible effectiveness of RO and RT but also the appropriateness and feasibility of these treatments in a nursing home setting.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Watt LM, Cappeliez P **Title:** Integrative and instrumental reminiscence therapies for depression in older adults: intervention strategies and treatment effectiveness **Source:** Ageing and Mental Health 4(2):166-77 **Year:** 2000 **Study type:** RCT	To determine the impact of integrative and instrumental reminiscence interventions on depressive symptom-atology and adaptive functioning in depressed older adults compared with a control group of active socialisation	Both types of reminiscence therapy, integrative and instrumental, led to significant improvements in depression. Fifty-eight per cent of participants in the integrative group demonstrated significant improvement at post-test, with an effect-size of 0.86 and at follow up 100 per cent had clinically improved with an effect size of 0.96. With regards to the instrumental group 56 per cent demonstrated significant clinical improvement at post-test with an effect-size of 0.81 and at follow-up this increased to 88 per cent with an effect-size of 0.89. However, it is important to note that the further improvements at follow-up could have been influenced by the follow-up booster ses-sions at one month and three months. The interventions had a less positive effect on social adjustment. In relation to depression both integrative and instrumental reminiscence interventions produced effect sizes in the moderate to high range that are comparable to other types of therapy.	This is a good-quality study despite having certain weaknesses. A limitation is the use of the same therapist for all groups, the authors commenting that the therapist may have been less enthusiastic when conducting the control group. Results are derived from a small sample (n=26) randomly allocated to three conditions. The attrition rate was quite high, with 40 participants entering the study but only 26 completing. The treatments are clearly described as integrating both reminiscence and cognitive approaches. Use of an active socialisation group controlled for the potentially therapeutic effects of group support and structured activities. The therapist who took all three groups was trained in all three interventions and sessions were monitored for treatment fidelity. The assessments of the participants were carried out by a psychologist who was not involved in the therapy and who was also blind to participants' group membership. Three well-validated instruments were administered pre-treatment, three weeks into the therapy, post-treatment (after six weeks) and at three months follow-up. Pre-treatment screening showed that all three groups had similar levels of depression (moderate to severe) and did not differ in terms of social adjustment. In assessing effectiveness, only participants whose scores have shown reliable change from pre-test scores and whose post-test scores are typical of a non-clinical population are considered to have made a significant clinical change. The study lends support to reminiscence therapy being integrated with cognitive approaches and offered in a structured and manualised manner.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Goldwasser AN, Auerbach SM, Herkins SW **Title:** Cognitive, affective and behavioral effects of reminiscence group therapy on demented elderly **Source:** International Journal of Aging and Human Development 25(3):209-22 **Year:** 1987 **Study type:** RCT	The study aims to assess the degree of change that reminiscence group therapy (RT) can have on affective, cognitive and behavioural functioning in older people who have dementia	Levels of depression in participants who had RT therapy were positively affected compared with participants in a support group and a no-treatment control group. However, the gains were not maintained at five weeks follow-up. The authors recommend that RT should be offered as part of a continuous programme of treatment. No significant changes were found in cognitive or behavioural functioning. The authors discuss the suitability of the measures used and whether these were sensitive to small changes over short time spans.	This is a fair-quality study which provides some good critical evaluation, uses well-validated outcome measures and additional observational data. The methods are clearly explained and data provided in graphical form. Results are based on a small and localised sample of 27 residents of a particular nursing home in Richmond, Virginia, USA, all with a diagnosis of dementia. Hence generalisability is limited. Participants were randomly allocated to either a RT treatment group, a support group (to control for the possible effects of attention and group interaction) or a no-treatment control group. The authors acknowledge that there were differences between the treatment and the other groups, which were not controlled for, particularly in terms of levels of depression. Relevant inferential statistics are clearly provided. Given the inferential tests used, the exclusion of two participants to balance groups when a member of the experimental group died was probably unnecessary. The authors conclude that because the benefits were lost at five-week follow-up, RT should be offered continuously to maintain improvements in older people's quality of life.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Author: Haight BK **Title:** The therapeutic role of a structured life review process in homebound elderly subjects **Source:** Journal of Gerontology; Psychological Sciences 43(2):40-4 **Year:** 1988 **Study type:** Double-blind randomised controlled trial	To examine the effects of a structured life review intervention on 60 home-bound elderly subjects with regard to life satisfaction, psychological wellbeing, depression and activities of daily living. To provide evidence for the use of life review as a therapeutic intervention in an elderly housebound population	Life satisfaction and psychological wellbeing were significantly affected by the life review process but there was no change in depression and activity of living scores.	This fair-quality study was well-conducted but had limitations in its design. The sample was of modest size (n=60) and derived from a single locality in the south of the USA limiting generalisability. Possible differences in the social and psychological profiles of the three groups used in the study were not adequately considered. Two of the outcome measures used showed no response to the intervention and may not have been appropriate with this particular sample. The gains in life satisfaction and psychological wellbeing were only measured over a seven week period ruling out any evidence of longer-term effects. The use of a non-clinical population meant that the study produced no evidence as to the effectiveness of the life-review therapy in the treatment of particular disorders. However, the conclusion that this treatment may be a useful preventive measure with the community-dwelling, homebound elderly seems justified.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Hseih HF, Wang JJ **Title:** Effect of reminiscence therapy on depression in older adults: a systematic review **Source:** International Journal of Nursing Studies 40:335-45 **Year:** 2003 **Study type:** Systematic review of RCTs	To determine the effectiveness of reminiscence therapy as an intervention for depression reduction in older adults outside the primary care setting (ie in nursing homes/ residential settings). To explore how reminiscence therapy can be used in the care of older adults. To identify areas for further research	Depending on the statistical analysis used, reminiscence therapy has varying effects on depression in the elderly. Some studies had statistically significant results but some did not. The review is inconclusive as to the effectiveness of reminiscence therapy. The authors suggest that the type of reminiscence therapy, the length of the sessions, the age of the participant and the level of depression may have an important effect on outcomes, but these factors remain uninvestigated. Further research should include qualitative approaches. The effect of the patient's personal characteristics on outcomes in reminiscence therapy should be investigated and protocols developed to define more clearly how reminiscence therapy should be offered.	This study is a fair, if inconclusive, systematic review of the literature relating to reminiscence therapy. The process of locating and including studies is clearly described. A number of methods of literature searching were used, and although the online searches of the five databases used in the study could have been more thorough, these were supplemented by other methods which helped to identify a range of potential studies for inclusion. Details of each study are provided in the form of a summary table and themes for various aspects of the studies are described. Methodological quality is described for the included studies as a whole, rather than each study being individually appraised. The limitations of the review are discussed by the authors with particular regard to heterogeneity of clinical condition among participants in studies; some had a primary diagnosis of depression, others dementia. Some studies included non-clinical populations but used depression scales as outcome measures. Other variations in the way reminiscence therapy was offered in different studies and the outcome measures used rendered a statistical meta-analysis unfeasible. The authors' conclusions tend to support the use of reminiscence therapy while at the same time emphasising the need for future research.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: McDougall GJ, Blixen CE, Suen LJ **Title:** The process and outcome of life review psycho-therapy with depressed homebound older adults **Source:** Nursing Research 46(5):277-83 **Year:** 1997 **Study type:** Qualitative: content analysis of case notes	To examine the process and outcomes of life review therapy (LRT) provided by an advanced practice gero-psychiatric nurse to depressed homebound older adults discharged from psychiatric hospitals	As a result of LRT there was a significant decrease in total disempowerment themes which may in turn indicate a lessening of depressive symptoms.	This is a well-conducted study which is fair in quality. The sample (n=80) is quite large for a qualitative study and derived from a southern region of the United States. The sample is described in detail as being predominantly female, white, all being homebound, with a diagnosis of depression and having been discharged from psychiatric hospital. Participants had a variety of co-morbid medical conditions and were taking various medications including antidepressants. The treatment was offered over a period of 60 days with differing degrees of intensity (between one and three sessions per week). The treatment is adequately described and data collection and analysis explained in quite some detail. A significant weakness of the study is its reliance of the case notes of one nurse-therapist which are not in any way triangulated with the views of the clients (for example by interviewing a selection of clients). This introduces a major bias into the study. However the paper offers a rich amount of detail as to how LRT may impact on depression in older people and its possible benefits as a home-delivered maintenance treatment following discharge from hospital.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Author: Parsons C **Title:** Group reminiscence therapy and levels of depression in the elderly **Source:** Nurse Practitioner 11(3):68-76 **Year:** 1986 **Study type:** Uncontrolled outcome study	To study the differences in levels of depression in older people after they had received group reminiscence therapy	Levels of depression in six participants, as measured by the geriatric depression scale, showed a statistically significant improvement in the post-test scores following group reminiscence therapy. The author, while acknowledging the limitations of the study, discusses the potentially important role of group reminiscence therapy for treatment of depression in older people.	This is a fair study, limited by its lack of a control group and its small convenience sample of just six participants, all of whom were female. Only one outcome measure is used, the geriatric depression scale, which is well validated. Bearing in mind the limitations of the study, the author's conclusions concerning the effects of reminiscence therapy must be viewed as speculative and requiring support from further, more robust studies.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Rattenbury C, Stones MJ **Title:** A controlled evaluation of reminiscence and current topics discussion groups in a nursing home context **Source:** The Gerontologist 29(6):768-71 **Year:** 1989 **Study type:** RCT	To investigate whether a reminiscence group intervention would enhance the psychological wellbeing, activity level and level of functioning of nursing home residents. A further aim was to assess whether individual differences in group participation mediated any benefit gained	Both reminiscence and current topic group discussion interventions were associated with improved psychological wellbeing relative to the control condition. There was no evidence that the interventions changed the level of activity, mood or ratings of behavioural competence.	This paper reports on a fair-quality, small-scale study with certain methodological weaknesses. The study uses a range of well-validated outcome measures. The sample size is small (n=24) and participants randomly allocated to one of three groups: reminiscence, current topics discussion, no-treatment control group. Sample characteristics are inadequately reported and socio-demographic detail is lacking. There is little reference as to how informed consent was obtained from participants, which overlooks an important issue when conducting research in this type of setting. Results failed to demonstrate any superiority of the reminiscence group intervention over the current topic discussion intervention and neither of these two treatments had any effect on activity, mood and functional levels. The authors recognised that this was a small study with brief interventions and that larger-scale investigations would be beneficial.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Youssef FA **Title:** The impact of group reminiscence counseling on a depressed elderly population **Source:** Nurse Practitioner 15(4):32-8 **Year:** 1990 **Study type:** RCT	To assess the effect of group reminiscence counselling (RT) on the level of depression of elderly women residing in nursing homes	Reductions in depression scores were statistically significant in younger old people (65-74 years) but not in older participants (74+).	This study is fair in quality but only briefly reported. Results are based on a sample of elderly women (n=60) recruited from four nursing homes in Washington DC, USA. There were two age-related experimental groups (65-74 and 74+) but only one control group. Only one outcome measure is used (Beck's Depression Inventory) which limits the amount of data gathered. Socio-demographic data was collected and groups tested for heterogeneity. The treatment was delivered weekly over a period of five weeks and tests administered pre- and post-treatment. There was no longer-term follow-up. The conclusion that RT was effective with younger but not older depressed elderly is justified by the findings but should be treated with some caution in view of the study's methodological weaknesses.

Quality rating: Poor			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Berghorn FJ, Schafer DE **Title:** Reminiscence intervention in nursing homes: what and who changes? **Source:** International Journal of Aging and Human Development 24(2):113-27 **Year:** 1987 **Study type:** Secondary analysis of the results of a RCT	To analyse the characteristics of those older people who derived most benefit from reminiscence therapy	Older people with low levels of mental adaptability are most positively affected by reminiscence therapy.	This is a poor-quality study, based on the results of an initial study to test the efficacy of a reminiscence intervention using literary materials designed by the National Council on the Aging. In this initial study reminiscence discussion groups were organised in 30 nursing homes in the mid-west region of North America and, subsequently, randomly assigned to one of three experimental conditions or a control condition. Scant information is provided about the sample (which is non-clinical) and the outcome measures used. The initial sample size was quite large at 277. However the attrition rate was very high with just 185 participants completing the study. The study reported in this paper uses the results from two of the previously mentioned experimental conditions. No attempt has been made to validate measures used to discern levels of mental adaptability which were devised by the researchers purely for the purpose of this study. Authors fail fully to report the statistics necessary to evaluate the findings of the study and as a consequence conclusions should be interpreted with a good deal of caution.

Quality rating: Poor			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Blankenship LM, Molinari V, Kunik M **Title:** The effect of a life review group on the reminiscence functions of geropsy-chiatric inpatients **Source:** Clinical Gerontologist 16(4):3-17 **Year:** 1996 **Study type:** Uncontrolled outcome study	Male inpatients in a psycho-geriatric unit received a structured life review group intervention. Outcomes were measured using the reminiscence functions scale (RFS). The study aimed: a) to determine whether participants changed in a psychologi-cally-healthy direction in terms of reminiscence functions; b) to determine whether psychiatric or cognitive functioning correlates with change in reminis-cence functions; c) to establish norms for the RFS in a psycho-geriatric population and compare them to a normal geriatric population	While there was significant improvement in the psychiatric functioning of participants, this did not correlate with scores on the RFS. Indeed there were no significant changes on the RFS following the life review intervention, although a non-significant trend towards a decrease in total reminiscing was discerned. Compared with a non-clinical geriatric population the sample showed a significantly greater tendency to reminisce.	This is a poor study, although clearly-reported and in some respects well conducted. Results are based on a sample of 25 participants, all male and predominantly white, making generalisation unfeasible. The attempt to compare scores within this all-male sample with a general non-clinical geriatric population is problematic. Five participants were lost to follow-up. Participants had a variety of psychiatric diagnoses. The authors acknowledge that the lack of a control group diminishes internal validity as participants receive additional treatments during the course of the study. The intervention is insufficiently described and the effects of changing group membership on participants' experiences minimally discussed. Authors use well-validated outcome measures, provide relevant statistics and assess the limitations of the study. Ultimately the study is inconclusive in its failure to establish a correlation between improvements in psychiatric symptoms and types of reminiscing behaviour. Although the life-review intervention was associated with significant improvements in the participants, weaknesses in the study design would signal a cautious interpretation of these results.

Quality rating: Poor			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Orten JD, Allen M, Cook J **Title:** Reminiscence groups with confused nursing centre residents: an experimental study **Source:** Social Work in Health Care 14(1):73-86 **Year:** 1989 **Study type:** RCT	The primary aim of the study was to assess the effectiveness of reminis-cence groups in improving the social behaviour of older people resident in nursing homes who were moderately confused. A secondary aim was to identify demographic characteristics associated with improvement	The study produces only limited support that reminiscence improves the social behaviour of elderly residents. There were no significant differences between the experimental and control groups on ratings of social behaviour at any of the assessment points. However, the one group with an experienced therapist showed significant difference at mid-point and end-point of therapy, and one other experimental group showed a significant difference at mid-point but not at the end-point. No significant correlations were found between social or demographic variables in relation to changes in social behaviour. The authors discuss how the skills of the therapist are an important variable in reminiscence therapy and that it is important to provide suitable training.	This study is of poor quality because of weaknesses in design. A total of 56 participants, who were moderately confused but without other diagnosable physical or psychiatric conditions, were selected from two USA nursing homes. Treatment consisted of 16 weekly sessions of group therapy. There are no checks to ensure different therapists delivered a standardised treatment. Three outcome measures were used but as they were devised by the authors specifically for the study there is no evidence as to their validity. Authors failed to find support for their main hypothesis that reminiscence group therapy would lead to higher levels of social behaviour and the tentative conclusion that the skills and training of the therapist are predictors of positive outcomes is not justified by the results.

Other therapies

Interpersonal therapy

Quality rating: Good

Bibliographic details/study type	Aims	Key findings	Summary evaluative comments
Authors: Miller MD, Frank E, Cornes C, Houck PR, Reynolds CF III **Title:** The value of maintenance interpersonal psycho-therapy (IPT) in older adults with different IPT foci **Source:** American Journal of Geriatric Psychiatry 11(1):97-102 **Year:** 2003 **Study type:** Secondary analysis of the results of a RCT	To establish whether maintenance interpersonal psychotherapy (IPT) can reduce the recurrence of depression in older adults and to identify any clinical or demographic differences between those who did, and those who did not, experience a recurrence of depression	IPT was more effective than clinical maintenance (CM) at reducing the reoccurrence of depression in older adults where role conflict was identified as the main source of the problem. IPT was not more effective than CM in reducing the recurrence of depression where the source of the problem arose from either abnormal grief or role transition. Subjects suffering from role conflict demonstrated the greatest level of personality dysfunction (according to the personality assessment form).	This paper reports on a secondary analysis of the data generated from a randomised controlled trial (Reynolds, Frank, Perel et al, 1999). Consequently, many of the methodological aspects of the original project are not reproduced in this article. Furthermore, the dataset was not generated for the analytical purposes to which it has been subjected, and the small sample size leads the authors to recommend caution when the results are interpreted. Results are based on outcomes for 53 participants, allocated to either a treatment or control group and analysed according to the focus of the primary problem: inter-personal conflict, abnormal grief or role transition. Consequently the research cells were quite small. Nevertheless, the conclusions of this study are in keeping with those of Lenze et al (2002) and, although requiring confirmation from larger-scale studies, support the use of maintenance IPT as a means of helping elderly people experiencing role conflict reduce the risk of falling back into major depression. Despite the brevity of the article, the authors offer some useful discussion. Overall the study can be described as of good quality.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Mossey JM, Knott KA, Higgins M, Talerico K **Title:** Effectiveness of a psychosocial intervention, interpersonal counseling, for subdysthymic depression in medically ill elderly **Source:** Journal of Gerontology: Medical Sciences 51A(4): M172-M178 **Year:** 1996 **Study type:** RCT	To assess the feasibility and efficacy of interpersonal counselling (IPC), a short-term psycho-therapy, as a treatment for medically-ill, hospitalised, older people suffering from subdysthymic depression	After six months there was a statistically significant improvement in the patients receiving IPC. There was no statistically significant change in the two control groups: one of which received usual care (UC) and the other comprising non-depressed people receiving no treatment. Although prevalent, subdysthymic depression is not a normative condition of medically ill older people. The successful screening of medically-ill elderly people for depressed mood and the provision of IPC therapy by psychiatric clinical nurse specialists means that treatment is feasible.	This article reports on a good-quality randomised controlled trial involving a total of 153 hospitalised elderly participants and is a useful investigation into the effectiveness of brief counselling with mildly depressed, hospitalised, elderly people. Seventy-six participants met criteria for subdysthymic (minor or non-clinical) depression and were randomly allocated to either an IPC (n=35) or a UC (n=41) group. These participants were then matched with a non-depressed control group comprising 77 participants. Treatment groups were matched for a wide range of variables, confounders were taken into account and multivariate analysis was undertaken. Reporting of the research methodology is detailed and authors acknowledge the limitations of the project. While justifying the definition of subdysthymic depression applied, the authors acknowledge that it is idiosyncratic to this study and confirmation of the results is required by further research using a similar definition. The treatment was offered in varying degrees of intensity (some participants had just one session, others up to 10) spread out over differing periods of time. It is noteworthy that the test which discerned the significant fall in depressive symptoms was six months from baseline and not at the end of treatment. Hence the results say little about the longer-term effects of the treatment. Authors note that the over-representation of African Americans in the sample and under-representation of individuals over the age of 80 years makes generalisation difficult.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Lenze EJ, Dew MA, Mazumdar S, Begley AE, Cornes C, Miller MD, Imber SD, Frank E, Kupfer DJ, Reynolds CF III **Title:** Combined pharmaco-therapy and psycho-therapy as maintenance treatment for late depression: effects on social adjustment **Source:** American Journal of Psychiatry 159(3):466-8 **Year:** 2002 **Study type:** RCT	To ascertain whether elderly patients recovering from depression would have better social adjustment with medica-tion and interpersonal psychotherapy (IPT) than with medica-tion or psychotherapy alone	After 12 months of maintenance therapy consisting of both nortriptyline and IPT, patients retained a higher level of social adjustment than patients in the comparison groups receiving either nortriptyline only or IPT only. When the effect in terms of the four domains of the social adjustment scale is scrutinised there is significant difference with regards to the friction domain (interpersonal conflict) but no significant difference between the groups on the other three domains (performance, inter-personal and satisfaction domains).	This article reports on a randomised controlled trial which is fair in quality. Depressed participants over 60 years of age were recruited from the community and by clinical referral. Screening took place with regards to their medical and cognitive ability. There is no other detail, however, of the sample's socio-demographic characteristics. The project spans 12 months with participants tested at baseline and at three-monthly intervals thereafter. The sample size is small given that there are three sub-groups and as the article is very brief, detail is limited. The availability of statistical data for research participants declines over the course of the study. At the outset of the project there is data for 49 respondents. By the end of the study there is data for 44 respondents. No explanation is offered as to why this data is missing. Although the findings support the hypothesis that a combination of interpersonal therapy and pharmacotherapy is more likely to facilitate social adjustment than one or other of the therapies alone, the effect is only modest. While the findings of the study appear to support the pursuit of policies and practice of combining therapies in an attempt to maintain social adjustment following late-life depression, the limitations of the study suggest that further evidence should be sought. It is noteworthy that the results of the study are comparable to similar research using younger participants.

Validation therapy			
Quality rating: Excellent			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Neal M, Briggs M **Title:** Validation therapy for dementia (Cochrane review) **Source:** The Cochrane Library, Issue 2. Oxford: Update Software **Year:** 2003 **Study type:** Cochrane review	To evaluate the effectiveness of validation therapy with older people diagnosed as having senile dementia of the Alzheimer's type, other forms of dementia, or cognitive impairment	There is insufficient evidence to draw any conclusion about the efficacy of validation therapy for people with dementia or cognitive impairment, although observational studies suggest there may be some positive effects. There is a clear need for well-designed randomised controlled trials of validation therapy for dementia.	This is an excellent study in terms of its methodological rigour but inconclusive in terms of its findings. A thorough search of the 'grey' literature, hand-searching of reference lists, internet searches, contacting leading figures in the field, combined with the searching of 11 electronic databases to the year 1998 yielded just three studies of the appropriate quality. As one of these was unobtainable only two studies form the basis of the review (Robb,1986; Toseland et al, 1997). Because of this the resulting pooled sample is relatively small: 87 in total with just 32 participating in treatment groups. Hence generalisation of results is limited. The use of disparate outcome measures meant that a statistical meta-analysis was not possible, reducing the rigour of the review. The authors suggest that the potential benefits claimed as to the effects of validation therapy may be a result of group activity per se or the attention received by an individual, rather than the application of a therapeutic technique. Future research should control more strictly for these possible confounders.

Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Toseland RW, Diehl M, Freeman K, Manzanares T, Naleppa M, McCallion P **Title:** The impact of validation group therapy on nursing home residents with dementia **Source:** Journal of Applied Gerontology 16(1):31-50 **Year:** 1997 **Study type:** Single-blind RCT	To examine the short- and long-term effectiveness of validation therapy (VT) compared with a social contact (SC) group and a usual care (UC) control group with nursing home residents diagnosed with dementia. The authors hypothesised that VT and SC would produce a reduction in problem behaviours, use of physical constraints and psycho-trophic medications and an increase in social interactions and psycho-social wellbeing compared to the UC group. It was further hypothesised that VT would be more effective than SC	The nurses caring for the clients reported an improvement in the clients' behaviour (reduction in physically and verbally aggressive behaviour) in the VT group. However, this was not supported by the independent observers at three and 12 months. Validation therapy did not cause a reduction in psychotrophic medication or use of physical restraint and was less effective than SC or UC in reducing physically non-aggressive problem behaviours. The SC group showed fewer verbally-aggressive behaviours than the VT or UC group, as identified by the independent observers.	This paper reports on a good-quality but inconclusive study. A sample of nursing home residents (n=88) was screened for the presence of at least moderate dementia combined with problem behaviours. Participants were randomly allocated to one of three groups (VT, SC, UC). Socio-demographic information is provided and no significant differences were discerned between the groups. The UC group acted as a no-treatment control and the SC group was to control for the effects of attention and group interaction. A good range of well-validated measures were used and tests carried out pre-treatment, three months into treatment and at one year. The treatment was carried out over 52 weeks. Twenty-two participants were lost to follow-up (18 of these died). The groups were videoed and monitored to ensure treatments were consistent. A significant issue in the study design is the use of observers to measure outcomes, presumably because self-report measures are not feasible with this type of population. Measures were completed by nursing staff and by non-participant observers who differed in their estimation of change among the participants. Nursing staff recorded significant reductions in physical and verbally aggressive behaviour in the VT group which was not supported by the non-participant observers. The authors discuss the possible reasons for this. The study fails to establish any significant effects for VT.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Morton I, Bleathman C **Title:** The effectiveness of validation therapy in dementia – a pilot study **Source:** International Journal of Geriatric Psychiatry 6:327-30 **Year:** 1991 **Study type:** Case study with crossover design	The study aims to investigate the effects of validation therapy (VT) on levels of sociability, mood and behaviour among older people with dementia	The study found that VT did not result in improvements in participants' cognitive functioning, behaviour or communication, as assessed by standardised observational measures completed by care staff. When the researchers assessed communication by direct observation, VT was associated with an improvement in the number of communications and length of communications, for two participants. For another participant VT was associated with a reduction in communication. The authors concluded that VT may be more appropriate for some clients than others.	This study is fair in quality and as a small-scale pilot study has limited external validity. The sample size is very small, initially comprising five participants, but due to the death of one and another's reluctance to participate, results are based on a final sample of three. The study was conducted over 40 weeks with baseline data collected in the initial 10 weeks, followed by a 20-week, weekly VT group intervention and finally a 10-week, weekly reminiscence therapy group intervention. The methods are clearly explained although more information about the nature of the interventions would have been useful. The care staff completed well-validated, standardised observational measures but the observational measure used by the researchers was developed for use in this study. Interestingly, positive outcomes were only discerned by the use of this latter, poorly validated measure. On the whole this is an interesting pilot study which could usefully form the basis of further research. However, because of its limitations there can be little confidence in its conclusions.

Task-centred/goal-focused therapy			
Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Kaufman AV, Scogin FR, Malone Beach EE, Baumhover LA, McKendree-Smith N **Title:** Home-delivered mental health services for aged rural home health care recipients **Source:** The Journal of Applied Gerontology 19(4):460-75 **Year:** 2000 **Study type:** Uncontrolled trial in a naturalistic setting	To test the efficacy of providing home-delivered, brief, task-centred psychotherapy to 78 elderly patients of a rural home health care agency	Patients completing the brief, task-centred psychotherapeutic intervention reported improvements in their emotional wellbeing and indicated significant reduction in severity of the problems targeted by the intervention. Home-delivered psychotherapeutic interventions may have an important role to play in treating the mental health problems of older, rural, home health care recipients.	This study is of fair quality, having weaknesses in its overall design which are to some degree compensated for in the detailed and candid reporting of the findings. Data for this paper forms part of a larger three-year study into the provision of in-home, psychosocial interventions to homebound, medically-frail, rural elders and their caregivers. The paper reports results of a clinical trial involving eight to 10 sessions of task-centred/goal-directed therapy carried out in a naturalistic setting with a sample of 78 participants. The lack of control or comparison intervention groups increases the possible influence of unforeseen confounders and undermines the internal validity of the findings. However the use of a realistic setting rather than laboratory-type conditions increases external validity. The treatment had significant effects on subjective emotional wellbeing and the target problems identified prior to the application of the intervention but no significant gains in social support, activities of daily living and subjective physical health. No minimum entry criteria were used in selecting participants with regard to mental health problems. Hence non-clinical participants within the sample may skew results. The study's conclusions lend some support to the proposition that home-delivered psychotherapy is feasible and may be effective with this population.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Klausner EJ, Clarkin JF, Spielman L, Pupo C, Abrams R, Alexopoulos GS **Title:** Late-life depression and functional disability: the role of goal-focused group psychotherapy **Source:** International Journal of Geriatric Psychiatry 13:707-16 **Year:** 1998 **Study type:** Randomised trial	To compare the effectiveness of goal-focused group psychotherapy (GFGP) and reminiscence therapy (RT) in the treatment of depression. Improvements in the areas of depression, hope, helplessness, anxiety, functional disability, social functioning and suicidal intention are used as measures of effectiveness	While both the GFGP and RT groups improved depressive mood and functional disability, the GFGP participants also improved in the areas of hope, hopelessness, anxiety and social functioning. The GFGP condition showed the greater improvements in depressive symptoms, moving from 'depressed' to 'non-depressed' on the Hamilton Depression Rating Scale. While improvements were seen in the reminiscence therapy, they were not of this magnitude.	This study is of fair quality having some weaknesses in its design. The sample size is very small (n=13) justifying the authors' description of the study as a pilot rather than a full-scale investigation. Of the 13 participants recruited, two were lost to follow-up, further reducing the sample. Socio-demographic information is not supplied and no details given of the source population. Participants are randomly allocated to the two groups but as the study lacks a no-treatment control group it is impossible to attribute outcomes solely to the intervention. A broad range of well-validated outcome measures is used, including both observer and self-report. However, the extremely small sample and lack of a no-treatment control group prompt caution when interpreting the results.

Gestalt therapy			
Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: O'Leary EO, Nieuwstraten IM **Title:** The exploration of memories in gestalt reminiscence therapy **Source:** Counselling Psychology Quarterly 14(2):165-80 **Year:** 2001 **Study type:** Qualitative study using discourse analysis	The study aimed to explore the types of memories that emerged during reminiscence therapy with older people	Memories recalled are related to objects, people, locations, past achievements, historical occasions, personal events and sensitive issues.	This is a good-quality qualitative study involving just five members of a residential home. Two group sessions of gestalt reminiscence therapy were recorded and transcribed and then subjected to discourse analysis. Methods of data collection and analysis are described adequately and the involvement of three investigators in the analysis reduces the level of bias in the interpretation of data. It is not made clear why these two particular sessions were selected for the study and whether they were in any way representative of therapy sessions in general. The study's theoretical framework is made clear, along with the nature of the intervention. The study is effective in identifying the types of memories recalled in gestalt reminiscence therapy and assessing their therapeutic value, thus providing some insight into how this type of therapy might work.

Quality rating: Fair			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: O'Leary E, Sheedy G, O'Sullivan K, Thoresen C **Title:** Cork Older Adult Intervention Project: outcomes of a gestalt therapy group with older adults **Source:** Counselling Psychology Quarterly 16(2):131-43 **Year:** 2003 **Study type:** Mixed-method: RCT plus qualitative questionnaire	To establish whether gestalt group therapy might impact on the mood of older people with particular reference to levels of anxiety, depression and anger	Researchers concluded that gestalt group therapy did have an impact on participants. Those who received therapy were more expressive of anger, less able to control their anger, more agreeable, less hostile, clearer-headed and less confused. Younger participants, compared to their counterparts in the control group, became more composed and less anxious. There was some indication that those who received therapy learned something more about themselves. The intervention had no impact on depression scores.	This paper is fair in quality, reporting on a randomised controlled trial combined with a qualitative collection of data. Conducted in Cork, southern Ireland, 43 older adults were recruited from the community to participate in the project. Only those who had no previous experience of therapy were selected. Twenty-two of these respondents participated in gestalt group therapy while the remaining 21 formed the no-treatment control group. Sample size is therefore quite small and drawn from one geographical area making generalisation difficult. The authors report significant social demographic differences between groups. Standardised outcome measures were used pre- and post-treatment, supplemented by a specifically-designed qualitative question-naire (administered at post-treatment only). Group therapy consisted of one session per week for six weeks. Tests were administered one week before and one week after the treatment, hence there was no longer-term follow-up. The analysis of qualitative data sheds useful light on the therapeutic process at work in such groups. The use of a non-clinical sample makes it impossible to draw conclusions about the effectiveness of this treatment with clinical populations.

Group therapy as defined by Yalom (1995)			
Quality rating: Good			
Bibliographic details/study type	**Aims**	**Key findings**	**Summary evaluative comments**
Authors: Young CA, Reed PG **Title:** Elders' perceptions of the role of group psychotherapy in fostering self-transcendence **Source:** Archives of Psychiatric Nursing 9(6)338-47 **Year:** 1995 **Study type:** Qualitative study involving a matrix analysis of group members' perceptions derived from open-ended interviews	To examine the effectiveness of group psychotherapy in facilitating self-transcendence in older people as perceived by group members. To discern what patterns of self-transcendence are evident in elders during the course of group psychotherapy	Reflective interpersonal group therapy facilitates an appropriate developmental process, termed self-transcendence. Three categories linked to self-transcendence were identified by the researchers from a matrix analysis of the data. These were inward expansion (reflective and affirmative thought and action), outward expansion (bonding and relating positively to others) and temporal integration (coming to terms with the past and developing a capacity to focus on the present and future). Self-transcendence by an outward expansion of boundaries was noted in 44 per cent of the responses. Bonding between participants was the most frequent theme that was referred to. Two thirds of the sample noted increases in self-affirmation. This theme represented nearly a quarter of all responses by participants. Temporal integration, reflected in the capacity to focus on the present was a theme that emerged from one third of the responses.	This paper reports on a good-quality qualitative study. Despite the authors' stated aim to look at the effectiveness of group psychotherapy the focus of the study is very much on how this intervention might work with older people, rather than whether it works. The latter would necessitate pre- and post-treatment outcome measures which are absent from the study design. A small sample of older adults (n=6), with a variety of physical and psychological problems, was recruited for weekly group psychotherapy of one year's duration in a clinical setting. The sample is outlined in some detail, although there is no mention of attrition. Details concerning the nature of the intervention are lacking. The method of analysis is explained in a detailed way and linked to the theoretical perspectives adopted in the study. The subjectivity of the researchers is acknowledged, especially with regard to one researcher also acting as group therapist. The conclusion that group psychotherapy supports the naturally-occurring maturation process and so is a developmentally appropriate treatment for older people is justified by the findings. However suggestions that group psychotherapy is time-effective and cost-effective are not supported by the findings.

Psychodynamic therapy

This approach is used as a comparison condition in studies which primarily focus on **cognitive-behavioural and related therapies**. Hence the relevant studies are summarised above.

Quality rating: Good

Authors: Thompson LW, Gallagher D, Steinmetz-Breckenridge J
Title: Comparative effectiveness of psychotherapies for depressed elders
Source: Journal of Consulting and Clinical Psychology 55(3):385-90
Year: 1987

Quality rating: Fair

Authors: Gallagher-Thompson D, Hanley-Peterson P, Thompson LW
Title: Maintenance of gains versus relapse following brief psychotherapy for depression
Source: Journal of Counselling and Clinical Psychology 58(3):371-4
Year: 1990

Supportive counselling

This approach is used as a comparison condition in studies which primarily focus on **cognitive-behavioural and related therapies**. Hence the relevant studies are summarised above.

Quality rating: Good

Authors: Barrowclough C, King P, Colville J, Russell E, Burns A, Tarrier N
Title: A randomized trial of the effectiveness of cognitive-behavioural therapy and supportive counseling for anxiety symptoms in older adults
Source: Journal of Consulting and Clinical Psychology 65(5):756-62
Year: 2001

Authors: Stanley MA, Beck JG, Glassco JD
Title: Treatment of generalized anxiety in older adults: a preliminary comparison of cognitive-behavioral and supportive approaches
Source: Behavior Therapy 27:565-81
Year: 1996

Quality rating: Fair

Authors: Doubleday KE, King P, Papgeorgiou C
Title: Relationship between fluid intelligence and ability to benefit from cognitive-behavioural therapy in older adults: a preliminary investigation
Source: British Journal of Clinical Psychology 41:423-8
Year: 2002