

ARTICLES

Providing Psychotherapy to Older Adults in Home: Benefits, Challenges, and Decision-Making Guidelines

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Mental health service providers have begun serving older adults in their places of residence. Providing psychotherapy in an elder's home presents numerous benefits and challenges, compared with in-clinic work. Because many of these differences are complicated, clinicians must make quick decisions and can benefit from guidelines to formulate responses. Based on each of the four authors' 10 to 15 years of experience, this article presents advantages to be gained by providing services in the home, including development of rapport, accessibility of information, and participation by the client with transportation challenges. The authors present a number of challenges such as interruptions, maintenance of professional boundaries, difficult transferences and countertransferences, threats to confidentiality, and safety issues. Decision-making guidelines are offered.

KEYWORDS *aging, decision-making guidelines, in-home psychotherapy*

INTRODUCTION

Older adults comprise 12.6% of the population in the United States, and that figure is estimated to reach 20% by 2030 (Administration on Aging, 2007).

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Research indicates that elders who receive mental health services can achieve a higher quality of life, while reducing depression (Scogin et al., 2005), anxiety (Ayers et al., 2007), and insomnia (McCurry et al., 2007). Reducing mental illness can improve an elder's health (Zarit & Zarit, 2007) and may lengthen the duration of independent living. While mental health services provided to older adults involve many of the same approaches used with younger adults, adaptations are required (Knight, 2004; Laidlaw, Thompson, Dick-Sisken & Gallagher-Thompson, 2003; Yang & Jackson, 1998). These include more frequent grief therapy; devoting more time for transmission of life stories; accommodating slower cognitive processes, sensory impairments and medical conditions; and overcoming this cohort's stigma against mental health services. Because of several of these aspects of aging, mental health service providers are offering services to elders in their places of residence.

In-Home Mental Health Services

Mental health services provided in older adults' homes have begun to be documented (Ammerman et al., 2007; Banerjee, Sharmash, Macdonald, & Mann, 1996; Burns et al., 2001; Craman, 1992; Dittbrenner, 1994; Kaufman et al., 2000; Knapp & Slattery, 2004; Lipsman, 1996; Muijen et al., 1992; Maxfield & Segal, 2008; Rosqvist et al., 2002). Some of the literature provides data for effective application of initially in-clinic, evidenced-based treatments in home settings. Steinberg and her colleagues (2007) provided screening and assessment, psycho-education, referral and linkage, and behavioral activation to depressed, frail older adults in their homes, leading to decreased depression (Quijano et al., 2007). Ciechanowski et al. (2004) provided home-based treatment to depressed, chronically ill elders and found that brief problem-solving therapy decreased depression. Reminiscence interventions have also shown effectiveness in in-home settings (Haight, 1988, 1992). Although addressing a younger adult population, Burns et al. (2001) also found that regular home visits from mental health service providers contributed to decreased psychiatric hospitalization. Little research has tested the application of cognitive-behavioral therapy (e.g., Laidlaw et al., 2003) or interpersonal psychotherapy (e.g., Hinrichsen & Clougherty, 2006) in home-based settings, although Maxfield & Segal (2008) provided a clinical case study of cognitive-behavioral therapy's effectiveness in the home. Interpersonal psychotherapy also offers promise for in-home work, but further research is needed to investigate the transfer of in-clinic research to the home setting.

Benefits of In-Home Mental Health Services

Providing mental health services in older adults' homes presents a number of benefits. Services can be offered to elders unable to drive, use public transportation, or access para-transit. Elders may participate for whom going

to an office is stigmatizing and/or requires too much energy. Rapport-building can be heightened, thus reducing suspiciousness or hesitancy. Services can be made more accessible to older adults with cognitive impairment. In all cases, clinicians stand to gain a wealth of first-hand information.

Challenges of In-Home Mental Health Services

Despite these benefits, the in-home setting poses a number of challenges (Knapp & Slattery, 2004; Maxfield & Segal, 2008). Because psychotherapists traditionally practice in a clinic or office, they presume a controlled and predictable setting. The therapist generally eliminates interruptions, restricts who is present, and creates and maintains a professional atmosphere. Because individual client homes present unknown and less controllable factors, decision-making demands on the therapist are multiplied and unavoidably immediate. Clear boundary-setting is necessary to conduct psychotherapy in the home setting, yet as a paradox, flexibility is also key (Knapp & Slattery, 2004; Maxfield & Segal, 2008).

The authors of this article work at a community-based, mental health clinic that serves older adults. Over each of the past 25 years, an average of 50 to 100 older adult clients have received psychotherapy in their homes through this clinic. Each author has supervised 40 to 50 therapists (social workers, marriage and family therapists, psychologists, and graduate students) for 10 to 14 years. Based on their experience, these authors discuss clinical, ethical, legal, and risk-management challenges arising during in-home psychotherapeutic work with older adults, along with guidelines to help navigate the unclear territory between flexibility and clear boundary-setting. The recommended approach is to: 1) conduct a traditional assessment leading to diagnosis; 2) establish a conventional treatment plan with treatment goals; 3) apply flexible ideas; and, 4) when unexpected events occur, test these ideas against the treatment plan, professional ethics, state laws, and agency risk-management guidelines. While flexibility is a hallmark of successful work in clients' homes (Muijen et al., 1992), adherence to a well conceived, assessment-based treatment plan is essential to optimal treatment when facing spontaneous decisions in the field. Ofer Zur's principles (2002, 2008) on boundary issues for psychotherapy are highly applicable to work with older adults in the home. While the overall practice of assessment, diagnosis, and treatment planning uses a standard approach, in-home work triggers such frequent and immediate challenges that clinicians must more regularly reference the treatment plan.

CLINICAL ISSUES

Some of the clinical benefits and challenges that uniquely arise in the home are: 1) rapport building, 2) information gathering, 3) access to collateral

significant others, 4) maintaining professional roles, 5) therapy interruptions, 6) pacing needs, and specific 7) transference and 8) countertransference issues.

Rapport

In many cases, rapport may be more easily established when working in the client's home. Many homebound elders are isolated; the clinician may be the only person who the elder sees regularly. These clients are often grateful to the clinician for coming to them. Additionally, the clinician can gather information from the home environment to facilitate rapport. For example, noticing and discussing certain artwork on the walls, or sharing appreciation for a pet, can help form a positive bond. In contrast, clients who have difficulty setting limits with others may experience in-home treatment as intrusive and utilize negotiation of space, scheduling, frequency, etc. to modulate their relationship with the clinician.

Information

Unlike the therapist-designed environment of the office, a client's home provides a wealth of direct information about the client. For example, a 60-year-old male client who comes into the clinic may present fairly well; the client and clinician may talk about loss issues and loneliness. But within the home, the clinician may see that the walls are covered with photographs of his deceased mother, that the rooms are filled with aged items, such as old dresses, old medication bottles, books and newspapers, information that the client may not have shared voluntarily. On a cautionary note, gathering non-verbalized information from the client's living space may precede the client's intention to share such information. Thus, therapists are encouraged to consider how use of this first-hand information can impact pacing, control, distance, and intimacy within the therapeutic relationship.

Access to Collateral Significant Others

When seeing a client in her home the clinician may encounter relatives, home health aides, neighbors, nurses, etc. On the beneficial side, information can be gathered, when appropriate and with client consent; collaterals can be accessible to engage in conjoint therapy. For example, while conducting therapy with a 94-year-old woman, the client reported that she was aggravated with her live-in caregiver who kept answering the phone *for* her, and talking to the caller *for* her. The opportunity was readily available for the therapist to support the client in talking with her caregiver, an opportunity which would be less likely to arise in an office.

Access to significant others can be challenging. Family members may involve themselves in therapy sessions, uninvited. For example, when a clinician arrived for his first session with a 74-year-old woman who was confined to her home because she was taking round-the-clock care of her quadriplegic son, the client invited the therapist to sit in the same room with her and her son. On the second session, she invited the clinician to sit in the living room in which her husband was watching television and through which other adult children walked. The clinician had to make a clinical decision as to whether to ask the client to meet privately, conduct family therapy, or proceed with individual work in front of other family members. He recognized that developing rapport was the first step in the treatment plan, and so decided not to immediately ask for privacy from the family members. After several meetings, the clinician asked the client and her husband to provide time and space for him to see the client privately. Once alone with the therapist, the woman revealed information about marital conflict and a history of domestic violence that had not emerged in the presence of her son or husband.

Maintaining Professional Roles

When seeing clients in an office, a professional, formal relationship is implied. The client announces him- or herself, waits in a waiting room, is called into the therapy room, sees the clinician's diplomas or the agency's licenses on the wall, etc. The clinician or his/her employer manages the seating arrangement, type of chairs, distance between the seats, air temperature, size of the room, etc.

In a client's home, these tools for role establishment are absent. The client may perceive the clinician as a friend or family visitor rather than a professional (Maxfield & Segal, 2008). The furniture may be set very close together or very distant; the clinician may need to sit on the bedside. The client may be dressed in night clothes or otherwise scantily attired. The very cues which may enhance rapport building may also lead the client and clinician to perceive themselves in a less formal relationship. A more informal relationship can deter the clinician from helping the client focus on the clinical treatment plan.

Given the paucity of professional cues, the clinician needs to consider how to establish and retain a professional relationship with the client. Supportive structures can include dressing formally, starting and ending appointments on time, and explaining the nature of the professional psychotherapist-client relationship, repeatedly when necessary (Knapp & Slattery, 2004; Maxfield & Segal, 2008). Additionally, therapists are encouraged to increase clarity through consultation, whether before, during, or after a confusing therapeutic situation.

Interruptions

Clinicians are not in control of auditory, visual, interpersonal, and other interruptions in the client's home. Telephones ring; televisions are on; neighbors come to visit; the client gets up to make tea; and so on (Maxfield & Segal, 2008). In responding to these interruptions, clinicians will be aided by referring, physically and/or mentally, to the treatment plan.

It may be helpful to initially observe how the client handles the interruptions the first time or two. This can help to facilitate rapport, increase understanding of how the client handles other people in his or her life and how he or she may be using interruptions to regulate the intimacy with the therapist or the depth of the content discussed. After one or two repetitions of an interruption, the clinician will have more understanding to inform an intervention, by a direct suggestion or by an interpretation. For example, when a client's caregiver continues to sit in the same room watching television during the third session, it may be helpful for the clinician to state his or her professional opinion that having the caregiver leave will benefit the client, or the clinician may help the client to ask the caregiver to leave. Alternatively, the clinician may see it as more therapeutic to interpret the client's behavior of allowing an interruption. In another example, while Mrs. S. typically answered the phone briefly and asked the caller to call back later during sessions, one day she took a phone call and engaged in a lengthy conversation. Given such a notable shift in behavior, the clinician noted this change of behavior and suggested this may be a sign that the subject matter being discussed was painful (the conflict in her previous marriage) and that she was seeking to regulate intense affect.

Pacing

Conducting psychotherapy in the homes of frail, isolated, possibly cognitively challenged, elders raises complicated questions about pacing. Clients who come to an office for therapy can discuss emotionally painful material, and leave the environment in which this affect was stimulated and processed. Homebound clients, however, remain in proximity to the same environmental cues reminding them of the therapeutic discussions. Clients confined to their homes often have fewer activities and engagements to help regulate painful material than socially and physically active clients. For example, 85-year-old Mrs. K. told her clinician that she dreaded the afternoon after her therapy sessions because she was filled with upsetting feelings. While the treatment plan included a grief therapy approach to help her mourn her lost husband, Mrs. K.'s lack of outside activities and sparse remaining friendships made her able to tolerate only a small amount of emotional processing in one session.

Because homebound elders often have limited social resources for support and distraction between sessions, some tools can be used to help manage

the depth of affect when doing in-home, emotionally focused work. These include:

1. Helping clients plan coping activities for after the session (e.g., talking with a friend, writing in a journal, calling the therapist);
2. Reminding clients that the clinician will be working with them on these feelings in subsequent sessions;
3. Helping clients keep associations to the therapeutic work to a certain part of the residence by keeping the therapy session in one area, arranging the furniture in a specific way for the session, and/or encouraging the client to "leave their feelings" in this place; and
4. Using visual imagery to help clients imagine putting their "precious" feelings into a container (e.g., a "treasure box"), which could be imagined to be given to the therapist to keep.

With Mrs. K, above, the therapist and client gradually talked about her feelings related to the loss of her husband. She felt that her lifeline had been taken away. As she talked about her grief of losing him, her depression lessened.

Transference Issues

A number of transference projections are more likely with in-home work. While some may be challenging, understanding them can benefit treatment. The greater intimacy of having the therapist in their own space may increase the possibility that in-home clients see the therapist as a friend or relative rather than a professional. Clients may request that the clinician engage in informal activities such as drinking tea or juice, moving chairs or otherwise adjust the environment, reading mail, etc. The intimacy may lead to more frequent offerings of food or gifts, presenting additional decision-making challenges for the therapist as he or she considers the context of the gift to in the in-home setting. The therapist must decide if it is more helpful to the treatment plan to accept or decline such offerings. At times, accepting the offer will beneficially enhance rapport. At other times, refusing may be more helpful in setting or maintaining professional boundaries. As a third option, Spandler et al. (2000) suggest holding the gift for a short time to avoid prematurely accepting, rejecting or analyzing it. Discussing the meaning of the offering can enhance understanding within the therapy, but at other times analytical discussions may feel rejecting or insulting to the client. Cultural meanings of food and gift offerings must be considered. For example, in our experience, in many Middle Eastern and Latino cultures, if the clinician questions or refuses an offer of food, the client may likely feel insulted or shamed.

Another transference reaction of an in-home client may be to feel intruded upon. Because in-home clients have fewer mechanisms to modulate the

interpersonal connection via “no shows,” there is a greater risk that a therapist will intrude into the client’s space when the client otherwise would have avoided an appointment in a clinic. Due to anxiety about a client’s welfare, especially a physically frail, isolated elder, clinicians may feel tempted to call the paramedics or law enforcement if a client does not answer the door. The clinician must carefully think through the actual likelihood of real danger to the client as well as the client’s right to deliberately not answer the door.

Countertransference

Going into clients’ homes can elicit a number of unique countertransference reactions. In one’s own office, a clinician controls his or her own sensory experience: smells, sights, sensations, sounds, even tastes. Some homes have a particular odor which a clinician may find disturbing. In an extreme example, Mr. R.’s plumbing was not functioning and he was too suspicious to allow repair, thus leading to feelings of disgust in the clinician. Therapists may feel guilty, inadequate, or embarrassed if their own health concerns impede engaging a client. For example, clinicians may experience allergies to pet dander, smoke, or perfume; claustrophobic-type responses to small, stuffy, or crowded spaces; or aversive reactions to fleas, cockroaches, or rodents, etc. that interfere with their ability to work with a client.

Clinicians may experience feelings of burden, anxiety, or even depression when learning of a greater level of need by going into the home. Within the office, a clinician may not gather that a client lives with unmet basic needs such as a leaking roof, no heating, broken plumbing, etc, but sees this on an in-home visit. The intensity, immediacy, and wide range of need may feel overwhelming to the clinician, sometimes precipitating action by the therapist to fix the problem, which may not align with a treatment plan of empowering the client.

Given the effort and time of traveling to a client’s home, the clinician may feel greater frustration when a client is not available to meet. In response, a clinician may call prior to sessions in order to confirm the client’s interest in and availability for meeting, an action that should be considered with reference to the treatment plan. Even when a therapist opts to call ahead to confirm appointments, a clinician may arrive at a client’s home and find the client not present or unwilling to have a session. Clients engaging in distracting interruptions may also contribute to feelings of frustration.

ETHICAL ISSUES

Some of the ethical difficulties frequently encountered during in-home therapy include threats to confidentiality, possibly harmful multiple relationships, and complicated informed consent.

Confidentiality

As previously noted, numerous significant others may challenge confidentiality. When approaching a client's home, a neighbor, apartment manager, or exiting home health aide may ask the clinician "Who are you?" and "Why are you calling here?" The clinician wants both to protect confidentiality *and* gain access to the client. Refusing to answer the question may impede access to the client and/or provoke greater interest and involvement on the part of the concerned other. At our clinic we often use generic but accurate responses such as "I have an appointment with Mr. T," "I am a worker" or "I'm from The Center for Aging Resources." Alternatively we teach our clinicians to suggest: "Perhaps you can ask Mr. T; he is expecting me." While these brief responses may suffice, sometimes a clinician is pressured to elaborate, requiring on-the-spot ethical decision making as the therapist works to balance the priority of confidentiality with the impact on accessing the client. The clinician may then follow up with the client, outlining the situation and clarifying the client's wishes regarding similar circumstances in the future.

Multiple Relationships

Homebound clients often have numerous needs and few resources. This increases the likelihood that they may either directly ask or indirectly imply a request that the clinician take on additional roles. For example, one of our Center's clinicians reported that his client asked him to buy some kitty litter and to change a light bulb (Maxfield & Segal, 2008). Whereas he refused the former request, deciding it would be more in line with the treatment plan to encourage independence, he felt it was more ethical to comply with the second, in the best interest of the client's safety. Another clinician reported that upon arrival at her client's home, she found that her post-stroke client had sat in her wheelchair all night, and had not eaten since the in-home aide had left at noon the previous day. This clinician felt an ethical duty to fix her client a meal, thus placing her in an alternate role with her client.

Ofer Zur (2002, 2008) distinguished "boundary crossings" from "boundary violations" (Guthiel & Gabbard, 1993). He suggested that while "boundary violations by therapists are harmful to their patients, boundary crossings are not and can prove to be extremely helpful. We must carefully think through how to achieve the greatest client benefit." Zur suggested we "take into consideration the welfare of the client, effectiveness of treatment, avoidance of harm and exploitation, conflict of interest, and the impairment of clinical judgment. These are the paramount and appropriate concerns." Sometimes clinicians must ethically meet an alternate need, and other times clinicians must therapeutically set a boundary and problem solve with the client, thus providing greater client empowerment.

Informed Consent and Undue Influence

Providing therapy ethically is based on the client's voluntary, informed consent. Providing treatment in the home may make undue influence a greater risk. While a client may have agreed to participate in therapy, a homebound client may have greater difficulty refusing service. For example, when a Center clinician arrived at her client's gated apartment complex, someone was leaving, so she entered without calling the client from the gate. Upon entering the client's apartment, she saw the client's phone was off the hook, suggesting her client had intended to "no show" by not answering her call from the gate. The client was denied the opportunity to passively avoid the session, thus impinging her ability to refuse service. Therapists conducting in-home sessions must be sensitive to their clients' wish to decline a session without verbalizing the request, i.e., "no show." Additionally, homebound clients' heightened isolation and strong desire for company may coexist with a wish to refuse therapy, thus creating ambivalence that inhibits them from declining therapy.

Older adults who have cognitive deficits present further challenges to obtaining informed consent. Clinicians may need to ascertain who holds the legal right to consent to treatment (e.g., the client, his or her power of attorney, a guardian). If the client is cognitively impaired but does not have a legally appointed surrogate decision maker, the clinician must explore the client's capacity to make the decision to consent to or decline treatment. This exploration could range from an accommodation of additional time to elicit the personal values and preferences of an elder with questionable capacity or a screening and referral for further assessment (American Bar Association Commission of Law and Aging and the American Psychological Association, 2006). For further suggestions on conducting therapy with cognitively impaired persons, please see, for example, Hausman (1992), Solomon & Szwabo (1990) and Carpenter et al. (2004).

LEGAL ISSUES

The need for legally mandated reporting, which varies from state to state, may become more evident during in-home work. For example, clues of possible elder and dependent adult abuse, self-neglect, and child abuse may be more apparent on a home visit. The clinician may see an unhealthy situation such as no plumbing, a fire hazard, extreme hoarding, or no food, that the client may not verbalize. Reporting to the designated agency as required by state law may be required more frequently. Clinicians must understand their reporting duties, as well as clinically useful ways of working with the client when reporting is required. For example, the clinician and client may decide together who will file the report, depending on the client's wishes and the treatment plan. To reduce related anxiety for the client,

and perhaps involved others, the clinician may outline what to expect once a report of suspected abuse is filed. Occasionally, the legal requirement to report suspected abuse may create an insurmountable breach in the therapeutic relationship, resulting in premature termination.

RISK MANAGEMENT ISSUES

Clinician Safety

Unlike the relatively controlled environment of the clinic or office, the in-home clinician walks into an unknown environment which may include neighborhood crime, weapons in the home, emotionally unstable clients, volatile family members, etc. Suggestions for training clinicians to enhance safety include 1) evaluating safety risks with the referring party, including familiarity with a client's mental health and criminal histories; 2) not entering a home when the therapist senses any danger; 3) sitting closer to the door; 4) leaving at any moment when clinicians might sense a lack of safety; 5) not fearing supervisory judgment for leaving; 6) feeling the freedom to stop in-home therapy if clinician feels unsafe in a client's house; 7) taking a second staff member if safety may be compromised; and 8) consulting in order to problem solve safety related barriers to treatment where possible. One female clinician had been successfully conducting in-home therapy with a male client for 5 months. She then reported that the client stood in front of her and refused to move when she was trying to exit. The therapist later reported that 2 weeks previously the client had rearranged the furniture so that a large couch blocked the passageway from the seating area to the door. This clinician feared for her safety, and was supported in her decision to conduct phone therapy until the client became willing and able to secure transportation to the clinic or to another mutually agreeable, neutral meeting place.

Client Safety

Client safety must also be considered. For example, at our clinic clinicians are trained on what to do if a client is perceived to be having an urgent medical incident (e.g., a fall, trouble breathing, chest pain, loss of consciousness). When does the clinician intervene if the client is unable to verbalize his/her preference or when the client refuses or resists emergency intervention? Given the risk management matters involved, each agency will need to set its own unique guidelines.

In summary, in-home therapy raises particular clinical, ethical, legal and safety or risk management benefits and challenges. Clinicians will be confronted with unique situations in which they will need to make quick decisions. While boundary "crossings" can be boundary "violations" and detrimental to client treatment, boundary "crossings" can also be helpful.

Boundary challenges can be understood to be evidence of the client's personality and behavior patterns, and therefore useful in increasing the therapist's understanding of and ability to help the client. Preparing for such challenging situations and having tools available to consider will help clinicians make decisions that optimize clinical benefit, maintain ethical and legal integrity, and maximize safety.

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