

# Late-Life Depression and the Counseling Agenda: Exploring Geriatric Logotherapy as a Treatment Modality

Depresión en edades avanzadas y la agenda de asesoramiento psicológico: Explorando la logoterapia geriátrica como modalidad de tratamiento



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## ABSTRACT

The counseling agenda established for dealing with late-life depression is often followed in consort with pharmacotherapy which has proven clinically to be quite effective in reducing and, in many cases, relieving symptoms of low self-esteem and anxiety. Whereas conventional medical intervention concentrates on the reduction of depression symptoms, psychotherapeutic modalities such as cognitive-behavioral therapy have proven somewhat effective in creating a more stabilizing experience of existential contentment, offering a deeper sense of well-being rather than simply symptom reduction. Geriatric logotherapy has come forth with an emphasis upon existential contentment drawn from accessing what is called the “life story window” wherein the therapist assists the patient in exploring the past in search of the “happy memory.” Since palliative rather than curative care is the therapeutic agenda in late-life counseling, this logotherapeutic approach has produced a treatment modality worthy of further exploration with particular attention to reminiscence and life review studies.

## RESUMEN

La agenda de asesoramiento psicológico establecida para tratar con la depresión en edades avanzadas es a menudo realizada con farmacoterapia, la cual ha probado clínicamente ser bastante efectiva reduciendo y, en muchos casos también, aliviando los síntomas. Mientras que la intervención médica convencional se enfoca en la reducción de los síntomas de la depresión, las modalidades psicoterapéuticas como la terapia cognitiva-conductual han probado ser de alguna manera efectivas creando una experiencia más estable de satisfacción existencial, ofreciendo un sentido más profundo de bienestar que simplemente reduciendo los síntomas. La logoterapia geriátrica se presenta con un énfasis en satisfacción existencial extraída de la entrada a lo que se denomina “la ventana a la historia de vida”, en donde el terapeuta asiste al paciente explorando el pasado en búsqueda de “la memoria feliz”. Puesto que la agenda de asesoramiento en edades avanzadas es más paliativa que de asistencia curativa, este enfoque logoterapéutico ha producido una valiosa modalidad de tratamiento de exploración adicional con atención particular en la reminiscencia y en el estudio de la historia de vida

## Key Words:

Logotherapy;  
Geriatric;  
Depression;  
Counseling;  
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## Palabras Clave:

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In just over 50 years, the American Medical Association has collected over twelve hundred articles in medical journals dealing with issues related to aging and depression. In the 1950s, the field was wide open for both psychiatric research in psychopharmacology as well as in psychological counseling (Alexopoulos & Kelly, 2009). During this period of half a century, the research has become increasingly sophisticated and disproportionately pharmacological (Steffens & Potter, 2008). Without in any way suggesting that psychotropic medication is inappropriate or over-used, the following exploration will be of the use and value of therapeutic counseling rather than medication as a first-choice treatment for late-life depression (Mitchell & Subramaniam, 2005). Of course, predicated on the clinically determined assurance that no biogenic disorders are operative within the patient, the use of psychotherapy as a mode of treatment for psychogenic depression among the elderly should be continually explored even in the face of overwhelmingly advancing psychopharmacological research in geriatric biogenic dysfunction.

The history and relevance of the relationship between the terms “geriatric depression” and “late life depression,” while providing an interesting historical and historiographical sideline, is not our focus here, so we will not be distracted by these linguistic niceties (Yohannes & Baldwin, 2008). While the AMA’s online library, PUBMED, provides an historically interesting roster of articles dating from the 50s dealing with geriatric depression and from the 70s with late life depression, the 1,200 articles of the former and the 2,200 of the latter category simply demonstrate the research explosion which has occurred in this field of medicine and counseling (Krishnan, 2007). For our purposes, we will use the terms interchangeably as no case has been made to medically differentiate them.

It should be made clear from the beginning of this exploration that late-life depression is not considered by the medical community as normal in the aging process, though it is, indeed, quite common (Atiq, 2006). Because our interest is particularly in the “close of life” period where palliative rather than curative treatment is sought, since the nurturing of the elderly is not aimed primarily as a cure for which there is none, we will employ both sets of terms, i.e., late-life depression and geriatric depression, as suggestive of “close of life” issues rather than using a broad-based application to individuals in a post-retirement period of life. Since “end of life” issues are covered more thoroughly by thanatologists, geriatric

psychotherapists are eager to make a disclaimer of that domain of study and research. Though close-of-life issues intersect with end-of-life issues, they are distinct and separate, particularly as relates to medical and psychotherapeutic intervention. With regarding to geriatric depression particularly, it is unfortunate that both the patient and the family are commonly disinclined to report a debilitating level of depression common among the elderly, attributing rather their depressed moods as either resulting from the side effects of medication (whether reasonably probable or not) or to the normal stresses and strains of the aging disengagement from power and responsibility (Alexopoulos, 2005).

Nevertheless, depression, whether major or minor in intensity, is a mental disorder encompassing such feelings, usually not articulated, as low self-esteem, loss of interest or pleasure in normal activities and, according to the American Psychiatric Association (APA, 2000:354), nearly 5 million of the 31 million Americans over 65 years of age suffer from clinical depression with 20% of those having major depression symptoms. Understandably, major debilitating depression is higher among the medically ill over 70 year olds with suicide more than double the average population. Chronic diseases, it should be noted, associated with deep depression among the elderly include, not surprisingly, stroke, coronary heart disease, cancer, Parkinson’s, Alzheimer’s, and dementia. According to Rapaport and colleagues (Rapaport et al., 2002), minor depressive moods eventually develop into full blown major depression up to fifty percent of the time according to a major study (Birrer & Vemuri, 2004).

Psychiatrically-diagnosed late-life depression within the close-of-life population is characterized by a variety of symptoms identified by Birrer and Vemuri. To meet the criteria for a major depression episode, they explain, a patient must have a presentable demonstration of 5 of the following 9 symptoms every day for at least two weeks. They include a depressed or sad mood, loss of interest in pleasurable activities, increased or decreased sleep, increased or decreased appetite, increased or decreased energy/activity level, poor memory and/or concentration, feelings of guilt or worthlessness, a change in mental and physical speed perceived by other people, and thoughts of wishing to be dead. Exacerbating the diagnosis and treatment of late-life depression is the fact that changes in brain chemistry and function which may be causing these feelings are simply not yet known, though medical studies have verified that these brain functions are triggered by such things as stress and life style (Wong & Licinio, 2001).

Treatment usually consists of a mixed combination of psychotherapy and pharmacotherapy, with proportions of each determined by both medical and psychiatric consultation and counseling resources and preferences dictated by either the patient or the patient's family (Frazer, Christensen & Griggiths, 2005). Studies consistently show that some improvement from medication is evidenced in the elderly patient but, due to the risks involved in increased pharmacological intervention in the health and well-being of the older patient, psychotherapy is usually preferred initially in dealing with geriatric depression (Smith & Alexopoulos, 2009). Cognitive-behavior therapy, supportive psychotherapy, problem-solving therapy, and interpersonal therapy are the most common forms of psychotherapeutic treatment which is often administered by either social workers or pastoral care givers rather than physicians or psychiatrists (Arean & Cook, 2002). Alexopoulos and colleagues (2008) have shown that older patients often have better treatment compliance, lower dropout rates, and more positive responses to psychotherapy than younger patients.

Pharmacotherapy and particularly psychopharmacotherapy have proven to be quite effective both separate from and in consort with psychotherapeutic treatment of late life and geriatric depression (Murphy, Kremer, Rodrigues & Schatzberg, 2003). Murphy and colleagues point out that antidepressant medications are frequently the first line of treatment for older adults presenting symptoms of the onset of deep depression. Though not a cure, Murphy points out, antidepressants do function effectively as a repressor of symptoms, particularly anxiety and low self-esteem. Both pharmaceutical and psychotherapeutic interventions are being proven effective in the treatment of late-life and geriatric depression but the struggle to keep a balance within both the medical community generally and the psychiatric community specifically is an ongoing effort within the medical profession (Morgan, 2012d). A too quick reliance upon a pharmaceutical "quick-fix" is sometimes countered with a too gradual psychotherapeutic intervention. The right balance, as in all medical and therapeutic practice, is the goal in spite of its elusive nature (Scogin & McElreath, 1994).

The psychiatric literature reports that geriatric logotherapy as an effectively viable treatment has begun to address the subject of late-life depression are reflected in my recent work (Morgan, 2012a,b,c). That logotherapy has historically been overlooked or ignored by traditional psychiatry and the more fully developed schools of

psychotherapy drawing from Freud, Adler, and Jung is not new information (Morgan, 2012e). Yet, and in spite of the oversight by practicing psychotherapists, logotherapy as a growing school of thought and professional practice cannot continue to be ignored owing to its aggressive and reportedly successful address to the treatment of depression. Logotherapy is a type of psychotherapeutic diagnosis and treatment which focuses on a "will to meaning," thus, the naming of this modality of treatment. It is founded upon the belief that striving to find meaning in one's life is the primary, most powerful motivating and driving force within the human experience. Sometimes called existential analysis (Frankl, 1967; 2004), logotherapy is the Third Viennese School of Psychotherapy founded by the Austrian psychiatrist, Viktor Frankl, the first and second schools were founded by Freud as psychoanalysis and Adler as individual psychology (Frankl, 1963; 1969; 1997; 2001). In recent years, Victor E. Frankl has emerged as the leading proponent in psychotherapeutic circles of the centrality of the experience of "meaning" in the treatment of mental illness, and demonstrating clinically the particular benefits of this approach in the treatment of depression. Though not specifically faith-based, logotherapy is practiced within the context of a spiritual awareness of self-transcendent reality (Graber, 2004). Geriatric logotherapy, then, is a subset of this analytical approach designed to address issues uniquely confronted in the treatment of the elderly suffering from late-life depression.

According to logotherapists, life has meaning under all circumstances, even in the direst situations. "What matters is not the meaning of life in general," Frankl suggests, "but rather the specific meaning of a person's life at a given moment." Meaning is not "invented" but rather "detected." We can discover meaning in life in three different ways: (1) by doing a deed; (2) by experiencing a value -- nature, a work of art, another person, love, etc., and (3) by suffering. Logotherapy discounts the effective utility of the Second Viennese School of Psychotherapy, i.e., Alfred Adler's notion of humankind's "will-to-power," by arguing that personal power in the face of suffering and in the absence of personal meaning has no visible function within the personality (Frankl, 1962b). This emphasis upon the existential encounter with life's meaning we will revisit within the context of late-life depression and its treatment.

A concept of humanity is held, consciously or not, by every school of psychotherapy (Morgan, 2012e). We see it in Freud, Adler, and Jung, and so likewise in Frankl. That concept of the human person, according to logotherapists, affects

everything, all conceptual development, all theories of treatment, all clinical perceptions. Resulting from his wartime concentration camp experience, Frankl became convinced of the *sui generis* nature of the will-to-meaning, what he later developed into logotherapy (Frankl, 1958). We must elevate this concept of the person for critical analysis from the logotherapeutic perspective if we ever hope to understand the differences in psychotherapeutic modalities of treatment. “For,” explain the logotherapists, “a psychotherapist’s concept of man can reinforce the patient’s neurosis and, therefore, can be wholly nihilistic.” Three fundamental characteristics of human existence converge in defining what it means to be human -- spirituality, freedom, and responsibility (Frankl, 1962a). The philosophical structure of logotherapy is based on the conviction that any model of psychotherapeutic analysis and treatment must have a strong philosophical basis (Frankl, 1961b).

Neither a protagonist nor an antagonist for a faith-based worldview, logotherapy simply intends for spirituality not to be tied up with a specific notion of religion. In the treatment of the elderly, logotherapists are eager to admit and even nurture a spiritual orientation within the worldview of the patient if and when it proves to be of benefit in addressing issues relevant to the presenting elements of depression. Where religious worldview and ethos stifle, cripple, or delude the individual, logotherapy opposes it. In this context what is meant by spirituality as a fundamental component of human nature is the individual’s capacity for a sense of awe, wonder, and mystery, even reverence, in one’s own assessment of the meaning, value, and purpose of life. The surprising feature about logotherapy’s formulations is that throughout, personal reference to the therapist’s own personal spirituality is avoided (Frankl, 1957; 1961a). The connectedness of all things as experienced in moments of high sensitivity or even ecstasy is the role spirituality plays in the human character. A deeply felt sense of beauty, power, and wonder in the universe, a heightened experience of integrality, what has been called “systemic integrality,” constitutes what spirituality means in logotherapy (Morgan, 2012e). Whether one is a theist, an atheist, or an agnostic, Frankl and logotherapy contend that the dynamics of spirituality can be equally and meaningfully operative within a person’s life bringing value and purpose (Frankl, 1954). It is here, in the existential moment, that geriatric logotherapy emerges as a helpful modality of treatment.

When logotherapy is applied to the geriatric patient, there is a challenge to transform the central

concepts of the therapeutic practice to the life situation of the individual whose life has, for all practical purposes, already been lived. Believing that logotherapy has, indeed, something yet to offer the geriatric patient, it is imperative that the will to meaning not be only thought of as an agenda for future living but as a hermeneutic for living in the moment (Thompson, Gallagher & Breckenridge, 1987). Existential episodes of happiness constitute what the clinician might imagine to be the practical application of logotherapy in dealing with older and elderly individuals (Morgan, 2006). Rather than seeking for that window of hope for the future which is so characteristic of this modality of therapeutic treatment, the logotherapist must creatively search for “existential episodes of happiness,” as I have chosen to call them, viz., remembered events in which the older person demonstrably attributes the experience of “happiness.” This approach, rather than focusing upon hope, focuses upon memories, times past which bring a moment of reflective happiness now (Frankl, 1953). The existential character of the remembered happy event constitutes the possibility for a treasure trove of episodic happiness vignettes bringing comfort to the elderly facing a limited future.

Though we have seen that psychotropic and pharmacotherapeutic intervention has its place and its uses, when dealing with late-life depression the therapist, psychiatrist or psychotherapist, must be in mind that we are dealing with patients who are not anticipating the lengthening of life. We are rather interested in easing the stress without dulling the senses, a side effect of medication, particularly antidepressants. Since life is not, for all practical purposes, to be lengthened, at least within the context of a quality-of-life consideration, then the existential episodes of happy memories constitutes the full-on agenda rather than a mere side effect. The “life story window,” as it has been called in logotherapy, is the avenue into the world of the patient, wherein the therapist assists the patient through a maze of memories until such time, usually a fleeting moment reflected upon the physiognomy of the patient’s facial expressions, as a “window” into a “happy memory” occurs. The listening as well as watching of the patient by the therapist is a crucial analytical technique, needing cultivating on the part of the practitioner, but of great value in spotting the moment when the happy memory has been discovered through wanderings within the patient’s life story.

Illustrative of this existential moment discovered through the life story window is the case of Mrs. Williams, a nursing home patient in her mid-

80s suffering from acute and near debilitating depression. Other complicating health issues included high blood pressure, diabetes, and arthritis. A retired librarian for some twenty-plus years, Mrs. Williams came to the nursing home after falling in her home where she lived alone following the death of her husband ten years before. The decision was made for institutional care in conjunction with family members (all distant cousins as she was widowed with no children). In meeting with her over several sessions, the therapist struggled with finding the window of happy memories through which to follow Mrs. Williams. Finally, during the third clinical session, some passing reference was made to her childhood farm life and swimming with her girlfriends in the cow pond behind the barn. As this passing reference seemed to cause her to pause and smile quietly to herself as she was formulaically reciting her "life's story" to the therapist, it became clear to the observant therapist that the patient enjoyed the memory and might enjoy elaborating upon it. The result was a meandering recollection of her childhood experiences with her friends on the family farm which, she said, "I haven't thought of in years." Subsequent sessions always harped back to these happy memories and provided a substance to her solitary reflections beyond the therapy sessions. There was a marked improvement in her attitude towards life and a gradual but steady decline in her depression.

Often, the geriatric patient needs assistance in conjuring these past episodes of happiness and the therapist then can employ what I have chosen to call "memory suggestions," viz., asking the individual to back track consciously in search of "illustrative events" in his or her life to which they themselves attribute a blissful and happy experience. However, an important key here for the therapist to keep in mind is "stress avoidance," that is, redirecting the individual away from remembered events in their past when clearly, by facial expression or voice intonation, suggest stress or anxiety or unhappiness (Morgan, 2012c). Places, times, and people constitute for me the three fundamental arenas within which the patient may find these points of conversation leading to the discovery and revisiting of happiness episodes in their earlier life.

Another case study example of geriatric logotherapy is the case of Dr. Watson, a retired philosophy professor living alone in his home as a widower with his two adult children living far away. Dr. Watson is in his late 80s, was once a nationally recognized scholar, author of several books, but these days finds reading increasingly difficult owing to glaucoma and writing virtually impossible due to

arthritis in both hands. Reduced to sitting on his expansive front porch when weather permits and before the fireplace otherwise, Dr. Watson has sunk into a debilitating depression resulting in a consistent failure to eat regularly or to converse over the phone with friends and family. A concerned son precipitated the contact with the logotherapist who made an initial home visit, finding the above situation. Dr. Watson had essentially "given up," as he put it to the therapist, because of an inability to read or write which constituted his life's work and passion. When the therapist encouraged the professor to "tell me about your life's work," Dr. Watson commenced slowly and deliberately rattling off his educational background, teaching appointments, books written, conferences attended, all with little passion and near expressionless. However, when the therapist asked about specific colleagues mentioned in the monotone narrative, he noticed that the patient became somewhat animated, enthusiastic, even excited to relate story after story involving colleagues, happy stories, fun stories, all leading to an extremely productive journey through time and people of importance. Subsequent sessions centered upon the same topics with the results that Dr. Watson began calling up old friends, inviting other retired colleagues in town to come for morning coffee and chat. The window of happy memories had been found and opened and the result was that Dr. Watson's life took on renewed vitality, not focusing upon the future but an existential reverie in the happy memory re-shared with friends.

One of the greatest challenges for the logotherapist is to acknowledge and own the inevitable reality of the brevity of life left to the elderly patient suffering from late-life depression (Frankl, 1961c). The therapeutic goal here is clearly not some form of contrived cure for what might be the presenting symptoms of depression for these are the most common driving forces in seeking help for the patient, whether that help is solicited from the patient or the family or, in many cases, the institutional staff responsible for patient care. A cure certainly is not what is sought here, but rather, beyond and after the notion of a cure for the aged patient, there is an urgent need for the identification of the rightful place for palliative care in such situations. A quest for existential happiness, episodic joy from happy memories, constitutes the driving force in the therapeutic encounter with the geriatric patient who most commonly is suffering from depression.

A concluding illustration of the value of geriatric logotherapy and its use in existential counseling is the case of Miss Horton, an elderly spinster school teacher from a small town, whose life

had been synonymous with teaching elementary school children, living in the background, watching them grow up, move away, establish families, and launch careers. Now nearly 90 years old and residing in an assisted living facility in her home town, she had drifted into depression within the context of a lack of social stimulus (most other residents were suffering from acute and severely debilitating dementia). Her health had declined gradually owing to heart problems and towards the end of her life, she had taken to the bed and was less and less willing to converse with even the nurses. The nursing director called in the logotherapist (based on the therapist's reputation in dealing with geriatric patients) and from the beginning the initial encounter appeared fruitless, bordering on hopeless. As the therapist explored Miss Horton's social life through interviews with nursing staff who knew the patient's personal history. In the therapist's search for the window of opportunity which would introduce happy memories and reflective thoughts of joys gone by, it occurred to her that since the patient's life had been lived for the children she taught, why not get some of those children, now adults, to come say goodbye to her in her closing days of life. It worked wonders. Through the local school, the therapist was able to contact several of the patient's past students, now parents and successful people, to come for a visit. Since most people are uncomfortable visiting someone on their death bed, the therapist always arranged to be present, coaching the visitor to help Miss Horton "remember" episodes in the classroom and on the playground in which she was a major player and to share with her, as she lay mute but alert, the stores of their own lives as they left school and entered the world, always with reference to the patient's contribution to their own personal lives. The results were remarkable, not that she lived much longer, for she did not, but during the closing weeks of her life, she became conversant, sitting up in bed, asking about this student and that student, remembering to the therapist more and more happy moments in her teaching life that brought a twinkle to her eyes and a smile on her face. These happy memories obviously combined with her realization of how meaningful her life's work had been to others.

The challenge to both the therapist and the attending medical team is to acknowledge and own the reality of the patient's finitude, a point made by Pollack thirty years ago (Pollack, 1982). Too often the knee-jerk reaction to a close-of-life debilitating symptom is to try to fix it or cure it. To own the reality of the close-of-life situation wherein late-life depression may appear with the realization that curing or healing is not the objective but to rather

enhance the existential moments left to the patient is a hard lesson to learn for both the physician and the psychiatrist are professional skewed to seek for a cure, a point made by Lazarus and colleagues nearly thirty years ago (Lazarus, Grovus & Newton, 1984). Palliative care is coming on stronger and stronger these days, thanks to hospice and other care-oriented modalities of treatment and with it the realization that the agenda as defined by geriatric logotherapy has its rightful place in the treatment scheme of the aged patient.

The practicality and professional humility of logotherapy is evidenced in its ready willingness to acknowledge the therapeutic limits of this modality of diagnosis and treatment. It has never claimed to be a comprehensive analytical treatment system for mental illness. Unlike other schools of psychotherapy which, too often, presume to be the panacea for all mental disorders, logotherapy has self-consciously identified its arenas of success and knows those in which it has little to offer. The distinctions center around psychogenic and biogenic classifications. Certainly and with little contradiction, logotherapy has a long clinical history of effective use in the treatment of psychogenic depression. When applied to the treatment of the elderly, not as a curative but as a palliative therapy, there is great promise. When it is not hope for the future which is being sought but rather an effective and celebrative address to the existential realities confronting the elderly patient who is facing decline and death, the quest for those happy moments conjured in the patient's memory constitute a promising field of treatment. Geriatric logotherapy is uniquely constructed to do just that.

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