Integrating Religion and Spirituality Into Treatment for Late-Life Anxiety: Three Case Studies

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Generalized anxiety disorder (GAD) is common in older adults and, although cognitive behavioral therapy (CBT) is an efficacious treatment for late-life GAD, effect sizes are only moderate and attrition rates are high. One way to increase treatment acceptability and enhance current cognitive behavioral treatments for GAD in older adults might be to incorporate religion/spirituality (R/S). The cases presented here illustrate the use of a 12-week modular CBT intervention for late-life anxiety, designed to allow incorporation of R/S elements in accordance with patient preferences. The three women treated using this protocol chose different levels and methods of R/S integration into therapy. All three women showed substantial improvement in worry symptoms, as well as a variety of secondary outcomes following treatment; these gains were maintained at 6-month follow-up. These preliminary results suggest that the incorporation of R/S into CBT might be beneficial for older adults with GAD. Strengths, limitations, and future directions are discussed.

Keywords: religion; spirituality; cognitive behavioral therapy; late-life anxiety; generalized anxiety disorder

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Integrating Religion Into Treatment for Anxiety

Potential Utility of Incorporating Religion/Spirituality Into Treatment

One potential strategy for reducing dropout rates and enhancing current CBT treatments for GAD in older adults is to incorporate religion/spirituality (R/S). Religion plays a role in many older adults’ lives, with most older adults stating that religion is either very important (72%) or fairly important (19%) to them (Newport, 2006). Furthermore, many older adults with anxiety and/or depression report being involved in religious practices (Chen, Cheal, Herr, Zubritsky, & Levkoff, 2007), and research has shown that church attendance and other forms of R/S coping positively impact physical and mental health (Chatters et al., 2008; Powell, Shahabi, & Thoresen, 2003; Wink & Scott, 2005; Worthington et al., 2003). R/S coping strategies may be particularly relevant for older adults of minority backgrounds, as they tend to report greater levels of religious participation and spiritual activities than Caucasian older adults (Krause & Chatters, 2005; Levin, Chatters, & Taylor, 2005).

Additional impetus to integrate R/S into therapy comes from clinical experience working with late-life anxiety. Several patients in previous clinical trials of CBT for GAD have chosen to incorporate R/S into the standard coping skills (Paukert et al., 2009), and 83% of patients surveyed indicated a preference for including R/S in therapy (Stanley et al., 2011). Characteristics of the patients who stated they would like to incorporate R/S into therapy include greater self-reported strength of religious faith and more positive religious-based coping than those who preferred not to incorporate R/S.

General Principles for Including R/S in Therapy

Only a limited amount of research has attempted to identify the best ways to include R/S into therapy. The majority of patients surveyed by Stanley et al. (2011) who liked the idea of integrating R/S into psychotherapy stated a preference for incorporating R/S into all therapy-based skills (56%), whereas a smaller number preferred to discuss R/S separately (19%). In addition, clinicians and researchers have suggested several practical guidelines. First and foremost, the decision to incorporate R/S into treatment should be a collaborative one between patient and therapist (Paukert et al., 2009). Many therapists might be concerned about bringing up the topic of R/S for the first time and simply prefer to include R/S questions or assessments in a standard intake packet. However, this approach is far from ideal because patients may have difficulty putting their R/S beliefs into words or may not feel comfortable sharing their beliefs (which are often quite personal) on paper without any interpersonal discussion (Pargament, 2007). Instead, the therapist can initiate the discussion by asking the patient whether R/S is important in his or her life. This simple inquiry allows the patient the option of saying no and also indicates to the patient that the therapist is willing to discuss R/S issues if the patient so desires. If the patient indicates that R/S is important to him or her, the therapist can then offer the patient the option of including discussion of R/S in treatment. However, it is important to emphasize that this decision should be based on the patient’s preference and should not be influenced by the therapist’s beliefs or preferences.

A related issue that may be important to consider is whether it is appropriate for the therapist to discuss his or her own R/S beliefs or values with the patient. Potential negative consequences of this type of therapist disclosure include patient rejection of a therapist with differing beliefs, patient reluctance to discuss his or her own beliefs, or the exclusive focus on religious issues in therapy (Worthington, Kurusu, McCullough, & Sandage, 1996). Interestingly, most patients in our prior study assessing patient preferences for the incorporation of R/S into treatment (Stanley et al., 2011) indicated that it would not be important to know the R/S orientation of their counselor. Even more important is the recommendation that therapists never challenge patients’ religious beliefs or values, as this will likely damage the therapeutic relationship (Morrow, Worthington, & McCullough, 1993). The exception to this is if a patient’s R/S beliefs are directly related to and exacerbate psychological symptoms, such as a battered woman’s belief that she must stay with her husband out of a moral or religious obligation (Robb, 2001), or maladaptive beliefs categorizing eating as a moral weakness that are sometimes associated with eating disorders (Spangler, 2010).

Finally, therapists should be careful not to assume they understand patients’ R/S views simply on the basis of religious affiliation. There are a variety of experiences and beliefs even within the same religious or spiritual traditions, and giving patients the opportunity to share their personal R/S beliefs allows the therapist to better understand how their R/S experiences have shaped their lives and also conveys a willingness to learn (Pargament, 2007).

Review of R/S-Integrated Treatments

Although interest in R/S-integrated psychotherapies is growing, few research studies have documented the method of integration or evaluated the effectiveness/efficacy of these interventions (Rosmarin, Pargament, & Robb, in press). A review by Hodge (2006) indicated that R/S has been successfully integrated into cognitive and cognitive behavioral therapies for a multitude of psychological disorders. The studies reviewed included integration of many different R/S perspectives, including Christianity, Islam, and Taoism, as well as non-tradition-specific R/S practices. Typically,
these R/S-integrated treatments used patients’ R/S beliefs to help restructure maladaptive thoughts. Few studies have integrated R/S practices into more behavioral interventions such as behavioral activation or exposure (Paukert, Phillips, Cully, Romero, & Stanley, 2011).

Comparisons of the efficacy of R/S-integrated therapies versus secular therapies have generally indicated that R/S-integrated therapies perform at least as well as secular therapies. For instance, a recent pilot study evaluating the efficacy of a spiritually based intervention for GAD reported comparable reductions in worry and anxiety symptoms for the R/S-integrated treatment and traditional CBT (Koszycki, Raab, Aldosary, & Bradwejn, 2010). Additionally, a randomized controlled trial of an Internet-based Jewish R/S-integrated therapy for worry found large effect sizes for primary outcomes for the R/S-integrated therapy in comparison to progressive muscle relaxation (Rosmarin, Pargament, Pirutinsky, & Mahoney, 2010).

Systematic reviews of studies involving R/S-integrated therapies for the treatment of anxiety and depression have also found similar rates of improvement in therapeutic outcomes between R/S-integrated therapies and secular therapies (McCullough, 1999; Paukert et al., 2011). A meta-analysis of R/S-integrated therapies for a variety of psychological disorders found a moderate effect size for R/S-integrated therapies when explicitly compared with secular psychotherapies (Smith, Bartz, & Richards, 2007). However, only half of the studies included in this meta-analysis used manualized treatments and less than one third used fidelity checks. Furthermore, several of the included studies did not specify the clinical issues being targeted in treatment. Similar methodological problems were noted in a recent review of R/S-integrated therapies by Hook, Worthington, Davis, Jennings, & Gartner (2010). These authors used the criteria for empirically supported treatments developed by Chambliss and Hollon (1998), and found that while only two R/S-integrated therapies met the criteria for efficacy, this was largely due to a lack of replication and methodological rigor of studies of R/S-integrated therapies. Hook and colleagues concluded that, overall, the existing literature supports the use of R/S-integrative therapies for psychological problems, but that more research is needed to determine the comparative efficacy of R/S-integrative therapies to secular therapies.

**Overview of Calmer Life Protocol**

Though these results are promising, a need remains to develop a therapeutic intervention for older adults with GAD that allows the integration of R/S based on patient preference. The three cases described here demonstrate one method by which R/S can be incorporated into cognitive behavioral interventions for late-life anxiety. A manualized treatment, the Calmer Life protocol, was developed based on procedures from prior evidence-based, modular treatments for late-life GAD (Stanley et al., 2009; Wetherell et al., 2009), with modifications to allow the integration of R/S according to patient preference. The program is patient centered with regard to skill choice, incorporation of R/S, and delivery method. The initial 3 months of CBT involve up to 12 individual sessions. The first three sessions are in person; and subsequent sessions are either in person or by telephone, based on patient preference. Sessions last approximately 40 minutes, with the exception of a slightly longer first session. The therapist assigns practice exercises each week, and brief telephone contact occurs between sessions to review skills and practice exercises.

The initial three sessions involve core modules consisting of anxiety education and awareness, motivational interviewing, life-values review, deep breathing, and calming self-statements. For patients who choose to incorporate R/S, an R/S assessment is conducted during the second session to help the clinician understand the patient’s R/S beliefs and practices. The clinician and patient together select three to four elective modules for the subsequent eight sessions based on patient preference and clinician recommendation. Elective modules include behavioral activation, anxiety exposure, forgiveness of self and/or others, sleep management, problem solving, progressive muscle relaxation, and cognitive restructuring. The final CBT session is a skills review. For the next 3 months, patients receive booster calls weekly (for 4 weeks) and then biweekly (for 8 weeks) to review skills and facilitate continued practice.

Patients may incorporate R/S into any of the core or elective modules, or they may complete the treatment without any attention to R/S (two versions of a patient workbook are available to accommodate R/S choices). For patients choosing to integrate R/S into treatment, the therapist provides examples of how this may be done in each module and then allows patients to determine their specific preferences for doing so. Guidelines for introducing R/S components in each module are discussed below. Additionally, specific examples of how the patients outlined in this report incorporated R/S into their treatment will be discussed in detail.

**Deep Breathing and Progressive Muscle Relaxation**

In the deep breathing and progressive muscle relaxation modules, the therapist may suggest that patients focus on a religious image or word while they practice the exercises. Therapists may ask, “Are there images in your R/S that bring you peace (e.g., Jesus, Virgin Mary, Buddha, Western Wall in Jerusalem, flowing water, a beach)?” and/or “Are there words unique to your R/S beliefs that help calm you (e.g., Allah, God, Father,
Jehovah, Lord, sacred, amen)? Patients can then choose a particular religious image or word that is personally relevant or meaningful.

Calming Thoughts and Cognitive Restructuring

In modules focusing on calming self-statements and cognitive restructuring, the therapist may introduce the option of incorporating the patient's R/S beliefs by suggesting that these skills may be used as a reminder that he or she is not alone and can depend on something greater than him- or herself to help cope with worrisome situations. Therapists offer suggestions of possible R/S statements such as “[One’s higher power] will give me the strength to handle whatever comes up in the moment,” “I can do what I need to do, with [one’s higher power’s] help,” or “I cannot say for sure what will happen; only [one’s higher power] knows what the future holds.” Patients may choose to use the suggested statements or may generate their own.

Thought Stopping

Thought stopping involves redirecting attention away from worry thoughts to relevant ongoing activities and surroundings. Patients choosing to incorporate R/S into this skill may find it helpful to move to a state of prayer or meditation after redirecting their attention to their surroundings. They may also choose to engage in an R/S activity such as reading R/S literature or focusing on their blessings, or to practice deep breathing while focusing on an R/S word or image.

Forgiveness of Self and Others

The forgiveness modules allow patients to use their R/S beliefs to help them practice forgiveness. Many spiritual traditions encourage forgiveness of self and others, and some people feel closer to their higher power when they forgive. To introduce R/S in the forgiveness-of-others module the therapist may ask the patient, “Does forgiveness fit with your R/S values?” and “Have you ever drawn on your faith to forgive someone?” In the forgiveness-of-self module the therapist may suggest that “Self-forgiveness may involve accepting forgiveness from [one’s higher power]. Does this fit with your R/S values?”

Anxiety Behaviors

The anxiety behaviors module focuses on avoidance behaviors and unhealthy anxiety-reducing behaviors such as checking. The therapist should take note of whether patients’ repetitive/avoidance/worry behaviors are R/S in nature. If so, therapists may have a discussion with patients about how R/S behaviors are usually helpful but can become problematic if they are used too rigidly or excessively to avoid other responsibilities or tasks.

Behavioral Activation and Gratitude

The module focusing on behavior change for managing depressive symptoms includes behavioral activation strategies and/or gratitude activities. This module offers many ways of incorporating R/S into patients’ daily lives, such as daily prayer, reading religious literature, or involvement in religious activities. Additionally, patients can choose to keep a daily gratitude list to remind them of things for which they are thankful. Therapists may also ask patients if they would like to say a daily prayer of gratitude in which they give thanks for the blessings in their lives.

Sleep Skills

The sleep skills module involves psychoeducation about sleep and sleep hygiene. If participants want to incorporate R/S into this skill, the therapist may suggest that they try adding prayer, meditation, brief scriptural or other spiritual reading, imagery, or calming R/S music to the bedtime routine, as this can increase a feeling of peace and security. Therapists may also encourage patients to use R/S imagery with deep breathing during their bedtime routine to aid relaxation.

Problem Solving

In this module the therapist may ask patients how their R/S beliefs affect how they solve problems. For example, the therapist may ask “What is your perception of [one’s higher power’s] role in solving or helping to solve your problems?” and “Do you and [your higher power] work together to solve your problems?” Therapists may also suggest that sometimes solutions to problems can be found through R/S means such as talking with an R/S leader or through prayer.

Assessment Measures and Procedure

Assessments were conducted over the phone by an independent evaluator and occurred at three time points: baseline assessments occurred immediately prior to treatment, 3-month assessments occurred immediately posttreatment, and follow-up assessments took place 6 months after treatment began.

Penn State Worry Questionnaire–Abbreviated

The Penn State Worry Questionnaire–Abbreviated (PSWQ-A; Hopko et al., 2003) is a modified version of the original PSWQ (Meyer, Miller, Metzger, & Borkovec, 1990). The PSWQ-A contains eight items that rate worry severity on a scale from 1 (not at all typical) to 5 (very typical). Total scores range from 8 to 40, with higher scores indicating increased worry. A score of 15.99 represents an...
average score for community samples of older adults (Knight, McMahon, & Skeaff, 2008). The PSWQ-A has good reliability and validity among older adults (Crittendon & Hopko, 2006; Hopko et al., 2003).

Geriatric Anxiety Inventory

The Geriatric Anxiety Inventory (GAI; Pachana et al., 2007) is a 20-item assessment tool designed to measure anxiety symptoms in older adults. Respondents are asked to either “agree” or “disagree” with each statement. Total scores on the GAI range from 0 to 20, with higher scores indicating increased anxiety symptoms. A score of 2.72 represents an average score for older adults in the community (Andrew & Dulin, 2007). The GAI has sound psychometric properties and is capable of discriminating between patients with and without GAD (Pachana et al., 2007).

Geriatric Depression Scale–Short Form

The Geriatric Depression Scale–Short Form (GDS-SF; Sheikh & Yesavage, 1986) is a 15-item measure of depressive symptoms in older adults. Respondents answer each item with either “yes” or “no,” yielding total scores ranging from 0 to 15. Higher scores correspond with higher levels of depressive symptoms. A score of 2.83 represents an average score for older adults in the community (Andrew & Dulin, 2007). The GDS-SF has demonstrated good reliability and validity (Kieffer & Reese, 2002).

Insomnia Severity Index

The Insomnia Severity Index (ISI; Morin, 1993) includes seven items designed to assess severity of sleep difficulties. Respondents are asked to rate the perceived severity of potential difficulties, including sleep onset, sleep maintenance, and early morning awakening problems and the extent to which one is satisfied with, is worried/distressed about, and notices sleep patterns and problems. Total scores on the ISI range from 0 to 28, with higher scores indicating more severe insomnia. A score of 6.63 represents an average score for older adults with no psychiatric diagnoses (Brenes et al., 2009). The ISI has good internal consistency and test–retest reliability (Bastien, Vallieres, & Morin, 2001).

Satisfaction With Life Scale

The Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985) is a five-item measure of global life satisfaction. Respondents indicate the extent to which they agree with each statement: 1 (strongly disagree) to 7 (strongly agree). Total scores range from 5 to 35, with higher scores representing greater life satisfaction. A score of 24.2 represents an average score for older adults (Pavot, Diener, Colvin, & Sandvik, 1991). The SWLS has good psychometric properties, including high internal consistency, test–retest reliability, and predictive validity (Diener et al., 1985; Pavot et al., 1991).

Recruitment

The patients described here were enrolled in an open trial of the Calmer Life intervention after receiving usual care in a prior trial of CBT for older adults with GAD (Stanley et al., 2009). Upon agreement to participate in the Calmer Life program, the patients completed a structured interview, the Structured Clinical Interview for DSM-IV-TR (SCID-I; First, Spitzer, Gibbon, & Williams, 2002), to ensure that they met criteria for a diagnosis of GAD, as well as a six-item cognitive screener (Callahan, Unverzagt, Hui, Perkins & Hendrie, 2002) to rule out cognitive impairment.

Clinical Case 1

Identifying Information and Relevant History

“Mary”1 was a 65-year-old Caucasian woman who had never married. She had attended college but did not graduate and worked part-time as a driver for seniors. Mary had been on a regular dose of Ambien for the past 7 years. At baseline, Mary met criteria for GAD and dysthymia, as assessed by the SCID. Her main worries included finances, her health, and social and familial relationships.

Treatment Process

Mary began the Calmer Life program with the first author as the primary therapist. She chose to conduct all treatment sessions in person. The treatment modules used in Mary’s treatment are reported in Table 1. The initial session focused on anxiety awareness and values identification. Mary reported that spirituality was important to her and that she wanted to make more of an effort to practice her faith on a regular basis. As an example, Mary noted that, although she valued regular attendance at mass, she currently attended mass only sporadically and often gave herself excuses for not going. During the R/S assessment in the second session, an effort was made to understand Mary’s personal religious beliefs and practices. Mary identified as Roman Catholic, although she noted that she occasionally attended lectures and events at the Methodist Church as well.

The first skill that Mary learned through treatment was diaphragmatic breathing. She was given the option of incorporating her religious beliefs into this skill by

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1 Details about the cases in this paper have been modified to protect the identities of the clients.
focusing on a religious image or word during her deep-breathing exercises. Mary chose to focus her thoughts on a statue of Christ from her childhood church that was particularly meaningful to her. Beginning in Session 4, Mary developed coping statements she could use in anxiety-provoking situations. She used the phrase, “God will not give me more than I can handle,” when she was feeling overwhelmed.

Sessions 5 and 6 introduced the concept of forgiveness as a way of letting go of hurt or anger and reducing worry and depression. Forgiveness was tied into Mary’s faith through her belief that we must forgive others as God forgives us. Mary used this belief as motivation to help her practice forgiveness. The forgiveness sessions were originally designed so that the first session focused on forgiveness of others, and the second session was about self-forgiveness, but Mary had a difficult time identifying transgressions for which she had not forgiven herself. She had a lot of anger toward her brother for perceived wrongs both past and present, and thus both sessions were spent discussing their relationship and helping her let go of her long-harbored anger. Mary came to the understanding that she could not change her brother’s personality, and that dwelling on his irritating habits and past transgressions was not fruitful and served only to upset her. As a symbol of her desire to let go of her anger and improve their relationship, Mary sent her brother a card to let him know she was thinking about him. Mary noted that making the effort to let go of this grudge helped her to feel as though she was better honoring her R/S values.

In Session 7, Mary worked on decreasing her anxiety behaviors such as checking and procrastination. She reported that she was worried about causing a fire, and that she checked the stove to make sure it was turned off and also checked the plug to the refrigerator multiple times each day. She also took her car to the service station to have the oil checked at least once a week. Mary was able to reduce her checking behaviors to manageable levels so that the checking no longer caused her to be late to work. She also agreed to have the oil checked in her car every other week rather than weekly.

Gratitude exercises were introduced in Session 8 as a way to reduce anxiety about the things in life over which Mary has no control. Mary indicated that she wanted to be thankful for the things she has rather than always focusing on what she lacks. She started a “blessings list” that she added to daily, and she also began to say a short prayer of gratitude to help her refocus her attention to the positive aspects of her life.

Sessions 9 and 10 focused on two cognitive strategies: thought stopping and cognitive restructuring. Mary learned to imagine a stop sign when she noticed she was worrying or becoming anxious as a cue to use some of her other coping strategies such as deep breathing or calming statements. This combination of techniques was quite helpful for Mary, and she reported liking being able to picture the stop sign and transition to deep breathing in almost any situation without anyone noticing. Mary also learned to use cognitive restructuring when she found herself predicting negative outcomes or catastrophizing. She incorporated her R/S beliefs with statements such as “I can’t say for sure what will happen; only God knows what the future holds.”

**Results**

Assessment measures were used to track changes in worry, anxiety, depression, and quality of life at baseline, 3 months, and 6 months. Scores on all measures are presented in Figures 1 through 5. Prior to beginning treatment, Mary scored in the clinical range on measures of worry (PSWQ-A = 39), anxiety (GAI = 17), and depression (GDS-SF = 12). Mary showed remarkable decreases in symptom measure scores following 12 weeks of treatment and maintained those gains at the 6-month follow-up. Her
sleep and global satisfaction with life also improved. At the 6-month follow-up, Mary reported that she was still using all the skills she learned during treatment and was continuing to incorporate R/S into her practice of the skills. She also stated that she was going to mass and other church activities regularly, and that this commitment to her spiritual life was very rewarding. Mary reported satisfaction with the overall treatment and especially appreciated the emphasis on gratitude and forgiveness. She indicated that incorporating R/S helped shift her focus away from her problems and toward the positives in her life.

**Clinical Case 2**

**Identifying Information and Relevant History**

“Martha” was a divorced 64-year-old Caucasian woman who was not taking any medications at the time of treatment. Martha was retired and financially stable but she often had to assist her daughter and grandson, which contributed to her worry about finances and her family. At baseline, Martha met criteria for GAD.

**Treatment Process**

The second author served as Martha’s therapist throughout the program. She chose to complete all treatment sessions in person. During the initial session, Martha identified health and the relationships between her daughter and grandson as areas of importance. In the R/S assessment session, Martha stated that she was raised Catholic but stopped practicing her religious faith after she got married. Martha indicated that she believes in a higher power but is not currently active in any organized religion. However, she wanted to increase her private practice of spirituality.
The first skill learned was diaphragmatic breathing, which Martha found to be somewhat difficult at first. However, once she overcame the initial challenges of learning to breathe from her diaphragm, Martha found the skill to be extremely helpful. She decided not to include an R/S image, as she felt it would not benefit her. Martha did choose to incorporate her faith beliefs into the second skill learned, calming thoughts. She developed statements such as “God grant me the strength to handle the things just for today” and “This too will pass” to help her manage her anxiety.

In Sessions 5 and 6, Martha learned thought stopping and cognitive restructuring, respectively. In thought stopping, Martha was able to imagine a picture of a large stop sign and then immediately transition her thoughts to the surrounding scene. For her, picturing the stop sign was a simple cue to alert her to stop the worrisome thoughts and to realize that feared outcomes may not occur. Martha had some difficulty with the cognitive-restructuring skill. She was able to identify her thoughts as overestimations of the likelihood of negative events occurring but struggled to generate more realistic alternative thoughts. However, Martha reported that the cognitive-restructuring exercises helped her become more aware when she was having these negative automatic thoughts and helped her to now realize that they may not occur.

Sessions 7 and 8 focused on decreasing anxiety behaviors, as well as pleasant activity scheduling. Martha reported snacking on chips, pretzels, and candy at night to help reduce worry. She wanted to reduce the snacking on unhealthy foods and created a grocery list with healthy food items to help her accomplish this goal. To add more

**Figure 3.** Graph showing the Geriatric Depression Scale–Short Form scores at baseline and 3- and 6-month follow-up for Mary, Martha, and Eva.

**Figure 4.** Graph showing the Insomnia Severity Index scores at baseline and 3- and 6-month follow-up for Mary, Martha, and Eva.
pleasant activities in her life, Martha chose to include meditation in her daily routine. Martha visualized a beach scene with the water hitting against the shore and also incorporated diaphragmatic breathing into her meditation practice. She reported that this combination of skills was very beneficial in helping her to relax.

Forgiveness modules were covered in Sessions 9 and 10. Session 9 focused on forgiveness of others. Martha discussed a situation in which her daughter forgot to take her daily medication, which caused Martha to be late for an appointment. After discussing the situation, Martha realized that she had rushed her daughter to get ready and recognized that this may have contributed to her daughter’s forgetting to take her medicine. Consistent with models of forgiveness that emphasize empathy (e.g., Worthington, 1998), such acknowledgment of one’s own contributions to a difficult interpersonal situation can promote forgiveness of another person’s actions. Session 10 covered forgiveness of self; Martha had a difficult time with this skill. Martha reported that, a few years earlier, she had had to call the authorities about her grandson, which resulted in his being incarcerated. Although her grandson had a history of run-ins with authorities, Martha had trouble overcoming her guilt because she felt that it was her phone call that ultimately led to him going to jail. Martha agreed to continue to work on letting go of her guilt by focusing on her grandson’s pattern of behavior and acknowledging that he was eventually going to be incarcerated regardless of her phone call.

Results

Martha’s assessment scores are presented in Figures 1 through 5. Before beginning treatment, Martha scored in the clinical range for worry (PSWQ-A = 29), anxiety (GAI = 10), and sleep (ISI = 20). After treatment Martha’s sleep scores decreased substantially and continued to lessen at the 6-month follow-up. Her worry symptoms also decreased substantially following treatment, and she maintained these gains at the 6-month follow-up. Martha had only marginal decreases in her anxiety and depression symptoms posttreatment, and these symptom measures returned to original levels at the 6-month follow-up. Her global satisfaction with life decreased slightly from baseline to the end of treatment but then improved at the 6-month follow-up. Martha reported continued use of the skills she learned through the Calmer Life program and stated that diaphragmatic breathing and calming thoughts were particularly beneficial in helping her relax before bedtime. Martha also had begun teaching the breathing and calming thoughts skills to her daughter.

Clinical Case 3

Identifying Information and Relevant History

“Eva” was a 65-year-old Hispanic woman who has been married for 50 years. She retired from her job 6 months prior to enrolling in the Calmer Life program; however, she continued to run a small accounting business from home. Eva had been taking Zoloft and Buspar for 11 years. She reported two previous episodes of depression at ages 11 and 28. At baseline, Eva met criteria for GAD and panic disorder without agoraphobia. Her main worries included her own finances and managing her workload.

Treatment Process

The first author served as Eva’s therapist throughout her participation in the Calmer Life program. Eva chose to conduct the first three sessions in person (as is required by the protocol) and the remaining sessions over the telephone. Due to holidays and scheduling conflicts, Eva
completed just nine sessions during the initial 12-week treatment period. During the anxiety awareness and R/S awareness sessions, Eva reported that family is very important to her, as are friendships and her faith. Her primary areas of worry were related to her finances and the well-being of her children and grandchildren. Eva identified as Roman Catholic and stated that she and her husband are active members of their church.

When presented with the option of incorporating R/S into the diaphragmatic breathing exercise introduced in Session 3, Eva chose to picture a nativity scene while practicing this skill. Eva reported using diaphragmatic breathing frequently, particularly when she noticed her anxiety or frustration levels rising, such as while driving. Although she initially focused on the nativity scene while practicing this skill, she later reported using diaphragmatic breathing in combination with the coping statements she developed in Session 4. Examples of these statements include “I am not alone, and for that I am grateful,” and “I can do what I need to do with God’s help.”

The fifth session introduced behavioral activation and gratitude exercises as tools for managing depressive symptoms. Eva identified several pleasurable activities that she wanted to engage in such as taking walks with her husband, stitching and needlepoint projects, and playing with her dog. She also made a goal of beginning her day with a prayer of gratitude, thanking God for the blessings in her life. In Session 6, Eva reported struggling with procrastination on work-related projects, which then led to feelings of anxiety and guilt. After identifying the pros and cons of changing her habit of procrastinating, Eva made a commitment to getting started on the projects she had been avoiding and breaking them into smaller, more manageable tasks so that she did not become overwhelmed. She reported a sense of accomplishment when she made headway on these projects.

Cognitive restructuring was introduced in Sessions 7 and 8 as a way to challenge Eva’s worry thoughts. Eva indicated that she had a tendency to get worked up over financial issues or problems at work. She found it helpful to write out her thoughts along with the cognitive-restructuring exercises to help her put things back in perspective. Through cognitive restructuring, Eva realized that her negative thoughts were making her feel worse and were not helping her accomplish anything. For example, when she had to help one of her clients prepare for an audit, Eva had negative thoughts about the outcome turning out badly. Instead of letting this thought lead her down a path of worry, she took the perspective that she had done the best she could to prepare for the audit and that was all she could do. Eva incorporated R/S into cognitive restructuring by asking God for help in managing her anxiety and helping her not to get worked up about things that are not under her control.

Results

Eva’s scores on the assessment measures are presented in Figures 1 through 5. At baseline, Eva scored in the clinical range on measures of worry (PSWQ-A=26) and anxiety (GAI=13). Her level of depression was low (GDS-SF=3). Eva’s worry and anxiety symptoms decreased over the course of treatment and continued to improve at the 6-month follow-up. She also reported a significant decrease in sleep problems at posttreatment. Finally, Eva’s global satisfaction with life increased following completion of the Calmer Life program. At the 6-month follow-up Eva reported continued use of all skills, including their R/S components. Eva found the Calmer Life program to be “very helpful” in helping her to manage her anxiety about a number of issues in her daily life. She reported a sense of accomplishment in managing her work projects without procrastination and also reported increased engagement in pleasurable activities, such as attending tap-dance classes with a friend. Eva liked the skills-based approach of the Calmer Life program and stated that through the program she learned to take control of her own worry by changing her thought and behavior patterns.

Discussion

GAD is a common and disabling disorder among older adults. Although CBT and pharmacotherapy are effective treatments for late-life GAD, patient outcomes and attrition rates suggest that there is room to improve our current treatments. One strategy for enhancing CBT for anxiety is allowing patients the option of incorporating their R/S beliefs into treatment. Preliminary research has shown the inclusion of R/S in psychotherapy to be beneficial for some patients (Hodge, 2006; Koszynki et al., 2010; McCullough, 1999; Paukert et al., 2011), but no studies have reported the development or evaluation of an R/S-integrated treatment for late-life anxiety. The three cases presented here illustrate multiple methods for incorporating R/S into CBT for late-life anxiety. Each module of the Calmer Life protocol provides guidelines for R/S integration that can then be tailored to the particular R/S beliefs of each patient. Importantly, the cases of Mary, Martha, and Eva demonstrate the flexibility of the Calmer Life protocol in allowing patients to choose how they want to incorporate their R/S beliefs into treatment. The protocol provides many options for R/S integration and allows for patient choice in integrating R/S throughout the entire course of CBT. Despite the similarities in religious identification in these patients (all reported Catholic upbringings), the therapists did not make assumptions about their current R/S practices or preferences. Each patient was given the opportunity to discuss her personal R/S beliefs in therapy and was able to tailor
the treatment and the incorporation of R/S to reflect her needs. Mary and Eva included R/S in almost every skill, while Martha chose to include R/S in only two modules: calming statements and activity scheduling. Although it is not possible to specify whether the incorporation of R/S is responsible for the treatment gains seen in these patients, all three patients did experience a substantial decrease in worry symptom severity. Two of the patients also experienced substantial decreases in general anxiety symptoms and substantial increases in their overall life satisfaction. All three patients reported improvements in their sleep patterns, and Mary also experienced a dramatic remittance of depressive symptoms following treatment.

The Calmer Life program was developed in accordance with current National Institute of Mental Health (2008) priorities of developing innovative and personalized interventions for mental illness. The goal of the program is to allow patients to tailor their treatment based on their specific needs and personal preferences. The Calmer Life program is well suited for use in communities in which access to traditional mental health services may be limited, such as communities with a high prevalence of minority elders. Minorities tend to prefer psychosocial treatments (Givens, Houston, van Voorhees, Ford, & Cooper, 2007), yet minority participants are poorly represented in clinical trials of CBT and other mental health interventions (Department of Health and Human Services, 2009). Spiritually integrated interventions like the Calmer Life program could be offered in settings in which treatment research is rarely conducted, such as community centers or churches, thus extending mental health services to minority elders. The integration of R/S into psychotherapy might increase treatment acceptability and improve outcomes for this population.

There are a few limitations to these case studies that should be considered when evaluating the potential utility of the Calmer Life protocol. First, although this intervention was clearly beneficial for the patients described in this report, the demographic characteristics of the three patients were fairly similar and preclude generalizability to other populations. All three patients were women and identified as either Caucasian or Hispanic. Additionally, although the Calmer Life protocol is designed to accommodate R/S beliefs from any faith, the R/S backgrounds of all of the patients presented here included ties to Roman Catholicism. However, the case of Martha provided an example of a patient who generally chose not to incorporate R/S into the practice of CBT skills. As with all case reports, the lack of an experimental control condition and randomization limit the internal validity of the study. A larger clinical trial of the Calmer Life protocol is necessary before it will be possible to draw conclusions about the efficacy and generalizability of this treatment. Finally, the sleep skills and problem-solving modules were not chosen by the patients in this report and will thus require further pilot testing.

In summary, one potential method of enhancing our current psychosocial treatments is to allow for the incorporation of patient R/S beliefs and practices. Although research examining the integration of R/S into psychotherapy is growing, a need remains to develop a CBT intervention for older adults with GAD that allows the integration of R/S, based on patient preference. The case studies presented here suggest that the Calmer Life program is a promising treatment approach for older adults with GAD who wish to have the flexibility of incorporating their R/S beliefs into a skills-based CBT intervention. We hope that future studies will continue to investigate the integration of R/S into psychotherapy, perhaps with special attention to older adults.

References


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