Innovations in CBT: Integrating Religion and/or Spirituality

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Current Status: Late-life Anxiety Treatment

• Most patients seen in primary care
  – Many unrecognized and without treatment
  – Medication effective
  – Side effects, fears, & preferences

• Cognitive behavioral treatment
  – Modest positive outcomes
  – Attrition
  – Limited reach
Calmer Life Program

• Personalize Treatment
  – Integrate religion-spirituality

• Expand Reach
  – Build community partnerships
  – Underserved, low income, minority communities
Why Religion-Spirituality?

• Clinical experience
  – Patients in our prior trials incorporate R/S into coping
  – Religion as coping fits many clients’ world views

• Data
  – Importance of R/S coping for older adults
  – Treatment outcome literature - R/S - CBT produces outcomes > CBT
Survey of prior CBT study participants

- 66 adults age 55+ (of 120 eligible patients)
- 71% had received CBT for anxiety/depression
- 73% said R/S played important role in lives
  - 82% Christian

Preferences for including R/S in counseling
- Majority preferred R/S
- Primary advantage – support, acceptance
- Primary barrier – R/S mismatch between patient and counselor
- R/S introduced by counselor, woven into all skills

MIRECC Pilot Study; Stanley et al. (2010), Aging and Mental Health
Calmer Life Treatment:

- Offer option for integrating R/S, not required

- Incorporate R/S into existing modules
  - Breathing – add R/S image or word
  - Calming statements – based on scripture, prayer
  - Behavioral activation – R/S activities

- Additional options
  - R/S assessment module
  - Forgiveness module
  - Gratitude focus (Calming Thoughts; Behavioral Activation)
Case Series: 3-month
Worry & Anxiety Outcomes

Effect size: $d = .94$

Effect size: $d = 1.29$
Testing intervention in Community Settings: Developing Partnerships

• Identify geographic regions
  – Low income, underserved
  – Mostly minority (African American)
• Choose organizations
  • Faith-based
  • Social service
  • Health care
• Connect with key community leaders
• Establish Community Leadership Advisory Council
## Calmer Life Pilot Study

<table>
<thead>
<tr>
<th>Demographics</th>
<th>N = 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>100% Women</td>
</tr>
<tr>
<td>Age</td>
<td>62 years</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>90% African American</td>
</tr>
<tr>
<td>Education</td>
<td>14 years</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>90% GAD; 10% ADNOS</td>
</tr>
<tr>
<td>Religious affiliations</td>
<td>50% Baptist; 30% Methodist; 20% Other Protestant</td>
</tr>
</tbody>
</table>
Treatment Characteristics ($n = 10$)

- Setting: 50% in home; 50% in community setting
- 52% telephone sessions
- Average 6 sessions
- 80% included R/S
Worry – Anxiety Outcomes: 3 months

**PSWQ-A**

![Graph showing changes in PSWQ-A scores from baseline to 3-month measurement.](chart1)

Effect size: $d = .74$

**GAI**

![Graph showing changes in GAI scores from baseline to 3-month measurement.](chart2)

Effect size: $d = .75$
Conclusions and Next Steps

• Integrating R/S into CBT for late-life anxiety has promise clinically and scientifically

• Continue pilot data collection

• NIMH resubmission 3/1/11

• VA version