Older Adults' Preferences For Religion/Spirituality In Treatment For Anxiety And Depression

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Abstract

Objectives: To examine patient preferences for incorporating religion and/or spirituality into therapy for anxiety or depression and examine the relations between patient preferences and religious and spiritual coping styles, beliefs and behaviors.

Method: Participants (66 adults, 55 years or older, from earlier studies of cognitive-behavioral therapy for late-life anxiety and/or depression in primary care) completed these measures by telephone or in-person: Geriatric Anxiety Inventory, Client Attitudes Toward Spirituality in Therapy, Patient Interview, Brief Religious Coping, Religious Problem Solving Scale, Santa Clara Strength of Religious Faith, and Brief Multidimensional Measure of Religiousness and Spirituality. Spearman's rank-order correlations and ordinal logistic regression examined religious/spiritual variables as predictors of preferences for inclusion of religion or spirituality into counseling.

Results: Most participants (77–83%) preferred including religion and/or spirituality in therapy for anxiety and depression. Participants who thought it was important to include religion or spirituality in therapy reported more positive religious-based coping, greater strength of religious faith, and greater collaborative and less self-directed problem-solving styles than participants who did not think it was important.

Conclusion: For individuals like most participants in this study (Christians), incorporating spirituality/religion into counseling for anxiety and depression was desirable.

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Introduction

Anxiety and depression are associated with reduced mental and physical health outcomes and poorer quality of life in older patients (Cully et al., 2006; Dickens et al., 2006; Unützer et al., 2000). Empirically based psychosocial interventions for anxiety and depression (in particular, cognitive-behavioral therapy [CBT]) are effective for older patients (e.g., Stanley et al., 2009; Unützer et al., 2002; see Thorp et al., 2009, for a review). However, effect sizes from these studies suggest that the effectiveness of these treatments could be improved significantly, and attrition rates among older adults in these studies are higher than in younger people (Wetherell, Lenze, & Stanley, 2005). To identify treatment modifications that may enhance outcomes and reduce attrition, it is useful to examine literature that investigates predictors of physical and mental health outcomes in medical patients.

Recently, attention has been given to the roles of spirituality and religion in health. In general, *spirituality* is a broad term used to describe a relationship with God or a higher being; whereas the term *religion* describes a set of beliefs and behaviors shared by a community (Hodge, 2006). Most Americans believe in God or a higher power and report a religious preference (Gallup Poll, 2008), and most patients in medical or mental health settings report a preference for discussing religious and spiritual issues (Pargament, 2007; Rose, Westefeld, & Ansley, 2001). This may be particularly true for medically ill older adults, as religiosity tends to be higher in older adults than in younger adults and in individuals with chronic/terminal illnesses (Ardelt & Koenig, 2006). Moreover, data have suggested that certain forms of religious and spiritual coping, such as church attendance, are associated with lowered stress and depression, and reduced rates of mortality, in addition to other health benefits (Powell, Shahabi, & Thoresen, 2003; Worthington et al., 2003). Further, struggles with religious issues predict mortality in medically ill older adults, even after statistically controlling for demographic characteristics and physical and mental health status (Pargament, Koenig, Tarakeshwar, & Hahn, 2001). Thus, the integration of religion and spirituality into empirically based treatments for anxiety and depression may enhance outcomes for older patients; although it is important to note that experts do not agree about the potential value or appropriateness of addressing religion/spirituality in the treatment setting (Koenig, 2001; Sloan & Bagiella, 2001). An approach that integrates religion and spirituality also may increase acceptability and accessibility among older adults living in rural settings and among

minority populations (e.g., African Americans), as these individuals often seek help and support from religious/spiritual leaders (Blank, Mahmood, Fox, & Guterbock, 2002; Campbell, Gordon, & Chandler, 2002).

Despite the potential value of incorporating religion and/or spirituality into evidence-based treatment for anxiety and depression, little is known about whether older adults would prefer this type of approach, and if so, which strategies might be best for accomplishing this objective. Treatment that integrates attention to religious and/or spiritual issues has been discussed in scholarly books (Pargament, 2007), self-help materials (Williams, Richards, & Whitton, 2002) and case studies (McCorke, Bohn, Hughes, & Kim, 2005); but the efficacy of integrating religion and/or spirituality into a specific form of therapy for anxiety or depression has been explored by only a few controlled treatment trials (see Hodge, 2006, for a review of spirituality-modified cognitive therapy). These studies also have incorporated only one religious perspective (e.g., Christian or Muslim) and have focused treatment efforts on young or middle-aged, physically healthy adults who identified themselves as religious. To our knowledge, no treatment approach has yet been developed or tested systematically for older adults suffering from depressive and/or anxiety disorders who express a range of religious/spiritual preferences.

In addition, patients' concerns regarding the match between clinicians' religious beliefs and their own have not been adequately explored. Past research indicates that CBT with religious/spiritual components can be efficacious when conducted by nonreligious therapists (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). However, others have warned that a known mismatch between the beliefs of the clinician and patient could have detrimental effects (Paukert et al., 2009). It is not known whether older adults consider the religious beliefs of the clinician to be an important factor when considering such treatment. Such information would help determine the acceptability and nature of treatments with integrated religious/spiritual components.

The proposed project is an initial step in a new program of research that addresses the potential value of incorporating religion and/or spirituality into evidence-based treatment for anxiety and/or depression for older patients. As a first step in this work, patients from prior trials of treatment for late-life anxiety and/or depression were invited to participate in a survey addressing the potential value of integrating attention to religion and/or spirituality into therapy. Patient preferences related to this type of integrated approach are crucial to efforts to develop a religious and/or spiritually accommodative version of treatment. Understanding the relations between patients' preferences for religious or spiritually modified treatment and their religious and spiritual coping styles, beliefs and behaviors also is important for treatment development and for identification of subgroups of patients for whom this approach might be of value. Further, exploring the perceived importance of the therapists' belief system may help to clarify his/her handling of religious/spiritual treatment approaches. We report here the results of an initial patient survey designed to examine patient preferences for incorporating religion and/or spirituality into therapy for anxiety or depression and to examine the relations between patient preferences and their religious and spiritual coping styles, beliefs, and behaviors.

Methods

This study was approved by the institutional review boards of Baylor College of Medicine and the Michael E. DeBakey Veterans Affairs Medical Center.

Participants

Participants were recruited from samples of older adults age 55 or higher who had participated in prior studies of CBT for late-life anxiety in primary care (Stanley et al., 2009) or anxiety and depression with co-morbid chronic medical illness (Cully, Paukert, Falco, & Stanley, 2009). Patients from these studies were men and women receiving medical services within either the Michael E. DeBakey Veterans Affairs Medical Center or insurance-based medical practice. At the time of participation in these prior trials, patients had symptoms that met criteria for generalized anxiety disorder, with or without coexistent depression (Stanley et al., 2009), or established cut-off criteria for clinically significant anxiety or depression (Cully et al., 2010). The sample included patients who had received either CBT for anxiety and/or depression or supportive care that was part of an enhanced-usual-care approach.

A total of 142 participants from prior studies were mailed a letter that asked patients the value of incorporating religion and spirituality into counseling. Two patients were ineligible (one was currently participating in a sister study, and one was deceased). If no response to the letter was received within two weeks, the individual was contacted by phone to assess his/her interest in participating. Of the remaining 140 patients, 20 did not respond to calls (phone numbers disconnected [$n = 7$]; patient never returned call [$n = 13$]). Of the 120 eligible patients who responded, 54 (45%) refused to participate, leaving 66 who signed consent. Participants ($n = 66$) did not differ from refusers ($n = 54$) with regard to age, gender, ethnicity, or marital status. However, more participants had at least some college education ($n = 61$; 92.4%) relative to refusers ($n = 43$; 79.6%; $X^2[1] = 4.21$, $p = 0.04$).

Measures

Measures were selected to assess (1) severity of anxiety and depressive symptoms; (2) attitudes toward incorporating religion and/or spirituality into

psychotherapy; (3) religious and spiritual coping; and (4) religious and spiritual beliefs and behaviors.

Anxiety and depression

The 20-item Geriatric Anxiety Inventory (GAI; Pachana et al., 2007) and the 15-item Geriatric Depression Scale (GDS; Yesavage et al., 1983) were used to assess the severity of anxiety and depressive symptoms. Participants indicated whether they endorsed the 20 statements on the GAI (1 = agree; 0 = disagree) and the 15 statements on the GDS (1 = yes; 0 = no). Both measures were developed specifically for older adults and have good psychometric properties (Montorio & Izal, 1996). Internal reliabilities (Cronbach's alpha) in the current study were 0.88 and 0.83, respectively. The Penn State Worry Questionnaire-Abbreviated (PSWQ-A) was used to measure worry severity. The PSWQ-A consists of eight items rated on a five-point Likert scale (1 = not at all typical; 5 = very typical) and has strong psychometric properties among older adults (Crittendon & Hopko, 2006; Stanley et al., 2003). Cronbach's alpha was 0.90.

Attitudes toward religion and/or spirituality in therapy

A portion of the Client Attitudes toward Spirituality in Therapy (CAST) (Rose et al., 2001) was administered to assess client preferences for discussing religion and/or spirituality in counseling. The original CAST includes four pairs of items to measure clients' preferences for discussing religious/spiritual issues in counseling. Three pairs of items require patients to currently have a presenting problem or counselor and, therefore, were not meaningful for the current sample. Only one pair of items (i.e., "In general, how important do you believe discussion of spiritual issues is to counseling?" and "In general, how important do you believe discussion of religious issues is to counseling?") was included in the current study. Each item was rated on a five-point Likert scale (1 = Not at all important; 5 = extremely important).

A semi-structured Patient Interview was also developed to obtain qualitative data from patients about their spiritual and religious backgrounds, as well as their preferences for discussing religious and/or spiritual issues in counseling, their perceptions of barriers to incorporating these issues, and their ideas about how best to incorporate religion and spirituality into therapy. Although most participants had previously received CBT, these interview questions were worded to ask about more general experiences and preferences related to therapy or counseling (e.g., "Would you consider it important for counseling to include attention to religion and/or spirituality?" "What advantages do you see for including religion/spirituality in counseling?" "What would be some downsides/barriers to discussing religious/spiritual issues in counseling?" "Would you prefer that religion/spirituality be woven into all of the skills you learn or would you prefer to learn separate skills that are based on religious/spiritual beliefs?").

Additionally, the structured interview assessed the importance of a therapist's beliefs and role in delivering treatment (e.g., "Would knowing the religious/spiritual orientation of your therapist be important?" "Who would you want to bring up religion/spirituality in counseling: You or your counselor?").[1]

Religious and spiritual coping

The Brief Religious Coping (Pargament, Smith, & Koenig, 1998) assesses positive and negative aspects of religious coping. The measure consists of two subscales with seven items each: The positive coping subscale (RCOPE-Positive; e.g., "Looked for a stronger connection with God") and the negative coping subscale (RCOPE-Negative; e.g., "Felt punished by God for lack of devotion"). Participants rated each item on a 4-point Likert scale (0 = I did not do this; 3 = I did this a lot). Internal consistency and validity are adequate, and the Brief Religious Coping has been used in a variety of populations, including adults living with physical and mental illnesses (Pargament et al., 1998). Cronbach's alphas for the RCOPE-Positive and the RCOPE-Negative in the current study were 0.94 and 0.84, respectively.

The Religious Problem Solving Scale-Short Version (RPSS; Pargament et al., 1988) has 18 items and evaluates the use of collaborative (RPSS-Collaborative; e.g., "When considering a difficult situation, God and I work together to think of possible solutions"), deferring (RPSS-Deferring; e.g., "When a situation makes me anxious, I wait for God to take those feelings away"), and self-directive (RPSS-Self-Directing e.g., "When deciding on a solution, I make a choice independent of God's input") religious problem-solving strategies. Each item was rated on a five-point Likert scale (1 = never; 5 = always). Among adults, internal consistency and test-retest reliability are strong for all subscales, and they correlate modestly with each other ($r = -0.34$ to 0.34; Fox, Blanton, & Morris, 1998). Reliabilities were between 0.91 and 0.95 in the current study.

Religious and spiritual beliefs and behaviors

The Santa Clara Strength of Religious Faith (Santa Clara; Plante & Boccaccini, 1997) consists of 10 items that measure the general role of faith or a higher being in one's life (e.g., "My faith is an important part of who I am as a person"; "I look to my faith as a source of comfort"). Each item is rated on a four-point Likert scale (1 = strongly disagree; 4 = strongly agree). The scale has been used in college students (Freiheit, Stonsegaard, Schmidt, & Vye, 2006; Sherman et al., 2001), cancer patients (Sherman et al., 2001), and healthy women in a clinic environment (Plante, Vallaeys, Sherman, & Wallston, 2002). The measure

has good reliability and constructs validity (Plante & Boccaccini, 1997). Internal consistency was 0.95.

The Brief Multidimensional Measure of Religiousness and Spirituality was developed for use in health research by the Fetzer Institute and the National Institute on Aging working group (1999). This instrument has a wide range of subscales to measure spirituality. It has been used in its entirety or via selected subscales in a wide range of populations, including older adults and those with chronic health conditions (Allen, Hilgeman, Ege, Shuster, & Burgio, 2008). The following three subscales were used to measure religious/spiritual beliefs and behaviors in the current study: Daily Spiritual Experiences (BMMRS-DSE), Values/Beliefs (BMMRS-VB), and Private Religious Practices (BMMRS-PRP). The BMMRS-DSE includes six items that assess the frequency with which one feels God's presence, finds strength and comfort in religion, and/or is spiritually touched by the beauty of creation. Responses were provided on a six-point Likert scale (1 = many times a day; 6 = never). Responses were reverse scored such that greater scores represent more frequent engagement in daily spiritual experiences. The BMMRS-VB includes four items that assess specific beliefs and feelings shared by an organized community about religion, including belief in God and life after death. Belief in a God and feeling a sense of responsibility for reducing pain and suffering were rated on four-point Likert scales (1 = strongly agree; 4 = strongly disagree), the extent to which one's whole approach to life was based on religion was rated on a five-point Likert scale (1 = strongly agree; 5 = strongly disagree), and belief in afterlife was answered on a three-point scale (1 = yes, 2 = uncertain, 3 = no). Items were reverse scored so that greater scores indicated stronger values/beliefs. Because items had unequal ranges, each item was normalized and the resulting z scores were summed to create overall scores. The BMMRS-PRP consists of five items that assess frequency of prayer, meditation, reading, religion, literature, and other religious practices). Participants indicated on a five-point Likert scale (1 = at all meals; 5 = never) how often prayers or grace are said before or after meals at their homes. The frequency with which one prays privately outside church or synagogue, meditates, watches or listens to religious programs on TV or radio, and reads religious literature was rated on an eight-point Likert scale (1 = more than once a day; 8 = never). Items were reverse scored so that greater scores indicated more frequent private religious practices. Each item was normalized, and the resulting z scores were summed. Internal consistency for these three domains was between 0.70 and 0.88 in the current study.

Procedure

Of the 66 included participants, 56% ($n = 37$) chose to participate by telephone; and 44% ($n = 29$) chose to participate in person. For those who chose to participate by phone, an informed-consent document was mailed and subsequently reviewed by phone. Participants then signed and returned the form before administration of study measures. For those who chose to participate in person, informed consent was obtained immediately before study participation. All measures were administered by a trained research assistant in a single session lasting an average of 61.6 min (SD = 15.22 min). All assessment sessions were audio taped for subsequent review of the Patient Interview. Patients were reimbursed $20 for their participation.

Data analyses

Patient Interview coding

Responses to the semi-structured Patient Interview were coded by three trained raters (MS, LP, and DZ). To promote reliable coding, 15% of interviews ($n = 10$) were reviewed; and coding guidelines were developed. For questions for which a large percentage (18% or more) of patients endorsed the "other" option, coding guidelines were reviewed and modified. All interviews were subsequently scored according to these modified guidelines. For the 10 interviews used to develop coding guidelines, an alternative rater listened to and scored the interview. Of the 66 interviews, 35% ($n = 23$) were randomly selected as reliability cases and coded by two raters. Averaged across all items and pairs of raters, inter-rater reliability was adequate (Cohen's Kappa = 0.69).

Patient characteristics and preferences

Descriptive data were examined to evaluate patient demographic and clinical characteristics, as well as spiritual/religious identification. Attitudes toward incorporating religion and/or spirituality into therapy or counseling were examined with data from both the CAST and the Patient Interview. For patients who expressed an interest in incorporating religious or spiritual issues into therapy or counseling, descriptive data from the Patient Interview were used to evaluate how best to carry out this kind of treatment.

Relationship of patient preferences to clinical and religious/spiritual variables

Although the CAST items are typically combined and used as an interval measure (Rose et al., 2001), responses to each individual item were expected to be negatively skewed, given the religious identification of the current sample. Therefore, CAST 1 and CAST 2 were treated as ordinal (i.e., ordered, not linear) scales in the current study. To assess relationships between clinical and religious/spiritual variables and perceived importance of discussing spirituality (CAST 1) or religion (CAST 2) in counseling, Spearman's rank-order correlation coefficient (rho) was calculated.

Subsequently, three sets of ordinal logistic regression analyses were conducted to examine unique predictors of the importance of discussing spiritual issues in counseling. Three parallel sets were also conducted to examine unique predictors of the importance of discussing religious issues in counseling. The first set consisted of three clinical variables (GAI, GDS, and PSWQ-A), the second set of five religious/spiritual coping variables (RCOPE-Positive, RCOPE-Negative, RPSS-Collaborative, RPSS-Self-Directing, and RPSS-Deferring), and the third set of four religious/spiritual beliefs and behaviors (Santa Clara, BMMRS-DSE, BMMRS-VB, and BMMRS-PRP). Bonferroni correction was used to control for experiment-wise error rates within clusters of correlations and ordinal logistic regressions.

Results

Patient characteristics

Demographics, clinical characteristics, and religious/spiritual beliefs of the sample are included in Table 1. Most of the sample was women, and patients overall were relatively well educated. Measures of clinical characteristics suggested mild levels of worry, anxiety and depression that were slightly less than established clinical cut-offs (PSWQ-A = 22; [Stanley et al., 2003]; GAI = 11 [Pachana et al., 2007]; GDS = 5 [Hermann et al., 1996]). These low levels of clinical symptoms reflect the fact that 47 of the participants (71%) had received CBT for anxiety and/or depression in prior studies; 19 participants (29%) had participated in an enhanced-usual-care treatment that involved biweekly supportive phone contact (Stanley et al., 2009).

According to the Patient Interview, a large majority of participants (91%; $n = 60$) indicated current identification with a particular religious group, with 90% ($n = 54$) Christian, 3.3% ($n = 2$) Jewish, and 6.7% ($n = 4$) other. Of those who identified themselves as Christian, 51.9% ($n = 28$) were Protestant, 38.9% ($n = 21$) were Catholic, 7.4% ($n = 4$) were nondenominational, and 1.8% ($n = 1$) were Pentecostal. Religious identification was reported to have been since later life (17%; $n = 11$), middle life (24%; $n = 16$), or childhood (59%; $n = 39$). Participants reported various strategies for using religion or spirituality to cope with negative emotions, including praying (46%; $n = 30$), reading the Bible or other religious/spiritual text (24%; $n = 16$), handing things over to God (20%; $n = 13$), and meditating (18%; $n = 12$).

Most participants also indicated that religion and/or spirituality played a significant role in their lives at present ($n = 48$; 73%); the remainder indicated that religion and/or spirituality played either a minimal ($n = 9$) or moderate ($n = 9$) role ($n = 18$; 27%). Those who said that religion and/or spirituality played a more significant role in their lives at present thought that it was more important to include both spirituality (Spearman's $r = 0.49$, $p < 0.0001$) and religion (Spearman's $r = 0.25$, $p = 0.043$) in therapy.

Table 1. Demographic and clinical, and religious/spiritual characteristics ($N = 66$).

Female, no. (%)	44 (66.67)	
Age (SD)	69.35 (5.94)	
Education, no. (%)		
Some high school	2 (3.03)	
High school graduate	3 (4.55)	
Some college	26 (39.39)	
College graduate	13 (19.70)	
Graduate school	22 (33.33)	
Marital status, no. (%)		
Never married	3 (4.55)	
Married	39 (59.09)	
Separated/divorced	17 (25.76)	
Widowed	7 (10.61)	
Ethnicity, no. (%)		
Non-Hispanic Caucasian	43 (65.15)	
African American	12 (18.18)	
Hispanic/Latino	6 (9.09)	
Asian	2 (3.03)	
Multirace	3 (4.55)	
		Possible range of scores
GAI (SD)	7.02 (5.15)	0–20
GDS (SD)	3.71 (3.35)	0–15
PSWQ-A (SD)	20.38 (6.89)	8–40
CAST 1 (spirituality), median	4.00	1–5
CAST 2 (Religion), median	4.00	1–5
RCOPE-Positive (SD)	13.95 (6.78)	0–21
RCOPE-Negative (SD)	2.24 (3.73)	0–21
RPSS-Collaborative (SD)	20.44 (6.58)	6–30
RPSS-Deferring (SD)	16.09 (6.30)	6–30
RPSS-Self-Directed (SD)	14.70 (6.79)	6–30
Santa Clara (SD)	32.89 (6.58)	10–40
BMMRS-DSE (SD)	26.18 (6.56)	6–36
BMMRS-VB (standardized) (SD)	0 (2.91)	–
BMMRS-PRP (standardized) (SD)	0 (3.94)	–

Notes: Values reported are means, unless noted otherwise. GAI, Geriatric Anxiety Inventory; GDS, Geriatric Depression Scale; PSWQ-A, Penn State Worry Questionnaire-Abbreviated; RCOPE, Brief Religious Coping; RPSS, Religious Problem Solving Scale; Santa Clara, Santa Clara Strength of Religious Faith; BMMRS, Brief Multidimensional Measure of Religiousness & Spirituality; DSE, daily spiritual experiences; VB, values and beliefs; and PRP, private religious practices.

Patient preferences

According to the CAST, most patients generally felt it was important to include spiritual and religious issues in counseling. Specifically, 83% of patients thought it would be important to discuss spiritual issues in counseling (44% extremely important, [$n = 29$], 39% somewhat important [$n = 26$], 14% uncertain [$n = 9$], and 3% not very important [$n = 2$]). No patients indicated that discussing spiritual issues in counseling

was not at all important. A smaller percentage of patients, but still a majority (61%), thought it would be important to discuss religious issues (26% extremely important, [$n = 17$], 35% somewhat important [$n = 23$]), 23% were uncertain ($n = 15$), 12% thought it would not be very important ($n = 8$), and 5% thought it was not at all important ($n = 3$).

According to the Patient Interview, 82% of patients ($n = 59$) considered it important for counseling to include attention to religion and/or spirituality. Most of these individuals (67%) indicated that both religion and spirituality were important; 14% felt that spirituality, but religion not so or less, was important; and 2% thought religion, but not spirituality, was important. Fifty-one patients (77%) reported on both the CAST and structured interview that the incorporation of religion and/or spirituality into counseling was important.

The 59 patients who reported on the Patient Interview that it was important for counseling or therapy to include attention to religion and/or spirituality were asked to indicate the advantages and downsides or barriers for this approach. These data are summarized in Table 2. The primary advantage reported was increased support, acceptance, and/or feelings of comfort. The primary downside was the possibility of a mismatch between patient and counselor with regard to religious/spiritual orientation. However, 53% of respondents ($n = 31$) said it would not be important to know the religious/spiritual orientation of the counselor (whereas 44% [$n = 26$] said it would be important, and 3% [$n = 2$] were uncertain). A majority (58%; $n = 34$) of respondents believed that discussion of religion and/or spirituality should be initiated by the counselor (17% believed it should be initiated by the patient, and 25% said either) and that the counselor should begin with an invitation or a question. With regards to preferences for how to include religion/spirituality in therapy, 56% ($n = 33$) preferred that religion/spirituality be woven into all therapy-based skills, 19% ($n = 11$) thought religion/spirituality should be discussed separately from other skills, 22% ($n = 13$) had a different suggestion, and 3% ($n = 2$) did not understand the question.

Table 2. Advantages and Downsides/Barriers for Including Religion and/or Spirituality in Counseling.

Advantages for including R/S in counseling, no. (%) ($n = 59$)	
Support, acceptance, comfort	28 (47.5)
A better understanding of patient	9 (15.3)
Something to connect with beyond session	8 (13.6)
Help in changing one's beliefs	9 (15.3)
Encouragement of R/S activities	4 (6.8)
No response/misunderstood question	3 (5.1)
Other	10 (16.9)
Downsides/barriers. no. (%) ($n = 60$)	
Counselor/patient mismatch in religious/spiritual orientation	33 (55.0)
Lack of encouragement by culture/society	5 (8.3)
Lack of desire by patient/discomfort at discussing	4 (6.7)
Counselor qualification/approach	6 (10.0)
Potential for being misunderstood	2 (3.3)
No downsides/unsure	10 (16.7)
Misunderstood question	2 (3.33)
Other	5 (8.3)

Note: R/S, religion/spirituality.

Relationship of patient preferences to clinical and religious/spiritual variables

Perceived importance of discussing spiritual issues in counseling (CAST 1) was related to perceived importance of discussing religious issues in counseling (CAST 2; Spearman's $r = 0.29$, $p = 0.02$). Although significant, the modest correlation suggests little shared variance between the two CAST items. Therefore, to examine unique associations between these perceptions and clinical and religious/spiritual variables, analyses were conducted separately for each CAST item. Tables 3 and 4 report correlations (i.e., Spearman's rho) and ordinal logistic regressions, respectively. Severity of anxiety/depression was not related to preference for incorporating either spirituality or religion into counseling. However, religious/spiritual coping and beliefs and behaviors were related to such preferences.

Patients who engaged in more (rather than less) positive religious coping and collaborative religious

Table 3. Correlations between clinical and religious/spiritual variables and preferences for including spirituality (CAST 1) or religion (CAST 2) in therapy.

	CAST 1 (spirituality)	CAST 2 (religion)
Anxiety and depression (critical alpha = 0.017)		
GAI	−0.19	0.02
GDS	−0.25*	0.14
PSWQ-A	−0.18	0.04
Religious-spiritual coping (critical alpha = 0.010)		
RCOPE-Positive	**0.43*****	**0.45*****
RCOPE-Negative	−0.22†	−0.04
RPSS-Collaborative	**0.49*****	**0.48*****
RPSS-Self-Directed	**−0.43*****	**−0.50*****
RPSS-Deferring	**0.33****	0.21
RS beliefs and behaviors (critical alpha = 0.013)		
Santa Clara	**0.48*****	**0.38****
BMMRS-DSE	**0.42*****	0.25*
BMMRS-VB	0.30*	**0.54*****
BMMRS-PRP	0.27*	0.29*

Note: Values shown are Spearman's rho. Bolded values are significant.
GAI, Geriatric Anxiety Inventory; GDS, Geriatric Depression Scale; PSWQ-A, Penn State Worry Questionnaire-Abbreviated; RCOPE, Brief Religious Coping; RPSS, Religious Problem Solving scale; Santa Clara, Santa Clara Strength of Religious Faith; BMMRS, Brief Multidimensional Measure of Religiousness & Spirituality; DSE, daily spiritual experiences; VB, values and beliefs; and PRP, private religious practices.
†$p < 0.08$, *$p < 0.05$, **$p < 0.01$, and ***$p < 0.001$.

problem solving reported greater preferences for discussing both spiritual and religious issues in counseling. Further, those who engaged in less (rather than more) self-directed religious problem solving reported a stronger preference for incorporating these issues into counseling. Additionally, those who engaged in more deferring religious problem solving felt it was more important to discuss spirituality in therapy than those who deferred less frequently (Table 3). Although the set of five religious-spiritual coping variables (i.e., RCOPE-Positive, RCOPE-Negative, RPSS-Collaborative, RPSS-Self-directed, and RPSS-Deferring) illustrated good model fit predicting preferences for including spirituality (likelihood ratio $X^2 = 18.07$, $p = 0.003$) and religion (likelihood ratio $X^2 = 19.94$, $p = 0.001$) in counseling, individual variables did not uniquely predict preferences (Table 4). Further, those who reported relatively greater general strength of religious faith and daily spiritual experiences reported greater preference for incorporating spirituality in therapy; whereas those who reported greater strength of religious faith and those who had stronger specific religious values and beliefs reported greater preference for incorporating religion into therapy (Table 3). The set of four religious/spiritual beliefs and behaviors (i.e., Santa Clara, BMMRS-DSE, BMMRS-VB, BMMRS-PRP) illustrated good model fit, predicting preferences for including spirituality (likelihood ratio $X^2 = 20.81$, $p = 0.0003$) and religion (likelihood ratio $X^2 = 21.00$, $p = 0.0003$) in counseling. Whereas general strength of religious faith was the only unique predictor of perceived importance of incorporating spirituality into counseling, religious values/beliefs was the only unique predictor of perceived importance of incorporating religion into counseling (Table 4).[2]

Discussion

In the current study, most participants (77–83%) indicated a preference for including religion and/or spirituality into therapy for anxiety and depression. The older adults interviewed had mild levels of anxiety and depression at the time of the survey, but all had prior experience with significant anxiety-depressive symptoms and some type of counseling or therapy. Most participants indicated a significant role of religion or spirituality in their lives at present, and most described themselves as Christians.

The characteristics of older adults' belief systems and practices may suggest the appropriateness of including spiritual/religious components in therapy. Here, participants who thought it was relatively more important to include religion or spirituality into therapy reported more positive religious-based coping, greater collaborative and less self-directed problem-solving styles, and greater strength of religious faith. As such, measures of these constructs may be useful for determining whether an invitation to include religion or spirituality into treatment should

Table 4. Predictors of CAST 1 and CAST 2 from ordinal logistic regression.

	CAST 1 (spirituality)			CAST 2 (religion)		
	p-value	Odds ratio (95% confidence interval)	LR X^2	*p*-value	Odds ratio (95% confidence interval)	LR X^2
Anxiety and depression (critical alpha = 0.017)	0.38		3.04	0.54		2.16
GAI	0.76	0.98 (0.86–1.12)		0.84	0.99 (0.87–1.12)	
GDS	0.44	0.93 (0.76–1.13)		0.21	1.13 (0.93–1.38)	
PSWQ-A	0.85	0.99 (0.90–1.09)		0.69	0.98 (0.90–1.08)	
Religious-spiritual coping (critical alpha = 0.010)	0.003		18.07	0.001		19.94
RCOPE-Positive	0.56	1.04 (0.91–1.19)		0.72	0.98 (0.86–1.11)	
RCOPE-Negative	0.09	0.89 (0.79–1.02)		0.76	1.02 (0.90–1.15)	
RPSS-Collaborative	0.20	1.11 (0.95–1.30)		0.047	1.17 (1.00–1.36)	
RPSS-Self-directed	0.93	1.00 (0.87–1.17)		0.17	0.91 (0.79–1.04)	
RPSS-Deferring	0.64	1.03 (0.92–1.15)		0.065	0.90 (0.81–1.01)	
RS beliefs & behaviors (critical alpha = 0.013)	0.0003		20.81	0.0003		21.00
Santa Clara	**0.0086**	**1.24 (1.06–1.46)**		0.99	1.00 (0.87–1.16)	
BMMRS-DSE	0.47	1.06 (0.91–1.21)		0.28	0.93 (0.81–1.06)	
BMMRS-VB	0.28	0.86 (0.65–1.13)		**0.0004**	**1.68 (1.26–2.23)**	
BMMRS-PRP	0.46	0.93 (0.77–1.13)		0.73	0.97 (0.81–1.16)	

Notes: An odds ratio >1 indicates that larger values of the variable are associated with increased CAST values. Bolded values are significant.

LR X^2, Likelihood Ratio test of overall model fit; GAI, Geriatric Anxiety Inventory; GDS, Geriatric Depression Scale; PSWQ-A, Penn State Worry Questionnaire-Abbreviated; RCOPE, Brief Religious Coping; RPSS, Religious Problem Solving scale; Santa Clara, Santa Clara Strength of Religious Faith; BMMRS, Brief Multidimensional Measure of Religiousness & Spirituality; DSE, daily spiritual experiences; VB, values and beliefs; and PRP, private religious practices.

be made. In fact, standardized questionnaires before initiation of treatment might be helpful, given strong relations between preferences for incorporating religion and spirituality into therapy and religious/spiritual beliefs and practices. Data also, however, suggested some differences of relations between beliefs and practices with preferences for incorporating religion and spirituality into counseling. Specifically, participants who reported more frequent daily experiences with spirituality reported stronger preferences for incorporating spirituality (but not religion) into therapy; whereas those who reported stronger specific religious values and beliefs felt it was relatively more important to incorporate religion (but not spirituality) into therapy. Thus, although the constructs of religion and spirituality are related, they may operate somewhat independently in considerations for inclusion in therapy. Specifically, those with stronger general spiritual beliefs about the role of faith in life may be more inclined to prefer incorporating spirituality into therapy; whereas those with stronger community-shared specific beliefs about the role of God in life may be more favorable toward incorporating religion into therapy.

The results of the survey provide some guidance for the successful integration of religious and spiritual components into psychosocial interventions for depression and anxiety. Most participants who indicated a preference for including religion or spirituality in therapy thought that the primary advantage for this approach would be increased support, acceptance, and comfort. Additionally, the data suggest that a religious or spiritually accommodative version of therapy for anxiety and depression should begin with an invitation from the therapist to discuss the patient's religious/spiritual beliefs, attitudes, and coping style. Therefore, therapists may wish to be proactive in addressing options for the incorporation of religious/spiritual components.

The present results also highlight some potential pitfalls of incorporating religious/spiritual components into psychotherapy, especially relating to the relationship between the patient and therapist. Survey participants here indicated that the major barrier to including religion and spirituality into therapy was a potential mismatch in religious/spiritual orientation between patient and therapist. However, most also indicated that it would not be important to know the religious orientation of the therapist. Different opinions exist in the literature with regard to therapist disclosure of religious/spiritual beliefs, and therapists may need to weigh carefully the potential impact of self-disclosure (Paukert et al., 2009). Based on the results here, it is also important to note that a mismatch (or unknown match) between the therapist and patient does not necessarily preclude the incorporation of religion/spirituality in treatment.

Based on the participant opinions and preferences expressed in this study, the opportunity to incorporate religion and spirituality into treatment for anxiety and depression should be offered in two important ways: (1) as a component within each therapy-based skill; and (2) as a separate component of treatment. Here again, patient preference is key; as the value of this approach lies in a collaborative framework (Paukert et al., 2009; Phillips, Paukert, Stanley, & Kunik, 2009).

The current study has several significant limitations, most notably the small and non-representative nature of the sample. The invitation to participate in a survey related to religion and spirituality likely biased the sample because of self-selection of people with interest in this topic. In fact, most participants reported significant roles of religion and spirituality in their lives; and most described themselves as life-long Christians. Therefore, the results probably overestimate the preference for and importance of incorporating religion/spirituality into psychosocial treatments in more heterogeneous groups of older adults. Study findings may not generalize to more heterogeneous groups of older adults, and patterns will need to be examined further in larger samples. However, if all eligible participants are considered (i.e., both those who participated in the surveys and those who declined to participate; $n = 120$), and if a conservative assumption is made that non-participants were uninterested in discussing religion and/or spirituality in any setting, preference rates for including religion and spirituality into therapy may range from 43% to 49%. Although this is slightly less than a majority, these highly conservative estimates still suggest that many patients would be interested in the possibility of including religion and spirituality into treatment for anxiety or depression. Additionally, all participants in the study had experience with some form of therapy; and these experiences may have influenced their responses to the survey. The advantage of including only participants with treatment experience is that these individuals may be able to offer an informed opinion of the therapy process and suggest ways to successfully integrate religion/spirituality. However, their attitudes and preferences may not reflect those of treatment-naïve individuals; and, therefore, the data here do not address the acceptability of such treatments among new patients. The next step in this program of research will require attention to people with a relatively broader range of religious/spiritual preferences and development of a flexible treatment approach that can incorporate religious/spiritual coping as it meets the needs of diverse people.

We conclude from this initial work that many older adults with anxiety and/or depression think it would be important to incorporate their religious/spiritual orientation into their treatment for anxiety/depression. Although this area requires further research, modifying CBT to include such an option might enhance outcomes.

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Notes

1. A copy of the Patient Interview is available from the authors upon request.
2. Primary analyses were repeated treating CAST variables in an interval (as opposed to ordinal) manner, as has been done in previous work on the CAST (Rose et al., 2001). Specifically, Pearson's zero-order correlations were calculated between variables of interest; and multiple regression analysis was employed to examine associations between sets of predictors and the CAST variables. These analyses revealed identical findings, with one exception (i.e., zero-order correlations revealed no association between strength of religious faith and CAST 2).

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