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Feasibility and Acceptability of Bibliotherapy and Telephone Sessions for the Treatment of Late-life Anxiety Disorders

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Abstract

This article describes the development of Biblio and Telephone Therapy or BTT, a cognitive-behavioral treatment program for late-life anxiety disorders. Although studies have examined bibliotherapy for the treatment of late-life depression, none have studied it as a format for treating late-life anxiety. The application of this treatment to 4 older adults with Generalized Anxiety Disorder (GAD) and/or Panic Disorder (PD) is described and benefits, advantages and limitations are discussed.

Introduction

With the increasing focus on the portability and cost-effectiveness of mental health treatment, alternative methods of delivering treatment are receiving more attention. Two such methods include bibliotherapy and telephone contact. Bibliotherapy consists of providing psychotherapeutic treatment in a written format. The level of therapist contact can vary from none to minimal to traditional psychotherapeutic contact with bibliotherapy as a supplement (Glasgow & Rosen, 1978). Similarly, telephone contact can be used to deliver or supplement psychotherapeutic intervention. Both are becoming more frequently used, particularly as mental health treatment has expanded into the primary care setting (van Boeijen et al., 2005).

Although bibliotherapy can be an effective treatment for depression in older adults and anxiety in adults, no one has studied bibliotherapy in the context of late life anxiety. Given that effect sizes for anxiety treatments are smaller in older adults than younger adults, it cannot be assumed that bibliotherapy will be equally effective in treating late-life anxiety. Furthermore, the acceptability of bibliotherapy as a treatment for anxiety in older adults has not been established. This paper describes the first use of Biblio and Telephone Therapy (BTT) for the treatment of late-life anxiety.

Method

Screening

Participants were recruited through a family medicine clinic ($n = 1$) and through a newsletter advertisement targeting older adults who indicated interest in participating in research studies ($n = 3$). Potential participants were screened with 2 questions from the PRIME-MD (Spitzer et al., 1995): In the last 4 weeks, have you felt nervous, anxious, on edge, or worried? In the last 4 weeks, have you had an anxiety attack when you suddenly felt fear or panic? Participants who responded yes to either question were then interviewed with the Structured Clinical Interview for DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 2002). Inclusion criteria included being 60 years or older, able to read English, and have a diagnosis of GAD or PD. Exclusion criteria included current psychotherapy, current alcohol or substance abuse, diagnosis of dementia or MMSE < 25 , psychotic symptoms, active suicidal ideation, and a change in psychotropic medications within the last 3 months.

Participants

Participants were 4 women between the ages of 62 and 73 years, and all had at least a high school diploma; 3 out of the 4 attended college. One participant had GAD, 1 had PD, and 2 had comorbid GAD and PD.

Measures

In order to assess the effects of treatment on symptoms, the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) was used to assess general anxiety symptoms, the Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990) was used to assess worry, and the Beck Depression Inventory (BDI; Beck & Steer, 1987) was used to assess depressive symptoms. These measures were administered before and after treatment. The Working Alliance Inventory Short Form (WAI-S; Tracey & Kokotovic, 1989) and the Client Satisfaction Questionnaire (CSQ; Larsen, Attkisson, Hargreaves, & Nguyen, 1979) were also administered upon completion of treatment.

Treatment

The workbook was adapted from Controlling Anxiety in Later-Life Medical Patients Workbook developed by Wetherell and colleagues (Wetherell, Sorrell, Thorp, & Patterson; 2005). The techniques in this CBT intervention have demonstrated efficacy in treating older adults with GAD (Stanley, Beck et al., 2003; Wetherell et al., 2003). The workbook consisted of 10 chapters. The first chapter described the treatment and presented a cognitive-behavioral model of anxiety. Chapters 2 through 9 each addressed a specific anxiety management technique or a specific problem that may be comorbid with anxiety, including deep breathing and progressive muscle relaxation, cognitive restructuring and the use of coping statements, problem-solving, worry control, changing behavior, increasing pleasurable activities, sleep hygiene, and coping with pain. Chapters were approximately 5 to 10 pages long and were written in lay terms at an 8th grade reading level. They were presented in a large font and key points were highlighted and reiterated in simple terms in order to aid readers in fully understanding the content. Each chapter contained multiple examples that were specific to situations that an older adult might experience. Chapters were also focused on techniques that are more relevant to older adults, such as sleep and pain, rather than assertiveness skills and time management. Each chapter was followed by a homework exercise that involved practicing the particular technique described in that chapter. A completed example was provided, followed by blank copies to be completed by the reader. The homework was used to encourage the application of the techniques to the

reader's daily life. All materials sent to the participant were hole-punched and participants were instructed to keep all materials in the provided binder.

Telephone calls

Calls lasted 20 to 50 minutes and started with a check in, which consisted of a review of the last week and any problems or stressors they encountered. During the scheduled telephone call, the study therapist reviewed the chapter and the exercise with the participant. The participant was encouraged to ask questions about the reading materials and discuss any difficulties he/she may have experienced when implementing the anxiety technique. If a participant reported difficulty with a particular chapter/technique, the participant was instructed to continue to work on that chapter and technique for another week and another call was scheduled. The study therapist only sent the next chapter when she was confident that the participant fully understood the current chapter. No participant required more than 2 sessions on any one chapter. The recommended rate of sessions was 1 every 1 to 2 weeks.

Procedures

After screening, participants were given the option of being interviewed either by phone (Participants 2 and 3) or in person (Participants 1 and 4). Participants were then sent a packet of self-report questionnaires, which they returned by mail. Upon receipt of these questionnaires, the first telephone session was scheduled and a binder containing the first chapter of the Controlling Your Anxiety Workbook was mailed to the participant. Telephone sessions were scheduled approximately 7 to 14 days after the participant received the chapter and upon completion of a chapter, the participant was mailed the next chapter. After completion of the workbook, participants were re-interviewed with the SCID-IV by telephone and completed all self-report questionnaires.

Results

All participants reported a decline in depressive symptoms, while 3 out of 4 participants reported declines in anxiety symptoms and 2 out of 4 reported declines in worry. Three of the participants reported high levels of working alliance with their telephone therapist and a high degree of satisfaction with treatment; the remaining participant reported only a moderate degree of working alliance and satisfaction with the treatment. This participant also demonstrated significantly less improvements after completion of the intervention. She demonstrated resistance to treatment throughout the course of the intervention. For example, she had difficulty identifying anxious thoughts and behaviors and therefore had difficulty completing the homework and required a lot of assistance from the therapist to do so. As a result, she frequently did not complete any homework exercises between sessions and had difficulty applying the anxiety management techniques to her daily life. Upon completion of the treatment, she stated she disliked the homework exercises and described them as inconvenient.

Discussion

The purpose of this pilot study was to determine if CBT presented through bibliotherapy and telephone sessions was feasible and acceptable to older adults. The results of this study support the conclusion that older adults like and benefit from the BATT program.

Ease of understanding the chapters varied by topic. Participants had no difficulty with the deep breathing and progressive muscle relaxation exercises; this was in part due to the fact that they were provided an audiotape of these exercises that accompanied the written materials. Similarly, the chapter on worry control was easily understood. The two chapters

that were the most difficult for participants were cognitive restructuring and problem-solving. Cognitive restructuring introduces a new way of thinking to most people, while problem-solving is a longer exercise. Most participants needed 2 sessions on each of these topics to fully understand the techniques. Changing behavior, although not difficult to understand, was not rated as an important chapter by any of the participants. Only one person had difficulty with the chapter on increasing pleasurable activities because she did not understand the difference between anxiety and depression. However, all participants liked the idea of doing more “fun” things. Finally, the chapters on sleep and pain were met with mixed interest, as not all participants had problems in these domains.

The telephone sessions definitely aided the understanding of the written materials. Upon completion of the intervention, all participants noted that the telephone calls were extremely useful. They stated that it was helpful to have someone to speak with about their specific problems and that the therapist contact helped participants apply the techniques to their individual problems. By presenting the “didactic” portion of the techniques through written materials, the telephone sessions could be much more focused on the application of the techniques to manage anxiety. Most of the telephone sessions were held approximately 2 weeks apart; it may be that older adults either need or like additional time to process the information. Participants did note that they read and referred back to the chapters multiple times in between telephone calls.

The lack of face-to-face sessions between the participants and the therapist did not appear to hinder the development of a therapeutic relationship as evidenced by the high scores on the measure of working alliance. Two of the 4 participants chose to have their baseline interview in person and therefore met the therapist. The other two participants never met face-to-face with the therapist. The therapist clearly explained that participants would have her undivided attention during their sessions. One participant commented that she initially thought it would be hard to talk with someone she had never met. However, she stated that she quickly learned that the therapist was carefully listening to her as the therapist was able to recall details of previous sessions. Similarly, all 4 participants appeared to take their sessions seriously. There was no noise in the background and the participants had their workbooks easily accessible. The therapist noted no difficulty in her ability to form an alliance with these patients.

From the therapist’s perspective, the most difficult part of telephone psychotherapy is the lack of visual cues. Patients must be distinguished by their voice and not their face. Taking detailed notes and reviewing them prior to the session can significantly enhance the therapist’s recollection. Furthermore, the therapist has no visual cues that indicate a patient’s feelings, such as facial expressions or tapping one’s foot. Instead, the therapist must pay careful attention to speech, such as a change in pitch, rate, or pauses.

The use of alternative formats for delivering psychotherapy overcomes a number of the traditional problems that older adults have with psychological treatments. By conducting the therapy in the privacy of their own homes, some barriers such as stigma and lack of transportation can be overcome. Older adults need more time to process information. By providing patients with written materials before their sessions, they were able to read and reread the information at their own pace. Participants commented that this was an important aspect of the study. They stated that they liked being able to read, highlight, take notes, and reread information before their sessions. They also stated that they liked being able to refer back to previous chapters.

There are some limitations of this treatment. First, participants must be able to read English. This excludes people who may have little education or immigrants who speak but do not

read English. The written chapters could be converted to audio files for those unable to read English. Second, although full psychotherapy sessions were conducted by phone, this time is not reimbursed by insurance companies. Thus, the use of bibliotherapy with telephone contact as described in this study is limited to the research setting at present. However, both bibliotherapy and telephone sessions may be a useful adjunct to face-to-face sessions in the clinical setting.

The next step is to determine the efficacy of this format of treatment through a randomized clinical trial, which is currently underway. Future studies should examine possible predictors of treatment response, such as the amount of telephone contact (Marrs, 1995). Also, anxiety severity should be examined as a moderator of the effect of treatment on outcome. BT may be a first line of treatment for anxiety and more intense follow-up with nonresponders may be needed.

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References

- Beck AT, Epstein N, Brown G, Steer RA. An inventory for measuring clinical anxiety: psychometric properties. *Journal of Consulting and Clinical Psychology* 1988;56:893–897. [PubMed: 3204199]
- Beck, AT.; Steer, RA. *The Beck Depression Inventory Manual*. San Antonio, TX: Psychological Corporation; 1987.
- First, MB.; Spitzer, RL.; Gibbon, M.; Williams, JBW. *Structured Clinical Interview for DSM-IV-TR Axis I Disorders-Patient Edition (SCID-I/P)*. Biometrics Department, New York State Psychiatric Institute; New York: 2002.
- Glasgow RE, Rosen GM. Behavioral bibliotherapy: A review of self-help behavior therapy manuals. *Psychological Bulletin* 1978;85:1–23. [PubMed: 343144]
- Larsen DL, Attkisson CC, Hargreaves WA, Nguyen TD. Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning* 1979;2:197–207. [PubMed: 10245370]
- Marrs RW. A meta-analysis of bibliotherapy studies. *American Journal of Community Psychology* 1995;23:843–70. [PubMed: 8638553]
- Meyer TJ, Miller ML, Metzger RL, Borkovec TD. Development and validation of the Penn State Worry Questionnaire. *Behavior Research and Therapy* 1990;28:487–495.
- Spitzer RL, Kroenke K, Linzer M, Hahn SR, Williams JB, deGruy FV, et al. Health-related quality of life in primary care patients with mental disorders. Results from the PRIME-MD 1000 Study. *Journal of the American Medical Association* 1995;274:1511–1517. [PubMed: 7474219]
- Stanley MA, Beck JG, Novy DM, Averill PM, Swann AC, Diefenbach GJ, et al. Cognitive-behavioral treatment of late-life Generalized Anxiety Disorder. *Journal of Consulting & Clinical Psychology* 2003;71:309–319. [PubMed: 12699025]
- Tracey TJ, Kokotovic AM. Factor structure of the Working Alliance Inventory. *Psychological Assessment* 1989;1:207–210.
- Van Boeijen CA, van Balkom AJLM, van Oppen P, Blankenstein N, Cherpanath A, van Dyck R. Efficacy of self-help manuals for anxiety disorders in primary care: A systematic review. *Family Practice An International Journal* 2005;22:192–6.
- Wetherell JL, Gatz M, Craske MG. Treatment of generalized anxiety disorder in older adults. *Journal of Consulting and Clinical Psychology* 2003;71:31–40. [PubMed: 12602423]
- Wetherell JL, Sorrell JT, Thorp SR, Patterson TL. Psychological interventions for late-life anxiety: A review and early lessons from the CALM study. *Journal of Geriatric Psychiatry and Neurology* 2005;18:72–82. [PubMed: 15911935]