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Telephone-delivered Psychotherapy for Late-life Anxiety

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Name of Institution: This work has been conducted at Wake Forest School of Medicine.

Services Delivered: We completed one randomized controlled trial (RCT) of telephone-delivered cognitive-behavioral therapy (CBT) vs. usual care for late-life anxiety disorders. Our current RCT comparing telephone-delivered CBT vs. nondirective supportive therapy (NST) for late-life Generalized Anxiety Disorder (GAD) is underway. CBT consists of 10–12 sessions that focus on psychoeducation, relaxation, cognitive therapy, problem-solving, and exposure therapy (with an accompanying workbook). In usual care, we provided participants with an NIMH brochure on anxiety disorders and information on referrals. NST consists of 10 sessions designed to provide a warm and therapeutic relationship; advice, suggestions, or coping methods are not presented.

Types of Professionals Involved: Licensed clinical psychologists supervise master's level clinicians.

Training for Telemental Services of Professionals Involved: Training for clinicians consists of readings, role plays, case reviews, and closely supervised treatment. Training specific to conducting sessions by telephone includes a focus on strengthening and modifying reflective listening skills, the importance of the therapist's voice, attentiveness to solely auditory cues from clients, and extensive discussion of varied client responses to telephone therapy (potential for treating sessions as informal “chats” versus scheduled therapy sessions) and licensure issues (e.g., where participant is located at the time of sessions).

Populations Served: The first study focused on adults aged 60 years and older with a diagnosis of GAD, Panic Disorder, and Anxiety Disorder Not Otherwise Specified (the treatment did not differ by diagnosis). In our second study, we are targeting older adults with a principal/co-principal diagnosis of GAD. Older adults with anxiety disorders are frequently overlooked in treatment research despite the variety of negative effects of anxiety in this age group.

Geographic Location Served: Participants in the first study resided in both urban and rural NC, while participation in the second study is limited to rural NC residents.

Funding Sources: Both studies have been funded by the National Institute of Mental Health.

Technology Used: We have chosen to use the telephone as our primary intervention delivery mode. Because sessions are conducted within the client's home, therapists discuss the limits of confidentiality at the start of the treatment and ask clients to schedule appointments when they will not be interrupted by other household members.

Telepsychology Choices that Would be Different Next Time and Why: We will continue to use the telephone as our primary means of delivering treatment over newer technologies for a number of reasons. Most U.S. households have a telephone line in their home (Federal Communications Commission, 2010), and fewer rural (than urban) residents have internet access (U.S. Department of Commerce, 2010). Use of video conferencing software challenges the limits of privacy; may require participant travel to a central site, thus limiting treatment access; and may be subject to technological difficulties.

Use of Electronic Medical Record (EMR): EMRs are not used because medication management is not provided as part of treatment.

Biggest Challenges: The biggest challenge has been dealing with crisis situations, as they must be handled differently due to the lack of onsite assistance. In order to limit potential crises, we exclude people who indicate suicidal ideation, homicidal ideation, or delusional thinking. However, symptom worsening may occur during treatment. We require that participants provide the names of 2 persons whom we can reach in an emergency. We also create a list of potential referrals in the counties we target in case more intensive treatment is needed. However, client use of cell phones can make it difficult to verify actual location.

Biggest Successes: Participants both liked and benefited from treatment. Client satisfaction, as assessed by the Client Satisfaction Questionnaire, was high ($M = 27.4$, range 8–32) and attrition rates were low (8.3%). Further, participants who received CBT demonstrated significant declines in general anxiety ($E.S. = 0.71$), worry ($E.S. = 0.61$), anxiety sensitivity ($E.S. = 0.85$), and insomnia ($E.S. = 0.82$) while the usual care group did not (Brenes, Miller, Williamson et al., in press).

Lessons Learned: Therapists may have a harder time adapting to telephone-delivered psychotherapy than clients, as they may be concerned about their ability to establish an effective therapeutic relationship in the absence of a face-to-face relationship. Some clients were initially ambivalent about therapy by telephone but stated they quickly grew comfortable when they realized that their therapist was very attentive. Other participants stated that they would not have received treatment if it had not been offered by telephone.

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