

EFFECTIVELY TRANSPORTING A SPIRITUALLY BASED INTERVENTION FOR  
REDUCING SUBSYNDROMAL ANXIETY AND INCREASING COPING SKILLS IN  
URBAN ADOLESCENTS: A MULTIPLE BASELINE DESIGN

A Dissertation Presented to the Faculty of  
The School of Behavioral Sciences  
Liberty University

In Partial Fulfillment of  
The Requirement for the Degree of

Doctor of Philosophy

by

Morais L. Cassell

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Of the Requirements for the Degree

Doctor of Philosophy

Liberty University, Lynchburg, VA

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## ABSTRACT

A critical review of literature revealed a gap in the literature of spiritually based interventions, most notably the subject of a spiritually based intervention for reducing subsyndromal anxiety and increasing coping skills in urban adolescents. The purpose of this study was to investigate the relationship between a spiritually based intervention, a triangulation approach, subsyndromal anxiety, and coping skills in urban adolescents, employing the add-on/integration of a Prayer Wheel intervention. Utilizing a multiple baseline design across subjects to demonstrate the controlling effects of spiritually based intervention/prayer wheel, research revealed a decrease in subsyndromal anxiety levels, and an increase in coping skills in urban adolescent subjects. Although the correlations between a spiritually based intervention, a triangulation approach, subsyndromal anxiety, and coping skills in urban adolescents was not as strong as hypothesized, the current study provides empirical (quantitative and qualitative) evidence that a Prayer Wheel intervention's potential impact has tripartite significance: in research, clinical, and Biblical practice, and suggests that THE PRAYER WHEEL™ Program may be an effective tool for the alleviation of symptoms of subsyndromal anxiety among urban adolescents.

*Keywords:* anxiety, coping, multiple baseline design, prayer, prayer wheel, protective factors, religion, religious cognitive behavior therapy, risk factors, spirituality, spiritually based intervention, subsyndromal anxiety, triangulation, urban adolescents, at-risk adolescents/youth.

## **Dedication**

This dissertation is dedicated to the two most important women in my life; my mother and wife. My mother Terry Cassell-Francis, this for all your sacrifice, and the culmination of my promise to you that one day I would be a doctor. My dear wife Diane, I could not have done this without you, my rock, biggest cheerleader, editor, statistician, and partner in life. You are the best gift, besides salvation. This dissertation is also dedicated to my aunt Fereta (Fay) Thompson, for playing such a vital role in my rearing and development. In addition, in memory of Mrs. Rebecca Veal (Women's League of Science and Medicine), this dissertation honors her for her early deposits in my educational pursuits. Finally, to the students/adolescents and their families who willingly participated in the research study for this dissertation, for them, I am eternally grateful.

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## TABLE OF CONTENTS

ABSTRACT.....	i
DEDICATION.....	ii
ACKNOWLEDGMENT.....	iii
LIST OF TABLES .....	xiii
LIST OF FIGURES.....	xiv
CHAPTER ONE: INTRODUCTION.....	1
Overview.....	1
Background to the Problem.....	1
Statement of the Problem.....	2
Purpose of the Study.....	3
Research Questions.....	3
Nature of Study.....	3
Significance of the study.....	5
Delimitations and Limitations.....	7
Operational Definitions.....	8

Prayer.....	8
Religion and Spirituality.....	9
General Anxiety Disorder.....	10
Subsyndromal Anxiety.....	10
Triangulation.....	10
Urban Youth Adolescents.....	11
Resilience.....	12
Child Risk Factors.....	12
Child Protective Factors.....	12
Family Risk Factors.....	12
Family Protective Factors.....	13
Theoretical Constructs.....	13
Organization of the Remaining Chapters.....	14
Chapter Summary.....	15
CHAPTER TWO: REVIEW OF THE LITERATURE.....	16
Overview.....	16
History of Spirituality in Treatment.....	17

Integration.....	19
Ethical Considerations for Spiritual Integration.....	21
Prayer.....	22
Ethical Considerations for the Integration of Prayer.....	24
Prayer Intervention with Children and Adolescents.....	25
Ethical Considerations for the Integration of Prayer with Children and Adolescents.....	26
Prayer and Anxiety.....	28
Cognitive Behavior Therapy, Anxiety and Prayer.....	29
Childhood Anxiety Disorders.....	30
Prayer and Subsyndromal anxiety.....	31
Triangulation .....	35
Urban Adolescents/Youth.....	40
At-Risk Adolescents/Youth.....	42
Urban Adolescent/Youth Demographics.....	43
Adolescent/Youth Group Counseling.....	44
Current Study.....	45
Chapter Summary.....	46

CHAPTER THREE: METHODS.....	47
Overview .....	47
Study Design .....	47
Participants/Subjects.....	47
Inclusion-Exclusion Criteria.....	48
THE PRAYER WHEEL™ Program .....	49
Measures.....	50
The Anxiety Status Inventory.....	50
Multidimensional Anxiety Scale for Children.....	51
The Brief Religious Coping.....	52
Research Questions and Hypotheses.....	53
Assessment/Procedure .....	54
Procedure (Summary).....	54
Statistical Analysis.....	55
Chapter Summary.....	56
CHAPTER FOUR: DATA ANALYSIS AND RESULTS .....	57
Demographics/Subjects.....	58

Results.....	60
Research Question One.....	60
Research Question Two.....	66
Chapter Summary.....	68
CHAPTER FIVE: SUMMARY, CONCLUSIONS, & RECOMMENDATIONS.....	70
Review of Demographics.....	71
Summary of Findings.....	71
Research Question One.....	71
Research Question Two.....	72
Discussion and Recommendations.....	73
Statement of the Problem.....	73
Research Question One.....	74
Research Question Two.....	79
Contrary Findings.....	81
Implications for Research, Practice, and Biblical Implications.....	82
Implications for Research.....	82

Implications for Practice.....	84
Biblical Implications of THE PRAYER WHEEL™ Program .....	86
Limitations of the Study.....	88
Recommendations for Future Research.....	91
Chapter Summary.....	92
REFERENCES .....	94
APPENDIXES.....	106
APPENDIX A: IRB APPROVAL.....	106
APPENDIX B: AFFIRMATION LETTER.....	107
APPENDIX C: PARENT/GUARDIAN CONSENT FORM.....	108
APPENDIX D: ASSENT OF CHILD TO PARTICIPATE IN RESEARCH.....	111
APPENDIX E: MASC 2 PERMISSION.....	112
APPENDIX F: RCOPE PERMISSION.....	113
APPENDIX G: THE PRAYER WHEEL™ Program .....	114

## List of Tables

Table 4.1: Scores for the measures at pretreatment, and post-treatment.....	65
Table 4.2: Follow-up participants' satisfaction after 6 weeks of intervention.....	65
Table 4.3: Demographic characteristics of the subjects.....	66



## List of Figures

Figure 1.1: A triangulation approach of intervention for urban adolescent populations.....	11
Figure 1.2: A “Funnel” approach of spiritually- based intervention.....	14
Figure 3.1: THE PRAYER WHEEL™ Program .....	50
Figure 4.1: Weekly subsyndromal anxiety levels.....	61
Figure 4.2: Weekly scores of religious coping.....	63
Figure 4.3: Triangulation approaches of the subjects.....	67

## **CHAPTER ONE: INTRODUCTION**

In recent years, the concept of the integration of psychology and religiosity/spirituality has received a great amount of interest and debate (Johnson & Myers, 2010, Kindle Location 42). While many researchers debate on how and what to integrate, several investigators have examined the relationship between prayer and anxiety, indicating that the intervention of prayer is therapeutically beneficial to clients (Blazer, 2007; Davis, Kerr, & Kurpius, 2003; Hawkins, Tan, & Turk, 1999; Koszycki & Taljaard, 2010; Martin & Booth, 1999; Tan & Johnson, 2005). While researchers suggest that spiritually based interventions such as prayer may be linked to reducing anxiety symptoms (Blazer, 2007; Davis et al., 2003; Hawkins et al., 1999; Koszycki et al., 2010; Martin & Booth, 1999; Tan & Johnson, 2005), to date, questions still remain about the therapeutic potential of spiritually based interventions/prayer with regard to subsyndromal anxiety (Cohen, Magai, Yaffee, & Walcott-Brown, 2006; Rajagopal, Mackenzie, Bailey, & Lavizzo-Mourey, 2002; Wu, Yeh, Michon, Weitzner, Abel, & Wright, 2015).

### **Background to the Problem**

In order to gain insight into the problem background and theoretical developments, this study highlights two significant studies on the subject of subsyndromal anxiety. Cohen, Magai, Yaffee, and Walcott-Brown (2006) examined the prevalence of subsyndromal and syndromal anxiety and associated factors among older persons living in an urban area, and concluded that there is a clear distinction between older adults who have syndromal anxiety, subsyndromal anxiety, and older adults who are non-anxious (Cohen et al., 2006). They further state that

subsyndromal anxiety can have an adverse impact on lives, and therefore it is incumbent on community psychiatrists to recognize untreated older persons with anxiety in the general community, particularly individuals with subsyndromal anxiety (Cohen et al., 2006, p. 1724). Rajagopal, Mackenzie, Bailey, and Lavizzo-Mourey (2002) examined the effectiveness of a spiritually based intervention in the alleviation of subsyndromal anxiety and minor depression in an elderly population. The study indicated that the use of a spiritually based intervention, more specifically a Prayer Wheel intervention, might be effective in alleviating subsyndromal anxiety, decreasing depression, and promoting psychological well-being in older adults.

### **Statement of the Problem**

While research has demonstrated that spiritually based interventions are effective for treating varied populations, there is little emphasis on the adolescent population, in particular urban adolescents. Empirically based studies on spiritually based interventions are often seemingly focused on the adult or elderly population (Flannelly, Weaver, Smith, & Handzo, 2003; Rajagopal et al., 2002). These interventions often do not reflect the unique growth, development processes, and particular issues of urban adolescents. The lack of consideration for these issues, such as cultural and multicultural effects on adolescent development, complicate effectively transporting spiritually based interventions into the urban population (Collins, Ready, Griffin, Walker, & Mascaro, 2007). A critical review of literature on urban adolescents reveals that consociation to non-urban adolescents, urban adolescents face many risk factors such as violence, poverty, poor health, poor academics, limited vocational training, low self-esteem, single-parent homes, and the pernicious effects of music on the culture (Chaves, Diemer,

Blustein, Gallagher, Devoy, Casares, & Perry, 2004; Dickie, Ajega, Kobylak, & Nixon, 2006; Roche, Enminger, Chilcoat, & Storr, 2003; Smith & Asiabi, 2007; Spano, Rivera, & Bolland, 2006).

### **Purpose of the Study**

The purpose of this study is to investigate the relationship between a spiritually based intervention, subsyndromal anxiety, and coping skills in urban adolescents, employing the add-on/integration of a Prayer Wheel intervention.

### **Research Questions**

This study seeks to answer the following research questions:

1. Can a spiritually based intervention/prayer effectively reduce subsyndromal anxiety and increase coping skills in urban adolescents?
2. Is a triangulation approach, which combines mental health services, a spiritually informed approach, and community resources, effective in reducing subsyndromal anxiety and increasing coping skills in urban adolescents?

### **Nature of Study**

The purpose of this study is to delineate and clarify the relationship between prayer and subsyndromal anxiety in urban adolescents. Researchers state that anxiety symptoms are not normally distributed, and many clients experience subsyndromal anxiety. A “subsyndromal group includes persons with symptoms that fall below the level associated with generalized anxiety disorder” (Cohen et al., 2006, p. 1719). Additionally, a review of literature reveals that

some researchers have proposed a threefold classification of anxiety symptoms, which would consist of a non-anxious group, a subsyndromal group, and a syndromal group (Cohen et al., 2006).

As previously mentioned, having critically reviewed the literature on spiritually based interventions, while discoveries show that spiritually based interventions are effective for treating many populations, there is little emphasis on the adolescent population, most notably urban adolescents. Empirically based studies on spiritually based interventions, although identified as being effective, often focus on the adult population (Flannelly et al., 2003; Rajagopal et al., 2002). The studies often fail to take into consideration the bio-psycho-social-spiritual experiences of adolescents (Collins et al., 2007). As mentioned, urban adolescents, like non-urban adolescents, face many risk factors such as violence, promiscuity, drugs, and anger. This study advocates gaining insights into the urban population because of the impact of urban adolescents on the culture at large in areas such as music, television, language, and education.

According to literature, “more than half of the world’s population lives in cities and approximately 40% of the world’s population is nineteen or younger” (Larson & Free, 2003, p. 12). Research reveals that violence and gang warfare significantly affect the urban youth population. According to studies, there is a direct correlation between violent behavior in urban youth, particularly inner-city youth, and high exposure to violence (Smith-Perez, Albus, & Weist, 2001). Studies reveal that urban youth who are exposed to violence often exhibit behaviors such as aggression, posttraumatic stress disorder, anxiety, depression, hopelessness, and low self-esteem (Smith-Perez et al., 2001).

According to researchers, the environment of the urban youth serves as risk factors to violence. “[A] growing body of evidence suggests that today’s victims of violence are at increased risk of becoming tomorrow’s perpetrators of violent behavior” (Spano et al., 2006). In addition to the issue of violence in urban youth communities, literature reveals common issues such as poor health, inadequate vocational training, low self-esteem, poverty, and single-parent homes (Chaves et al., 2004; Davis et al., 2006; Hoffman, 2006; Roche et al., 2003; Smith & Ashiabi, 2007; Spano et al., 2006). In sum, having discovered that studies on subsyndromal anxiety are often focused on the adult or elderly population (Cohen et al., 2006; Rajagopal et al., 2002), this study aims to examine more directly and advocate for the use of spiritually based intervention/prayer for reducing subsyndromal anxiety levels and increasing coping skills in urban adolescents, using a Prayer Wheel intervention.

### **Significance of the Study**

In order to make an adequate case for conducting this study, two significant studies on the subject of subsyndromal anxiety are highlighted: one a secularly based study and the other a spiritually based study focused on the adult or elderly population.

The secularly based study by Cohen and colleagues (2006) examines the prevalence of subsyndromal and syndromal anxiety and associated factors among older persons living in an urban area (Brooklyn, New York). The study reveals that about 14% of older adults have anxiety, much of it untreated (Cohen et al., 2006, p. 1719). The researchers also note a clear distinction between older adults who have subsyndromal anxiety and older adults who are non-

anxious (Cohen et al., 2006, p. 1719). They conclude that subsyndromal anxiety can disrupt lives and therefore, “Community psychiatrists must recognize that there are many untreated older persons with anxiety in the general community. Notably, persons with subsyndromal anxiety, who represent slightly more than one-sixth of older adults” (Cohen et al., 2006, p. 1724).

The second study of significance tested the effectiveness of a spiritually based intervention in the alleviation of subsyndromal anxiety and minor depression in an elderly population. The researchers argue that, given the widespread occurrence of subsyndromal anxiety and numerous issues surrounding polypharmacy use in the older adult population, the use of a spiritually based intervention, namely a Prayer Wheel intervention, may be effective in alleviating subsyndromal anxiety, decreasing depression, and promoting psychological well-being in older adults (Rajagopal et al., 2002).

Despite numerous studies that indicate spiritually based intervention/prayer may be linked to reducing anxiety symptoms (Blazer, 2007; Davis et al., 2003; Hawkins, Tan, & Turk, 1999; Koszycki & Taljaard, 2010; Martin & Booth, 1999; Tan & Johnson, 2005), less is known about the therapeutic potential of spiritually based interventions/prayer with regard to subsyndromal anxiety (Rajagopal et al., 2002). Consequently, in order to extend the literature, this study advocates for a spiritually based intervention for reducing subsyndromal anxiety and increasing coping skills in urban adolescents.

### **Delimitations and Limitations**

As mentioned earlier, while urban adolescents face similar risk factors to non-urban adolescents, this study is limited to urban adolescents engaged in therapy with a licensed clinician from a community clinic. This study argues that providing intervention for subsyndromal anxiety symptoms in urban adolescents could serve as both proactive and preventive factors against the risk factor of generalized anxiety disorder.

This current study identifies several variables that may be associated with subsyndromal anxiety in urban adolescents, such as gender (female and male), age, lower income, traumatic events, comorbidity with depression, diminished social resources, coping, daily functioning, and religious/spiritual coping. Variables such as education level, personal income, marital status, physical illness, and current or past alcohol abuse have been omitted from the study, as they have been deemed irrelevant to the urban adolescent population in the specific context of this study. Literature seems to indicate that the formerly mentioned variables may be associated with anxiety in older adults (Cohen et al., 2006). Thus, the theoretical construct of this study has been used as the scaffolding to incorporate the relevant variables described in the literature.

Limitations of the study may include adequate sample size, gap between treatment and follow-up being too close, religious diversity, clinically demarcating syndromal and subsyndromal anxiety, clarity of the adolescents' spirituality/religiosity (Pearce, Koenig, Robins, Nelson, Shaw, Cohen, & King, 2015, p. 57 &63), and intra-religious differences /subgroup issues



(Pearce et al., 2015, p. 64). Additionally, the study may not be able to identify the effective ingredients and mechanisms of change with certainty. Components such as being engaged in ongoing treatment, such as cognitive behavior therapy, anger management, etc., and subject/adolescent-therapist alliance, may either alone or in concert with other components, be responsible for the changes. Furthermore, the measure/instrument, the Anxiety Status Inventory (ASI; Zung, 1971), has yet to be validated on children, but has shown good internal consistency in studies within the urban context (Cohen et al., 2006; Rajagopal et al., 2002).

Finally, there may be critical events surrounding intervention with adolescents, such as attrition, adolescents moving away, death in the family, school dropout, or health crises. Consequently, this study will take into account these critical events when gathering data. While some researchers may argue that longitudinal design, which provides data sequentially over an extended period, provides a richer set of data, this study speculates that given the possible critical events surrounding interventions with urban adolescents, a cross-sectional design that limits collection to a single moment in time may be more advantageous.

## **Operational Definitions**

### **Prayer**

Multiple components define prayer. There is no one definition of prayer, as it is practiced in diverse ways, across diverse cultural, religious, and spiritual traditions. William James espouses that prayer is “every kind of inward communication or conversation with the

power recognized as divine” (Walker & Hathaway, 2013, p. 183). In order to conceptualize prayer in the context of counseling and psychotherapy, Walker and Hathaway (2013) define prayer as “an intervention involving communication with the divine for the purpose of meeting a treatment goal that is psychological or spiritual in nature” (p. 183). This study embraces Canadian psychiatrist Rossiter-Thornton’s concept of prayer as a self-help technique that is usable by anyone regardless of background, belief, religion, or race (Rossiter-Thornton, 2000, p. 125).

### **Religion and Spirituality**

A review of literature reveals that although the terms religion and spirituality are interchangeable, it is important for any study of religious/spiritual integration that both the client and clinician understand the clear distinction between these terms. Worthington and colleagues (2011) state,

Religion can be defined as adherence to a belief system and practices associated with a tradition in which there is agreement about what is believed and practiced. Spirituality, in contrast, can be defined as a more general feeling of closeness and connectedness to the sacred (p. 205).

According to Hodge (2006),

Spirituality can be defined in individual, existential terms as a person's relationship with God (or ultimate transcendent reality), and Religion can be understood as the expression of spirituality, manifested in particular beliefs, forms, and practices that have been

developed in conjunction with others who share similar understandings of transcendent reality (p. 158).

This study delineates that spirituality is primarily defined by personal experiences, feelings, practices, and relationships of transcendence that are found to be meaningful and give purpose to life; this may or may not take place in the context of a formalized religion. Religion is an agreed upon set of beliefs and practices by an identified set of individuals within the context of a formal institution or organization (Biggs & McMahon, 2012, p. 4).

### **General Anxiety Disorder**

Generalized anxiety disorder (GAD) is a common mental health concern that is treated by many clinicians, and one of the most common psychological experiences in both adult and adolescent populations. General anxiety disorder is, as defined by APA (2013), “Persistent and excessive anxiety and worry about various domains, including work and school performance that the individual finds difficult to control” (p. 190).

### **Subsyndromal Anxiety**

A “subsyndromal group includes persons with symptoms that fall below the level associated with generalized anxiety disorder” (Cohen et al., 2006, p. 1719).

### **Triangulation**

Investigators of the urban adolescent population advocate for some variation of a triangulation approach to intervention in order to transport interventions effectively to urban

settings. Jick (1979) states, “Triangulation is broadly defined as the combination of methodologies in the study of the same phenomenon” (p. 2). The triangulation approach consists of either mental health services, medical care, consultation (e.g. with teachers), caregiver–child interactions, or community services (Collins et al., 2007; Flaherty, Weist, & Warner, 1996; Ungar, Liebenberg, Landry, & Ikeda, 2012). In order to extend the literature on spiritually based interventions, the present study seeks to embrace a triangulation approach that combines mental health services, a spiritually informed approach such as THE PRAYER WHEEL™ Program, and providing community resources to the urban adolescents (see Figure 1.1).

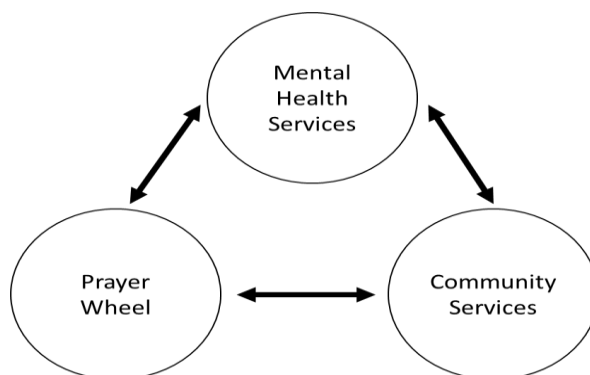


Figure 1.1 A triangulation approach of intervention for urban adolescent populations

### Urban Youth/Adolescents

The term urban youth “is used to denote young people who live in urban areas whose families, some of whom are recent immigrants, are financially impoverished or struggling to make ends meet” (Chaves et al., 2004, p. 275). One author defines issues relating to the urban context as urbanization, “the global movement from rural and traditional cultures to city living” (Larson & Free, 2003, p. 31). In regards to the urban adolescent population, discoveries show

that at-risk youth are not always equated with urban or inner city adolescents (Chaves et al., 2004).

### **Resilience**

“Good developmental outcomes and adaptive abilities in spite of growing up in high-risk situations” (Davies, 2004, p. 62).

“The process of, the capacity for or outcome of successful adaptation despite challenging or threatening circumstances” (D’Imperio, Dubow, & Ippolito, 2000, p.129).

### **Child Risk Factors**

“Conditions that create developmental risk” (Davies, 2004, p. 66). Examples of this include absence of father in the home, and taking on parenting roles by children (Kotlowitz, 1991, p.14-15).

### **Child Protective Factors**

“Factors in the child that influence vulnerability and resilience” (Davies, 2004, p. 63). Examples of this include positive self-esteem, internal locus of control (Kotlowitz, 1991).

### **Family Risk Factors**

“Parenting that heightens developmental risk involves inability to carry out the normal functions of parenthood” (Davies, 2004, p. 73). Examples of this include single parenting characterized by an absent father who sporadically lives in the home, or a sibling who is imprisoned or involved with drugs (Kotlowitz, 1991, p.13-14).

## **Family Protective Factors**

“Parenting that mitigates risk” (Davies, 2004, p. 64). Examples of this include warm, positive, and supportive relationships between mother and children (Kotlowitz, 1991).

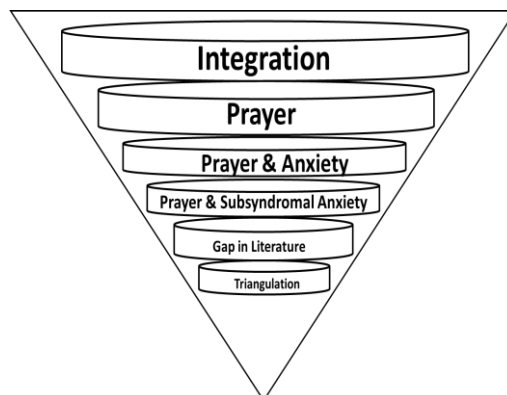
## **Theoretical Constructs**

The integration of psychology and religiosity/spirituality continues to be a topic of sharp debate as religious/spiritual interest in psychology has increased in the last fifty years (Johnson, 2010, Kindle Location 42). Though efforts to integrate psychology and religiosity/spirituality have seemingly gained strength, there is much debate on how and what to integrate. Consequently, approaching the subject of integration should be done with much caution and respect for both sides of the continuum.

Spirituality is an integral component utilized by many individuals to promote overall well-being. Mohr (2006) explains there are four components that promote overall well-being: physical, emotional, social, and spiritual dimensions. Within these components, individuals make decisions for living based upon their spiritual and religious constructs. These decisions for living help individuals address and cope with life stressors such as anxiety.

Within the aforementioned context, the “funnel” approach on the subject of a spiritually based intervention for reducing subsyndromal anxiety and increasing coping skills in urban adolescents provides a construct for the study. The “funnel” approach is comprised of the following stages (Figure 1.2): (a) integration, (b) prayer, (c) prayer and anxiety, (d) prayer and subsyndromal anxiety, (e) the gap in literature shown through this research, and (f) a

triangulation approach (Figure 1.1). The integration of prayer for reducing subsyndromal anxiety in urban adolescents aims to fill the gap in literature.



*Figure 1.2.* A “Funnel” approach of spiritually- based intervention

Assuming that the research finds what it is looking for, the study postulates that the results will be clinically and socially meaningful for addressing and using the spiritually based intervention of THE PRAYER WHEEL™ Program for reducing subsyndromal anxiety, and increasing coping skills in urban adolescents as well as in other adolescents. In sum, the intervention of THE PRAYER WHEEL™ Program may be an effective tool for the alleviation of symptoms of subsyndromal anxiety in urban adolescents.

### **Organization of the Remaining Chapters**

The remainder of the study is organized as follows: the second chapter will present a review of the literature related to spirituality and integration, prayer, prayer and anxiety, prayer and subsyndromal anxiety, the gap in literature (this study), and the triangulation approach. The third chapter will discuss methods/design, participants/subjects, inclusion-exclusion criteria, the

intervention (Prayer Wheel), assessment/procedure. The fourth chapter will report the data and results obtained from the study. The fifth chapter will discuss the implication of the results, make recommendations for future research, and identify limitations of the study.

### **Chapter Summary**

Despite an empirically supported relationship between interventions for subsyndromal anxiety and the adult or elderly populations, little is known about the relationship between spiritually based interventions for subsyndromal anxiety and the adolescent population. The goal of this study is to examine and advocate for the use of a spiritually based intervention (THE PRAYER WHEEL™ Program) for reducing subsyndromal anxiety levels and increasing coping skills in urban adolescents.



## CHAPTER TWO: REVIEW OF THE LITERATURE

### Overview

In a critical review of literature, this study conceptualizes the subject of a spiritually based intervention for reducing subsyndromal anxiety and increasing coping skills in urban adolescents as a “funnel” approach (Figure 1.2) consisting of (a) integration, (b) prayer, (c) prayer and anxiety, (d) prayer and subsyndromal anxiety, (e) the gap in literature shown through this research, and (f) a triangulation approach (Figure 1.1). The integration of prayer for reducing subsyndromal anxiety in urban adolescents aims to fill the gap in literature. The integration of psychology and religiosity/spirituality provides the theoretical underpinnings for a spiritually based intervention for reducing subsyndromal anxiety.

This chapter provides a brief review of the history of spirituality in treatment, integration, prayer, prayer and anxiety, prayer and subsyndromal anxiety, and triangulation. This review of literature highlights the urban adolescent demographic as the primary focus of this proposed study. While research indicates that spiritually based intervention/prayer may be linked to reducing anxiety symptoms (Blazer, 2007; Davis et al., 2003; Hawkins et al., 1999; Koszycki et al., 2010; Martin & Booth, 1999; Tan & Johnson, 2005), to date the relationship between the therapeutic potential of spiritually based interventions/prayer with regards to subsyndromal anxiety has not been fully explored (Rajagopal et al., 2002).

### **History of Spirituality in Treatment**

The historical roots of spirituality in treatment are traceable back to the birth of modern psychotherapy in the United States over 90 years ago, with the help of leading proponent Sigmund Freud (Kurtz, 1999). Freud defined the term psychotherapy as, “the discovery of the unconscious” (Kurtz, 1999, p. 20). However, the earliest form of psychotherapy was rendered in ancient Greece through philosophy, where philosophers attempted to make a distinction between mythology and rationalism, paving the way for the later distinction between psychotherapy and spirituality (Kurtz, 1999). The quest for making these distinctions gave rise to the demarcation of seeking help from beyond, seeking help outside one’s self, and reliance on the human self (Kurtz, 1999).

With the advent of Christianity and the early pursuits of spirituality, the emergence of several practices made significant contributions to psychotherapy with historical terms such as, *cura animarum*--“the care of souls.”, *imitatio*- “personal change and growth”, *asceticism* – “the reality of divided human nature,” and *spiritual direction*- “being malleable to a chosen mentor” (Kurtz, 1999). These practices would give rise to psychotherapeutic practices such as rational emotive therapy and cognitive behavior therapy (Kurtz, 1999).

During the seventeenth century, there was a focused effort to separate spirituality from physical health; a movement influenced by Rene´ Descartes, who placed great emphasis on separating the mind from the body, and the physical from the spiritual (Becker, 2001). Consequently, this gave rise to the dichotomy of medicine and spirituality, and the church and physicians (Becker, 2001).

From the early medieval period into the nineteenth century, local healers commonly practiced integrating medicine, spirituality, and psychology, providing both spiritual and physical care (Kurtz, 1999). During this period, images depicting the spiritual and human life standardly portrayed the journey, warfare, and a ladder (Kurtz, 1999).

The Enlightenment period, with leading proponents such as Aristotle, gave rise to understanding the differences among the physical, mental, emotional, and spiritual (Kurtz, 1999). Although the Enlightenment thinkers surmised that the Age of Reason would replace the Age of Faith, Enlightenment psychology rekindled the premise that human beings are the center of the universe (Kurtz, 1999). In addition, the Enlightenment period was known as the age of magnetism and electricity, integrating the concept of “force” into psychotherapy. In this context of psychotherapy, the belief that a superior force was needed to cope with mental health issues was common during this period (Kurtz, 1999).

In the nineteenth century, the United States saw the rise of the “mind-cure” approach; those who argued that spirituality should be the chief therapeutic instrument, and medical science should address issues such as personality dissociation and the subconscious mind (Kurtz, 1999). In nineteenth century Europe, theorists such Sigmund Freud and Carl Jung were becoming popular as they recognized and highlighted concepts such as “human doubleness,” or the conscious and the unconscious (Kurtz, 1999). The twentieth century in the United States saw the development of Christian Science (Kurtz, 1999).

A major shift in ideas occurred through the influential views of Sigmund Freud, who contended that religion and spirituality were at the root cause of mental issues (Becker, 2001).

Sigmund Freud advocated that individuals should shun religion and spirituality, and seek no help for spiritual issues (Becker, 2001). Freud's views were enthusiastically embraced by the field of psychiatry (Kurtz, 1999), supporting its stance of not integrating religion/spirituality into research or treatment approaches.

While the current stage offers little resolve on the historical debate of the relationship between psychotherapy spirituality, this study concurs, "Both psychotherapy and spirituality have to do with the acceptance of realistic limits" (Kurtz, 1999, p. 40), attempts to review the existing approaches of integration, and extends the literature by advocating for the spiritual intervention of prayer for treating subsyndromal anxiety in urban adolescents.

### **Integration**

In a critical analysis of the various approaches of integration, literature reveals that the integration of psychology and religiosity/spirituality has been a heated topic of debate as religious/spiritual interest in psychology has increased in the last fifty years (Johnson, 2010, Kindle Location 42). While there have been significant efforts to integrate psychology and religiosity/spirituality, there is much debate on how and what to integrate. This study embraces the premise, "The persons best equipped to contribute to the debate between two rival traditions to be those trained in the discourse of both" (Johnson 2010, Kindle Locations 216-217).

The literature demonstrates that the debate on integration is employed through different models: "A biblical counseling view", with advocates such as David Powlinson and Stuart Scott; "Level of explanation view", with advocates such as Plante and David Meyers; "Integrative

Psychotherapy view”, with advocates such as Stranton Jones and Mark McMinn; “A Christian Psychology view”, with advocates such as Robert Roberts, P. J. Watson and Diane Langberg; and “Transformational Approach”, with advocates such as Gary Moon, Coe, and Hall. The debate on integration can be categorized into four camps.

The first of these camps is the integrationist, who purports that all truth is God's truth, and the integration of scriptural truth with psychological "truth" is not an issue as long as psychological "truth" does not contradict the Bible (Carter & Narramore, 1981). The integrationist argues that God can reveal himself through both the Bible and psychology (Johnson 2010, Kindle Locations 1142-1143).

The nonintegrationists assert that it is not possible to integrate God's Word with psychological views. The nonintegrationists believe that the Bible and psychology should have no common ground; they are very skeptical and contend that secular psychology has nothing useful to offer. Historical proponents of this view include Jay Adams, (Adams, 1986; Owen, 1993), the founder of the biblical counseling model defined as “nouthetic model.” Adams (1986) asserts that the Bible is sufficient for all spiritual needs, and that there is little benefit to integration of psychology and theology; counseling should rely of the word of God and the ministry of the Holy Spirit. The outcome of counseling, according to this view, should be conviction, correction, and disciplined training (Adams, 1986). In sum, the nonintegrationists argue that there is no reconciliation between the conflict of psychology and religiosity/spirituality, the source of truth is revelation, not science, and psychology usurps the work of the Holy Spirit.

A third camp isolates biblical truth from psychological truth. They assert that the Scriptures should address spiritual issues, while psychology should address psychological problems that are outside of the Bible.

Those who hail in the final camp believe that they can draw the best tenets from psychology without integration with the Scriptures. Larry Crabb (1977) theorizes this approach as "spoiling the Egyptians" and "the separate but equal approach." While this current study approaches the subject of integration with much caution and respect for both sides of the continuum, several questions remain regarding the subject of integration. In order to extend the literature on integration, this study argues, "we can become so intent on avoiding a 'secular' worldview that we end up rejecting all that psychology and counseling theory have to offer" (McMinn, 1996, p. 21).

### **Ethical Considerations for Spiritual Integration**

While researchers agree that clinicians are ethically bound to treat spirituality, including integrating spiritual practices such as prayer (APA, 2010) there are several ethical issues to take into consideration for effective spiritual integration. Firstly, clinicians should be prepared to address the spiritual needs of his/her client. Clinicians should be open, nonjudgmental, and empathetic to the client's issues relating to spirituality (Miller & Thoresen, 1999). Therapeutic alliance will be compromised if clinicians are not open to the spiritual needs of the client. Secondly, it is important for clinicians to address their client's feelings surrounding spiritual intervention before and during treatment, especially with those who may be opposed spiritual

intervention (Worthington & Sandage, 2002). A third ethical consideration clinicians should be aware of, is integrating spirituality and culture. Notably, a client's worldview and God concepts influence the client's schemas. Additionally, clinicians should be aware that client schemas can impact the client's successful assimilation back into their relational systems and society (Worthington & Sandage, 2002). A final ethical consideration is that both the clinician and client should agree on treatment modalities in spiritual integration. Research notes that some clinicians prefer a more implicit approach, while other clinicians prefer a more direct approach (Worthington & Sandage, 2002). Consequently, both the clinician and client should agree on treatment approaches.

### **Prayer**

Evidence gathered from literature reveals that prayer is a common intervention used in the integration of spirituality and psychotherapy. Prayer has been defined as every kind of inward communication or conversation with the power recognized as divine (Walker & Hathaway, 2013), or an intervention involving communication with the divine for the purpose of meeting a treatment goal that is psychological or spiritual in nature (Walker & Hathaway, 2013). Literature reveals that there are many types and forms of prayer, such as spontaneous, recited, sung, silent, communal, or private prayer, each differing according to an individual's religious or spiritual tradition (Farah & McColl, 2008). Prayer integrated with psychotherapy can be elicited by the psychotherapist alone, by the client alone, or by both the psychotherapist and client

together (Walker & Hathaway, 2013). Additionally, prayer interventions can be engaged within the therapeutic session or outside the session (Walker & Hathaway, 2013).

Several studies reveal the effectiveness of prayer on mental health. Koenig (1998) notes that religious practices such as prayer can be effective in reducing depression in elderly patients. Other studies also indicate better outcomes in mental health with the integration of prayer (Propst, Richard, Watkins, Dean, & Mashburn, 1992; Rajagopal et al., 2002). Muelder (1957) reveals that prayer is associated with emotional health and physical well-being. Among the benefits are awareness of needs and realities; confession and harmonious adjustment; trust and relaxation; perspective and clarification; decision and dedication; renewal of emotional energy; social responsiveness; joy, gratitude, and relaxation; loyalty, perseverance, and integration; and personality, love and forgiveness.

Regarding integrating prayer into counseling, McMinn (1996) asserts that integrating prayer into psychotherapy should be based on the theoretic orientation of the clinician and the diagnostic needs of the client. McMinn (1996) reveals several benefits of prayer in counseling, including the strengthening of therapeutic alliance. According to McMinn (1996), there are several factors to consider when integrating prayer with psychotherapy, notably: prayers can minimize the counseling relationship, prayer becomes ritualistic, prayer can develop into a defense against reality, and prayer raises the risk of fostering intimacy and crossing ethical boundaries between the clinician and client.

While there are several advantages to integrating prayer into psychotherapy, literature findings warn that there are several possible disadvantages of using prayer. The potential



disadvantages include that prayer may be experienced as an attempt at coercion, prayer can evoke negative reactions that could jeopardize the therapeutic relationship, potential role confusion, lack of training in the use of prayer, and that colleagues and/or employer may not understand or support prayer in some settings (Farah & McColl, 2008).

### **Ethical Considerations for the Integration of Prayer**

Drawing from the works of McMinn (1996), clinicians must be aware of several ethical considerations for assessment and integration of prayer in psychotherapy. Foremost is the clinician's competency in using prayer as an integration tool in psychotherapy. *The Ethical Principles of Psychologists and Code of Conduct* (APA, 2017) state that clinicians should have an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, and religion for effective implementation of their services. Second, a required informed consent from the client is needed for prayer as a spiritual intervention. Third, the clinician must assess whether or not spirituality is a contributing factor to the client's problem. Fourth, the clinician must consider the client's receptiveness to prayer. Lastly, the clinician must assess whether or not prayer is a necessary treatment modality into the treatment plan. In summation, Farah and McColl (2008) assert that clinicians should employ the following questions when making decisions about the use of prayer:

- Is there a spiritual component to the client's problem?
- Is the therapist equipped to offer prayer?
- Would the client be receptive to the prayer?

- Would the workplace support the use of prayer?

### **Prayer Intervention with Children and Adolescents**

While researchers agree that psychologists are ethically bound to treat spirituality, including spiritual practices such as prayer, other researchers acknowledge and argue that the same ethical ethos applies to prayer interventions in children and adolescents (Walker & Hathaway, 2013). Advocates for prayer interventions in children and adolescents explain that children and adolescents experience the divine differently (Walker & Hathaway, 2013).

Evidence gathered from studies to address children's understanding of prayer demonstrated that children conceptualize prayer differently. For example, children younger than age 9 viewed prayer as magic or making requests to Santa (Walker & Hathaway, 2013). In another study, researchers discovered that children understand prayer in a stage-like progression where 5 to 7 year olds had a vague sense of prayer and God, 7 to 9 year olds understand prayer from behavioral aspects, and children age 9 and older understand prayer similar to adult concepts of prayer as private conversations with God (Walker & Hathaway, 2013). Concerning engaging in prayer as a means of coping with stress and anxiety, research notes that while adults believe people should engage in prayer when they experience negative emotions, young children believe that people should pray when they experience positive emotions (Walker & Hathaway, 2013). Consequently, this study notes that when implementing spiritual interventions in children adolescents, several questions need to be addressed:

- How do children and adolescents define spirituality?

- How do young children experience the divine?
- How do young children and adolescents incorporate his/her religious beliefs?
- What do religious practices mean to the young child?
- What do religious practices mean to the adolescent?

### **Ethical Considerations for the Integration of Prayer with Children and Adolescents**

Proponents for the integration of prayer with children and adolescents assert that when engaging the use of prayer in psychotherapy, there are several ethical considerations to employ. Firstly, the clinician must attain competency through education, training, and experience (Walker & Hathaway, 2013). Among the suggested competencies are formal training in graduate courses that focus on psychology and spirituality, continuing education, and consulting with other clinicians and religious leaders who are trained and experienced in the integration psychology and spirituality (Walker & Hathaway, 2013). Secondly, the clinician must obtain consent from a parent or guardian when engaging in any form of psychotherapy or treating a minor (Walker & Hathaway, 2013).

Clinicians have a responsibility to follow the laws of their states and ethical codes. APA (2017) Ethics Code Standard 3.10(b) states,

For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or

required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare. In addition to receiving informed consent from a parent or guardian, clinicians are encouraged to attain voluntary assent from the minor client (Walker & Hathaway, 2013).

A third area of ethical consideration is maintaining boundaries. According to Walker & Hathaway (2013), boundaries needed in the framework of integrating prayer with children and adolescents encompass competence (education, training and supervision), clinician's awareness of his/her role (evaluation, intervention), effectively managing time (sessions and appointments), executing context (individual psychotherapy, family therapy, or group therapy), determining the place for therapy (office, school, place of worship), and level of disclosure (professional vs. personal information).

A fourth area of ethical consideration is the need to respect differences in the counseling experience. Researchers suggest that clinicians ask several questions relating to multiculturalism when contemplating using prayer in psychotherapy:

- What are the multicultural implications of using prayer with a client?
- What is the significance of using prayer with respect to the client's age, sex, race, ethnicity, religion, national origin, indigenous heritage, or sexual orientation?
- What is the prevailing practice in the client's local community, organization, or institution? (Walker & Hathaway, 2013).

Lastly and most notably, when contemplating the use of prayer in psychotherapy, the clinician should avoid harm to clients all at costs (Walker & Hathaway, 2013). In summation, literature

contends that in order for prayer to be both spiritually beneficial and therapeutically effective in children and adolescents, clinicians should strive to use approaches that are developmentally appropriate, and congruent with the client's religious traditions (Walker & Hathaway, 2013).

### **Prayer and Anxiety**

Anxiety is a widespread and debilitating condition. Despite the high rates of anxiety in various communities, researchers argue that there are too few studies on the relationship of spirituality, including spiritual practices such as prayer, and anxiety (Shreve-Neiger & Edelstein, 2004). Although there are seemingly meager studies on the relationship of spirituality and anxiety, several studies indicate that religion/and or spirituality can be linked to psychological well-being in various demographics. Pardini, Plante, Sherman, and Stump (2000) revealed that anxiety and stress levels among recovering substance abusers were significantly lower in individuals who scored higher on measures of religious faith and spirituality. While examining the relationship between anxiety, spirituality, and religiosity in a group of at-risk youth, a study by Davis et al. (2003) demonstrated a significantly positive relationship between higher levels of spiritual well-being, existential well-being, religious well-being, intrinsic religiosity, and lower levels of anxiety. In an attempt to examine the relationship between spirituality, religiosity, and coping among university students who were engaged in exam preparations, researchers found that existential well-being was the best predictor of reduced anxiety (McMahon & Biggs, 2012).

Germane to this study, the intervention of prayer for reducing anxiety symptoms, researchers revealed that older adults who used a Prayer Wheel intervention indicated

significantly reduced levels of subsyndromal anxiety and lower depression scores (Rajagopal et al., 2002). In addition, THE PRAYER WHEEL™ Program intervention indicated positive health outcomes in self-esteem, trait-anxiety, mood, and psychological well-being (Rajagopal et al., 2002). With regards to the relationship between religious/spiritual commitment and anxiety, researchers argue that spiritually oriented interventions such as prayer can be effective in addressing anxiety and developmental issues in adolescents (Davis et al., 2003; Dew, Armstrong, Goldston, Triplett, & Koenig, 2008; Walker & Hathaway, 2013).

### **Cognitive Behavior Therapy, Anxiety and Prayer**

In interacting with the literature, this study notes that while retrospective and prospective studies indicate that cognitive behavior therapy is one of the most effective treatments for anxiety in adolescents, advocates of spiritually based interventions such as prayer, argue that standard cognitive behavior therapy may not be effective for religious adolescents (Propst et al., 1992). They argue that aspects of cognitive behavior therapy, which emphasize personal autonomy and self-efficacy, may oppose the religious values of religious adolescents (Propst et al., 1992). Consequently, researchers assert that spiritually oriented interventions such as prayer are essential for religious adolescents who have many spiritual concerns, such as what they ascribe to be sacred, convictions about ultimate reality, assimilation of good and evil, core values, pursuits for meaning and purpose, religious faith, religious practices, and religious doubts (Davis et al., 2003; Kézdy, Martos, Boland, & Horváth-Szabó, K., 2011). Relative to cognitive behavior therapy, anxiety, and prayer, empirically based studies reveal that cognitive behavior

therapy integrated with spiritual values and schemas to treat clients indicate that spiritual practices such as prayer assist in decreasing anxiety (Blazer, 2007; Propst et al., 1992).

This study highlights ongoing empirical studies of the spiritual integration approach of religiously integrated cognitive behavior therapy. Literature reveals that the goal of religious cognitive behavior therapy is to develop spiritual identity that is consistent with the client's core beliefs and traditions (Koenig, 2012; Pearce, Koenig, Robins, Nelson, Shaw, Cohen, & King, 2015). Religious cognitive-behavioral techniques include contemplative worship with religious imagery, prayer between client and clinician, scripture memorization, and spiritual/religious support groups. In addition, religious cognitive-behavioral therapy involves cognitive restructuring of distorted/unhealthy thinking through spiritual interventions (Tan & Johnson, 2005). For future research, this study proposes the spiritual integration of a Prayer Wheel intervention and religiously based integrated cognitive behavior therapy for reducing subsyndromal anxiety in an urban context, using a group therapy approach.

### **Childhood Anxiety Disorders**

Pertinent to this study, literature reveals that childhood anxiety disorders are the most commonly diagnosed psychiatric disorders in children and adolescents (Chorpita, 2004). Studies reveal that without proper treatment, anxiety conditions will worsen over time, lead to long term consequences, and impact adult functioning (Chorpita, 2004). Additionally, research has revealed that childhood anxiety negatively affects daily functioning, academic performance, and social functioning (Chorpita, 2007). According to Galla (2011), pediatric anxiety disorders

disrupt children's ability to accomplish their normal developmental tasks, and are often linked to refusal to attend school, failure, family and peer problems, substance abuse, violence, and suicide. A review of literature shows that unlike other childhood disorders, anxiety manifests itself through a variety of disorders and syndromes (Chorpita, 2007). Some of the most common disorders include: generalized anxiety disorder (excessive and uncontrollable worry about self, family, friends, and grades), separation anxiety disorder (fear of being separated from a caregiver, and something happening to self or the caregiver), social phobia (fear of social situations and peers), specific phobia (fear of specific objects or situations), obsessive-compulsive disorder (thoughts that are repetitive and unwanted), panic disorder (sudden intense fearful feelings), and posttraumatic stress disorder (emotional disturbance and frightening thoughts as a result of exposure to traumatic events). Children with anxiety disorders experience anxiety related symptoms such as fear, nervous system arousal, and impairment in functioning (Wood, 2009).

### **Prayer and Subsyndromal Anxiety**

A review of literature reveals that anxiety symptoms are not normally distributed, and many individuals experience subsyndromal anxiety. As previously mentioned, subsyndromal anxiety is defined as symptoms that fall below the level associated with generalized anxiety disorder (Cohen et al., 2006, p. 1719). In addition, drawing from research, Cohen and colleagues (2006) extend the literature on subsyndromal anxiety by highlighting the threefold classification of anxiety symptoms: a non-anxious group, a subsyndromal group, and a syndromal group.



As noted, this study highlights two studies significant to the subject matter. The first study, by Cohen and colleagues (2006), is a multiracial epidemiological community-based study of anxiety conducted with older adults living in an urban area. The second study, conducted by Rajagopal and colleagues (2002), tested the effectiveness of a spiritually based intervention for alleviating subsyndromal anxiety and minor depression in older adults.

In Cohen and colleagues, (2006), the literature argues that there are few epidemiological studies of anxiety disorders in older adults. The study identifies several variables that are linked with anxiety, both early and later in life: female gender, race (black), lower income, physical illness, unmarried status, traumatic events, comorbid psychiatric conditions, and diminished social resources (Cohen et al., 2006). Analysis of these variables revealed marked differences in older adults who have subsyndromal anxiety, those with syndromal anxiety, and those who were identified as non-anxious.

Individuals who were subsyndromally anxious were distinctly different from individuals who were non-anxious. Compared to non-anxious adults, subsyndromally anxious individuals were generally older, more educated, coped better with conflicts, and had better daily functioning, but also reported more lifetime trauma, physical illness, and higher rates of depressive, phobic, and stress-related symptoms (Cohen et al., 2006, p. 1722).

Syndromally anxious individuals also showed differences in symptoms compared to non-anxious individuals. Demographically, syndromally anxious individuals generally tended to be lower-income older white females with a history of alcohol abuse, high rates of intimate contacts, high rates of physical illness, and appeared to deal with conflict internally (Cohen et al.,

2006, p. 1722). Conversely, subsyndromally anxious individuals were more likely to be male, have fewer illnesses, have more symptoms of phobia, and lower rates of intimate contacts (Cohen et al., 2006, p. 1722).

In terms of mental health intervention, the researchers' study revealed that 23% of the syndromal anxiety individuals, 12% of the subsyndromal anxiety individuals, and 3% of the non-anxious individuals reported seeking mental health intervention in the past year (Cohen et al., 2006, p. 1722). In summary, the researchers conclude that syndromally anxious individuals were more likely to seek help for his/her symptoms than subsyndromally anxious or the non-anxious individuals (Cohen et al., 2006, p. 1724). The researchers assert that psychiatrists should be aware that there are many older individuals in the community that have untreated anxiety, most notably, subsyndromal anxiety (Cohen et al., 2006, p. 1722). The researchers further predict that the prevalence of subsyndromal anxiety may increase with age, resulting in higher rates of depressive symptoms and physical disorders (Cohen et al., 2006, p. 1724).

In a study to test the effectiveness of a spiritually based intervention in the alleviation of subsyndromal anxiety and minor depression in an elderly population, the researchers contend that although there are numerous studies that indicate that religion and/or spirituality is associated with psychological well-being among older adults, little is known about the relationship between spiritually based interventions, anxiety, and depression among older adults (Rajagopal et al., 2002). Using the spiritually based intervention of a Prayer Wheel (Figure 3.1), the researchers recruited twenty-two residents diagnosed with minor depression, from six continuing care retirement communities to participate in the study. Participants engaged the

intervention in either a group format or an individual basis, determined by the site where they were recruited (Rajagopal et al., 2002).

As previously mentioned, THE PRAYER WHEEL™ Program intervention was developed by Canadian psychiatrist Rossiter-Thornton (2000), who reports that his patients experienced therapeutic benefits such as improvements in interpersonal communication, feeling calmer, increased sense of peace, less anxious, and an increase in focus (p. 127). In advocating the use of THE PRAYER WHEEL™ Program as an intervention, Rossiter-Thornton (2000) explains that this self-help prayer technique is useful because it is easy to use, puts the patient in charge, does not require any particular belief, is flexible, and it is psychologically sound (p. 128). In engaging the use of THE PRAYER WHEEL™ Program as an intervention, the researchers revealed that there was a significant decrease in anxiety and a trend toward decrease in depression (Rajagopal et al., 2002). They further explain that since anxiety and depression is a significant occurrence in the elderly population, this intervention serves as alternative to poly-pharmacy interventions (Rajagopal et al., 2002). Poly-pharmacy (the excessive and sometimes unnecessary use of medication) is a significant issue in the elderly population, and many are seeking efficacious non-pharmacological interventions (Rajagopal et al., 2002).

Concerning the mechanism of using THE PRAYER WHEEL™ Program in a group format versus an individual format, the research reported no significant differences (Rajagopal et al., 2002). In conclusion, the researchers contend that given the widespread occurrence of subsyndromal anxiety and depression in the elderly population, the ongoing poly-pharmacy issues, and the need for non-pharmacological and spiritual interventions, THE PRAYER

WHEEL™ Program indicates therapeutic effectiveness in alleviating subsyndromal anxiety, decreasing depression, and promoting psychological well-being in older adults (Rajagopal et al., 2002).

This study highlights the significance of Rajagopal and colleagues' (2002) research, which serves as the underpinning and catalyst for the current study. Specifically, this study focuses on the following features: the need to replicate their study within an urban adolescent population; addresses the limitations of their study, such as homogeneity (all white, higher SES, mostly Christian); seeks to answer the researchers' question of the acceptability of treating individuals from other ethnic, cultural or religious backgrounds; and follows their suggestion of the effectiveness of THE PRAYER WHEEL™ Program intervention for subthreshold anxiety (Rajagopal et al., 2002, p. 164).

### **Triangulation**

A review of literature reveals that researchers of the urban adolescent population often advocate for some variation of a triangulation approach to transport interventions to urban settings effectively. Triangulation approaches can be either mental health services, medical care, consultation (e.g., with teachers), caregiver–child interactions, or community services (Collins et al., 2007; Flaherty et al., 1996; Ungar et al., 2012).

Triangulation, according to Jick (1979), is “the combination of methodologies in the study of the same phenomenon” (p.602). In addition, Jick (1979) explains that triangulation can capture a more complete, holistic, and contextual portrayal of a study (p. 603). In the context of

family systems, triangulation is defined as, “two parties that are aligned but, because of conflict or need, position a third party in their interactions” (Ungar et al., 2012, p. 203). Additionally, in the context of family systems, but salient to adolescents’ triangulation in marital conflicts, triangulation is defined as “a family system-level construct in which two people in a family bring in a third party to dissolve stress, anxiety, or tension that exists between them” (Buehler, Franck, & Cook, 2009, p 670).

In a study that used qualitative interviews and file reviews from 44 youth to determine the impact that multiple services have on family systems, the researchers argue that that there is little research on how multiple services interact in family systems to serve as protective factors and promote well-being (Ungar et al., 2012). The research found five patterns of triangulation among provider, caregiver, and adolescents (young people with complex needs). In the pattern of triangulation of family empowerment, characterized by a family engaged with helping their child/children and working with service providers, they note that when there is a weak relationship with the service provider, the family’s decision-making process and ability to empower the adolescent declines over time (Ungar et al., 2012, p. 199).

In triangulation cases where one or more service providers assumed responsibility of care to the adolescents and enlisted the cooperation of caregivers, the researchers discovered that the relationship with the service provider and both the caregiver and adolescent was conflicted, and the relationship between caregiver and adolescent was weak. In addition, the researchers noted that services to the family were often discontinued (Ungar et al., 2012, p. 200).

In triangulation patterns where there was conflict between the system provider and caregiver over who should provide care to the adolescent, the researchers noted that the caregivers resisted involvement of the service provider, and the adolescent experienced conflicted relationships with both caregiver and service provider (Ungar et al., 2012, p. 201).

In triangulation patterns where both the caregiver and adolescent sought help from the service provider to help them cope with each other, the researchers noted that alliance developed among all parties (Ungar et al., 2012, p.201).

In the triangulation pattern where service providers expect caregivers and adolescents to take responsibility for their own care, the researchers note that if either the caregiver or adolescent resists treatment, the service provider is forced to withdraw services (Ungar et al., 2012, p. 202).

In summary, the researchers discovered that triangulation provides opportunities for service providers to resemble family members, while providing service to caregivers and adolescents (Ungar et al., 2012, p. 203). The researchers conclude that the more service providers engage both adolescents and caregivers, build alliance with both adolescent and caregiver, empower families, and provide resources to the family, the more secure the relationship is with the service provider (Ungar et al., 2012, p. 203).

Finally, the researchers explain that while interviews give insight to services provided, file reviews supplied a better source of documenting services provided (Ungar et al., 2012, p. 203). Relevant to this study, a review of literature helps provide the framework that when delivering the triangulation approach of mental health services, THE PRAYER WHEEL™

Program intervention, and providing community resources to urban adolescents, the service provider must view themselves as an integral part of the family dynamics, empower both caregiver and adolescent, and build alliance with both parties. This study embraces the premise, “interventions, should be adapted to the needs of both the caregivers and the youth for whom they are intended” (Ungar et al., 2012, p. 204).

While Ungar and colleagues (2012) revealed the impact that service providers have on families through various triangulation patterns, Buehler and colleagues (2009) suggests that triangulation in marital conflicts serves as a risk factor for adolescents, which may be manifested in adolescent problem behavior and peer socialization issues. For their study, the researchers conceptualize triangulation as alliance formation, loyalty conflicts, complaining, and deleterious communication (Buehler et al., 2009, p. 677). Perceived peer relations are conceptualized as best/close friend support, general peer support, and peer rejection (Buehler et al., 2009, p. 678). Adolescent problem behaviors are categorized as either internalizing or externalizing. Marital conflicts were viewed as hostility, angry coercion, verbal attack, or antisocial interactions (Buehler et al., 2009, p. 679). In their study of 416 families, the researchers revealed that triangulation into parents’ marital conflict can be associated to lower levels of perceived support and peer relations, and high levels of perceived rejections from peers by adolescents (Buehler et al., 2009, p. 681).

Contrary to the hypothesis that daughters would show a stronger association between triangulation into marital conflicts and peer relations than sons, Buehler et al. (2009) discovered that triangulation into marital conflicts served as a risk factor for both sons and daughters

concerning peer relations (p. 682). Concerning adolescent problem behaviors, the researchers discovered that adolescents triangulated into marital conflicts displayed greater problem behaviors and perceived greater dislikes, less peer support, and greater rejection from peers (Buehler et al., 2009, p. 685). The researchers highlighted that when adolescents internalized their problems because of triangulation into marital conflicts, their perception of peer rejection was significantly impacted, resulting in depression, anxiety, and withdrawal (Buehler et al., 2009, p. 685). Therefore, the researchers argue that triangulation into marital conflicts creates anxiety in the triangulated family, impairs socialization outside the family, and affects socioemotional functioning (Buehler et al., 2009, p. 686).

In response to the limitations of this literature, “The sample included predominantly families of European descent. The findings should be generalized to families with other ethnic backgrounds with caution” (Buehler et al., 2009, p. 686). With regards to triangulated families, this current study is aware that the focus sample of urban adolescents facing triangulation issues relates more to single-parent and unstable family systems (Chaves, Diemer, Blustein, Gallagher, Devoy, Casares, & Perry, 2004; Dickie, Ajega, Kobylak, & Nixon, 2006; Roche, Enminger, Chilcoat, & Storr, 2003; Smith, & Asiabi, 2007; Spano, Rivera, & Bolland, 2006). This study speculates that triangulation with urban adolescents may resemble urban adolescents triangulated single parent/unstable families and peer/societal socialization. In summation, while the current study is for a triangulation approach which combines mental health services, THE PRAYER WHEEL™ Program, and providing community resources to the urban adolescents (see Figure 1.1), this study is aware of triangulation in urban adolescent family systems.



### **Urban Adolescents/Youth**

Pertinent to this study is the review of literature to gain insight into the urban adolescent demographic and address the overall research problem.

The term urban youth is defined as “young people who live in urban areas” (Chaves et al., 2004, p. 275). In addition, Chaves and colleagues (2004) contextualize urban youth as “some of whom are recent immigrants, are financially impoverished or struggling to make ends meet” (p. 275). Larson and Free (2003) qualify issues relating to the urban context as urbanization, defined as “the global movement from rural and traditional cultures to city living” (p. 31). This study notes that counterpart to their non-urban adolescent peers, urban adolescents face risk factors such as violence, poverty, poor health, poor academics, limited vocational training, low self-esteem, single-parent homes, and the deleterious effects of music on the culture (Chaves et al., 2004; Dickie et al., 2006; Hoffman, 2006; Roche et al., 2003; Smith & Ashiabi, 2007; Spano et al., 2006).

In the area of violence, literature indicates that the urban adolescent population experiences notable impact by violence and gang warfare. In a study of urban sixth graders, it was revealed that over 90% had heard gunshots, witnessed someone killed, witnessed someone beaten up, or had witnessed someone arrested (Smith-Perez, Albus, & Weist, 2001). In another study, 37% of boys had been beaten up, 31% threatened, and 42% had seen someone shot. Concurrently, 16% of girls had been beaten up, 14% threatened, and 30% had seen someone shot (Smith-Perez et al., 2001). A review of literature indicates that urban youth exposed to violence

can exhibit maladaptive behaviors such as aggression, anxiety, posttraumatic stress disorder, depression, hopelessness, and low self-esteem (Smith-Perez, Albus, & Weist, 2001).

Regarding the urban adolescent environment, literature seems to indicate that exposure to violence in urban communities serves as both a risk factor and precursor to violent behavior among urban youth. Spano and colleagues (2006) note, “a growing body of evidence suggests that today’s victims of violence (children who were abused and neglected) are at increased risk of becoming tomorrow’s perpetrators of violent behavior” (p. 282). Consistent with longitudinal studies, Spano and colleagues (2006) revealed that youth exposed to violence were 84% more likely to display violent behavior.

A review of literature reveals that among urban adolescents, music such as rap often promotes decadence, destruction, death, domestic violence, sexual immorality, perversion, and rebellion against authority (DeCarlo & Hockman, 2003). According to DeCarlo and Hockman (2003), “rap music is a communicative cultural manifestation of the worldview of many American urban adolescents” (p. 50). Salient to this study, in their research, which advocates effectively transporting interventions outside clinical settings for urban adolescents, DeCarlo and Hockman (2003) conducted research comparing rap therapy to a traditional psychoeducation group therapy. The results indicated that rap therapy group is a feasible alternative to traditional group therapy, and effective in promoting prosocial behavior among urban youth. In summary, they contend, “Regardless where one stands on the palatability of rap music, its communicative influence is deeply embedded in the culture of urban adolescents” (DeCarlo & Hockman, 2003, p. 46).

Research reveals that as with their suburban peers, urban adolescents face issues of self-esteem. According to research, while both boys and girls experience a decline in self-esteem during their teens, contributing to increased levels of anxiety, young women of color seem to experience higher levels of anxiety due to contributing issues such as socially imposed prejudices and discrimination, resulting in lowered expectations and higher levels of low self-esteem (Davis et al., 2003). Important to this current study are the findings in the literature that religious/spiritual practices can promote positive cognitive adjustments to negative life events, spiritual well-being, existential well-being, religious well-being and intrinsic religious orientation (Davis et al., 2003).

### **At-Risk Adolescents/Youth**

A review of literature reveals that urban adolescents differ from at-risk youth. At risk-adolescents can be defined as youth between the ages of 13 and 19 who, (a) live in impoverished economic settings, (b) perform poorly in their academics, (c) manifest characteristics of low self-esteem, (d) have the propensity for risk-taking and delinquent behavior, and (e) are exposed to delinquent behavior (Davis et al., 2003, p. 358). Extending the literature on at-risk youth, Sapp (2006) categorized at-risk youth as:

A student who is a dropout, a student who is a parent, a student who is an adjudicated delinquent, a student who is 1 or more years behind his or her grade level in credits earned, and/or a student who is 1 or more years behind his or her age or grade level in mathematics or reading skills. (p. 112).

Academically at-risk students are defined as, “students who do not receive a high school diploma, students who graduate with inadequate competencies, and students who do not become gainfully employed” (Sapp, 2006, p.112). Building on research of test anxiety, assessment, and treatment intervention, Sapp (2006), notes that academically at-risk middle school students had higher levels of test anxiety.

This study finds the literature review important, because as noted earlier, urban adolescents face risk factors consistent with some of the characteristics of at-risk adolescents, such as poor academics and the propensity toward violent and risk-taking behaviors. Additionally, a review of literature on the characteristics of at-risk adolescents will aid this current study in recognizing characteristics that put urban adolescents at a disadvantage for completing developmentally appropriate tasks for their age/and or grade levels.

### **Urban Adolescent/Youth Demographics**

In interacting with the literature, this study notes that literature relating to urban adolescents often pivots towards African-Americans, more specifically African-American males and their pronounced issues of violence, conduct disorder, and poor academic performance (Baggerly & Parker, 2005; Bradley, 2001; Bruce, Geten, & Daigle, 2009; Day-Vines & Day-Hairston, 2005; Goicoechea, Wagner, Yahalom, & Medina, 2014; Steen, 2009; Toldson & Toldson, 1999). This study understands that among the delineated urban adolescent population are African-American females and males, Hispanics/Latinos, Asians, Native Americans, and

Caribbean-Americans (McGoldrick, Giodarno, & Garcia-Preto, 2005).

### **Adolescent/Youth Group Counseling**

As previously mentioned, for future research, this study proposes the integration of a Prayer Wheel intervention, and religiously based integrated cognitive behavior therapy for reducing subsyndromal anxiety in an urban context, using a group therapy approach. Advocates of group counseling for adolescents purport that group counseling allows adolescents to experience positive peer culture, provides problem-solving strategies, provides practice of prosocial relations, assists in behavior modification, helps adolescents overcome negative self-impressions, and helps mitigate psychological distortions (DeCarlo & Hockman, 2003).

Concerning urban adolescents, a growing body of literature suggests group counseling approaches/interventions that are culturally relevant for addressing the needs of urban adolescents (Day-Vines & Day-Hairston, 2005; DeCarlo & Hockman, 2003; Goicoechea et al., 2014; Sibinga, Kerrigan, Stewart, Johnson, Magyari, & Ellen, 2011; Warner & Weist, 1995). Among the suggested approaches are music therapy, mindfulness-based therapy assessment and treatment for urban youth who have witnessed violence, and multiple family group intervention (DeCarlo & Hockman, 2003; McKay, Gonzales, Quintana, Kim, & Abdul-Adil, 1999; Sibinga et al., 2011; Warner & Weist, 1995).

### **Current Study**

A review of literature reveals a gap in the literature of spiritually based interventions, such as prayer and religiously based integrated cognitive behavior therapy, for reducing subsyndromal anxiety, whether from an individual or group therapy approach. The primary purpose of this study is designed to address this need by suggesting a Prayer Wheel intervention for reducing subsyndromal anxiety in urban adolescents, a future replication of the study using THE PRAYER WHEEL™ Program, and religiously based integrated cognitive behavior therapy for urban adolescents in a group therapy approach. While the study advocates for spiritually based interventions for reducing subsyndromal anxiety, it is important to note that this current study does not dismiss empirically based research that reveals the combination of medication and cognitive-behavioral therapy as two of the most effective treatment interventions for clients experiencing anxiety symptoms (Gabbard, 2009). The goal of this study is to examine the relationship between urban adolescents, subsyndromal anxiety, and a spiritually based intervention. This study explores the following research questions:

RQ1. Can a spiritually based intervention/Prayer effectively reduce subsyndromal anxiety and increase coping skills in urban adolescents?

RQ2. Is a triangulation approach that combines mental health services, a spiritually informed approach, and community resources, effective in reducing subsyndromal anxiety and increasing coping skills in urban adolescents?

### **Chapter Summary**

The subject of the integration of psychology and religion/spirituality has experienced increased interest from both fields of psychology and religion/spirituality. Researchers indicate positive relationships between higher levels of psychological well-being, spiritual well-being, existential well-being, religious well-being, and lower levels of anxiety. However, a review of literature reveals limitations regarding spiritually based interventions for urban adolescents and anxiety. This chapter reviews the history, conceptualization, and the theoretical underpinnings of integration, prayer, anxiety, subsyndromal anxiety, triangulation, urban adolescent demographics, proposes future replication and research of this current study, and discusses how the relationship between urban adolescents, subsyndromal anxiety, and a spiritually based intervention is conceptualized in the current study.

## **CHAPTER THREE: METHODS**

### **Overview**

This chapter outlines the methods employed to investigate the relationship between a spiritually based intervention, subsyndromal anxiety, and coping skills in urban adolescents. The study's design, participants/subjects, inclusion-exclusion criteria, intervention, measures, research questions, assessment/procedures, and statistical analysis will be discussed herein.

### **Study Design**

Since the purpose of the study is to investigate the relationship between a spiritually based intervention, subsyndromal anxiety, and coping skills in urban adolescents, a quantitative method is used. A multiple baseline design across subjects will be used to demonstrate the controlling effects of a spiritually based intervention/prayer for reducing subsyndromal anxiety and increasing coping skills in urban adolescents.

### **Participants/Subjects**

Three (3) or four (4) adolescents who will be and/or are engaged with mental health services (therapy) with a licensed clinician will be recruited from a community clinic or treatment facility in Upstate New York, for the add-on/integration of a spiritually based intervention, using THE PRAYER WHEEL™ Program. The target population is urban youth, ages 11-17. Parent or guardian written informed consent forms will be required of all under



participants under the age of 18. Each participant will complete an assent (consent) child form to participate in the research study. Protocol will include receiving the administration of the following instruments: The Anxiety Status Inventory, Multidimensional Anxiety Scale for Children, and The Brief Religious Coping (RCOPE). The researcher, will conduct assessments.

### **Inclusion-Exclusion Criteria**

Adolescent inclusion criteria are: (a) youth between the ages of 11 and 17 at the time of recruitment; (b) identified by the researcher as an urban adolescent; and (c) demonstrated cognitive ability to understand the study and actively participate in the research, based on semi-structured interviews and responses on the assent (consent) child form. Exclusionary criteria are pervasive developmental disorders, psychotic disorders, or current involvement in other psychosocial or psychopharmacological treatment for phobic or anxiety problems. Adolescents will be categorized as having syndromal anxiety if they meet the Anxiety Status Inventory (ASI) cutoff score of 40 or higher. For those scoring less than 40 on the ASI, criteria for subsyndromal anxiety will be met if the individual reported at least one of the five Anxiety Status Inventory (ASI) “worry” items: nervousness, fear, panicky, going to pieces, or something bad happening, and experience three or more ASIS items either a “good part” or “most or all of the time” in recent weeks. Those who meet the criteria for subsyndromal anxiety will be included in the study; those categorized as having syndromal anxiety or “non-anxious” will be excluded from the study.

## **THE PRAYER WHEEL™ Program**

THE PRAYER WHEEL™ Program (Figure 3.1) is an inexpensive, non-denominational, non-pharmacological intervention. The method is a standardized, replicable, and structured format for praying, developed by Canadian psychiatrist Rossiter-Thornton for use in his private practice. He reports that patients received therapeutic benefits from THE PRAYER WHEEL™ Program intervention. When used in therapy, Rossiter-Thornton (2000) instructs the therapist to explain to the patient that THE PRAYER WHEEL™ Program is not provided for religious reasons, but as a self-help technique. He further explains that the Prayer Wheel can be used by anyone, regardless of background, belief, religion or race (Rossiter-Thornton, 2000, p. 125). THE PRAYER WHEEL™ Program contains eight components, each one designed to be completed in approximately 5 minutes (See Figure 3.1). Rossiter-Thornton (2000) provides a detailed description of the contents of each section and use of THE PRAYER WHEEL™ Program. The components of THE PRAYER WHEEL™ Program are as follows:

I. “Count your Blessings,” Give Thanks and Praise

II. “Sing of Love”

III. “Request Protection and Guidance”

IV. “Forgive Yourself and Others”

V. “Ask for Needs, Yours and Others”

VI. “Fill Me with Love and Inspirations”

VII. “LISTEN with Pen in Hand”

### VIII. “Your Will is My Will”

In addition, a study by Rajagopal and colleagues (2002) suggested that within the population of older adults, THE PRAYER WHEEL™ Program may be an effective tool for the alleviation of symptoms of subsyndromal anxiety, and may be beneficial in treating minor depression. Literature indicates that anxiety in adolescents can be comorbid with depressive symptoms, and treating these anxiety symptoms can improve depressive symptoms (Suveg et al., 2006).

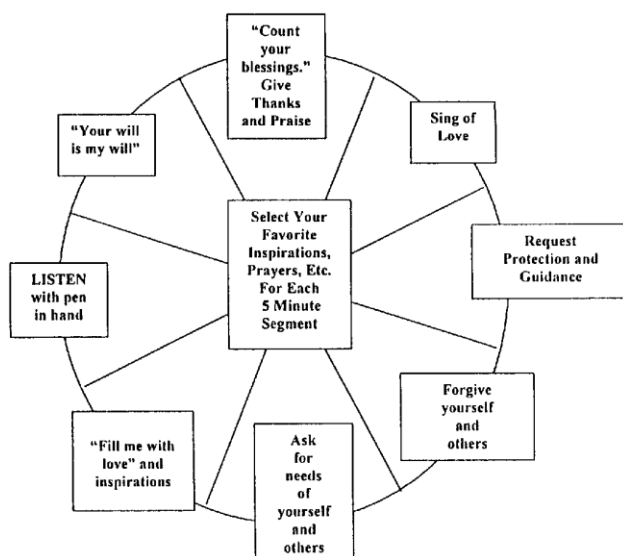


Figure 3.1. THE PRAYER WHEEL™ Program

## Measures

### The Anxiety Status Inventory

The Anxiety Status Inventory (ASI; Zung, 1971) is a clinician-rated instrument. It contains the diagnostic criteria for anxiety as a psychiatric disorder (5 affective and 15 somatic

symptoms) and an interview guide for eliciting each of the symptoms (Zung, 1971). The ASI is a four-point scale (rated 1–4) in which severity is assessed based on the combination of intensity, frequency, and duration of symptoms (Leentjes et al., 2008). Questions include, “Do you ever feel nervous and anxious?” and “Have you ever felt afraid?” Zung (1971) reveals statistical tests of significance using analysis of variance, and indicated that the mean ASI Z score obtained by patients with diagnoses of anxiety disorders was significantly higher than those of the other four diagnostic groups ( $p < 0.05$ ).

### **Multidimensional Anxiety Scale for Children**

Multidimensional Anxiety Scale for Children (MASC; Miller et al., 2011), is a 39-item self-report measure used to assess a broad spectrum of anxiety. Items are rated on a 4-point Likert scale (*never true to often true*), and the tool is easily administered in school settings in approximately 15 minutes. The MASC has a sum of the 39 items, with scores ranging from zero to 117: the higher scores indicating increased anxiety symptoms. Items are distributed across four scales: Physical Symptoms (12 items), Harm Avoidance (9 items), Social Anxiety (9 items), and Separation Anxiety/Panic (9 items). The MASC has reasonable internal consistency, test-retest reliabilities, and satisfactory convergent and divergent validities (Miller et al., 2011). The MASC is widely used in community and clinical settings. Its use is increasing in school settings across age and gender samples (Miller et al., 2011).

This study used the updated Multidimensional Anxiety Scale for Children, 2<sup>nd</sup> edition (MASC 2). The update retains the essential features of the original MASC and introduces several important refinements. One of the most significant changes of the MASC 2 is the

number of items; 50. The MASC 2 has demonstrated excellent reliability with alpha coefficients and test-retest reliabilities. Result of analyses reports indicate that the MASC 2 scores are 1) able to discriminate between relevant groups, 2) correlated meaningfully with scores from other measures of anxiety, 3) generalizable across rater type and racial/ethnic groups (March, 2013).

### **The Brief Religious Coping**

The Brief Religious Coping (RCOPE; Pargament et al., 2011) is a 14-item self-report measure of religious coping with major life stressors. Factor analysis validated the conceptualization and construction of the subscales, and provided evidence of high internal consistency and incremental validity. The Brief RCOPE has demonstrated good internal consistency in a number of studies of varying samples, including patients undergoing cardiac surgery, African American women with a history of partner violence, cancer patients, older adults in residential care, outpatients with alcohol use disorders, HIV patients, Catholic middle school students, and residents in Massachusetts and New York City following 9/11 (Pargament et al., 2011, p. 58). The Brief RCOPE has also demonstrated concurrent validity (Pargament et al., 2011, p. 59). All but two of the RCOPE scales had alpha values of 0.80 or greater confirming generally high reliability estimates (Pargament et al., 2011). The RCOPE subscales assess items such as “Looked for a stronger connection with God”, “Focused on religion to stop worrying about my problems”, “Questioned God’s love for me”, and “Decided the devil made this happen” (Pargament et al., 2011, p. 57).

### **Research Questions and Hypotheses**

As noted in the introduction chapter, this study seeks to answer the following research questions, which will be examined through the exploration of their related hypotheses:

RQ1. Can a spiritually based intervention/prayer effectively reduce subsyndromal anxiety and increase coping skills in urban adolescents?

H1. A spiritually based intervention/prayer will effectively reduce subsyndromal anxiety and increase coping skills in urban adolescents.

Null Hypothesis: A spiritually based intervention/prayer will not effectively reduce subsyndromal anxiety and increase coping skills in urban adolescents.

RQ2. Is a triangulation approach that combines mental health services, a spiritually informed approach, and community resources, effective in reducing subsyndromal anxiety and increasing coping skills in urban adolescents?

H2. A triangulation approach that combines mental health services, a spiritually informed approach, and community resources, will be effective in reducing subsyndromal anxiety and increasing coping skills in urban adolescents.

Null Hypothesis: A triangulation approach that combines mental health services, a spiritually informed approach and community resources, will not be effective in reducing subsyndromal anxiety and increasing coping skills in urban adolescents.

### **Assessment/Procedure**

A parent/guardian will complete a parent/guardian consent form, which details background information, procedures, risk/benefits of the study, compensation, confidentiality, voluntary nature of the study, and statement of consent. Each adolescent participant will complete an assent (consent) form, which details the nature of the study, procedures, and voluntary agreement to participate in the study.

#### **Procedure (Summary)**

1. First task/procedure. Participants will complete the measures - The Anxiety Status Inventory (ASI), Multidimensional Anxiety Scale for Children (MASC), and The Brief Religious Coping (RCOPE). Completion should take approximately 45 minutes.
2. Second task/procedure. Baseline measures will be obtained at week 1, week 2, week 3, or week 4, for each adolescent. Baseline measures will be confidentially compared to the two or three other adolescent participants.
3. Next task/procedure. Participants will continue to engage with clinician-directed treatment, and continue for the consecutive six weeks of intervention.
4. Next task/procedure. Adolescents' subsyndromal anxiety levels will be assessed weekly.
5. Next task/procedure. In order to assess subsyndromal anxiety levels and coping skills, each adolescent will complete the THE PRAYER WHEEL™ Program (Rossiter-Thornton 2000) and review both The Anxiety Status Inventory (ASI; Zung, 1971) and The Brief Religious

Coping (RCOPE; Pargament et al., 2011) weekly. Weekly scores of religious coping will be reported.

6. Next task/procedure. A brief follow-up will be performed based on each participant's satisfaction ratings after 6 weeks of intervention.

### **Statistical Analysis**

A multiple baseline design across subjects will be used to demonstrate the controlling effects of spiritually based intervention/prayer for reducing subsyndromal anxiety and increasing coping skills in urban adolescents. Baseline measures will be obtained for 1 week for adolescent 1, week 2 for adolescent 2, week 3 for adolescent 3, week 4 for adolescent 4. During the extended baselines for adolescents 2-4, the adolescents will be engaged with clinician directed treatment and continue for the consecutive 6 weeks of intervention. Subsyndromal anxiety levels will be assessed weekly (Figure 4.1).

In order to assess subsyndromal anxiety levels and coping skills, the adolescents will complete the THE PRAYER WHEEL™ Program (Rossiter-Thornton 2000), and review both The Anxiety Status Inventory (ASI; Zung, 1971) and The Brief Religious Coping (RCOPE; Pargament et al., 2011) weekly. Weekly scores of religious coping will be reported (Figure 4.2).

Scores for the adolescents on the three measures (ASI; MASC 2; RCOPE) at pretreatment and post-treatment will be reported (Table 4.1). A brief and systematic follow-up will be performed based on the participants' satisfaction ratings after 6 weeks of intervention (Table 4.2). For this study, the participant's satisfaction questions will consist of: (a) "How satisfied are you with improvements in your problems?", (b) "How satisfied are you with improvements in



your family relationships?”, (c) “How satisfied are you with your knowledge and skills in better managing future problems?”, (d) “How satisfied are you with your progress?”, (e) “How satisfied are you with the quality of advice and support you received?”

### **Chapter Summary**

This chapter discusses the methodology employed in the study. Included in this section are the study’s design, participants/subjects, inclusion-exclusion criteria, intervention, measures, research questions and hypothesis that explicate the study, assessment/procedures, and statistical analysis. Finally, this chapter culminates by highlighting the succinct and systematic follow-up assessment that each participant will undergo.

## CHAPTER FOUR: DATA ANALYSIS AND RESULTS

The goal of this study was to examine the relationship between urban adolescents, subsyndromal anxiety, and a spiritually based intervention, using a Prayer Wheel. This study employed a multiple baseline design across subjects to demonstrate the controlling effects of spiritually based intervention and prayer in reducing subsyndromal anxiety and increasing coping skills in urban adolescents. Baseline measures were obtained at week one for adolescent 1, weeks one and two for adolescent 2, and weeks one, two, and three for adolescent 3. During the extended baselines for adolescents 2 and 3, the adolescents were to be engaged with clinician directed treatment, and continued for the full period of intervention. Subsyndromal anxiety levels and religious coping were assessed weekly. The study was designed to answer two research questions: first, can a spiritually based intervention/Prayer Wheel effectively reduce subsyndromal anxiety and increase coping skills in urban adolescents? Second, is a triangulation approach which combines mental health services, a spiritually informed approach, and community resources, effective in reducing subsyndromal anxiety and increasing coping skills in urban adolescents?

The first research question required that the predictor variable/independent variable (spiritually based intervention) correlate with the outcome variable/dependent variable (subsyndromal anxiety), establishing the existence of an effect. This was addressed using the spiritually based intervention of a Prayer Wheel (Figure 3.1). Based on the recommendation and intervention protocol of THE PRAYER WHEEL™ Program, all eight components were used.

It was hypothesized that the spiritually based intervention of using all eight components of THE PRAYER WHEEL™ Program would effectively reduce subsyndromal anxiety and increase coping skills in urban adolescents.

The second research question required that the predictor variable/independent variable (triangulation) correlate with the outcome variable/dependent variable (subsyndromal anxiety), establishing the existence of an effect. This was addressed using a triangulation approach, which combines mental health services, a spiritually informed approach, and community resources (Figure 1.1). It was hypothesized that a triangulation approach, which combines mental health services, a spiritually informed approach, and community resources, would be effective in reducing subsyndromal anxiety and increasing coping skills in urban adolescents.

### **Demographics/Subjects**

Demographic characteristics of the subjects are shown in Table 4.3. The adolescents met full criteria for the study of subsyndromal anxiety on both the Anxiety Status Inventory (ASI), and the Multidimensional Anxiety Scale for Children (MASC 2). According to the endorsements of the ASI and the MASC 2, they reported that on some occasions they “felt nervous and anxious”, “felt afraid”, “felt uneasy that something terrible was going to happen”, “felt sick to their stomach”, “had dreams that scared them”, “have headaches/neck/back pains”, “are restless and can’t sit still”, “keep their eyes open for danger”, “worried about what people think of them.” In all instances, subsyndromal anxiety was determined by the author as a secondary diagnosis based on the severity and interference with functioning. Of the three adolescents, none evidenced comorbidity for a diagnosis of depression. Using the Patient Health Questionnaires

(PHQ-2 and PHQ-9), the author assessed for depression (Arroll, Goodyear-Smith, Crengle, Gunn, Kerse, Fishman, & Hatcher, 2010; Kroenke, Spitzer, & Williams, 2001), as literature indicates that patients with symptoms of anxiety can also have comorbid depression (Cohen et al., 2006; Rajagopal et al., 2002; Suveg et al., 2006). As noted, subject characteristics are summarized in Table 4.3.

S1, a 16-year old African American male reported mild to moderate levels of recurring anxiety as a result of his mother's health challenges and an old brother who is incarcerated. He fears for his older brother's safety in prison, and reports that praying for his older brother's protection helps reduce his levels of anxiety. Based on DSM-5 criteria, S1 has several diagnoses which include ADHD Predominantly Inattentive Presentation, Conduct Disorder unspecified onset, and Adjustment Disorder with mixed disturbance of emotions and conduct.

S2, a 13-year old African American female reported mild to moderate levels of recurring anxiety due to being given up for adoption by her birth parents. S2 lives in a single parent home; her adopted mother reports challenges in raising several children by herself and keeping S2 focused in the midst several risk factors, such as parent-child relations, limited finances, and "keeping S2 off the streets." Based on DSM-5 criteria, S2 has a diagnosis of Adjustment Disorder, Unspecified.

S3, a 14-year old African American male reported mild levels of anxiety due to a home that is unstable because of parents. Based on DSM-5 criteria, S3 has several diagnoses which include Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, and Sibling Relational Problem. S3 receives support from his grandmother who does all she can to promote

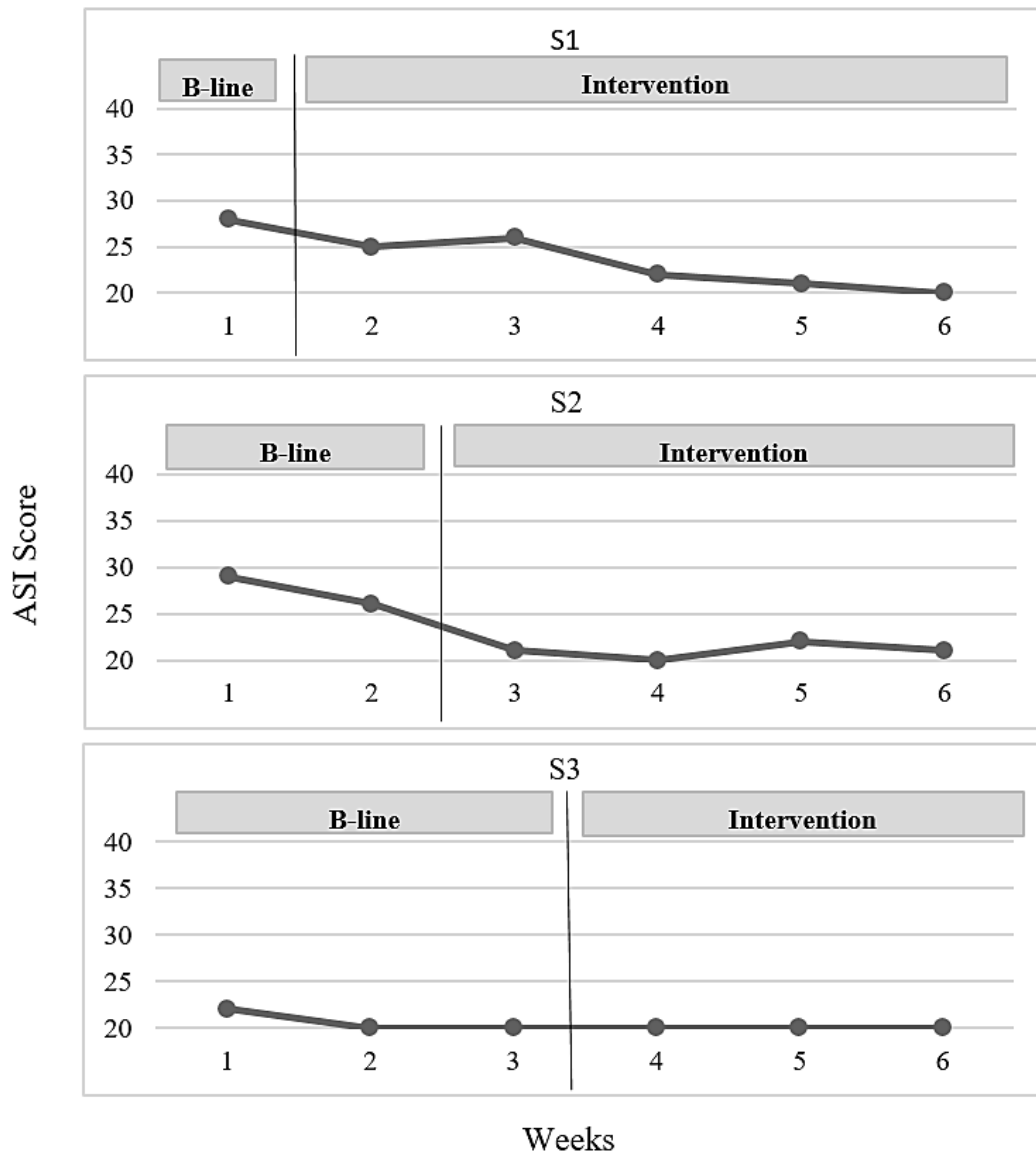
child protective factors such finances, a safe and encouraging environment in her home, and engagement in community resources.

## **Results**

### **Research Question One**

The first research question required that the predictor variable/independent variable (spiritually based intervention) correlate with the outcome variable/dependent variable (subsyndromal anxiety), establishing the existence of an effect. This was addressed using the spiritually based intervention of a Prayer Wheel (Figure 3.1).

**Subsyndromal anxiety.** As seen in Figure 4.1, weekly subsyndromal anxiety levels on the ASI decreased upon implementation of THE PRAYER WHEEL™ Program for each adolescent. The average weekly scores of subsyndromal anxiety levels during baseline were 28.0 for S1, 27.5 for S2, and 20.7 for S3. The average weekly scores during treatment were 22.8 for S1, 21 for S2, and 20 for S3, evidencing the decrease.



*Figure 4.1: Weekly subsyndromal anxiety levels*

**Religious coping.** Figure 4.2 displays weekly scores of religious coping. Based on the scoring and algorithm of the Brief RCOPE, scores can range from low spiritual struggle to high spiritual struggle. Lower scores on the negative subscales (questions 8-14) indicate better coping

skills, and higher scores indicate weaker coping skills. As can be seen from Figure 4.2, weekly scores on the negative subscales of Brief RCOPE decreased upon implementation of THE PRAYER WHEEL™ Program for S1 and S2, indicating increased coping skills, and the positive role of religion/spirituality in the process of dealing with anxiety, crisis, trauma, transition, and life's issues. S3's Brief RCOPE did not deviate from his pretest scores, and remained stable throughout the intervention. These scores indicate consistency in coping skills, and the positive role of religion/spirituality in the process of dealing with anxiety, crisis, trauma, transition, and life's issues. Pargament et al. (2011) reveals,

Positive religious coping methods reflect a secure relationship with a transcendent force, a sense of spiritual connectedness with others, and a benevolent world view. Negative religious coping methods reflect underlying spiritual tensions and struggles within oneself, with others, and with the divine (p. 51).

The average weekly scores of the Brief RCOPE during baseline were 12 for S1, 10 for S2, and 7 for S3. The average weekly scores during treatment were 12 for S1, 7.5 for S2, and 7 for S3.

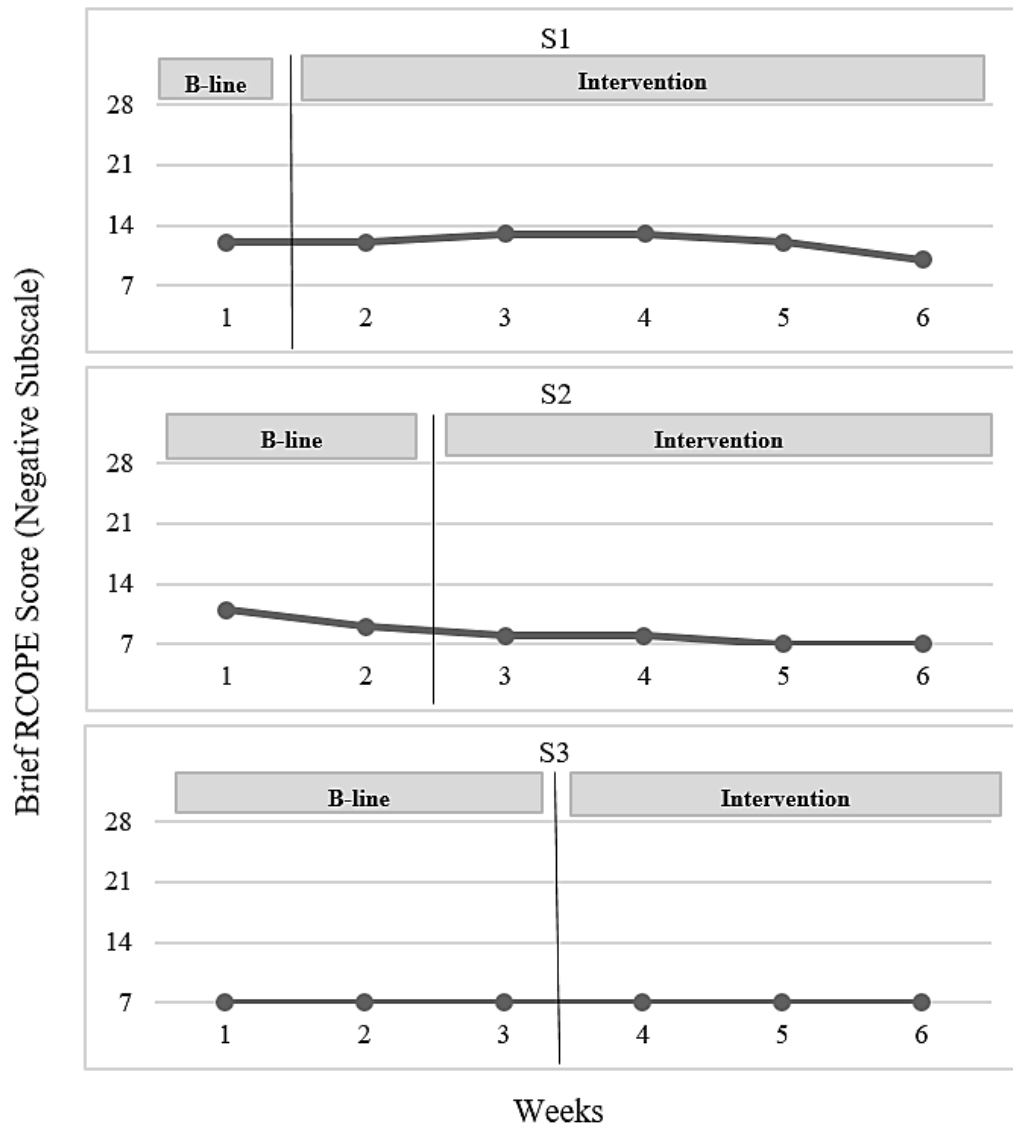


Figure 4.2 : Weekly scores of religious coping

**Scores for measures.** Table 4.1 provides scores for the adolescents on the three measures at pretreatment and post-treatment. Diminution in subsyndromal anxiety levels (ASI and MASC 2) were noted from pretreatment to post-treatment. Increases in coping skills (based



on the negative subscales of Brief RCOPE) were noted from pretreatment to post-treatment. Based on the brief follow-up assessment reflected in Table 4.2, the efficacy of the intervention seems to have persisted into the follow-up, as indicated by responses and satisfaction ratings.

At pretreatment, S1 and S2 reported clinically significant levels of subsyndromal anxiety per the ASI measure (approximately 2 SDs from normative means). In addition, S2 reported a marginally significant level of subsyndromal anxiety per the MASC 2 (greater than 1 SD from normative mean). Specific to coping skills, S1 reported marginally significant coping skills per the negative subscales of the Brief RCOPE (greater than 1 SD from normative mean). At post-treatment, scores for the ASI for the three adolescents were within normative levels except for the MASC 2 score for S2 which remained in the marginally significant range (greater than 1 SD, but less than 2 SDs). Thus, overall, the changes in the adolescents' scores between pretreatment and post-treatment suggest that that THE PRAYER WHEEL™ Program was effective in alleviating symptoms of subsyndromal anxiety.



Table 4.3  
*Demographic Characteristics of the Subjects*

Subject	Sex	Age	Diagnosis
S1	M	16	ADHD Predominantly Inattentive Presentation Conduct Disorder unspecified onset Adjustment Disorder with mixed disturbance of emotions and conduct
S2	F	13	Adjustment Disorder, Unspecified
S3	M	14	Disruptive Mood Dysregulation Disorder Oppositional Defiant Disorder Sibling Relational Problem

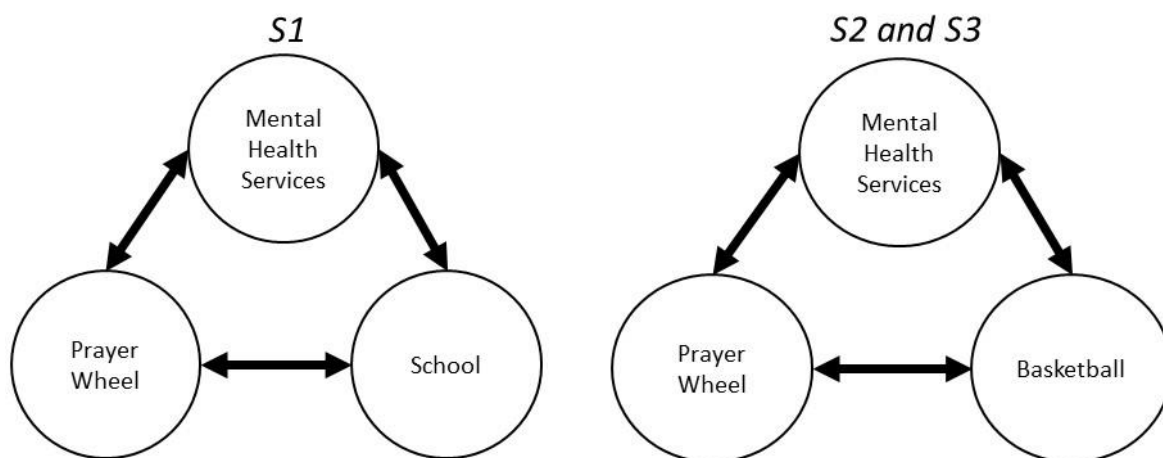
**Quantitative results summary.** Reflective of the literature related to multiple base design (Ollendick, 1995; Wolff & Ollendick, 2012), the multiple baseline design of this study, and small sample size, statistical analyses were performed limited.

### **Research Question Two**

The second research question required that the predictor variable/independent variable (triangulation) correlate with the outcome variable/dependent variable (subsyndromal anxiety), establishing the existence of an effect. This was addressed using a triangulation approach, which combines mental health services, a spiritually informed approach, and community resources (Figure 1.1).

**Triangulation.** As seen in Figure 4.3, this study documented the three triangulation approaches of S1, S2, and S3. S1's triangulation approach occurred in the context of a school

setting, partnering with the school social worker and school services to offer intervention. The author of this study met separately with the school social worker and with S1 in his school for his sessions. Preliminary findings from the school social worker revealed that S1 was chronically tardy for school and in jeopardy of failing several classes including math, United States history, and literature. The preliminary findings from the school social worker became a motivating factor for S1, and also helped to promote alliance between the author and S1. Both S2 and S3's triangulation approach occurred in the context of basketball. Both S2 and S3 were student athletes on their respective school basketball programs. Both reported that the requirements of their school basketball programs included good school attendance, good grades, attendance to basketball practices, personal development of their individual skills, and high standards set by their respective coaches.



*Figure 4.3.* Triangulation approaches of the subjects

**Qualitative results.** Qualitative results are organized according to two triangulation approaches within the intervention reflection: (a) mental health services, a spiritually informed approach, and school; (b) mental health services, a spiritually informed approach, and basketball.

Regarding the triangulation approach of mental health services, a spiritually informed approach, and school, S1 reported that he appreciated both the author's and school social worker's interest in his overall health, and accepted the challenge to improve both his grades and comply with school attendance policies. S1 triangulation approach seems to indicate that this approach can serve as protective factors against (a) internalizing problems, such as anxiety and depression; (b) externalizing problems, such as delinquency and criminal behaviors; (c) social adjustment, such as pro-social behavior and a positive sense of self; and (d) coping. Regarding the triangulation approach of mental health services, a spiritually informed approach, and basketball, both S2 and S3 reported feeling a sense of fulfillment when accomplishing their individual goals. The parent of S2 reported that having her daughter involved with the school basketball program has served as a protective factor of keeping her engaged and "off the streets." S3 requested the author's help in serving as a "voice" to attain his basketball goals. S2 and S3's triangulation approaches seem to indicate that this approach can serve as protective factors against (a) internalizing problems, such as anxiety, depression, and low self-esteem; (b) externalizing problems, such as delinquency and criminal behaviors; (c) social adjustment, such as pro-social behavior, positive sense of self, and emotional control; and (d) coping.

### **Chapter Summary**

Two hypotheses were presented in this study. The first hypothesis posited that a spiritually based intervention/prayer will effectively reduce subsyndromal anxiety and increase coping skills in urban adolescents. The second hypothesis speculated that a triangulation approach which combines mental health services, a spiritually informed approach, and

community resources will be effective in reducing subsyndromal anxiety and increasing coping skills in urban adolescents. Both hypotheses were supported, indicating that adolescents who participated in the spiritually based intervention, integrated with a triangulation approach, experienced a decrease in subsyndromal anxiety levels and an increase in coping skills. In support of the hypotheses, although the adolescents in the present study experienced overall improvements, it is noted that the degree of change in subsyndromal anxiety levels was minimal. Discussion of these findings is provided in the next chapter.

## **CHAPTER FIVE: SUMMARY, CONCLUSIONS, & RECOMMENDATIONS**

While research indicates that spiritually based intervention/prayer may be linked to reducing anxiety symptoms (Blazer, 2007; Davis et al., 2003; Hawkins et al., 1999; Koszycki et al., 2010; Martin & Booth, 1999; Tan & Johnson, 2005), to date the relationship between the therapeutic potential of spiritually based interventions/prayer with regards to subsyndromal anxiety has not been fully explored. The purpose of this study was to examine the relationship between urban adolescents, subsyndromal anxiety, and a spiritually based intervention, using a Prayer Wheel. This study used a multiple baseline design across subjects to demonstrate the controlling effects of spiritually based intervention/prayer for reducing subsyndromal anxiety and increasing coping skills in urban adolescents. With related hypotheses in mind, two research questions were developed:

1. Can a spiritually based intervention/Prayer Wheel effectively reduce subsyndromal anxiety and increase coping skills in urban adolescents?
2. Is an approach which combines mental health services, a spiritually informed approach, and community resources, effective in reducing subsyndromal anxiety and increasing coping skills in urban adolescents?

In this chapter, the major findings are summarized first. Second, conclusions drawn from the findings are discussed. Third, limitations of the study are summarized. Fourth, the chapter ends with exploring implications for research, implications for practice, and making recommendations

for future research.

### **Review of Demographics**

As previously mentioned, demographic characteristics of the subjects are shown in Table 4.3. Only three adolescents (N=3) met full criteria for the study of subsyndromal anxiety on both the Anxiety Status Inventory (ASI), and the Multidimensional Anxiety Scale for Children (MASC 2). The participants were two males, one female. The participants ranged in age from 13 to 16. The participants self-identified as African Americans. Based on DSM-5 criteria, the participants had several diagnoses ranging from ADHD Predominantly Inattentive Presentation to Sibling Relational Problem.

### **Summary of Findings**

This study utilized two research questions, using a multiple baseline design to examine the relationship between urban adolescents, subsyndromal anxiety, and a spiritually based intervention, using a Prayer Wheel. The findings from each of the two research questions will receive a truncated summary in this section.

#### **Research Question One**

The first research question required that a spiritually based intervention correlate with subsyndromal anxiety and coping skills, establishing the existence of an effect. It was hypothesized that a spiritually based intervention/prayer would effectively reduce subsyndromal anxiety and increase coping skills in urban adolescents.



**Subsyndromal anxiety.** Weekly subsyndromal anxiety levels on the ASI and post-treatment scores on the both the ASI and MASC 2 revealed moderate decreases with the implementation of THE PRAYER WHEEL™ Program intervention for each adolescent. Consequently, positive correlation between a spiritually based intervention and subsyndromal anxiety was revealed, supporting the hypothesis.

**Religious coping.** Weekly scores of negative religious coping, as well as post-treatment scores of religious coping, based on the Brief RCOPE, revealed moderate decreases with the implementation of THE PRAYER WHEEL™ Program for S1 and S2, indicating increased coping skills and the positive effect of religion/spirituality in dealing with anxiety and some of life's issues. S3's Brief RCOPE scores remained stable throughout the intervention. Consequently, positive correlations between a spiritually based intervention and coping skills were revealed, supporting the hypothesis.

## **Research Question Two**

The second research question required that a triangulation approach correlate with subsyndromal anxiety and coping skills, establishing the existence of an effect. It was hypothesized that a triangulation approach which combines mental health services, a spiritually informed approach, and community resources, would be effective in reducing subsyndromal anxiety and increasing coping skills in urban adolescents.

**Triangulation.** The triangulation approach of the three urban adolescents was documented and organized in two contexts; (a) mental health services, a spiritually informed approach, and school; and (b) mental health services, a spiritually informed approach, and

basketball. Qualitative results of the intervention of mental health services, a spiritually informed approach, and school, indicate that this triangulation approach can serve as protective factors for urban adolescents. Qualitative results of the intervention of mental health services, a spiritually informed approach, and basketball, indicates that this triangulation approach can also serve as protective factors for urban adolescents. Consequently, positive correlations between the triangulation approach, subsyndromal anxiety, and coping skills, were revealed, supporting the hypothesis.

### **Discussion and Recommendations**

In this section, the major findings in regards to the statement of the problem and each research question are discussed in light of literature, concluding with recommendations for future studies.

#### **Statement of the Problem**

As noted in the statement of the problem, empirically based studies on spiritually based interventions are often seemingly focused on the adult or elderly population (Flannelly et al., 2003; Rajagopal et al., 2002), and reveal challenges of effectively transporting interventions outside of clinical settings and into the urban population (Collins et al., 2007; DeCarlo & Hockman, 2003). Consistent with the literature of the challenges of effectively transporting interventions outside of clinical settings and into the urban population, this study experienced treatment engagement issues relating to individuals in low socioeconomic status (SES) urban environments; these issues included lack of reliable transportation, family stressors and

maladaptive family interactions, single parenthood, tardiness, and behavioral problems (Collins et al., 2007; Davis et al., 2003; DeCarlo & Hockman, 2003). Thus, the experiences of the researcher, consistent with the literature and the data from the current study, support the idea of finding effective ways to transport interventions outside of clinical settings and into the urban population, where intervention is most needed. The researcher discovered the importance of cultural sensitivity and relevance.

It was also noted that partnering with parents through healthy “triangulated” relationships (Ungar et al., 2012), partnering with school officials (principal, counselors), partnering with other mental health services providers, and embracing the posture of patience and flexibility, enhanced the effectiveness of transporting interventions outside of clinical settings and into urban settings, and reduced the risk of treatment/intervention drop out. As experienced in this study, the researchers concur, “One significant stressor for low SES families is transportation, so a truly culturally sensitive intervention should not be rigidly attached to the notion that patients must come to therapists” (Collins et al., 2007, p. 440). Consequently, this study contends that in order to be effective in transporting services outside of clinical settings and into urban settings, the practitioner must maintain the delicate balance of cultural sensitivity, challenging and motivating urban adolescents and their families towards behavior modification, and providing intervention structures that are reliable, collaborative, flexible, and integrative in assessing outcomes and processes.

### **Research Question One**

The first research question sought to establish a correlation with spiritually based

intervention, subsyndromal anxiety, and coping skills. It was hypothesized that a Prayer Wheel intervention would be effective in reducing subsyndromal anxiety and increasing coping skills in urban adolescents.

**Prayer wheel intervention.** As noted previously, this study employed the addition/integration of a Prayer Wheel intervention for the purpose of investigating the relationship between a spiritually based intervention, subsyndromal anxiety, and coping skills in urban adolescents. While the researcher is not aware of any studies to date that have specifically examined the relationship between a Prayer Wheel intervention, subsyndromal anxiety, and urban adolescents, in keeping with the findings of Rajagopal et al. (2002), it was hypothesized that a Prayer Wheel intervention would be effective in alleviating subsyndromal anxiety levels.

Though moderate, decreases in subsyndromal anxiety levels in adolescents were noted from baseline to post-treatment. Brief qualitative interviews revealed that the subjects felt “more settled and relaxed” during engagement with THE PRAYER WHEEL™ Program intervention. S1 reported that THE PRAYER WHEEL™ Program helped him to pray for the safety of his imprisoned brother. S2 reported that THE PRAYER WHEEL™ Program keeps her focused. S2 shared that, “the more I do it, the more I want to do it”, and she stated that she would recommend it to other adolescents. S3 reported that THE PRAYER WHEEL™ Program helps him become closer to God. In addition, the satisfaction rating from each adolescent showed they were satisfied with treatment goals, procedures, outcomes, and improvements in general psychological health. This indicates that the participants found THE PRAYER WHEEL™ Program intervention to be helpful in alleviating anxiety symptoms and

overall problems. Based on literary review, the researcher notes that qualitative interviews, reflections and self-narratives, and patient satisfaction are effective in determining the impact of services (Arco, 2015; Mason, Malott, & Knoper, 2009; Ungar et al., 2012).

In conclusion, reflective of the literature, the research concurs that THE PRAYER WHEEL™ Program is a self-help prayer technique that is useful because it is easy to use, puts the patient in charge, does not require any particular belief, is flexible, and is psychologically sound (Rossiter-Thornton, 2000, p. 128). Thus, the data emerging from the current study supports the hypothesis and indicates that within the urban adolescent population, THE PRAYER WHEEL™ Program may be an effective tool for the alleviation of subsyndromal anxiety and increasing coping skills.

**Subsyndromal anxiety.** As previously noted, this study highlights two significant studies on the subject of subsyndromal anxiety (Cohen et al., 2006; Rajagopal et al., 2002). While the researcher is not aware of any studies to date that have specifically examined the relationship between an intervention, subsyndromal anxiety and urban adolescents, in keeping with the findings of Cohen et al (2006) and Rajagopal et al (2002), this study discovered that although the anxiety symptoms may be mild, subsyndromal anxiety can disrupt lives. The disruption of lives due to subsyndromal anxiety symptoms was particularly highlighted for S2 during week 3, where he reported an increase in stress due to an ongoing custody battle between his parents. The researcher notes that a review of the MASC 2 at pretreatment revealed S1 and S2 recorded the highest scores on the question, “I keep my eyes open for danger” (MASC 2; Miller et al., 2011). In qualitative semi-structured interviews, both S1 and S2 reported that they

are worried about being in their respective environments because of gun violence. S1 reports that he learned to keep his eyes open because, in the past, he has been robbed in the streets. The subjects' responses were consistent with literature on the prevalence and impact of violence on urban communities (Chaves et al., 2004; Davis et al., 2006; Hoffman, 2006; Roche et al., 2003; Smith & Ashiabi, 2007; Spano et al., 2006).

It was hypothesized that with the implementation of a Prayer Wheel intervention, subsyndromal anxiety levels would decrease. Though moderate, the data reflects decreases in subsyndromal anxiety levels in adolescents from baseline to post-treatment. The researcher notes that the data from this study aligns with the study of an elderly population on the East Coast, whose anxiety levels decreased with the implementation of THE PRAYER WHEEL™ Program (Rajagopal et al., 2002). Based on the findings of this study and the use of the literature as scaffolding to develop hypotheses in regards to the study of subsyndromal anxiety, this study echoes the sentiment of the literature that it is imperative that community mental health providers, most notably within the urban context, be cognizant there are many untreated individuals who may not seek help for mental health reasons because they maintain adequate levels of daily functioning, have limited social resources or are misdiagnosed because they fall below the criteria of a diagnosis of general anxiety disorder diagnosis (Cohen et al., 2006). It was also discovered that subsyndromal anxiety may increase with age (Cohen et al., 2006, p. 1724). It was also noted that variables such as race (Black), low income, and limited social resources may be associated with anxiety (Cohen et al., 2006). Consequently, this study argues that providing intervention for subsyndromal anxiety symptoms in adolescents could serve as

both a proactive and preventive factor against the risk factors of generalized anxiety disorder and physical disorders later in life. In conclusion, data garnered from this study supports the hypothesis and indicates that interventions, such as a spiritually based intervention, may be effective in alleviating subsyndromal anxiety in urban adolescents.

**Religious coping.** Using the scoring and algorithm of the Brief RCOPE to assess the weekly subsyndromal anxiety scores, as well as pretreatment scores, post-treatment scores of negative religious coping revealed moderate decreases with the implementation of THE PRAYER WHEEL™ Program for each adolescent, indicating that religion/spirituality helped the urban adolescent to cope and deal with anxiety. It was hypothesized that a spiritually based intervention/prayer would effectively reduce subsyndromal anxiety and increase coping skills in urban adolescents. Consequently, the scores for S1, S2, and S3 at pretreatment, weekly assessment, and post-treatment showed that as the scores for negative religious coping moderately decreased, there was an increase in coping skills. Thus, data emerging from this study supports the literature and hypothesis that the fewer spiritual struggles adolescents have, the more they are able to cope with life's stressors, such as anxiety (RCOPE; Pargament et al., 2011). The researcher discovered that,

Positive religious coping methods reflect a secure relationship with a transcendent force, a sense of spiritual connectedness with others, and a benevolent world view. Negative religious coping methods reflect underlying spiritual tensions and struggles within oneself, with others, and with the divine (RCOPE; Pargament et al., 2011, p. 51).

In sum, positive correlations were noted between a spiritually based intervention and coping skills, supporting the hypothesis.

## **Research Question Two**

The second research question sought to establish a correlation between a triangulation approach, subsyndromal anxiety, and coping skills, establishing the existence of an effect. It was hypothesized that a triangulation approach which combines mental health services, a spiritually informed approach, and community resources, would be effective in reducing subsyndromal anxiety and increasing coping skills in urban adolescents. As noted, the triangulation approach of the three urban adolescents were documented and organized in two contexts, (a) mental health services, a spiritually informed approach, and school, and (b) mental health services, a spiritually informed approach, and basketball. Qualitative results of the intervention of mental health services, a spiritually informed approach, and school indicate that this triangulation approach can serve as protective factors for urban adolescents.

In the current study, the triangulation approach for S1 occurred in a school setting, where the researcher partnered with the school social worker and school services to offer intervention. As mentioned, the researcher of this study met separately with the school social worker and with S1 in his school for his sessions. Preliminary findings from the school social worker gave insight into the behavioral patterns of S1. It was noted that the preliminary findings from the school social worker served as motivation for behavioral activation in S1, and assisted in building therapeutic alliance between the researcher and S1.

The qualitative results report that S1 found satisfaction in the collaborative and integrative efforts of both the school social worker and researcher, indicating that this approach



can serve as protective factors against (a) internalizing problems, such as anxiety and depression; (b) externalizing problems, such as delinquency and criminal behaviors; (c) social adjustment, such as pro-social behavior and a positive sense of self; and (d) coping. The findings from this current study are in line with literature.

According to Miller et al. (2011), providing mental health services in schools is both advantageous and optimal, because there is a strong correlation between mental health outcomes and educational achievement. It was reported that, “70–80% of children and adolescents who receive mental health services receive them in the school setting” (Miller et al., 2011, p. 287). Reflective of the literature, the researcher concurs that, “Due to growing caseloads, school counselors are experiencing increasing difficulty meeting the demands for school counseling services” (Miller et al., 2011, p. 287). The researcher recalls the school counselor for S1 affirming the need for assistance in providing intervention services. In summary, this study concurs with the literature that adapting to the changing demographics of the United States society requires collaborative work across teachers, counselors, students, families, and administrators to educate the whole child/student, inclusive of spiritual variables such as coping mechanisms (Yeh, Borreror, & Shea, 2011).

Qualitative results of the intervention of mental health services, a spiritually informed approach, and basketball indicate that this triangulation approach can serve as protective factors for urban adolescents. In the current study, both S2 and S3 were involved with their school basketball programs. Qualitative results reveal that basketball seems to serve as a protective factor against behavioral problems, and instead, promoted behavior that built, optimized, and

improved communication skills and socialization. In addition, basketball may serve as a tool for reducing low self-esteem. As reported, both S2 and S3 felt a sense of fulfillment and accomplishment when meeting their individual benchmarks and goals in basketball. The findings of this study are in line with the literature.

In an attempt to fill the gap within literature concerning the factors surrounding Black males and basketball, an ethnographic study of Boston street basketball by Woodbine (2016) reports through participant observation and interviews, that Black males gravitate to inner city basketball courts to discover their humanity, express grief, find hope, express their story, and celebrate resiliency. One participant in Woodbine's (2016) research expressed, "Basketball is my release. My family knows that I have to play basketball every week and everything stops when I'm playing. That's how you let go of all your problems". According to Woodbine (2016), "If people turn to religion to reimagine their place in the world, then Black streetball players are indeed the hierophants of the asphalt." In summary, positive correlations between a triangulation approach, subsyndromal anxiety, and coping skills were noted, supporting the literature and hypothesis.

### **Contrary Findings**

As mentioned, the researcher assessed for depression, as literature indicates that patients with symptoms of anxiety can also have comorbid depression (Cohen et al., 2006; Rajagopal et al., 2002; Suveg et al., 2006). Contrary to the literature, scores from the PHQ-2 and PHQ-9 did not indicate depressive symptoms in the adolescent subjects. The findings suggest that several factors may account for the contrary findings, including

- the subjects' preexistent engagement in ongoing therapy,
- triangulation with a spiritually informed approach, mental health services and community services, such as school and basketball,
- pharmacological intervention, and
- subject/adolescent-researcher alliance.

In sum, the study revealed that these findings were consistent with the researcher's expectations.

### **Implications for Research, Practice, and Biblical Implications**

While further studies are needed to validate the efficacy of transporting a spiritually based intervention for reducing subsyndromal anxiety and increasing coping skills in urban adolescents, this study has the potential to impact both research and practice within the mental health community. Furthermore, the components of THE PRAYER WHEEL™ Program correspond to biblical principles, and may be used as a tool for spiritual growth. In this section, implications in these three areas are briefly discussed.

#### **Implications for Research**

As discussed in Chapter Two, a critical review of literature reveals a gap in the literature of spiritually based interventions, particularly the subject of a spiritually based intervention for reducing subsyndromal anxiety and increasing coping skills in urban adolescents. It is noted that

empirically based studies on spiritually based interventions and/or subsyndromal anxiety are often focused on the adult or elderly population. In addition, as mentioned, studies often fail to take into consideration the bio-psycho-social-spiritual experiences of urban adolescents. Within this context, the results of this study supported literature and highlighted the need for more research on the correlation between a spiritually based intervention, subsyndromal anxiety, and urban adolescents.

This study's findings have several implications for research. First and most importantly, spiritually based interventions may be used over a cross-section of studies including science, medicine/health care, psychotherapy, psychiatry, and religion. Second, spiritually based interventions may serve as a tool for addressing variables such as anxiety, depression, age, gender, race/culture, and religious/spiritual beliefs. Third, this study supports ongoing research to identify empirically supported interventions that can be transported outside of clinical settings, and useful in urban communities. Fourth, this study supports literature and the ongoing research to clinically assess and classify anxiety as a triadic presentation (non-anxious, subsyndromal, syndromal). Fifth, the implementation of a triangulation approach within this study helps to advance research using qualitative and mixed method designs to provide data for family systems, analyze demographic factors, and address problems in organizational research. Sixth, though not without its limitations, this study supports ongoing research for use of multiple baseline designs as a viable alternative to randomized controlled trials. Finally, the results of this study help to extend the literature to advocate the use of a Prayer Wheel intervention as a non-pharmacological intervention to promote mental health and psychological well-being.

## **Implications for Practice**

While the results of this study help to clarify the theoretical underpinnings for a spiritually based intervention for reducing subsyndromal anxiety, a number of implications for practice can be drawn from the results as well. This study provided implications for the practice of a Prayer Wheel intervention in general.

First, a Prayer Wheel intervention can be used for the training of therapists, both religious and non-religious. As previously mentioned, researchers agree that clinicians are ethically bound to treat spirituality, including integrated spiritual practices such as prayer (APA, 2010). They also concur that clinicians must be competent in assessing and integrating spiritually based interventions (McMinn, 1996). Consequently, a Prayer Wheel intervention and its protocols can assist in training therapists in integrating spiritually based interventions.

Second, a Prayer Wheel intervention can assist in advancing the field of Pastoral Counseling, integrating the practice of effective treatments such as religiously based cognitive behavior therapy (Koenig, 2012; Pearce et al., 2015; Propst et al., 1992). In addition, a Prayer Wheel can serve as an intervention tool that assists clients' cognitive behavior skills through a religiously informed approach. As mentioned, the practice of religious cognitive-behavioral therapy, using biblical truths and emphasizing the ministry of the Holy Spirit for cognitive restructuring of distorted thinking, can elicit change in clients (Tan & Johnson, 2005).

Third, in religious traditions, a Prayer Wheel intervention may be used to help promote spiritual growth, development, and transformation. As a means of community outreach, religious leaders and houses of worship may use a triangulation approach by integrating a Prayer Wheel intervention and a basketball program into a community outreach program (i.e. a youth/men's basketball league, which includes engaging THE PRAYER WHEEL™ Program, prior to basketball games). In this regard, because of THE PRAYER WHEEL™ Program characteristics of being a non-denominational, non-pharmacological intervention, and not provided for religious reasons, outreach participants may more readily accept THE PRAYER WHEEL™ Program as a self-help technique, and not solely as a religious/spiritual exercise.

In addition, in keeping with the literature on religiously based cognitive behavior therapy that uses the client's own religious tradition (i.e., Judaism, Christianity, Hinduism, Buddhism, Muslim) to elicit change (Pearce et al., 2015), this study supports replicating THE PRAYER WHEEL™ Program, but replacing the eight components of the Prayer Wheel (Figure 3.1) with the sacred texts of the various religious traditions. For those in the Christian tradition, the scriptures of the Holy Bible; in the Jewish tradition, the Torah and Talmud; in the Hindu tradition, the Bhagavad Gita; in the Buddhist tradition, the Dhammapada; and for the Muslim tradition, the Holy Qur'an.

Fourth, a Prayer Wheel intervention supports literature in advocating for the practice of training school counselors to attend to the spiritual issues of their students (Yeh et al., 2011).

Finally, as previously noted, a Prayer Wheel intervention can be used in private practice - irrespective of background, belief, religion or race - to improve interpersonal communication,

help clients feel calmer, decrease anxiety in clients, and increase client focus (Rossiter-Thornton, 2000).

### **Biblical Implications of THE PRAYER WHEEL™ Program**

While the Prayer Wheel is not provided for religious reasons, but as a self-help technique, the eight components correspond with biblical principles. Initially, the idea of self-help appears contrary to the biblical premise of depending on God, in verses such as “Trust in the Lord with all your heart and lean not on your own understanding; in all your ways submit to him, and he will make your paths straight (Proverbs 3:5-6, NIV). However, there are several biblical principles that are reflected in the components of THE PRAYER WHEEL™ Program including, thanksgiving, worship, protection, forgiveness, intercession, love, solitude and silence, and submission.

Component one of THE PRAYER WHEEL™ Program corresponds with the biblical challenge to “Bless the Lord and remember His blessings” (Psalm 103:1-5), highlighting the principle of thanksgiving.

Component two corresponds with the biblical act of worship. For example, Ephesians 5:19 teaches, “Speaking to yourselves in psalms and hymns and spiritual songs, singing and making melody in your heart to the Lord.”

Component three aligns with the biblical principle of protection and being spiritually dressed for battle. Ephesians 6:10-18 reveals the elements of the armor of God needed to be

effective in spiritual battle and warfare (i.e., belt of truth, breastplate of righteousness, shoes of the gospel of peace, shield of faith, helmet of salvation, and the sword of the Spirit).

Component four corresponds with the biblical teaching on the importance of forgiveness of self and others. Matthew 6:12 teaches the need to request forgiveness of self by God, and the practice of forgiving others, having received forgiveness from God.

Component five aligns with the biblical practice of intercession or praying on behalf of others. James 5:13-16 teaches that where there is sickness, others (i.e., elders of the church, the faithful) should be called in to pray.

Component six reflects the biblical chapter that defines love; “Love is patient, kind, protects, hopes, perseveres, not envious, not boastful, not proud, etc.” (1 Corinthians 13:4-8, NIV).

Component seven is consistent with the biblical discipline of silence and solitude; “Be still, and know that I am God” (Psalm 46:10).

Finally, component eight of THE PRAYER WHEEL™ Program teaches the biblical practice of submission and dependence on God, as reflected in the biblical references of Proverbs 3:5-6 (NIV) and “Nevertheless, not my will, but thine, be done” (Luke 22:42, King James Version).

Thus, in light of this study, THE PRAYER WHEEL™ Program can be used not only as a clinical tool, but as a potential tool for spiritual growth and spiritual transformation.



### **Limitations of the Study**

The limitations of this study pivot on design, sample selection, instruments, assessments, clinical demarcation of syndromal and subsyndromal anxiety, intervention time-frame, follow-up, and identifying the mechanisms of change. First, this study used a multiple baseline, cross-sectional design. Although some researchers argue that a cross-sectional design limits data collection to single moment in time, while a longitudinal design provides data sequentially over an extended time frame and provides a richer set of data, this study discovered that because of critical events surrounding intervention with urban adolescents (such as transportation issues, triangulation with mental health providers and schools, and behavioral problems), it was more advantageous to limit collection to a single moment in time, with smaller sample sizes. While literature indicates that randomized controlled trials (RCT) is the accepted standard for the evaluation of intervention in health care (Hawkins, Sanson-Fisher, Shakeshaft, D'Este, & Green, 2007), this study discovered that applying randomized controlled trials required large sample sizes, is expensive, and proved challenging in recruiting urban adolescents.

Second, as previously mentioned in the results section, this study resembled literature where statistical analyses were unavoidably limited, due to the small sample size inherent to the multiple baseline design approach (Ollendick, 1995; Wolff & Ollendick, 2012). To address the limitations of a multiple baseline design, this study ensured methodologic rigor, as recommended by the literature, by showing that (a) a change in behavior occurred (i.e, decrease in anxiety symptoms and increase in coping skills), (b) the change is as a result of the intervention (i.e., THE PRAYER WHEEL™ Program), (c) the change is both statistically and practically

significant (Hawkins et al., 2007). Consequently, this study supports the literature that multiple baseline designs can serve as a practical and statistically significant alternative to randomized controlled trials. In addition, multiple baseline designs can serve as a viable option for evaluating population groups, such as urban adolescents. In summation, multiple baseline designs are advantageous for smaller sample sizes, and are less expensive.

With regards to the measure/instrument, the Anxiety Status Inventory (ASI; Zung, 1971), although it has not been validated on children, showed good internal consistency in studies within the urban context (Cohen et al., 2006; Rajagopal et al., 2002). This study found the ASI effective in assessing the anxiety levels of urban adolescents, and helped in promoting therapeutic alliance with adolescents through the clinician-directed instrument.

In terms of THE PRAYER WHEEL™ Program as an assessment for reducing subsyndromal anxiety and increasing coping skills, this researcher is not aware of any study that used THE PRAYER WHEEL™ Program as an assessment for adolescents. However, this study suggests that based on the results and qualitative reports of the subjects, THE PRAYER WHEEL™ Program may be an effective tool for the alleviation of symptoms of subsyndromal anxiety, and increasing coping in urban adolescents.

With regards to clinically demarcating syndromal and subsyndromal anxiety, this study does little to extend the literature. As previously mentioned, the research literature offers no consistent criteria for subsyndromal anxiety. To address this gap in the literature, this study suggests the development of an instrument that can clinically demarcate syndromal and subsyndromal anxiety. Regardless of this limitation, this study supports the literature's ongoing

research into classifying anxiety as a triadic presentation: non anxious, subsyndromal, syndromal (Cohen et al., 2006).

While some researchers would argue against the short time-frame of a six-week intervention, and gap between treatment and follow-up being too close, this study discovered the challenges of engaging the adolescent subjects for more than six weeks, due to critical events such as transportation issues, behavioral problems, difficulty in coordinating sessions due to competing extracurricular activities, and school attendance issues. This study echoed the sentiments of literature, “Many trials in psychiatry are short, lasting 6 weeks or less. This is simply because they are easier to do. Longer trials are complex, expensive and liable to suffer from large numbers of people dropping out of the trial” (Johnstone, 2010, p.164).

Finally, as speculated in chapter one, this study was not be able to identify the effective ingredients and the mechanisms of change with certainty. This study speculates that components such as being engaged with ongoing therapy, pharmacological intervention for adjustment issues, subject/adolescent-researcher alliance, and the triangulated approach of combining mental health services, a spiritually informed approach, and community resources, either alone or in confluence with other components, may be responsible for the changes. In terms of THE PRAYER WHEEL™ Program’s apparent efficacy, literature indicates that similar to the effects of social support in enhancing immune system functioning, spiritual support such prayer can impact anxiety symptoms, and in turn promote physical and mental health (Rajagopal et al., 2002). Consequently, THE PRAYER WHEEL™ Program intervention could account for

changes which occurred in treating subsyndromal anxiety in urban adolescents.

### **Recommendations for Future Research**

First, the use of a longitudinal study design would allow future researchers access to data gathered sequentially over an extended time frame. This would enable researchers to assess the results and each subject's experience with a Prayer Wheel intervention at multiple intervals in time, thus extending the literature's support of using a Prayer Wheel intervention, and validating the findings of a multiple baseline design.

Second, conducting epidemiological community-based studies with urban adolescents (i.e., studies on human populations that attempt to link human health effects) on subsyndromal anxiety, using a Prayer Wheel intervention, can give insight into treating subsyndromal anxiety and the overall impact on the well-being of urban adolescents in the community. In addition, epidemiological studies that give insight into interventions for subsyndromal anxiety symptoms could serve as both proactive and preventive factors against the risk factor of generalized anxiety disorder.

Third, in order to assess demographic variables, urban adolescents should be assigned to either a group intervention format or an individual basis format to determine if there would be significant differences between adolescents using THE PRAYER WHEEL™ Program intervention in a group format, or those using THE PRAYER WHEEL™ Program on an individual basis. In addition, this study recommends larger sample sizes to analyze the

differences of subsyndromal anxiety scores among male and female participants to extend the literature's inquiry into the contributing factors of anxiety in urban adolescents (Davis et al., 2003).

Fourth, as mentioned in chapter two, this study recommends integrating a Prayer Wheel intervention and religiously based integrated cognitive behavior therapy for reducing subsyndromal anxiety in an urban context, using a group therapy approach. As previously noted, research indicates that religious patients found that the integration of CBT-related religious interventions is effective for treatments such as anxiety and depression (Blazer, 2007; Butler, Chapman, Forman, & Beck, 2005; Koenig, 2012; Pearce et al., 2015; Propst et al., 1992).

Finally, in order to verify THE PRAYER WHEEL™ Program's effectiveness as an intervention for subsyndromal anxiety in urban adolescents, replication and implementation of this study for more than 10 weeks may be considered. This study's findings indicate that interventions may be more effective at 10 weeks or more for the treatment of subthreshold anxiety (Rajagopal et al., 2002; Cohen et al., 2006).

### **Chapter Summary**

This study examined the relationship between urban adolescents, subsyndromal anxiety, and a spiritually based intervention, using a multiple baseline design. Congruent with the results, and in keeping with the theoretical underpinnings of the Rajagopal and colleagues' (2002) study that a Prayer Wheel intervention is effective in the alleviation of subsyndromal anxiety, this

study found positive correlations between a spiritually based intervention, a triangulation approach, subsyndromal anxiety, and coping skills in urban adolescents. Employing a multiple baseline design across subjects to demonstrate the controlling effects of a spiritually based intervention/Prayer Wheel demonstrated a decrease in subsyndromal anxiety levels, and an increase in coping skills in urban adolescent subjects. Although the correlations between a spiritually based intervention, a triangulation approach, subsyndromal anxiety, and coping skills in urban adolescents was not as strong as hypothesized, the current study provides empirical evidence that THE PRAYER WHEEL™ Program intervention's potential impact has tripartite significance in research, clinical and biblical practice.

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## APPENDIX A: IRB APPROVAL

**LIBERTY UNIVERSITY.**  
INSTITUTIONAL REVIEW BOARD

February 19, 2018

Morais Cassell

IRB Approval 3096.021918: Effectively Transporting a Spiritually Based Intervention for Reducing Subsyndromal Anxiety and Increasing Coping Skills in Urban Adolescents: A Multiple Baseline Design

Dear Morais Cassell,

We are pleased to inform you that your study has been approved by the Liberty University IRB. This approval is extended to you for one year from the date provided above with your protocol number. If data collection proceeds past one year, or if you make changes in the methodology as it pertains to human subjects, you must submit an appropriate update form to the IRB. The forms for these cases were attached to your approval email.

Thank you for your cooperation with the IRB, and we wish you well with your research project.

Sincerely,

**G. Michele Baker, MA, CIP**  
*Administrative Chair of Institutional Research*  
The Graduate School

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UNIVERSITY.  
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## APPENDIX B: AFFIRMATION LETTER

**REV. SIMON UDEMGBA, PH.D.**

Compassionate Treatment Center 401 New Karner Road  
Albany, NY 12205  
phone: (518) 301-5946  
fax: (518) 456-3689

re: Morais Cassell  
02/19/18

To Whom It May Concern;

This is to state that Morais Cassell sought and received permission to conduct his dissertation research with some of my patients. As he presented and explained, this study will be an add-on to the psychotherapy treatment the selected patients are already receiving.

He promised that issues of privacy and confidentiality will be adequately explained to the patients and their parents, with appropriate guidelines followed in dealing with informed consent.

Please do not fail to let me know if you have any question related to this issue.

Sincerely,

Rev. Simon Udemgba, Ph.D.

## APPENDIX C: PARENT/GUARDIAN CONSENT FORM

The Liberty University Institutional  
Review Board has approved  
this document for use from  
2/19/2018 to 2/18/2019  
Protocol # 3096.021918

**PARENT/GUARDIAN CONSENT FORM**

Effectively Transporting a Spiritually Based Intervention for Reducing Subsyndromal Anxiety  
and Increasing Coping Skills in Urban Adolescents: A Multiple Baseline Design.

Morais L. Cassell, M.A., M.S., PH.D. (Candidate)  
Liberty University  
DEPARTMENT OF  
COUNSELOR EDUCATION  
AND FAMILY STUDIES

Your child is invited to be in a research study that aims to examine more directly and advocate for the use of a spiritually-based intervention/prayer for reducing anxiety levels and helping urban adolescents deal with life's issues, using a Prayer Wheel intervention/activity. Your child was selected as a possible participant because he/she meets the criteria of being an urban adolescent (living in a city), between ages 11 and 17, engaged with therapy, and may have experienced some anxiety. Please read this form and ask any questions you may have before agreeing to allow him or her to be in the study.

Morais L. Cassell, a doctoral candidate in the Department of Counselor Education and Family Studies at Liberty University, is conducting this study.

**Background Information:** The purpose of this study is to answer the question Can a spiritually-based intervention/prayer effectively reduce anxiety and help urban adolescents deal with life's issues?

**Procedures:** If you agree to allow your child to be in this study, I would ask him/her to do the following things:

1. First task/procedure. Complete the measures - The Anxiety Status Inventory (ASI), Multidimensional Anxiety Scale for Children, and The Brief Religious Coping (RCOPE). Should take approximately 45 mins.
2. Second task/procedure. Using the measures/forms, baseline measures will be obtained either at week 1, week 2, week 3, or week 4 for each adolescent. Your child's baseline measure will be confidentially compared to 2 or 3 other adolescent participants. Should take approximately 30-40 mins.
3. Next task/procedure. Your child will continue to meet with his/her regular therapist, while we meet for the study for 6 consecutive weeks.
4. Next task/procedure. Your child's anxiety levels will be assessed weekly, using the measures/forms. Should take approximately 30-40 mins.
5. Next task/procedure. In order to assess your child's anxiety levels and coping skills, your child will complete the "Prayer Wheel Activity" and review both The Anxiety Status Inventory (ASI) and The Brief Religious Coping (RCOPE) weekly. Please have your child complete the prayer wheel activity, at least once per week before we meet. 30-40 mins.
6. Finally- Your child will be asked to complete a satisfaction questionnaire, using a rating scale to share his/her thoughts on the study after 6 weeks of intervention. 10-20 mins.

Review Board has approved  
this document for use from  
2/19/2018 to 2/18/2019  
Protocol # 3096.021918

**Risks and Benefits of being in the Study:** The risks involved in this study are minimal, which means they are equal to the risks your child would encounter in everyday life.

**Note:** During research, I may become privy to information that triggers the mandatory reporting requirements for child abuse, child neglect, elder abuse, or intent to harm self or others. I am a mandatory reporter and will first consult with St. Anne Institute before making any reporting procedures.

The direct benefits participants could expect to receive from taking part in this study are reduced anxiety symptoms and increased coping skills.

Benefits to society include an understanding that the Prayer Wheel may be an effective tool for the alleviation of symptoms of anxiety in urban adolescents.

**Compensation:** Your child will not be compensated for participating in this study.

**Confidentiality:** The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records. I may share the data I collect from your child/student for use in future research studies or with other researchers; if I share the data that I collect about your child/student, I will remove any information that could identify him/her, if applicable, before I share the data.

- I will conduct the study/sessions at VISHEALTH, 401 New Karter Rd, Albany, NY 12205, where your child regularly meets his/her therapist.
- The data will be password protected in Excel spreadsheets on my computer. The completed assessments will be destroyed once I have copied the data over to your spreadsheets. The data may be used in future studies and presentations. Per federal regulations, data must be retained for three years upon completion of the study. I will not include any information that will make it possible to identify a subject.

**Voluntary Nature of the Study:** Participation in this study is voluntary. Your decision whether or not to allow your child/student to participate will not affect his/her current or future relations with Liberty University or VISHEALTH. If you decide to allow your child to participate, he/she is free to not answer any question or withdraw at any time without affecting those relationships.

If your child chooses to withdraw from the study, you or your child should contact the researcher at the email address/phone number included in the next paragraph. Should your child choose to withdraw, data collected from him/her will be destroyed immediately and will not be included in this study.

**Contacts and Questions:** The researcher conducting this study is Morais Cassell. You may ask any questions you have now. If you have questions later, you are **encouraged** to contact him at [moraiscassell@gmail.com](mailto:moraiscassell@gmail.com) or 518-727-5604 (cell). You may also contact the researcher's faculty advisor, Dr. John Thomas at [jcthomas2@liberty.edu](mailto:jcthomas2@liberty.edu)



The Liberty University Institutional  
Review Board has approved  
this document for use from  
2/19/2018 to 2/18/2019  
Protocol # 3096.021918

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are **encouraged** to contact the Institutional Review Board, 1971 University Blvd, Green Hall 1887, Lynchburg, VA 24515 or email at [irb@liberty.edu](mailto:irb@liberty.edu).

*Please notify the researcher if you would like a copy of this information for your records.*

**Statement of Consent:** I have read and understood the above information. I have asked questions and have received answers. I consent to allow my child to participate in the study.

(NOTE: DO NOT AGREE TO ALLOW YOUR CHILD/STUDENT TO PARTICIPATE  
UNLESS IRB APPROVAL INFORMATION WITH CURRENT DATES HAS BEEN  
ADDED TO THIS DOCUMENT.)

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Signature of Minor \_\_\_\_\_ Date \_\_\_\_\_

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Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

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Signature of Investigator \_\_\_\_\_ Date \_\_\_\_\_

## APPENDIX D: ASSENT OF CHILD TO PARTICIPATE IN RESEARCH

The Liberty University Institutional  
Review Board has approved  
this document for use from  
2/19/2018 to 2/18/2019  
Protocol # 3096.021918

**ASSENT OF CHILD TO PARTICIPATE IN A RESEARCH STUDY****What is the name of the study and who is doing the study?**

Effectively Transporting a Spiritually Based Intervention for Reducing Subsyndromal Anxiety and Increasing Coping Skills in Urban Adolescents: A Multiple Baseline Design.

Morais L. Cassell, M.A., M.S., PH.D. (Candidate)

**Why are we doing this study?**

We are interested in studying if a Prayer Wheel can reduce stress and help you to deal with life's issues.

**Why are we asking you to be in this study?**

You are being asked to participate in this study because you live in a city area and may have some stress.

**If you agree, what will happen?**

If you are in this study you would be asked to do the following things:

1. First-Complete the forms. This should take approximately 45 mins.
2. Next- You will continue to meet with your regular therapist, while we meet for the study for 6 weeks.
3. Next - You will complete the forms on a weekly basis.
4. Next- Please complete the prayer wheel activity, at least once per week before we meet. 30-40 mins.
5. Finally- You will be asked to complete a form to share your thoughts on the study. 10-20 mins.

**Do you have to be in this study?**

No, you do not have to be in this study. If you want to be in this study, then tell the researcher. If you don't want to, it's OK to say no. The researcher will not be angry. You can say yes now and change your mind later. It's up to you.

**Do you have any questions?**

You can ask questions any time. You can ask now. You can ask later. You can talk to the researcher. If you do not understand something, please ask the researcher to explain it to you again.

Signing your name below means that you want to be in the study.

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Signature of Child

Date

Morais Cassell, researcher, [moraiscassell@gmail.com](mailto:moraiscassell@gmail.com), 518-727-5604 (cell). You may also contact the researcher's faculty advisor, Dr. John Thomas at [jcthomas2@liberty.edu](mailto:jcthomas2@liberty.edu)  
Liberty University Institutional Review Board,  
1971 University Blvd, Green Hall 1887, Lynchburg, VA 24515  
or email at [irb@liberty.edu](mailto:irb@liberty.edu).



## APPENDIX E: MASC 2 PERMISSION

Hello Morias,

Happy New Year.

Thank you for submitting your Student Research Application.

We are pleased to inform you that you have been approved for a 30% Research Discount for the Multidimensional Anxiety Scale for Children 2nd Edition™ - MASC 2™, for your research entitled "Effectively Transporting a Spiritually Based Intervention for Reducing Subsyndromal Anxiety and Increasing Coping Skills in Urban Adolescents: A Multiple Baseline Design."

This discount will expire on January 5, 2019.

This discount grants you 30% off MASC 2 orders over \$50 (before shipping). The Shipping charges are not eligible for the discount.

Please call client services at 1.800.456.3003 using the following customer number to place your order: **218271**. Keep this number on file as you will need it to place future orders with us.

Thank you,  
Betty

*Betty Mangos - Permissions & Licensing Specialist*

**MULTI-HEALTH SYSTEMS INC. (MHS)**

In Canada: 1-800-268-6011 ext.388 Address: 3770 Victoria Park Ave. Toronto, Ont. M2H 3M6

In U.S.: 1-800-456-3003 ext.388 Address: P.O. Box 950 North Tonawanda, NY 14120-0950

International: 416-492-2627

## APPENDIX F: RCOPE PERMISSION

Dear Morais:

You have my permission to use the Brief RCOPE. I have attached a copy of the measure and related paper. Let me know if you have any questions, and please keep me posted on your findings.

Sincerely,

Kenneth I. Pargament, Ph. D.

Professor Emeritus

Department of Psychology

Bowling Green State University

Bowling Green, Ohio 43403

[\(419\) 372-8037](tel:(419)372-8037)

Author, *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred*. New York: Guilford Press.

Editor-in-Chief, *APA Handbook of Psychology, Religion, and Spirituality* (Vols. 1 and 2). Washington, DC: APA Press.

APPENDIX G: THE PRAYER WHEEL™ Program PERMISSION TO PUBLISH

Dear Morais

I write to confirm that I have given you, Morais Cassell, permission to publish  
“THE PRAYER WHEEL™ Program” Figure in your project/dissertation.

Yours sincerely,

John F.Thornton MD FRCPC

Trademark and copyright holder for“ THE PRAYER WHEEL™ Program”