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Effectiveness of Cognitive-Behavioural Therapy with Family Counselling for Generalised Anxiety Disorder: A Case Study

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ABSTRACT: *Mrs. D came with complaints of excessive worry and not being able to control it, apprehensiveness, worrying about worry and hesitance to take challenges in life. She also had anxious thoughts of whether her issues of worry would affect her marital family relationships. She was diagnosed with Generalised Anxiety Disorder based on the criteria given by DSM-5 (American Psychiatric Association, 2013) and the scores of the Anxiety Scale (Sarkar & Das, 2018). Management was done based on the CBT model. Treatment goals were achieved by working on her cognitive, behavioural and physiological components with the support of family counselling. Supportive techniques were also actively used. The client's GAD symptoms significantly reduced by the end of the therapy sessions.*

KEYWORDS: *Generalised anxiety disorder, intolerance of uncertainty model, cognitive-behavioural therapy, metacognition, family counselling, supportive technique*

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I. INTRODUCTION

The relentless worrying of various contexts causing an individual to have dysfunctional personal, social and occupational lives is categorised under Generalised Anxiety Disorder (GAD). GAD consumes 5.8% of the anxiety disorders in India. Apart from excessive worry, Diagnostic Statistical Manual for Mental Disorders (DSM-5) has also stated that this excessive worry is difficult to control and should have at least three or more physiological and cognitive symptoms such as restlessness, easily fatigued, difficulty concentrating, muscle tension, sleep disturbance, and irritability (American Psychiatric Association, 2013). Stress in one's life, physical conditions such as diabetes, genetic factors, environmental factors such as child abuse and substance dependency are all important etiological factors of GAD (Munir & Takov, 2019).

Objective of the Study

The objective of the study is to check the efficacy of using a combination of Cognitive-Behavioural Therapy and Family Counselling in treating Generalised Anxiety Disorder (GAD).

Hypotheses of the Study

Cognitive Behavior Therapy will significantly reduce client's presenting complaints such as excessive worry about her family relationships, family health and her fear of leaving home for going abroad. Furthermore, CBT will reduce disturbed sleep patterns, fatigue, difficulty concentrating at work, and irritability.

II. METHODOLOGY

Research Design

An A-B research design was used in the study to check the efficacy of CBT in treating GAD. In the A-B design the target behaviour is operationally defined and measurements of this behaviour are made throughout the study. During the A phase of the investigation, baseline observations are made of the behaviour being studied to determine the frequency of occurrence. During the B phase the treatment variable is introduced and any changes in the dependent variable are noted and attributed to the independent variable. In this research design assessment is done prior to the treatment and after the treatment is given.

Sample

The sample consisted of a 25 years old woman who had done Bachelors in Technology and was the only offspring of parents based in Mumbai. She settled in Kerala after her marriage.

Case Description

Mrs. D is 25 years old, married and both are IT professionals. She came in for counselling when her yoga master recommended that she go for it because of her excessive worry about daily situations in her life. She presented with the complaints of excessive worry and not being able to control it and that she would lose her mind if kept worrying, apprehensive of leaving husband and going abroad, transfer of worry from mother's health to husband's health, unable to concentrate on work and household chores, anxiety and tiredness. She also reported disturbed sleep and muscle tension especially on the sides of her forehead where she feels that it has become hard. The client presented her complaints of excessive worry about her husband's health and her fear of leaving him and going abroad for work. She said that since childhood she had always been worried about her mother's health. She also said that she had been excessively worried about her exams and thought to the level of failing them though she was studious and worked hard for it. She also said that she had heard that if one is a single child, they would be lonely and no one would be there for support. She also would repeatedly express to her husband the concern of how their life would be if they have more than two children. She is also worried that her 'future children' would have effects of the medicine that her husband takes for urinary infection or migraine. She is also excessively worried that her 'worries' would disrupt her relationship with her family members including her mother in law and father in law. She also is concerned that since she is a single child she is unable to take care of her sister in law and her family when she comes home to visit. Once, her husband and father in law commended on her initiative to go abroad for on-site work. The client quickly questioned her decision of going. She started worrying about leaving her husband and whether her decision would be right at this point where her husband's health is not satisfactory to her.

In 2021, when Mrs. D was visiting her family in Mumbai with her husband for a festival, her mother had made a lot of sweets. Her husband enjoyed having these sweets but the client became stressed and worried of whether this would lead to any health issues like diabetes. Seeing her anxious situation, her husband and mother discussed how she easily gets tensed about everything. This bothered the client a lot and since then she was not interested in taking her husband to meet her mother. She was tensed that her mother would keep telling stories of her childhood worries. The client gets quite irritated when her husband does not follow her instructions in taking care of his health.

The client also said that she had thoughts about how she had troubled her family members when she was with them. She told about the time when she was considered for campus placement. The client was an above average student who had the skills and abilities to land a good job through the placements but she got worked up and did not eat or sleep during those days. Her parents were really concerned and tried to calm her down but in vain. During the time of her marriage proposals, she was very concerned about whether she had to leave her parents and stay far away as well as if the groom would be a good person. She questioned the grooms a lot and one of them even asked her why she had to cling on to her parents this much.

Assessment Measures

DSM Diagnosis

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; *DSM–5*; APA, 2013) describes Generalised Anxiety Disorder (GAD) as "excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)." Mrs. D has been experiencing excessive worry since adolescence. She was then worried about her mother's health, her exams and a fear of her future as she was a single child. This anxiety then transferred to her concern of her husband's health who was previously diagnosed with urinary tract infection (UTI). Though the condition was treated completely, the client continues to worry about his health and is apprehensive of what might come in the future if she doesn't take care of him. She is unable to have good sleep at night and spends her nights thinking whether her husband has any difficulties. She is also worried about her worry which might affect her marital and familial relationships. She worries a lot when she is not at home or not with her husband. Both are currently planning to have children. Now her anxious thoughts are that her children, when born, would have any health concerns as her husband takes a lot of medicines.

The client also explains how she feels restless about these tensions and has difficulty in concentrating in her work and household chores. She reported that her heartbeat increases and sweats excessively before some important work, and feels a chest pain when overloaded with work. She also said that she feels negative about herself and frequently suffers from indecision. During examinations and presentations, her throat becomes dry

and she is afraid of thinking about her future. She does a lot of thinking about a particular matter but is never able to come to a solution. Whenever she gets a task, she spends a lot of time pondering over the ways to execute it effectively rather than doing it. The client becomes frantic if any work comes pending and she expresses her need to finish all her tasks prior to a deadline, failing which she becomes restless and overthinks about it.

Excessive worry will in general overpower people with GAD, frequently prompting taking on a pessimistic or cynical point of view. Additionally, the individual may likewise will quite often stress over a few subjects at a specific time. Furthermore, individuals with chronic worry report physical symptoms such as "restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, and sleep disturbances (i.e., difficulty falling asleep, staying asleep, restless and unsatisfying sleep)" (APA, 2013, p. 222). Another indication of excessive worry is that when engaging in worry, it is difficult to stop worrying. If one does not worry in response to a triggering event, the person may believe that something terrible will happen. One more example of excessive worry is running away from the situation instead of confronting it (Craske & Barlow, 2006; APA, 2013).

Anxiety Scale (AS) (Sarkar, 2018)

The Anxiety Scale is a standardised tool developed by the test constructors for measuring the anxiety level of boys and girls belonging to the age range 15-25 years. This scale consists of 48 items divided into Six Dimensions–1. Worry, 2. General Anxiety, 3. Low Self Confidence, 4. Over Thinking, 5. Panic Attacks, 6. Depression.

Reliability. The reliability of this scale was calculated by a split-half (odd-even) method, and with a view of boys and girls. The coefficients of correlations are : for boys – 0.79 and for girls – 0.80 at 0.01 level of significance.

Validity. The validity of the anxiety scale was estimated on three levels : (1) Expert's opinion where 100% agreement of the experts was the criteria of selection or elimination of statements. (2) First try-out and as per difficulty level, selection and elimination of items. (3) Item validity by finding out the 't' differences between the mean of the high scoring (30%) and low scoring group (30%) and on the basis final selection of the items. The scale s+-uccessfully compiled all the above criterions.

The pretest scores of Mrs. D on the Anxiety Scale were 117 which indicated above average anxiety. She scored 18 on the worry subscale which means she has above average worry. She then scored 18 on general anxiety subscale showing that she has above average levels of general anxiety. On measuring the low self-confidence subscale, she scored 17 which indicated that she has comparatively below than average self-confidence. The score 21 on the overthinking subscale shows she has a high level of overthinking and 25 on panic attack subscale indicates a high number of symptoms of panic attack. The depression subscale gave 18 as the score which is indicative of an above average level of depressive symptoms.

Case Conceptualisation

Mrs. D's symptoms, life experiences, and responses to worry seem to coincide with the Intolerance of Uncertainty Model (IUM) of GAD. The model involves four interacting factors including intolerance of uncertainty, positive beliefs about worry, cognitive avoidance, and negative problem orientation (Hunsley & Mash, 2018). The cycle begins with an internal or external triggering event that catalyses a pessimistic progression of "what if" questions (i.e., worrisome thoughts) that trigger physiological (i.e., muscle tension) and emotional (i.e., irritability) manifestations of anxiety. This pattern leads to an intolerance of uncertainty in which the person may believe that uncertainty causes stress and frustration, reflects poorly on a person, prevents the person from taking action, and should be avoided.

In Mrs. D's life, the IUM is manifested when she entertains "what if" questions after experiencing anxiety. In addition, individuals with GAD require greater evidence when they experience higher ambiguity. For instance, Mrs. D kept asking questions about the future of her unborn children which manifested into her headaches and irritability. The worry of these physical manifestations reinforced her anxious thoughts.

Furthermore, the second element of the model includes positive beliefs about worry in that worrying keeps the person organised, helps with completing tasks, and helps with problem- solving by thinking about all possible scenarios associated with a potential problem. Some individuals adopting positive beliefs about the usefulness of their worry believe worrying shows that one is a responsible and caring person. As individuals with GAD are so accustomed to chronic worry, some may tend to worry something is inherently wrong with them if they are not currently engaging in worry. Here, Mrs. D frets over every detail when her sister in law and her family come to visit. She thinks that unless she gets worried and completes every task she would not be able to serve her sister in law well. She plans and prepares everything in advance but by the end she gets exhausted.

Cognitive avoidance is the third element of the IUM that involves both implicit and explicit aspects of avoidance. Mental images play a role in generating fear responses (i.e., unpleasant emotions and physiological responses) when exposed to a triggering event (Freeston et al., 1994). Therefore, worry serves to suppress the mental images that elicit fear. Implicit avoidance occurs when a person engages in worry in order to avoid unpleasant affect associated with the mental images or as a means of distraction from thinking about more distressing issues. Explicit cognitive avoidance occurs when a person attempts to suppress worrisome thoughts, substitutes neutral thoughts for worries, uses distractions as a way to interrupt worry, and avoids situations that can lead to worry. The client had reported that she worries less of her husband when he has to go to other states for work. She said that she feels most anxious when he is near her but when he is away she does not have much worry of his health.

Negative problem-orientation is the final factor associated with the IUM. A negative problem-orientation involves a pessimistic perception of the problem as well as the person's inability to solve the problem. The person may catastrophize the problem and expect that negative outcomes will occur (Behar et al., 2009; Dugas & Ladouceur, 2000). The client also catastrophizes when her husband takes medicines and extrapolates it to problems that might affect their children when born.

Ethical Considerations

The research was conducted with the consent of the participant. The participant was assured about their confidentiality. The researcher stated to the participant that they could withdraw from the study at any time without any prejudice.

Treatment Goals and Plan

The present case was conceptualised using the cognitive behavioural model. In the 1960s, Aaron Beck developed cognitive behaviour therapy (CBT). Cognitive behaviour therapy is a structured, didactic, and goal-oriented form of therapy. The approach is hands-on and practical wherein the therapist and client work in a collaborative manner with the goal of modifying patterns of thinking and behaviour to bring about a beneficial change in the client's mood and way of living his/her life (Chand et. al., 2022). Three aspects of cognition are emphasised:

1. Automatic thoughts
2. Cognitive distortions
3. Underlying beliefs or schemas

CBT also adopts a metacognitive perspective in the sense that therapists and patients discuss and challenge negative thoughts and maladaptive beliefs. CBT conveys metacognitive knowledge, particularly that thoughts are thoughts and should not be regarded as facts (Moritz et. al., 2019).

In Indian social context CBT for a client becomes more beneficial when the family is involved. Families form an important part of the social fabric and support system, and as a result, they are integral in being part of the treatment and therapeutic process involving an individual with mental illness. Mental illnesses affect individuals and their families too. Working with families involves education, counselling, and coping skills with families of different psychiatric disorders. Such families require psychoeducation about the illness in question, and in addition, will require information about how to deal with the index person with the psychiatric illness. This therapeutic process is termed as family counselling. Additional family interventions may cover specific aspects such as future plans, job prospects, medication supervision, marriage and pregnancy (in women), behavioural management, improving communication, and so on. At any given time, families may require specific focus and feedback about such issues (Varghese et. al., 2020).

Session 1

1. Case History and Mental Status Examination.

Clients are welcomed and seated comfortably and then rapport is established. The session includes case history taking where details of the client's issues, medical history, family history, personal and social history as well as premorbid personality was collected and a Mental Status Examination was also conducted. Through this it was identified that the client showed symptoms of GAD which was confirmed with the help of DSM V.

2. Pre -Test.

The Pre-Test is conducted using the following questionnaires after a detailed description of the test.

1. Personal Data Schedule

2. Anxiety Scale - (Subhash Sarkar and Goutam Das, 2018)

3. Psychoeducation.

Psychoeducation involves teaching the clients and caregivers about their anxiety symptoms and providing an overview and rationale for therapeutic techniques. The client and her family were given information on how the therapy would progress by working on the client's thoughts, feelings and behaviour. They were also given an understanding of how these are connected through a cycle. The client was given an awareness on physical exercise and the science of sleep. An activity chart was provided to help the client keep a track of their routine.

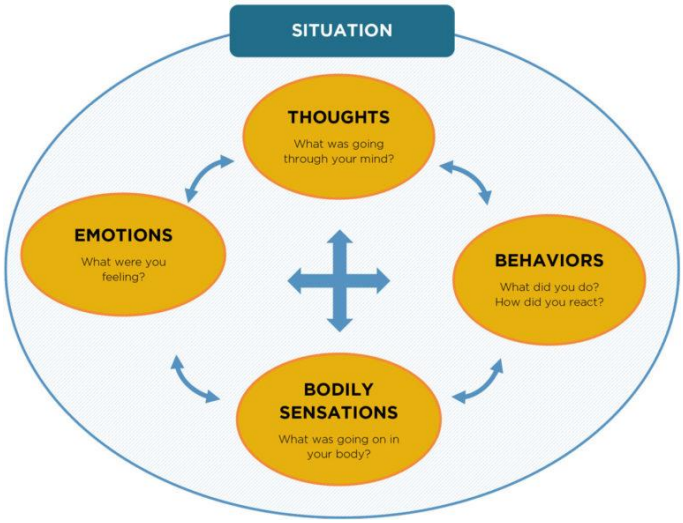

Figure 1. Cycle of Thoughts, Behaviours, Bodily Sensations and Emotions

4. Family Counselling.

The client's mother in law and husband were the active members of the family who took part in counselling. They were given an understanding on how the anxious symptoms can be controlled just from the way they communicate at home. They were told to avoid any negative affirmations of the client's apprehensions. They were also educated on the importance of proper diet, sleep and exercise. They were told to divert the client's attention to focus on her physical health when she gets wound up in her anxious thoughts.

5. Summarising of the session by Counsellor.

6. Next follow up after 2 weeks.

Session 2

1. The session began with summarising the client's past two weeks. The client, her husband and her mother in law gave inputs.
2. The client's change in routine to include a proper diet, sleep and exercise was reinforced.
3. The client was taught to maintain a thought diary to track her thoughts, their frequency, situations and experiences.
4. The husband was given an insight on how to avoid discussion of anxiety provoking thoughts of the client especially of her travelling abroad for onsite work.
5. The family members were given an insight on how to focus in the present situation and the issues can be resolved step by step.

Session 3

1. Activity chart was reviewed and she was given encouragement to continue the routine.
2. Relaxation therapy was introduced. The client was taught the JPMR technique and was told to include this in her activity chart.
3. Thought diary was reviewed and the client was given an insight on the increased frequency and time spent in worrying
4. A stimulus control technique, scheduled worry time was introduced to control the generalisability of her worry thoughts.
5. The husband was psycho-educated on this technique and told him to track and encourage this new routine.

Session 4

1. The client was introduced with the worry tree where she was made to distinguish real event worry and hypothetical event worry. It was understood from the worry tree that the anxious thoughts were shared between the husband and the client. The client was then given an insight on finding a reason to change. She recognised that she should change because these might affect her children when born.
2. The client was then taught to maintain a thought log where she had to write an alternative positive thought for every unproductive negative thought.
3. The husband was then given an understanding how currently the client's worries would just increase if his physical symptoms are shared with her and he told that he would take care of himself in case of emergencies rather than creating a panic at home.

Session 5

1. The worry tree and thought log were reviewed. During the session, her distorted cognitions of generalization and filtering negative thoughts were identified. The long chain of unproductive negative thoughts in the worry tree was given a focus and alternate positive thoughts were assigned to each one of them in the thought log. This created an insight in the client that consistent worry about these unproductive thoughts is a waste of time and energy rather than indulging in positive thoughts gives relaxation. She also understood the need to close the loop on her worry about her mother's health. The client's efforts to take initiatives on her path to change was acknowledged and reinforced.
2. The client was then told to consciously avoid her need for reassurance when asking her husband whether he is alright midday and overprotection of her husband's health.
3. The discussion with the husband and mother in law was focused on identifying the client's anxious thoughts and diverting her attention to write them in the thought diary which would also avoid sharing of anxiety. They were also taught to acknowledge the positive changes of the client and give the right encouragement.

Session 6

1. The client was made to summarise her past few weeks including her areas of improvement and current issues. A cost benefit analysis of her activities and thoughts were done. It was noted that there has been a significant reduction in the amount of time spent worrying and increase in the quality of her relationship with her husband.
2. To maintain this reduction and to increase positive thoughts, worry free zone technique was introduced where the client was told to figure out different times and locations as worry free zones. She was told to engage in meaningful activities with herself or with her family members during this time and to consciously avoid any kind of anxious thoughts popping up then (pleasurable activity scheduling).
3. The client's husband and mother in law communicated that there has been significant improvement. She takes conscious efforts to avoid sharing anxious thoughts within the family and has started trying to become independent.

Session 7

1. During this session, the husband and mother in law expressed their joy in seeing significant changes in the client.
2. The client reported that she has started to enjoy her worry free zones and feels much more confident in going abroad.
3. The client was told to increase her worry free zones from two to five. She was also psycho-educated on improving her quality of life which included her personal space and time, leisure, career, family relationships and social belongingness.
4. The husband reported that she has become much more comfortable in their sexual intimacies and her worry of having children was significantly reduced.

Session 8

1. During this session, the client reflected on her journey throughout the therapy process. Her achievements and improvements were brought to notice and encouraged her to maintain them in the future.
2. She was told to continue tracking her routine through the activity chart and maintain her thought diary now to include her improvements as well.
3. A post test was conducted using the anxiety scale and the scores of each dimension had reduced.

III. RESULTS AND DISCUSSION

Dimensions	Pre-test Scores	Post Test Scores
Worry	18	12
General Anxiety	18	13
Low Self-Confidence	17	12
Overthinking	21	9
Panic Attack	25	16
Depression	18	10

Table 1 Pre Test and Post test Scores of Anxiety Scale

She gave the complaints of over the top worry and not having the option to control it. She would lose mind when stressed and is apprehensive of leaving her spouse and travelling to another country. She talked about her inability to focus on work and family tasks, uneasiness and sleepiness. She additionally mentioned her sleep disturbance and muscle tensions. The following symptoms were consistent with the Generalized Anxiety Disorder diagnosis according to DSM-5. According to DSM-5 (APA, 2013) a person becoming excessively worried and apprehended most of the time for at least 6 months and not being able to control the worry despite trying would give an indication of the diagnosis of Generalised Anxiety Disorder. The patient should also experience three or more of the associated symptoms such as fatigue, feeling easily keyed up, sleep problems etc most of the day for the diagnosis of GAD. Moreover, the symptoms should be severe enough to cause significant impairment in social and occupational functioning of the patient. All these symptoms helped in formulating the diagnosis of the current patient.

The Pre and post test scores indicate that there have been significant changes in Generalised Anxiety in the client with the use of CBT along with family counselling. The therapy of Mrs. D involved CBT techniques applied to improve her cognitive, physiological and behavioural components. The cognitive techniques included cognitive restructuring, scheduled worry time, worry free zones, worry tree and cost benefit analysis. The behavioural component included response prevention and pleasurable activity scheduling. The physiological component was treated using progressive muscle relaxation (Rygh & Sanderson, 2004). These techniques were proved to be effective in the combination of family counselling.

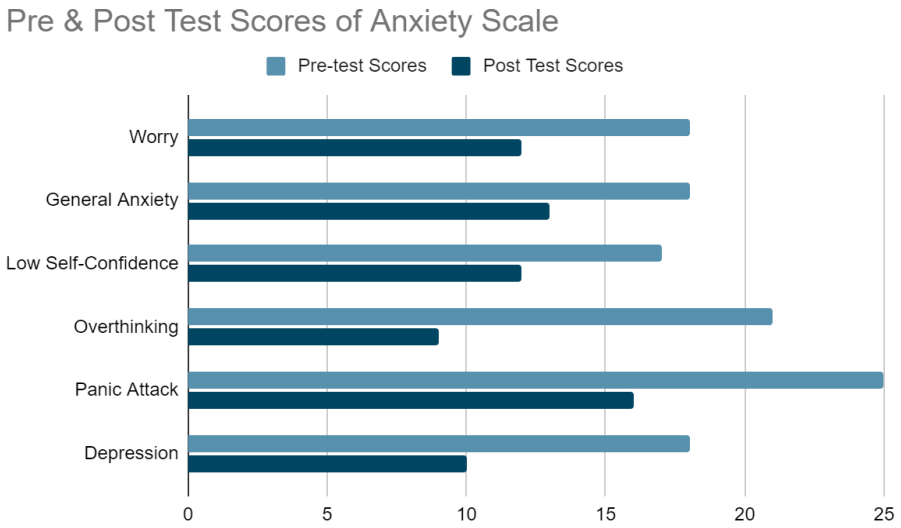

Figure 2 Bar Graph of Pretest and Post-test Scores of Anxiety Scale

The client was psycho-educated on the cognitive emotive loop where her thoughts about the health of her mother and husband fuels her anxiety which in turn continues to add on to her apprehensive thoughts. She

was told that through this therapy this loop would be broken and positive alternate thoughts and behaviours would be practised. The client's family members were also made to be actively involved in the therapy session, psycho educating and empowering them to help the client out of the worry loop. By the end of the sessions, the client became physically, psychologically and emotionally independent.

Supportive techniques were introduced for the client. Exercise is cost-effective and performed in a variety of ways (e.g., walking and swimming). Along with mindfulness techniques and aerobic exercise, there are a variety of things that the client did to reduce anxiety: involved in a hobby she loved (e.g., baking, gardening, reading, painting, etc.), listened to favourite music, journaled her feelings, took a warm bath, made sure to eat healthy, as junk food can have adverse effects on physical and psychological health, got enough sleep, went out in nature, avoided emotional triggers (e.g., people and places that consistently increase anxiety) and organised her home and workspace, as clutter may exacerbate anxiety and spend time with family and friends.

The cognitive behavioural therapies are relatively short-term, goal directed, problem-focused treatments that are fundamentally based on the model that changing cognitions is possible and leads to behavioural change (Dobson, 2002). The CBT techniques are proved to be effective in various studies including anxiety, depression and ADHD (Chand et.al., 2022). The study conducted by Hoffmann et. al. (2012) states that CBT has been proved effective in multiple studies. In the present study, using techniques of CBT has brought in potent changes in cognition, behaviour and emotions.

The CBT techniques were supported with family counselling. Supportive work with families is very important in therapeutic programmes for the management and resolution of current difficulties, taking life decisions using the family's strengths and available resources, ventilation, reassurance, enhancement of the affected family's social support network as well as maximising adaptive coping strategies of the family members (Varghese et. al., 2020). Often, we find that supportive work helps a single family member approach interventions for anxiety problems.

IV. CONCLUSION

The present case study described a client who had symptoms of Generalised Anxiety Disorder which was diagnosed on the basis of DSM V and Anxiety Scale (Sarkar & Das, 2018) after collecting information using the clinical case history taking method. The case was conceptualised using the Intolerance of Uncertainty Model where four interacting factors including intolerance of uncertainty, positive beliefs about worry, cognitive avoidance, and negative problem orientation were identified. With these factors in mind, a treatment plan was developed based on Cognitive-Behavioural Therapy and Family Counselling. By the end of the intervention, the post test scores revealed that the client had significant reduction in her symptoms of GAD. Two sessions were conducted after the posttest to maintain the changes. The client reported that there have been significant changes in her life. She reported that her mother in law and husband were thoroughly involved in the journey of these therapeutic sessions. She is currently preparing to leave for the job abroad. Thus, through this case study it can be understood that the combination of CBT with family counselling is an effective method of treatment of GAD.

Limitations of the Study

1. The unanticipated hit of the pandemic disrupted the sessions in between because of which few of the sessions were conducted online though all members of therapy were present.
2. The techniques of CBT, family counselling and other supportive techniques introduced are case specific and cannot be generalised to other studies.

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