Family Therapy and Cognitive Behavioral Therapy for a Case with Co-morbidity of Depression and General Anxiety Disorder in Hong Kong - A Single Case Study

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Introduction:

Family Therapy

Family therapy, a type of psychotherapy, is commonly applied in families having gridlocks, conflicts or misunderstandings, aiming at improving family functioning. The goals of family therapy include improving communication among family members, improving autonomy for each member, improve agreement about roles, reducing conflicts and reducing stress in the member who is the patient. (Gelder, Harrison & Cowen, 2006) In Virgina Satir's model, congruence is an essence in achieving good communication between family members. Congruence refers to a state of being as well as a quality of communicating. It is viewed at three different levels. First, congruence entails acknowledging and accepting our inner experiences (sensations, interpretations, and consequent feelings about those feelings) and being able to express them. In the second level, it involves listening to our perceptions and expectations, and translating those into a responsible pattern of meeting our needs by tapping our yearnings. At level three, we move into harmony with spiritual essence, or what Satir called the universal life force. (Satir, Banmen, Gerber & Gomori, 1991)

The Satir Change Model
In the process of family therapy, change is an important focus of internal shift that brings about external change. To elicit change, the concepts of discovery, awareness, understanding and new applications were examined. (Satir, Banmen, Gerber & Gomori, 1991)

Stages of change
Once an accepting, positive context for change are established, the client can begin with the process of change.

According to Satir, the process has 6 stages:

Stage 1: Status Quo
When a system is in status quo, we can make reliable predictions about how it is operating. The system has set up a clear set of expectations and reactions. We can count on these. Stable relationship gives member a sense of belonging and identity. They know what to expect, how to react and how to behave. Nevertheless, the system could become unhealthy when some members routinely respond to anger or guilt by placating, blaming, overly reasonable or being irrelevant. In this way, some individuals may impose a burden to another, resulting in system imbalance. Stress may lead to physical symptoms such as headache and abdominal pain that could possibly increase absenteeism.

Stage 2: Introduction of a foreign element
"Foreign element" refers to a psychotherapist or a family counselor who was not in the system before. This outside person needs to be accepted by the majority of the system's member so as to make the therapy work. The therapist is responsible for the process, such as guiding the members to examine the barriers to change and the resistance. It is helpful for the members to identify the aspects that they believe they cannot change. In Satir's model, resistance contains elements of reframing, in which the therapist helps the clients see themselves as capable and open to change.

Stage 3: Chaos
Chaos means the system is operating in ways that are not predictable. The unpredictability often makes members to become fearful and anxious. Therapist assists client to normalize the chaotic stage by neutralizing client's fear and anxiety. Clients consider a new perception of self and others, and let go of their perceptions that no longer fit. Attaining positive, healthier, and more functional possibilities requires moving through a period of chaos. It is significant because it accepts people's fear of unknown, anxiety, uncertainty, and panic. It also moves the person or system from a dysfunctional status quo to a new functional state of being.

Stage 4: New Opinions and Integration
In this stage, clients develop new possibilities, integrating new ideas and reevaluating past and present expectations. Clients learn to take charge of consciousness and become more responsible for internal process of self. Joyfulness, new hope and regained energy become part of new status quo.

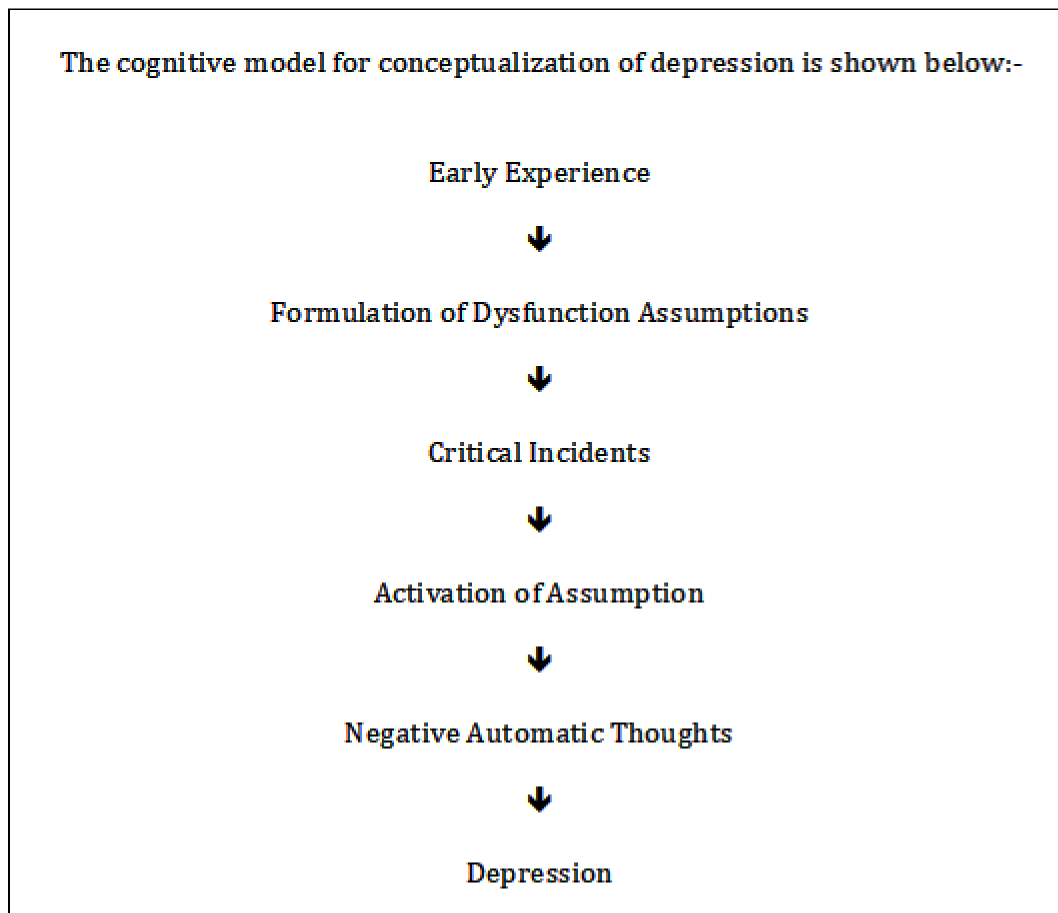
Stage 5: Implementation
As the past patterns are very strong, family members are encouraged to maintain and practice new options. To achieve this, they are taught to write things down, or have reminders in the car, on the refrigerator door, or on the bulletin board. The longer the practice, the more familiar and comfortable they feel.

Stage 6: The New Status Quo
The last stage provides a new status quo, a healthier equilibrium, and better functioning of individuals and relationship between family members. A new sense of comfort has taken the place of old familiarity. Moreover, new sets of predictions develop about how the system operates. New self-images and new hopes emerge with enhanced sense of well-being radiating.

Based on the concepts of family therapy and the change model proposed by Virginia Satir, a lot of studies were conducted by various practitioners. According to Markus et al., (1990) the effect of family therapy was found to be comparable to other forms of psychotherapy. Approximately 75% of clients had a better outcome with family therapy, when compared to those receiving minimal or no treatment at all. In a randomized control trial (Diamond et al., 2002) of an attachment-based family therapy for depressed adolescents, it was found that the majority of client no longer meet the criteria of major depressive episode as seen from the post-test result. In a meta-analysis, (Karver, Handelsman, Fields & Bickman, 2006) family therapy served as a promising intervention with an examination on youth and parent willingness to participate in treatment, and their actual participation performance. Besides, therapist's professional interpersonal skills and direct influence skills also

contribute to the success of the treatment.

Cognitive Behavioral Therapy
All psychiatric illness has cognitive and behavioral components. Alterations and changes for cognitive or behavioral, or both features are one of the processes to promote recovery. Since 1970s', cognitive behavioral therapy has gained popularity as a choice of treatment due to the strong evidence base of its effectiveness. The assessment and case formulation in CBT were used to provide an individualized treatment program for clients presenting with a variety of clinical problems. CBT teaches client to recognize their own maladaptive thinking and to become aware of those thoughts, feelings and situations that trigger negative automatic thoughts. Once this has been accomplished, CBT aims to clarify if the client would like to change their current problems. CBT is based on a series of principles originated from Aaron Beck's cognitive triad which states that an individual may be vulnerable to negative thinking about the self, the world and the future. (Thomas & Drake, 2012) Beck suggested that thinking is underpinned by attitudes (assumptions), which are based in early childhood experiences and later life events. It is believed that everyone has a tendency to react in a certain way for a particular situation. The predisposition is based on genetics, early experience, environment and life events. Some life events, nevertheless, could be traumatic and painful which give rise to negative thinking and lower mood states. Low mood can possibly intensify the probability of more negative thinking and eventually result in negative circle that influence daily living. Negative thinking is sometimes known as cognitive distortion. People with cognitive distortion often establish a negative view of themselves, the current experience of the work, or about their future. Changing the way that an individual sees from a negative perspective to a positive one is referred to the process of cognitive restructuring. However, the process is not always easy and it takes time to go through.



CBT for depression has is one of the most effective psychotherapy treatments in many cases. In fact, CBT has also commonly applied to other psychiatric disorders such as anxiety disorder and eating disorder. In particular, for generalized anxiety disorder, Borkovec and Ruscio (2001) pointed out that CBT for GAD has greater improvement than no treatment or non-specific treatment in terms of the severity of symptoms. A meta-analysis conducted by Covin, Quimet, Seeds & Dozois (2008) have found that CBT was effective in reducing worry with the use of a valid and reliable indicator of pathological worry, The Penn State Worry Questionnaire. In another meta-analysis, it indicated that

CBT could not only reduce the main symptoms of anxiety, but also the associated depressive symptoms, thus improving quality of life (Mitte, 2005). Moreover, the treatment effect is considered to be satisfactory since the improvements from CBT are maintained 1 year post-therapy (Borkovec & Ruscio, 2001; Gould, Safren, Washington & Otto, 2004).

Selection of treatment
Clients experiencing a major depressive episode is commonly seen to present with additional symptoms, including anxiety, phobias, worry about physical health, obsessive rumination, irritability, and complaints of pain. The co-occurrence of anxiety disorders appears to have a negative effect on treatment outcome for depression (Gorman, 1996). Clayton et al., (1991) stated that depressed patients with higher levels of anxiety took longer time to recover. Due to the complexity of a co-morbid condition, the advantages and limitations of different therapies were carefully considered. With regard to family therapy, especially in Chinese families with prominent hierarchy where parents have the power and decision-making for most of the time, it maybe common to see the unwillingness or inability for all family members to engage in the therapy sessions (Lebow, 1984). On the other hand, CBT is well structured and tends to focus on thinking process rather than emotion (Riva at al., 2011). It may not be the best therapy for people who have strong and immediate emotional reactions. In other words, when a client becomes very emotional, a focus on cognition and behavior is less effective for change. In this case study, one single treatment is unlikely to address all the issues including family dynamics, depression and anxiety symptoms. In order to achieve a holistic approach, this case adopts the values of both family therapy and cognitive behavioral therapy. Since the presenting problem of this client relates significantly with family members. Family therapy was selected as a part of treatment plan to deal with family dynamics. In addition, CBT was applied to cope with the client's anxiety symptoms.

Ethical issue and approval:
All the assessments and interviews were solely for treatment purpose. The data and information were kept confidential. Informed consent was obtained from client before intervention started.

Methodology

Participant

The client was recruited from the community who attended private psychiatrist consultation regularly. A total of 14 sessions with 1 session of initial interview, 3 sessions of family therapy and 10 sessions of CBT were conducted between Sept 2012 to Mar 2013. The sessions were run by a registered occupational therapist. Each session lasted for 60-90 minutes. Pre- and post- assessments were administered for outcome measures.

Measure

Beck Depression Inventory (Beck, et al., 1961). The BDI is a 21-item self-reported measure designed to assess the symptoms and attitudes of depression. Each item measure the severity of a particular symptom from 0 (not at all) to 3 (extremely). The BDI demonstrates high internal consistency, with alpha coefficients of .86 and .81 for psychiatric and non-psychiatric populations respectively (Beck et al., 1988).

Hospital Anxiety and Depression Scale (Zigmond & Snaith 1983). The HADS is a self-assessment scale consists of 14 items, divided into two subscales: Anxiety (HADS-A) and Depression (HADS-D). The respondent rates each item on a 4-point scale ranging from 0 (absence) to 3 (extreme presence). Higher score on each subscale reveals a higher level of anxiety or depression. The HADS possessed good psychometric properties in terms of factor structure, inter-correlation, homogeneity and internal consistency (Mykletun et al., 2001).

Procedure

(Part I) Initial assessment

An initial interview and assessment was conducted before the commencement of treatment sessions. Client (Ms. K) is a 20-year old, single female. She has reported to have low mood since 2011. She applied for a diploma course of Child Education in a local institute after graduating from secondary 5. Ms. K revealed that she had academic stress since Year 1. Later, Ms. K began to develop other depressive and anxiety symptoms including insomnia, poor appetite, loss of interest, fatigue and difficult to concentrate. In terms of clinical formulation, the predisposing factor was identified as having the idea of perfectionism. In addition, her parents were strict and over-criticized at times. The precipitating factor was about the distress in facing the final year program with challenging assessments and clinical placement. The perpetuating factor was that she believed she was always judged by other people for her performance and achievement. She thought people often criticize her ability. Moreover, if she did not need to go to school, she did not have to face the stress and any failure of study.

(Part II) Family Therapy

With the information obtained from intake assessment, a systemic hypothesis was developed. It was hypothesized that Ms. K had an intra-psychic conflict. In conscious level, Ms. K thought it was important for her to complete the 4-year program and obtained a bachelor degree to become a kindergarten teacher. On the other hand, in unconscious level, she was afraid of failure because her parents often compared her with elder sister who already had some bright achievements in academics and work. The goals of the family therapy are to establish better communication among family members, enable the family to develop coping skills, make people to aware that they have the ability to choose, and enhance the relationship. Three sessions were conducted in total, with the following members participating:
Session 1: Ms. K and mother;
Session 2: Ms. K and both parents;
Session 3: Ms. K and both parents.
In each session, family members were invited to an interview room with comfortable seats and environment. The participating members were allowed to choose their sitting arrangement. The therapist also reminded members that they could still be able to change their mind if they wished.

(A) Introduction of family members

To start with, the therapist invited each family member to make an introduction of him/her. The therapist could also observed who was the “spokesperson” of the family. At the initial stage, family members expressed some ideas and goals to be achieved in the upcoming sessions. Ms. K wanted to find out a clearer pathway. Mother hoped Ms. K could utilize the time in a better way. Father did not have much concrete idea, but he wished to have more understandings about her daughter’s plan and choice.

(B) Communication pattern

Communication is an important component in family functioning. By assessing the general patterns of communication in the family, the therapist gains information about the way in which family members experience their relationships with one another, their ability to express intimacy, how they pass information back and forth, what meaning they make of their communication, and in general the ability of family members to use words appropriately. Since good communication is such an important factor in healthy family life, modification of the family’s communication process is essential in family therapy. Nevertheless, it is often see

that people lack methods and skills to do so. During the session, Ms. K revealed the difficulty of maintaining concentration in class, the physiological reactions including palpitation, sweating and shortness of breath, and psychological emotion with a lot of crying. She was overwhelmed by the heavy workload. She felt unhappy and she wondered why she kept doing something she did not prefer. She considered quitting school and began to work. She thought, in this way, she could earn money to alleviate parent's financial stress. Her desired occupation was being a make-up artist or wedding planner. On the other hand, Mrs. K focused more on the outcome. Mother considered completing the final year as a more ideal way for Ms. K, since she has already spent 3 years in school. If her daughter could finish the whole program, she would rather continue to work at old age home, despite low back pain, in order to earn sufficient money for daughter's school fee.

(c) Family sculpture

Sculpting is an in-motion interaction that uses bodies in space to make overt the family's patterns of interrelating. It also externalizes people's inner processes. (Satir, Banmen, Gerber & Gomori, 1991) Family members were asked to sculpt their relationships to each other, using gestures and bodily pictures together with components of distance and closeness, which show the communication and relationship pattern. Members' coping would be demonstrated by different stances. For instance, power is represented by variations in vertical positions; intimacy is demonstrated by the horizontal distance from each other. Each family member took a turn in sculpting.

Scenario 1: Ms. K arranged mother to stand on a chair, and look at other family members from a high position. Father sat on a chair. Ms. K stood next to father, but kept a distance with mother and elder sister (elder sister simulated by therapist). Elder sister stood next to mother, but on the ground instead of standing on a chair.

Scenario 2: In the second turn, Mrs. K placed herself and husband sitting on chairs close to each other. Ms. K sat on the ground, faced to parents. Elder sister walked and circulated outside three family members, with not greater than one-meter distance from the members inside the circle.

Scenario 3: Lastly, Mr. K arranged all family members sitting on chairs. From the sequence (left to right) of Ms. K, Mr. K, Mrs. K and elder sister. Ms. K leaned towards Mr. K. Mr. K put his hand on Mrs. K's shoulder.

Next, each family member was given opportunity to share his or her feelings about the sculpting. Ms. K thought mother and elder sister had more power. Father and her had to follow their suggested ways or directions usually. Mother stated that elder sister worked very hard to earn money in mainland. Although she was not living with the family most of the time, she was thought to be always around. Yet, Mrs. K thought Ms. K was still not mature enough, therefore husband and her still have to look after her and give appropriate guidance. Mr. K revealed a simple mind. He hoped the family to be harmonious.

In summary, all the family members show positive comments to this exercise. Each family member had a different view of family in space. The discovery of sculpting differences leads to a greater understanding, acceptance and openness among family members. In particular, Mrs. K gained more insight about daughter's thought and feeling. She learned that her expectation has imposed great stress on daughter, making them to have a communication gap, which was depicted in sculpting. For Ms. K, she could see both parents wished to stay close together with all family members. For the ideas and plans suggested by parents, they were all out of love, concern and support. Nevertheless, similar to many traditional Chinese, the wordings or messages were seldom conveyed among members, resulting in possible frustration or even conflicts. In addition, they realized some strengths and uniqueness of each member, which is an essence to move the family from their earlier dysfunctional picture to a more desired, supportive ways of relationship.

(D) Validation of hypothesis

After obtaining some ideas of family pattern, communication dynamics and the presenting problem, the hypothesis proposed in earlier stage could begin to validate. Circular questioning was considered to be useful in eliciting systemic information. Some questions were guided by the therapist: "Who contributed the idea for Ms. K to study child education?", "Did the problem begin before or after she entered school?", "How was it decided when Ms. K consider taking a gap year?", "If the problem persist, would it be more or less likely for her to complete the program?", " How would it be consider if Ms. K should go on with Year 4 study or choose some

other subjects?", "Who will get the greatest sense of satisfaction when Ms. K graduate?"

During the process, Mr. and Mrs. K revealed that they and elder daughter had suggested Ms. K to pick the subject of child education since she did not have a definite direction after graduated from Secondary 5. They wished she could have a stable job with stable income. In contrary, Ms. K stated some of her interest and preferences. In fact, she did not want to become a kindergarten teacher. However, she wanted to please her parents and tried to meet their expectations. She hoped she could be as successful as her elder sister. Her elder sister was the manager of a textile factory in Mainland. Therefore, Ms. K struggled a lot and tried to study hard in the previous 3 years. In further elaboration, she believed elder sister and her were two different individuals with different characters. Each of them had merits and shortcomings. Yet, Ms. K kept doing something she disliked. Eventually she has reached her stress limit, and she could not cope further. Therefore she accepted the suggestion by school social worker of taking a gap year.

(E) Suggestions

The discrepancy for each family member's concern, feeling and expectation was illustrated during the process of sculpting and validation of hypothesis. They uncover and discover things that they did not know before. Parents, especially mother, started to accept the actual condition of daughter. Mrs. K expressed, no matter daughter chose to continue with Year-4 program, or change to study other program, or began a full time job, she would offer support to her daughter. She hoped Ms. K could set some short-term or long-term goal instead of idling at home all the time. On the other hand, Ms. K felt relieved that she no longer had to force herself to become a kindergarten teacher. She would like to transform her energy to her interested fields. In a preliminary plan, she may consider taking a 6-months course for make-up artist. In order not to create further financial burden to family, Ms. K decided to choose courses with "Continuing Education Fund", with a portion of course fee to be reimbursed upon completion of program.

(Part III) Cognitive Behavioral Therapy (CBT):

After resolving some problems of family disharmony, cognitive behavioral therapy was applied to deal with client's anxiety problem.

(A) Initial interview and assessment:

In the first part of cognitive behavioral therapy, education of CBT and the agenda of the following sessions were introduced to Ms. K. Next, she was asked to describe her current situation and mood status. She was also asked to rate her mood with 0-10 point scale. The ratings were used for later comparison. Simultaneously, the therapist began to identify Ms. K's automatic thoughts and explore further with her core beliefs.

(B) Treatment goals:

Once completed with assessments, Ms. K was invited to describe her problems and make a list for later goal setting. The process was collaborative, and client was facilitated to devise some goals. To handle Ms. K's issues, 4 treatment goals are planned.

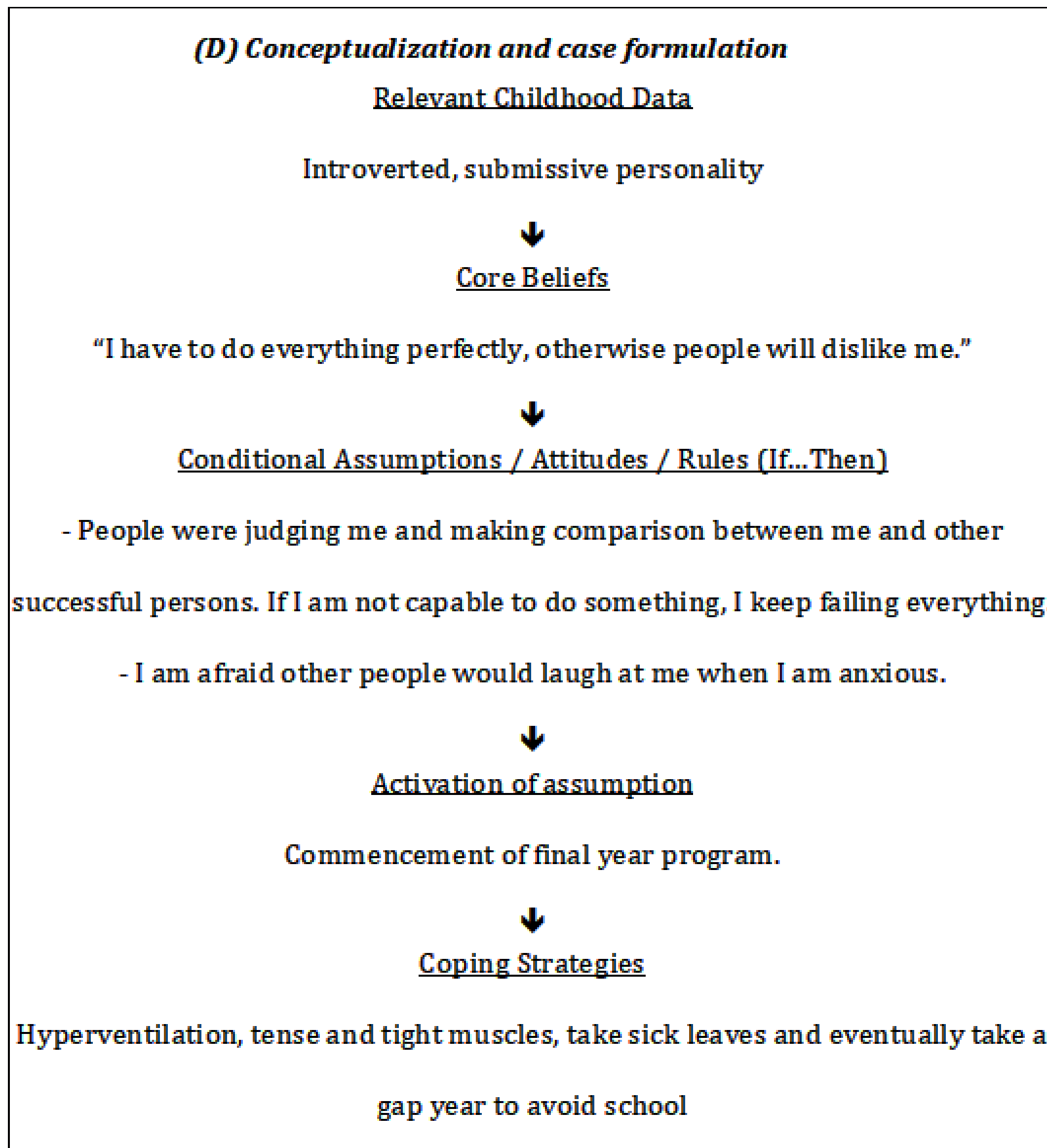
(1) She would be aware of her current behaviors.
(2) She needs to make clear about the intentions of such behaviors and the alternative ways in managing some difficult situations.
(3) She began to understand herself better in order to avoid maladaptive coping strategies or avoidant behavior.

(4) She would have decrease in symptoms of anxiety: headache, dizziness, palpitation and shortness of breath.

(C) Evaluation of intake assessment and to elicit automatic thoughts:

With the background information and detailed intake assessment, Ms. K was found to have some thinking errors. For example, she mentioned some "should statements" such as "I should follow my elder sister's career pathway and become as successful as her.", "I should never let down my parents since they have spent a lot of money for my 4-year higher education program." Besides, she said, "If I fail one subject, I may fail in other subjects as well and I need to re-take and re-take." (Over-generalization) Moreover, Ms. K stated, "If I cannot graduate and get a certificate, it would be unlikely for me to find any good job." (Jumping to conclusion) In

addition, she expressed negative feelings about the experience of clinical placement. She thought that it was hard to achieve standard in any aspects. She believed the mentors always criticized her. (Mental filter) She became anxious when people made comments on her, and she would experience accelerated heartbeat. She thought people could see her face became pale and could almost hear her heartbeat.



(E) Challenge the automatic thoughts:

In the feedback session, the therapist made an evaluation of automatic thoughts by identifying how often and how intense they were. Which of them was most upsetting and how much did Ms. K believe it? The therapist also attempted to explore any alternative explanation by Ms. K. Later, Ms. K was challenged by the therapist with the automatic thoughts. Some questions for challenging were suggested as "You told me about getting a certificate is important, I wonder if completing the Diploma course is the only way to become success?", "Tell me the idea about 'success'.", "Are you sure you are not doing well in all aspects during your placement?", "Can you recall any piece of satisfactory tasks including preparation of teaching material, looking after the kids, engaging in play group, etc.?", "Do you think your mentors were always judging you? Did they give you any ideas or feedback which you think they were useful?" "Do you really think other people can hear your heartbeat when you feel anxious? Would people offer you help in case if you are not feeling well?"

(F) Core beliefs and modification:
With reference to the case conceptualization, Ms. K's core beliefs were recognized, as "I should do everything perfectly. I must not let anyone down otherwise they hate me." In modifying the core belief, downward arrow technique may apply. Some leading questions may also be asked, "What if this will happen? What is the worst thing that could happen? In the event that the worst would happen, what would you do? What does it mean to you? And then what would happen? And then what?" Therapist would ask until Ms. K revealed some of the past the catastrophic ideas & into the probability that she would cope.

(G) Cognitive-restructuring:
Cognitive restructuring aimed at establishment of various alternative perspectives. During the process, Ms. K was taught to alter distorted information processing. Therapist facilitated her to learn about the interpretation of circumstances that is threatening, instead of the circumstances themselves that caused the distress. Moreover, Ms. K was taught to access the actual "probability" in a rational way, as compared to "possibility" that an undesirable event would occur. In addition, relaxation training and problem solving were also apply to Ms. K. Since she reported to have difficulty in relaxing, especially before assessment in school, or within a crowd where she felt being compared or judged. Techniques such as progressive muscle relaxation, diaphragmatic breathing and guided imagery were practiced. She was taught to tense and relax each of the major muscle groups, thus allowing herself to focus on the feelings distinguishing tension from relaxation. After that, she was guided to imagine a relaxing scenario e.g. resting on a warm beach with sea breeze. For problem solving approach, she was prompted to raise problems from daily-living situation. Then, she was guided to brainstorm with possible solutions. The advantages and disadvantages of each proposed solutions would be examined and decisions were made in how to implement. The therapist also prepared some scenarios for role-play with Ms. K so that she could practice with adaptive response.

Apart from the practice during the treatment session, Ms. K was taught to do Thought Diary as a take home assignment, which facilitates her to identify unhelpful thoughts and encourage her to consider alternative thoughts. From Ms. K's feedback, the thought diary was very useful because the thought record would be brought back to later CBT sessions for the therapist to review, discuss and evaluate with her. She could compare the ratings of emotion (0-10 scale) after applying more adaptive response.

(H) Relapse prevention:
For the purpose of maintenance, Ms. K was encouraged to recognize the factors that increased her worry and anxiety. She was suggested to identify some at-risk situations and those stressors she was likely to experience, and her interpretation of these situations. Moreover, she could also review the successful experience and apply the newly learned skills to upcoming problems. Lastly, he should be rewarded with positive behaviors such as using new coping skills, or avoid repeating previous negative behaviors.

Result

The scores of Beck Depression Inventory indicated a distinguished reduction from 25/63 in pre-test to 11/63 in 6-month post-test. Secondly, from the assessment of Hospital Anxiety and Depression Scale, the baseline score of anxiety and depression was 12 (moderate level) and 10 (mild level) respectively. Significant improvement was shown in the result of re-assessment with anxiety score decreased to 7 (normal) and depression score reduced to 3 (normal). Thirdly, the mood check from each CBT session also showed gradual improvement in mood states.

Discussion

The followings were essential parameters, which accounted for the success of intervention and case management.

(I) Choice of intervention

Single case study allowed flexible and various treatment approaches. Therefore, the choice of relevant intervention based on the results of initial interview and assessment including family therapy, cognitive behavioral therapy, relaxation training and problem solving skills was one of the critical successful factors.

(II) Positive family attitude

The degree of participation of each family member was also an important factor. If any of the family member(s) refused to participate, or did not speak at all, the process would probably take longer time and more difficult to go through. Nevertheless, the K's family was cooperative throughout the sessions. They were willing to make changes and improvement. Moreover, they were open to discussion with guidance by therapist. Mutual help and understandings were raised between family members, which contribute to later communication and suggestions for future plan.

(III) Exercise and skill training

Ms. K showed positive feedback on tension-releasing exercise and rhythmic diaphragmatic breathing in CBT treatment session. The techniques were useful in reducing anxiety symptoms. Exercise and practice within session enabled the client to experience and gain more confidence to perform again in daily living.

Conclusion

Family therapy is helpful in young people and adults, couples, and families. It enables them to build on strengths and understandings and find ways forward in their lives. On the other hand, CBT has been shown to effective in many evidence-based studies, with reduced negative symptoms for client, more positive health outcomes and changes in their daily living. A combination of therapies, family therapy and cognitive behavioral therapy in this case, served different purposes on systemic and individual needs. Nevertheless, whether single intervention or combined intervention was more appropriate varied in different cases. In this single case study, the treatment effect was considered to be most beneficial to client in dealing with family dynamics and her anxiety symptoms. It has been a valuable experience to go through a case in details with positive progress demonstrated. The stages of change in family therapy, from chaos to new status quo, were also clearly shown in the process.

To achieve higher efficacy of intervention, continuous assessment is necessary for the monitoring of treatment outcome, and make any necessary adjustments.

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