Psychosocial Issues and Intervention Strategies in Case of a Youth with Anxiety Disorder: A Case Study

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ABSTRACT

Introduction: Persistent and chronic worry is a hallmark of generalized anxiety disorder. This excessive, multi-focused worry about money, family, health, and the future, for example—is hard to manage and is frequently accompanied by other vague psychological and physical symptoms. The diagnosis of generalized anxiety disorder may be applied inappropriately to almost any anxious patient due to the misperception that the condition's symptoms are extensive. But in fact, the core characteristic of generalized anxiety disorder is excessive worry. The study aims to explore the various psychosocial factors in the case of a youth with generalized anxiety disorder.

Methodology: This case report demonstrates a 24-year-old male with a history of 5 years of Worries related to career, finance, and health, chest tightness, episodes of racing heartbeats and restlessness, and a Burning sensation in his stomach. A comprehensive psychosocial assessment was conducted both qualitatively and quantitatively. Quantitative assessment was undertaken and formulated using assessment tools such as the McMaster Family Assessment Device, Family Attitude Scale, Family Accommodation Scale Anxiety (FASA), Dysfunctional Analysis Questionnaire, Rosenberg self-esteem scale, Lubben Social Network scale-revised, social interaction anxiety scale (SIAS), Level of expressed emotion scale(lee).

Result: The findings of this case report highlight a complex interplay of multiple psychosocial factors such as family environment, economic factors, interpersonal relationship factors, and social and psychological factors that result in the onset of anxiety disorder in the individual.

Conclusion: The comprehensive psychosocial assessments help in formulating holistic intervention plans to the specific needs of the individual and addressing the associated psychosocial problem that has potential impacts on the bio-psychosocial functioning of the individual.

Keywords: Generalized anxiety disorder, Psychosocial factors, Case study, Biopsychosocial Functioning

INTRODUCTION

Anxiety disorders are the most pervasive class of mental disorders, with a 12-month

prevalence in the community of about 18%. While anxiety is a common emotion for everyone, those who suffer from anxiety disorders frequently experience extreme and overwhelming fear and worry. Physical tension and other behavioral and cognitive signs usually accompany these feelings. If left untreated, they can be very distressing, hard to manage, and long-lasting. Anxiety disorders can affect a person's personal, social, academic, and professional lives in addition to interfering with everyday activities. An estimated 4% of the global population currently experience an anxiety disorder. In 2019, 301 million people in the world had an anxiety disorder, making anxiety disorders the most common of all mental disorders (WHO,2019). With 301 million cases worldwide in 2019, anxiety disorders rank as the most prevalent mental illnesses. Several literature suggests that anxiety impacts more women than men and symptoms frequently start in childhood or adolescence. Like other mental health issues, anxiety disorders are the product of a complex interplay of biological, psychological, and social variables. Anxiety disorders can affect anyone, although they are more common in those who have experienced abuse, significant losses, or other traumatic events. Physical health has an impact on and is closely tied to anxiety disorders. Numerous negative effects of worry, such as tense muscles, hyperactivity of the neurological system, or excessive alcohol consumption, are also recognized risk factors for illnesses like cardiovascular disease. As a result of the challenges involved in managing their illnesses, people who have these problems may also develop anxiety disorders. Generalized anxiety disorders are one of the most important subtypes of anxiety disorders. Generalized anxiety disorder is characterized by chronic and persistent worry. This worry, which is multi-focal (e.g., about finances, family, health, and the future), excessive, and difficult to control, is typically accompanied by other nonspecific psychological and physical symptoms.

ICD-10, short for the International Classification of Diseases, 10th Revision, is a globally recognized system for classifying medical conditions, including mental disorders like anxiety. For anxiety disorders, the category code starts with F41. Different subcategories and codes exist within this category to differentiate between specific anxiety disorders.ICD 10 has defined different subcategories of anxiety disorders such as Panic disorder(F41.0)characterized by recurrent panic attacks and persistent worry about having future attacks, Generalized anxiety disorder (GAD)(F41.1) marked by excessive and uncontrollable worry about multiple aspects of life, Other specified anxiety disorders(F41.8) includes diagnoses such as specific phobias, social anxiety disorder, and separation anxiety disorder, Unspecified anxiety disorder(F41.9) cannot specify the exact type of anxiety disorder present. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013) has defined seven anxiety disorders that are distinguished from each other by their associated behaviors and cognitions (APA, 2013; Zinbarg et al., 2015). Each disorder is also marked by functional impairment (APA, 2013). These anxiety disorders are: separation anxiety disorder (SAD), marked by a developmentally inappropriate fear of separation from major attachment figures (such as parents or primary caregivers) or the home; specific phobia (SP), characterized by an intense, extreme fear of specific stimuli that induces an immediate fear response; social anxiety disorder (social phobia), marked by a persistent fear of social situations where the child may be judged or evaluated; panic disorder (PD), characterized by recurrent, unexpected panic attacks, and a

persistent fear of panic attacks; agoraphobia, characterized by fear or distress in situations where escape might be difficult or help not easily available should symptoms of panic occur; selective mutism (SM), characterized by the absence of speech in situations in which it is expected of the child with no evidence of speech difficulties in other situations; and generalized anxiety disorder (GAD), characterized by excessive, uncontrollable worry about different facets of life (e.g., schoolwork, friendships, and parents all at the same time). A generalized anxiety disorder may incorrectly suggest that symptoms are entirely nonspecific, and this misconception may sometimes lead to the inappropriate use of this diagnosis for virtually any anxious patient. However, excessive worry is, indeed, the core and defining feature of generalized anxiety disorder.

From a developmental perspective, however, it is important to consider that mild fear and anxiety are part of normal human development. Many youth experience unwanted anxious arousal associated with performance and when it does not interfere with functioning, this is a reasonable emotional reaction. This paper endeavour to explore the intricate web of psychosocial issues surrounding it, drawing on contemporary research and clinical insights.

METHODOLOGY

This case report demonstrates a 24-year-old male with a history of 5 years of Worries related to career, finance, and health, chest tightness, episodes of racing heartbeats and restlessness, Burning sensation in his stomach. A comprehensive psychosocial assessment was conducted both qualitatively and quantitatively. A quantitative assessment was conducted and formulated using assessment tools such as the McMaster Family Assessment Device, Family Attitude Scale, Family Accommodation scale-anxiety (FASA), Dysfunctional Analysis Questionnaire, Rosenberg self-esteem Scale, Lubben social Network scale-revised, Social Interaction Anxiety Scale (SIAS), Level of expressed emotion scale(lee).

CASE SUMMARY

The index patient was maintained well until 2019 and pursuing a bachelor's in economics degree from college. He chose economics as he was interested in finance and thought it could be a good career option for him after discussing with his family and well-wishers along with his online research he realized that could acquire a job easily and become financially independent quite early as compared to his peers to support his family because his father had taken multiple loans for his and his sibling's education. But a year into the course he started to find the course to be difficult and gradually lost interest and started to think about changing his course of study. Thus, he began exploring other alternative career options, mainly searching on the internet, and started to spend an excessive amount of time contemplating it as for most of the time he spent awake he felt like his mind was preoccupied with thoughts related to his career which also led him to spend a lot of time scouring the internet regarding career related topics His family had financial issues in the past too but that only motivated him to work harder but now he would frequently wonder how he would support his family

financially if he did not find a job after graduation. Eventually, he decided to prepare for the bank examinations as it held every year and that could ensure that he started earning at the earliest after securing a good enough rank and joined a coaching institute in Patna after consulting with his seniors and family. But to his dismay, due to the constant worry, he continued to feel disturbed and would often have difficulty concentrating. He also started to feel fatigued and could feel his self-confidence decrease accompanied by chest pain. He felt chest pain most of the time when he tried to solve arithmetic operations. After solving a couple of them he started to experience a sudden tightness in the centre of his chest as if someone had put a heavy weight on his chest. After a few days when he returned home, his father took him to a friend who was an X-ray technician. He told them it could be due to gas or chest infection and suggested they do a chest x-ray, which came out normal. After spending time with his family he returned to Patna but the moment he started attending his classes and studying, he again started having a similar experience of chest tightness which would end up only stopping studying and it was relaxing gradually after resting.

He soon realized that chest tightness would appear when he required intense concentration especially while solving arithmetic problems, on the other hand, he was able to read newspapers for current affairs and solve reasoning questions without any chest tightness. He took antacids to relieve the pain as advised but had no improvement. So, he started to avoid learning maths and data integration. The worry that he was physically unwell returned as well. All of this again resulted in him having decreased interest in studies though he continued to go to his coaching classes regularly. In his coaching class or when he was spending time with his friends he never felt chest tightness and maintained that it only happened when a task required intense concentration. However, he also thought that his hectic schedule of attending coaching classes in the morning and evening and studying in the afternoon might be leaving him tense and thought that taking more rest from studying would solve his problem. In 2020 he returned home due to the COVID lockdown and after returning home he confided in his father that he was having difficulty studying and had been experiencing the chest tightness he had previously talked to him about. This time his father asked him to relax realizing he might be stressed because of the exams and college coursework. But ultimately, he stopped studying, worried that he might again start having chest tightness. His family members also report he would worry about having an unknown illness that could affect his career during this time. He continued to have chest tightness and sometimes also reported a headache at the back of his head. These started to happen when he searched in Google for electric circuit mechanisms and component circuit diagrams which he was able to do without any problem before. He says whenever he had to "push his limits" or tried to do things that required his "utmost concentration" or "complex tasks" he would experience these symptoms. There was a gradual improvement in his symptoms after he started spending time with his family. He helped his father in his repair shop by repairing LED TV motherboards, music systems, and electronic gadgets before but stopped studying for competitive exams altogether for a while, worried that the chest tightness might return. And said he wanted to relax and thought he would feel worried and feel chest tightness again if he started studying. He was able to believe he would be alright and things would get better soon. Unfortunately, he started to feel the same chest tightness when he needed to repair the LED TV motherboards. In September 2021 though he

went back to Patna to continue with preparing for his bank examination after completing his graduation in 2021. During an English coaching, he felt that he had an increased heart rate which continued after having lunch and when he wanted to rest in the afternoon he was not able to but ended up questioning what could have caused it. During this time he also experienced headaches which started either from the left or right side of the forehead and would radiate towards the back of his head relieved by sleep and aggravated by tasks that require intense concentration which lasted the whole day. He also continued to experience chest tightness. The negative thoughts regarding his health and financial security worsened in the midst of all this.

PSYCHOSOCIAL ASSESSMENT

In the psychosocial assessment qualitatively it is revealed that in childhood and adolescence, the home atmosphere was uncongenial. The contributing factors for this uncongenial atmosphere include an authoritarian parenting style from the father and permissive parenting from the mother, behavior control and social control high from the father with rigid rules and punishment, tolerance of deviance was poor, high expectations from the parents, emotional needs of the child was unmet. During the childhood of the individual, both the parents were busy in their jobs. The father was running an electric shop of his own and the mother was an Anganwadi teacher. Both the parents had high expectations for the children especially high expectations from the father. The father had some negative experiences during his childhood from his father. So he wants to up-bring his children in a way different from that. For that, he followed strict ways of discipline. When the individual attained 3 years of age the parents admitted him to nearby private tuition where the tuition master followed strict actions against the children. The primary focus of the parents during that time was on the education of the children where the emotional needs of the children were unmet. The parents tried to accomplish the materialistic needs of the children. Thus the individual had a strong relationship with the grandmother at that time and during their free time, the individual came to her and shared things with her. Apart from this the parents also followed strict measures about the relationship of children with the natives. They usually did not allow them to interact with local children assuming that it would affect their behaviour and discipline. So the individual did not have fruitful friendships during childhood apart from one or two in school. Because of the stringent punishment from the tuition center as well as the home the individual was reluctant to share his feelings and emotions that happened during that time. The complex interplay of the rigid and string disciplinary methods by the parents as well as the tuition master along with restriction in social connections results in the onset of illness in adulthood encompassing anxiety disorders with different paradigms such as inhibitions in social interactions, meaningful expression of feelings etc

The scholastic history is also suggestive of some unpleasant events such as bullying which also leads to the escalation of resistance with regard to relationship building and fear of criticism. Even though the individual acquired high grades in all the classes he was not

satisfied with the results. The sense of discontent was persistent throughout the educational history with the passive influence of the parents with regard to the same.

Sexual history reveals that Index patients gained sexual knowledge from friends at the age of 13 years during the same time started watching pornography. He started masturbation this time and stopped practicing the same for 1yr due to guilt. He liked a girl in the class but never expressed it.

CURRENT FAMILY DYNAMICS

Table No:2 Family Dynamics

Type of family	Nuclear family
Boundaries	Internal boundary- Flexible External boundary - Rigid
Subsystem	Three subsystems are operating in this family A couple of subsystems functioning adequately The parent-child subsystem is formed but not functioning adequately. All the materialistic needs are met by the guardians but emotional needs are unmet. Sibling subsystem formed patient currently has a need-based relationship with the both the siblings.
Leadership patterns	The father is the nominal head and both parents are functional heads of the family.
Decision making	Democratic decision-making is practiced.
Role Structure and Functioning	Role complementarity is present. The instrumental role is carried out by the father and mother. Expressed roles are unmet.
Communication	Direct communication present in the family Affective status (communication of feelings) - inadequate
Cohesiveness	Inadequate. The involvement of the patient in the social, personal, and emotional activities of the family is poor. Participation in family rituals is minimal.
Reinforcement and behavioral control	Behavioral and social control is high. Appreciative interactions are poor.
Adaptive Pattern	Conflict Resolution: Problem-solving ability is inadequate The coping strategy is adequate
Social support	Primary: Adequate Secondary: Inadequate Tertiary: Adequate

QUANTITATIVE ASSESSMENT

The family assessment has been carried out qualitatively through the application of different scales. The family assessment has been carried out qualitatively through the application of different scales. In the Mc Master Family Assessment Device three domains were dysfunctional such as affective responsiveness, affective involvement, and behavioral control. In the Family Attitude Scale, the score was 24 which denotes the low level of criticism towards the individual from the family. The Family Accommodation scale-Anxiety denotes a moderate level of accommodation present in the family. With regard to self-esteem, social networking, and social interaction of the individual on the Rosenberg self-esteem scale the score was 13 which denotes low self-esteem, in the Lubben Social network scale a score of 13 denotes less social engagement, in the Social interaction anxiety scale (SIAS) the score was 42 suggests a possible diagnosis for social anxiety. In the Level of expressed emotion scale, three domains came in the moderate range such as perceived lack of emotional support, perceived irritability, and perceived intrusiveness. In order to assess the psychosocial functioning of the individual Dysfunctional analysis questionnaire was applied in which four domains were dysfunctional such as social, personal, vocational, and family domains.

FACTORS INVOLVED IN THE INDIVIDUAL'S CURRENT CONDITION

Table No:3 Factors affecting the illness

Risk/Contributing factors	Maintaining/ Perpetuating Factors	Protective factors
Individual Factors Inadequate social skills Unfulfilled emotional needs Poor self-esteem	**Individual Factors** Poor problem-solving skills Poor coping strategy Unemployment	**Individual Factors** Willingness for professional help Good compliance
Family Factors High Behaviour control Emotional neglect High expectation Rigid boundary Financial constraints	**Family Factors** Lack of knowledge of illness Poor communication of feelings	**Family Factors** Supportive for treatment Role complementarity
Environmental Factors Inadequate secondary support Bullying	**Social Factors** Poor social network Inadequate secondary support	**Social Factors** Adequate tertiary support system Adequate Material resources

PSYCHOSOCIAL FORMULATION:

Index patient Mr.R,24 years old, Graduate, unemployed, single, Hindu, male, belonging to lower middle socioeconomic status, hailing from rural Godda, Jharkhand, living in a nuclear family with a family size of 05 members. Personal history is suggestive of authoritarian parenting from the father and permissive parenting from the mother.

Currently, in the life cycle stage VI of the family with launching young adults; The subsystems are formed in the family but the patient has a need-based relationship with his

father, mother, younger sister, and younger brother. Affective status is inadequate. The involvement of the patient in the social, personal, and emotional activities of the family is poor. Behavioral and social control is high. Appreciative interactions are poor. In family adaptive patterns: problem-solving is inadequate and coping strategy is adequate but the secondary support system is inadequate.

Psychosocial diagnosis as per ICD-10

Z 56 Problem related to employment and unemployment
Z 62.4 Emotional Neglect of Child
Z 73.3 Stress, not elsewhere classified
Z 73.4 Inadequate social skill, not elsewhere classified

PSYCHOSOCIAL INTERVENTION PROVIDED
No of sessions: 08

- Individual sessions with the patient: 05
- Sessions with father and mother: 03

Individual sessions with the patient for psychoeducation

The patient was seen for four sessions of psychoeducation in the cottage. The psycho-education session was divided into mainly three parts:

- Introduction to Generalized Anxiety Disorder (GAD)-Session 1
- Causes and Triggers of GAD-Session 1
- Understanding the Anxiety Cycle-Session 2

Table No. 5: Psycho-education session of the individual

Session 1 Explained about GAD and its prevalence in the population. Followed by an explanation of the core symptoms of GAD, including excessive worry, physical tension, restlessness, and irritability. Psycho educated him on how to Differentiate between normal levels of anxiety and pathological anxiety characteristic of GAD. Discussed the potential causes and contributing factors to the development of GAD, such as genetic predisposition, neurotransmitter imbalances, environmental stressors, and life experiences. Identification of common triggers that exacerbated anxiety symptoms, such as stress, uncertainty, major life changes, and interpersonal conflicts.
Session 2 Explained the concept of the anxiety cycle, which involved triggers, cognitive distortions, physical sensations, and behavioral responses.Illustrated how worry and anxiety could fuel each other, leading to a cycle of heightened anxiety and distress

Activity scheduling and social skill training (3 Sessions)

The patient was met in the cottage and discussed formulating structured activity scheduling. Since the patient was spending time mostly staying alone before. So activity scheduling is

planned for the patient so that his mind can be diverted and engaged in meaningful activities. As per the plan activity scheduling started initially focusing on engaging the patient in social activities such as engaging in playing with the child ward patient. Initially, the patient faced issues in interacting with the children. After two days the patient started going voluntarily to the playground to play but still faced issues in interaction. After two days the patient was discharged from the hospital. Then two teleconsultation sessions were conducted and the activity schedule was converted into a structured one including engaging in household chores. The patient started engaging in household activities.

A session with the father and the mother for psychoeducation (3 sessions)

The patient's father was seen twice in the ward. In the first session, both of them were educated about mental illness by giving them various examples that they would understand. The patient's illness was then discussed with them telling them how a mental illness is different from a physical illness. They were educated about psychiatric medicines and how they work in reducing the symptoms and leading to recovery. They were explained about the importance of psychiatric medicines and the duration of intake in comparing it with medicine taken for general physical illness. The patient's father has been psycho-educated about how the childhood experience affected the patient and how it became a triggering factor for the onset of the illness. Explained about the importance of addressing the emotional needs of the child during the childhood. In the third session, the patient's mother was called over the phone and explained the same. Both the parents were cooperative throughout the session.

DISCUSSION

The case report is a clear manifestation of how the family environment especially in childhood leads to the formation of anxiety in the youth. The current case depicts different familial factors in childhood such as an uncongenial home atmosphere during the childhood. The contributing factors for this uncongenial atmosphere include an authoritarian parenting style from the father and permissive parenting from the mother, behavior control and social control high from the father with rigid rules and punishment, tolerance of deviance was poor, and high expectations from the parents. Most importantly the emotional needs of the individual were unmet during that time. This in turn leads to the formation of resistance with regard to the expression of feelings and interaction with others in the subsequent developmental stages. This is clearly reflected in the adolescence and adulthood of the individual where it exhibited worry and other physical symptoms which ultimately leads to the anxiety spectrum. During the childhood of the individual, both the parents were busy in their jobs. Both the parents had high expectations for the children especially high expectations from the father. These high expectations are reflected as rigid rules and punishment from the side of the parents. This also contributed to the anxiety and resistance in the individual. The parents primarily focused on education and meeting the materialistic needs of the individual leaving behind the emotional needs. The complex interplay of the rigid and string disciplinary methods by the parents as well as the tuition master along with restriction in social connections results in the onset of illness in adulthood encompassing anxiety disorders with different paradigms such as inhibitions in social interactions, meaningful expression of

feelings.etc. These actions indirectly paved the way for building anxiety in the individual which during the time of adulthood exhibited as self-imposed anxiety with worries with regard to multiple domains such as education, job, and social interaction. The fear of failure was persistent in the individual throughout history where he was unable to accept failures and tried to avoid such situations. This in turn hinders the individual's interaction with others where he is afraid of their criticism.

From a developmental perspective, however, it is important to consider that mild fear and anxiety are part of normal human development. Many youth experience unwanted anxious arousal associated with performance and when it does not interfere with functioning, this is a reasonable emotional reaction. But when it is beyond the limit and affects psychosocial functioning it becomes a problem and should be addressed in a time-bound manner. The case is the clear depiction of how an individual over a period of time develops anxiety and further intensified.

According to the treatment history of the individual, he consulted multiple doctors for his physical complaints where the underlying mental stress was left untreated for a longer duration. This was primarily due to a lack of knowledge regarding the mental condition of the individual as well as the stigma prevalent in the home. According to WHO an estimated 4% of the global population currently experience an anxiety disorder. In 2019, 301 million people in the world had an anxiety disorder, making anxiety disorders the most common of all mental disorders. Although highly effective treatments for anxiety disorders exist, only about 1 in 4 people in need (27.6%) receive any treatment. Barriers to care include lack of awareness that this is a treatable health condition, lack of investment in mental health services, lack of trained health care providers, and social stigma.

Thus the primary focus of the treatment was to build insight into the individual as well as the family and address the stigma with regard to mental illness. So initial sessions were focused on providing psycho-education to both the individual and family. Parallelly the activity scheduling of the individual with a prime focus on improving the social interaction. Initially, the individual showed resistance in interacting with others but later on he started talking with regard to the same. The anxiety with regard to education was persistent for a while. Here a multidisciplinary approach was implemented in collaboration with the clinical psychologist colleague with a prime focus on relaxation techniques and addressing negative thoughts in Cognitive behavioral therapy. The intervention by Psychiatric Social Work has resulted in notable changes. At the individual level, the patient reported a 60% improvement, while the parents noted a 65% enhancement in his behavior and adoption of a healthier lifestyle. He started interacting with the family members and engaged in meaningful time with the family as recommended by the psychiatric social work trainee. Apart from this, the individual started going to the nearby ground in the evening and interacting with the children there which is a good sign of improvement.

The case reports provide a comprehensive and holistic analysis of various familial factors that contribute to the formation of anxiety in an individual as well as how illness condition affects family dynamics. The major limitations are that the findings and interventions presented in the case report e are based on a single case report, limiting the generalization of the results.

CONCLUSION

The findings of this case report highlight a complex interplay of multiple psychosocial factors such as family environment, economic factors, interpersonal relationship factors, and social and psychological factors that result in the onset of anxiety disorder in the individual. The comprehensive psychosocial assessments help in formulating holistic intervention plans to the specific needs of the individual and addressing the associated psychosocial problem that has potential impacts on the bio-psychosocial functioning of the individual.

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