

## Effectiveness of Schema Based Group Therapy on Reducing Uncertainty Intolerance in Generalized Anxiety Disorder Sufferers

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### Abstract:

The study was conducted to examine the effectiveness of schema based group therapy on reducing uncertainty intolerance in generalized anxiety disorder (GAD) sufferers. 24 clients with GAD were randomly divided into 2 groups: an experimental (n=12) and a control group (n=12). As pre-test and post-test measurement, participants completed the Young's Mindfulness Questionnaire, Young's Treatment Questionnaire, Freeston Intolerance Questionnaire (1994) and the Beck Anxiety Questionnaire (1996), before and after inducing interventions. Experimental group members participated in the 17 two -hour schema based group therapy sessions twice a week while the control group members received no intervention. ANCOVA were used to emerge 2 groups differences in terms of measures. Findings indicated that schema based group therapy decrease uncertainty intolerance scores in experimental group in compare with control group significantly ( $p<0.05$ ). In conclusion, the schema therapy as an integrated model consisting of cognitive, behavioral, interpersonal, attachment, and experimental procedures can be effectively applied in group therapy modality for reducing uncertainty intolerance in GAD patients.

**Keywords:** schema based group therapy, uncertainty intolerance, generalized anxiety disorder

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## Introduction

Anxiety as a multidimensional phenomenon, constitutes physical, perceptual, mental, and behavioral aspects. It is a depressive feeling characterized by the physical and emotional effects of the future (Barlow, 2010; Eghbali, Zare, Bakhtiari, Monirpoor and Ganjali, 2013: Diagnostic and statistical manual of mental disorders, 2017). A generalized anxiety disorder (GAD), as a persistent and pathological fear, is a prevalent disorder in which a patient has mentally occupations with fear of possible negative events constantly. Physical complications often exacerbate this condition concerning the activities that contribute to the insistent worrying (Psychopathology, 2013). Researchers use different frameworks in explaining the pathology of GAD. According to the Intolerance of Uncertainty Model (IUM), anxious people encounter with doubt or misunderstanding in the tensely situations (McVeigh, Mahoney, 2012; Douglas, 2007).

Among the cognitive components of GAD, intolerance of uncertainty (IU) contributes significantly to the anxiety experience of this and other anxiety disorders, such as obsessive-compulsive disorder (Bolen et al., Regentis, 2009; Aghili, Hassanzadeh, and Ghasemian, 2015) and mood disorders (Bahr and Dagas, 2006). (Freeston et al., 1994). People are reluctant to accept a possible negative event (Holawei, Himberg, & Kollis, 2006). Anxiety and IU may play a protective role in avoiding negative consequences in generalized anxiety disorder (Dagas et al., 2004).

All individuals with generalized anxiety disorder report a tendency toward confusion and tolerance of negative consequences. Medical evidence suggests that IU leads to generalized anxiety disorder (Himberg, Turk, & Menin, 2004). Even today, various strategies and approaches are used to alleviate anxiety problems, but each medication has been shown to have a remarkable effect on anxiety and is only marginally successful in curing this condition (Clark and Fairborn, 2001). Cognitive-behavioral treatment techniques have been used to treat mood and anxiety problems in recent decades. Although this therapeutic strategy is beneficial for social anxiety disorder, many people do not benefit from it (Ikartork, Kyogipers, OneStarton, DeGraph 2009; Gordon, Wong, & Himberg, 2014; Mayo-Wilson et al. et al. 2014).

In contrast to the conventional cognitive-behavioral paradigm for anxiety disorders, Hoffman (2007) found that recovery interventions had shown little efficacy in large-scale studies. Concerning anxiety disorders, this issue often draws experts' attention to the underlying causes for the development of these disorders, the absence of which may influence the treatment of the disorder.

According to Hamidpour (2009; as cited in Khorshidzadeh, Borjali, Sohrabi, Delavar, 2011), to further understand the main causes of anxiety disorders, different treatments need to be added to meet the individuals' different needs (Amanda et al., 2016). Therefore, a holistic new therapy should be applied, derived primarily from the existing techniques and procedures of cognitive-behavioral

therapy. In other words, this approach integrates cognitive-behavioral therapy, attachment-oriented, object-centered, Gestalt-oriented, constructivist, and psychoanalytic methods into a single psychological and philosophical framework (Klug & Young, 2006). Several scholars explored this topic, including Ahmadzadeh, Zomorodi (1397), whose study examined the effectiveness of schema-based education on generalized anxiety, IU, and cognitive biases in students. Tashkeh, Dovazdeh Emami, Bakhtiari, and Jafari (2015) contrasted the intolerance of individuals with body trauma and social anxiety towards intolerance and difficulty in emotion control. Akbari (2017), in his study, contrasted the effectiveness of ambiguity aversion treatment, buspirone drug therapy, and combination therapy in improving the patients' symptoms with the generalized disorder. Ghaderi, Kalantari, and Mehrabi (2016) studied the effectiveness of group schema therapy in modulating early maladaptive schemas and reducing symptoms of social anxiety disorder. Saffarinia, Zare, Karami, and Selki (2015) examined the efficacy and persistence of group schema therapy in treating students with social anxiety disorder. We intend to investigate this issue further, as few studies have shown the effects of schema-based group therapy on uncertainty in people with generalized anxiety disorder. Therefore, the present study examined whether group model therapy affects IU in patients with a generalized anxiety disorder?

## Method

A quasi-experimental design with a pretest-posttest and a control group was used in this analysis. We randomly allocated adult Iranian participants to one of two groups: experimental ( $n = 12$ ) and control ( $n = 12$ ). One week before the pre-treatment examination, each subject got one and the Freestone Intolerance (1994) and Beck Anxiety Questionnaire (1996). The present study group received 17 two-hour sessions twice a week, using the Young Group therapy regimen. These sessions were set once a week. The control group underwent no treatment. The monitoring and experimental groups were retested in a posttest after the therapy sessions. As pretests, each participant completed Young's Positive Thinking Questionnaire, the Young's Treatment Questionnaire, the Freestone Intolerance Questionnaire (1994), and the Beck Anxiety Questionnaire (1996) one week before the intervention. The experimental group then received 17 two-hour intervention counseling sessions twice a week, using Young's group therapy procedure.

We retested the control and study groups as a posttest after the therapy sessions and analyzed the findings. The sessions were scheduled to occur once a week while no intervention was provided to the control group. The study's supervisor supervised the group schema therapy method using the group therapy manual, which clinical psychologists confirmed from the Islamic Azad University of Qom, Iran. The sessions were carried out following the directions devised by Farel and Shaw (2014).

The counseling sessions included an introductory session, three sessions of familiarization with the psychiatrist, four sessions of positive thought management, four sessions of positive thinking experimental work, and a final community session.

## Results

Table1. The mean and standard deviation of IU components for each group before and after the test

Post		Pre		N	Group	IU
STD	Mean	STD	Mean			
6.09	97.08	5.03	99.41	12	Control	
6.07	83.25	5.41	98.58	12	Experiment.	

In the pretest step, IU's mean and standard deviation were 98.58 (5.41) for the experimental group and 99.41 (5.03) for the control group, as seen in Table 1. In the post-test, the experimental group's mean and standard deviations were 83.25 (6.07) and the control group one were 97.08 (6.09). As an assumption of the study, the Kolmogorov-Smirnov procedure was used to test the normality of the score distribution.

ANCOVA was used in the inferential statistics section to assess the impact of schema therapy training on IU in patients with anxiety disorders; in this study, sample participants from both the experimental and control groups were used as independent variables, and pretest and IU scores in pretest were used as covariates. The Levin test results were used to evaluate if the study variables' variances were identical. The insignificance of the F-statistics in this examination indicated that the

Data analysis methods were performed at both descriptive and inferential levels. We used SPSS-23 software to Interpret and score while using mean and standard deviations at the descriptive level and ANCOVA at inferential level.

variances of the sample variables were similar. Table 2 displays the results.

Table2. Leven's test for equal variance in investigating IU variables

Variables	F	Df1	Df2	Sig.
IU	0.007	1	22	<b>0.934</b>

The assumption of equal variance was commonly confirmed for IU and its components (P 0.5).

Table3. Uncertainty in the experimental and control groups with pretest control

Resu lt	Total Sq.	D F	Mean Squar es	F	Sig.	Eta
Pre	248.640	1	248.640	9.217	0.006	<b>0.305</b>
Group	1053.678	1	1053.678	39.058	0.001	<b>0.650</b>
Err.	566.526	21	26.977	----	---	---

Table 3 shows a significant variation in the IU component between the experimental and control groups of generalized anxiety disorder patients admitted to the therapy center under pretest control (p 0.5).

## Discussion

The procedure decreased the experimental group's IU as opposed to the control groups. The impact or difference on the IU component equaled 0.29, meaning that the effect of schema therapy training caused 29 percent of the difference in IU's posttest scores (group members).

Schema theorists have criticized cognitive, cognitive-behavioral, and other approaches as not having designed an effective solution for reducing the effects of generalized anxiety disorder and depression. According to this perspective, Schemas are equally profound and ubiquitous schemas or themes composed of memories, feelings, cognitions, and bodily experiences developed throughout infancy and adolescence.

The expanded life schema helped people with cognitive-behavioral problems, including depression and generalized anxiety disorder, not receiving enough help from cognitive or emotional-behavioral therapy. According to Young, schema counseling aims to address the core of the problem by focusing on the deepest stages of perception, and it alleviates symptoms and avoiding relapse of conditions like generalized anxiety and depression. The top-down approach to interpreting behaviors is seen in cognitive-behavioral counseling. For example, in generalized anxiety disorder, the treatment begins with anxiety, and moves on to underlying beliefs, then to schemas; but, in schema therapy, the schema is inverted, and the treatment

begins from the bottom up. Schema therapy enters the schema's most fundamental stage.

Schema therapy is an integrated, new therapeutic model that draws on traditional cognitive-behavioral therapy to provide a protocol for assessing and changing early maladjustment behaviors. It often employs a combination of perceptual, behavioral, interpersonal, attachment, and longitudinal approaches to assess and alter early maladaptive behaviors. Since people with generalized anxiety disorder are often in a state of generalized anxiety and worry, schema therapy stresses the evolutionary origins of psychiatric disorders in infancy and puberty, employs therapeutic strategies, and incorporates maladaptive coping styles. Since their generalized anxiety causes a high level of intolerance to uncertainty and a decline of metacognitive beliefs due to their fear and generalized anxiety, a treatment program incorporating the requisite strategies will help the patient resolve generalized anxiety. They maintain self-control when studying, which decreases IU and raises individual distress metacognitive beliefs.

## Conclusion

The Schema Therapy approach is an applied therapeutic paradigm composed of cognitive, behavioral, emotional, attachment, and experimental methods using four primary cognitive, behavioral, relational, and experimental interventions, besides questioning maladaptive schemas, which are the leading source of unhealthy and irrational thinking that describe these results. Anxious and depressed people have submerged unpleasant feelings,

including frustration at not fulfilling their spontaneous needs and secure attachments to others, where you are still a teen. The behavioral simulation capacities in schema therapy may also account for these effects. This technique assists clients in developing and sustaining therapeutic tasks that eliminate recurring schemas of inefficient and inadequate coping responses. For example, in a counseling partnership, the psychiatrist fails to keep the client's unmet desires by staying within therapeutic limits while adhering to ethical values. The psychiatrist, for example, creates a situation in which the individual that follows the contradictory trend is less obedient, i.e., the individual is subjected to negative remarks regarding the therapist and the therapy procedure. If a client has a broad secretarial schema, we can restrict the time he has with us by limiting the number of interactions he has. Finally, these several and realistic effects of schema therapy contribute to an individual's IU. Because IU is crucial in developing anxiety, and because of recurrent generalized anxiety disorder, clients' concerns and anxieties are common, schema therapy assists them in influencing and reducing their IU.

### Limitation

This research cannot be applied to other countries, age classes, or people with generalized anxiety disorder in various cities since it was performed among people with generalized anxiety disorder in Tehran. The findings cannot be applied to other groups of people, such as homemakers and elders and employees, teachers, and patients. Most of the

questionnaire and fatigue-related answer queries affect the study's precision and generalizability. The researchers fail to control intervening variables, which might affect the results.

To follow the present study, these recommendations were suggested: Replicating the present study in other environments where the clients suffer from a generalized anxiety disorder; Examining the effect and interaction with other factors that affect the schema therapy for the clients with generalized anxiety disorder and comparing the findings using other measuring measures; Replicating this study to other social groups, including homemakers and the elders. Researching to evaluate the efficacy of this method in terms of other disease prevention approaches.

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