

The Affect of Religious Cognitive-Behavior Therapy on Quality of Life Obsessive –Compulsive Disorder

Case Study

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Abstract

Obsessive – compulsive disorder is one the most common psychiatric disorder and strong to treatment that affect on patients quality of life. It is widely supposed that religious is one of the most background in OCD. The aim of this study was evaluated the affect religious cognitive behavior therapy on OCD patients with religious contents. 39 OCD patients were initially recruited. The patients were assed with Y-BOCS and WHO QOL_brief before and after treatment. Norm values were driven from general population to characterized by randomize into 2 sample as well as a recently enlisted psychiatric and control sample, that analyzed by Wilcoxon test and Pierson correlation. The results show significant differences Y_BOCS and WHO QOL scores before and after treatment $P < .001$. On the basis of the above data, it's possible to predict that religious cognitive behavior therapy can be effective to reduce OCD severity symptoms and enhance QOL in obsessive- compulsive disorder.

Keywords: Obsessive Compulsive Disorder (OCD); Religious cognitive Behavioral Therapy (RCBT); quality of life.

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Background

Obsessive-compulsive disorder (OCD) is represented by a various group of symptoms that include intrusive thoughts, rituals, preoccupations, and compulsions. These recurrent obsessions or compulsions cause severe distress to the person. OCD patients attempt to prevent hurt or correct mistakes and most of the time they are superfluous in front of real threat. The obsessions or compulsions are time-consuming and interfere significantly with the person's normal routine, occupational functioning, usual social activities, or relationships. A patient with OCD may have an obsession, a compulsion, or both [1]. The World Health Organization has reported that OCD accounts for 2.5% of global years lost due to disability [2]. Given the high rates of disability and impairment associated with OCD and comorbid conditions, it is

not surprising that quality of life (QoL) will be negatively affected by the presence of OCD. Evidence indicate, OCD patients report general impairment in their functioning and report poor quality of life (QoL) [3,4], also they suffer from disability in several areas, specially in marital, position, emotional and social functioning [5]. more severe OCD symptoms were related to general impairment in functioning [6]. They can develop any thought, feeling, fear or image and there fore can be present on daily expression of art, love, science and religion [7]. The families of OCD patients report considerable burden Couseillness and decrease their social activities, directing their family into increase feeling of isolation and distress [8]. They also report poor QoL in the domains of physical, psychological well being and social relationships [9]. The main goal of this study was the affect of religious cognitive –behavior therapy on quality of OCD patients.

Methodology

39 subject were recruited using randomize clinical trails in Noor hospital, Esfahan, Iran, with principle diagnosis of OCD, according the diagnostic manual of mental disorder - fourth edition [10]. Participant were chosen by special criteria.

- OCD diagnosed based on DSM-IV criteria,
- no history of head trauma, neurological disorder or mental convention,
- no diagnose of schizophrenia psychotic disorder or abusing any drug and depend on any,
- the patients in both group should were been under drug therapy at least for 6 month before CBT. Fulfilled Y_BOCS and WHO QOL before and after treatment.

Data were analyzed by Wilcoxon test and Pearson correlation methods. Demographic traits such as status of marriage, educa-

tion and job were noted. Also letter of permission was requested from patients by ethic medical committee. Data management and analyses was performed by spss 15

Assessment

Yale-Brown Obsessive - Compulsive scale

This rater-administered 10-items scale with specific probes and anchors assesses severity of 5 domains for obsessive and compulsive. These domains include time, distress, interference, resistance, and control. This scale, which established reliability and validity, is widely accepted as the major outcome measure for OCD [11]. The symptom checklist, which is included in the Yale-brown obsessive-compulsive scale (Y-BOCS). Y-BOCS developed by Goodman et al. (1989) to assess the type and severity of obsessive-compulsive symptoms. The questioner, was given on two occasions to the patients once at the beginning of the section therapy (step1), and second time on the end of the section therapy (step2), the scale is administered by an interviewer and is composed of 19 questions, but only the first 10 questions (except for 10, 1b and 6b) are used to calculate the total score. The score for each answer ranges between 0 and 4. The scale also has a symptom Check list for the evaluation of symptom distribution. Patient insight is assessed by question 11.

WHO - QOL - Brief

Used the World Health Organization (WHO)-Quality of Life (QoL) (brief version), to assess global function, quality of life and disability. The WHO-QoL is a 26-item self-administered questionnaire, which emphasizes to the subjective patient's responses rather than their objective life conditions. The psychometric property is comparable to that of the full version of WHO-QoL [12-13].

This scale asses 4 original health domain: mental health, social relationship, environment or condition and life status. $\alpha = 0.92$ in psychiatric patients and $\alpha = 0.86$ in other society [14].

Result

Data shows mean and SD variants wilcoxon, the lowest mean is about QOL in social function domain (before treatment means 8.26 ± 2.30 , after treatment 10.46 ± 2.58). In psychological domain (before treatment 15.67 ± 4.06 , after treatment 20.23 ± 3.63), quality of life scores before treatment 76.33 ± 12.97 , after treat-

ment 97.05 ± 15.36 . Y-BOCS mean score before treatment $27.23 \pm 5 \pm 21$, after treatment 13.44 ± 7.65 .

Discussion

Totally quality of life scores have significant differences before and after treatment P-value < 0.01 before treatment was 76.33 ± 12.97 and after treatment 97.05 ± 15.36 . Between total scores mean an all domain of QOL (general health, psychological, functional, social relationship, life status and condition) has significant differences between before and after treatment P-value < .001. Y-BOCS mean score had significant difference P-value < .001 before treatment $27.23 \pm 5 \pm 21$ and after treatment 13.44 ± 7.65 . Rodrigues in this study report, the mean QOL OCD patients were remarkable low in comparison normal population and delay for treatment Cause to worse. The most striking observation to emerge from the data is that there was negative correlation between Y_BOCS and QOL scorers before treatment ($r = 0.398$ P = .001) and after treatment ($r = .73$, p = 0.001). The wilcoxon test in this study showed significant differences between before and after treatment in quality of life and OCD severity (p-value < .001), also in all domain of quality of life showed significant differences, negative mean rank in before and after treatment Y-BOCS test were higher and this show reduce OCD severity (p-value < .001). Positive rank in quality of life is equal with 18.90 that its show higher quality of life after treatment and other domain of quality of life show improve after treatment, Mental health (N.Mean.R=4.00) (P.Mean.R=19.81). Quality of psychological life N.Mean.R=11.00) (P.Mean.R=16.34). Social relationship (N.Mean.R=6.75) (P.Mean.R=15.79). Environment and statues of life (N.Mean.R=9.12) (P.Mean.R=20.20). These result show, that cognitive behavior therapy based on religious on OCD patients with religious content could be effective on reduce OCD severity and improve quality of life in these patients, because this kind of treatment could be design based on culture and religious patients, and it work on their cognitive and behavior patients. Data in this paper could be confirmation on this claim.

The current study show QOL in OCD patients is low. Assessing the QOL in four domain that contain health, psychological, relationship, social function and condition, that data indicate OCD patients suffer from low relationship, social function and psychological domain, that is correlate with Coran bob and Morise, of course should mention psychological score domain in OCD patients were reasonable to psyzophernia patients. OCD patients have distress about their thoughts, or obsession, because they interpret them as warning of events that are dangerous and

Table 1

Positive mean rank	Negative mean rank	Mean				
		wilcoxon	Differences between before & after	(M±SD)after	(M±SD) before	Variant
19.81	4.00	.000*	7/13±6/61	26/95±4/98	19/82±3/87	Mental health
16.34	11.00	.000*	4.67±3.65	20.33±3.63	15.67±4.04	Quality of psychological life
15.79	6.75	.000*	2.21±2.60	10.46±2.58	8.26±2.30	Social relationship
20.20	9.12	.000*	5.08±4.53	31.23±5.64	26.15±5	Environment and statues of life
18.90	4.50	.000*	20.72±12.26	97.05±15.36	76.23±12.97	Quality of life
18.50	.00	.000*	-13.79±7.01	13.44±7.65	27.23±5.21	OCD Severity

p-value < .001

likely to occur. Cognitive-behavior therapy was designed to help patients identify these automatic unrealistic thoughts and change their interpretation of the meaning of thoughts, resulting in decreased anxiety and compulsion. CBT aims at helping the individual to assemble and experience a new and less threatening model of their experience, thought development, and awareness of how the problems may be worked and then testing out thoughts. Predictors of decreased QoL in obsessive-compulsive disorder (OCD) patients and to explore which aspects of QoL are most affected in OCD. In line with prior research, it was expected that low QoL in OCD patients would be most pronounced for the emotional and social aspects of the construct. Studies looking specifically at QoL in OCD have shown that increases in OCD symptom severity and number of symptoms correlate with greater QoL impairment across all domains [15-3]. Interestingly, some studies have found that QoL impairment is more highly associated with the severity or number of obsessions [15], whereas others have found QoL impairment to be more highly associated with the severity or number of compulsions [3]. Study results have shown that the Y-BOCS compulsion subscale has no relationship to QoL impairment whereas the Y-BOCS obsession subscale contributes significantly to the relationship between QoL impairment in social and occupational functioning and OCD [15]. A study in India compared family burden across various anxiety disorders; study reported degree of burden was essentially comparable across all the groups [16]. We hypothesized that patients suffering from severe OCD may have a comparable level of global functioning, family burden, QoL and disability with patients suffering from schizophrenia. Knowing that resistance to symptoms plays a protective role in social functioning QoL is important to clinical practice; CBT can be tailored to improve social functioning QoL by incorporating homeworks involving increased social interactions. Motivational interviewing may be useful in enhancing exposure and response prevention techniques by encouraging resistance to symptoms during anxiety-provoking situations [17-18]. Ultimately, treatment for OCD must focus on both symptom reduction through the use of psychotherapeutic techniques and/or psychopharmacology (in severe cases; Foa, 2010) and on the improvement of QoL and daily functioning through psychosocial rehabilitation and the maintenance of symptom attenuation or eradication [19].

Psychopharmacological therapy with various SRIs and psychotherapeutic treatments utilizing CBT are widely used for the treatment of OCD [20]. Attenuation of obsessive-compulsive symptoms with these treatments is often directly related to improvements in various domains of QoL [21-22]. However, despite the efficacy of both psychopharmacology and CBT in attenuating obsessive-compulsive symptoms and improving QoL, there is more work that needs to be done to attain a more complete QoL. Treatments specifically aimed at improving daily functioning for the long-term must be incorporated into psychotherapy with the goal of significantly enhancing QoL [23]. A two-tiered approach, outlined by Bystritsky 2001 suggests that initial treatments must aim to reduce obsessive-compulsive symptoms as they impede QoL and hinder the person's ability to excel in psychosocial functioning. Subsequently, this treatment must be followed by psychosocial rehabilitation which strives to increase.

QoL by improving social functioning, enhancing coping techniques and aiding with practical goals such as finding appropriate employment. The mediating role of interference of symptoms and resistance to symptoms helps better our understanding of

what exactly impacts QoL in persons with OCD. In addition to including psychosocial rehabilitation, psychotherapeutic practice for the treatment of OCD must carefully incorporate CBT techniques (including psych education, cognitive restructuring and exposure and response prevention) that target the reduction of interference and increase efforts to resist symptoms. Knowing that resistance to symptoms plays a protective role in social functioning QoL is important to clinical practice; CBT can be tailored to improve social functioning QoL by incorporating homeworks involving increased social interactions. Motivational interviewing may be useful in enhancing exposure and response prevention techniques. By encouraging resistance to symptoms during anxiety-provoking situations [17].

The conclusion of this study showed well designed treatment program concerning the religious cognitive-behavior therapy techniques can affect and improve quality of life in OCD patients. Some investigations that could corroborate our findings are: Moritz et al (2005), in a study found, Correlations with QoL were most pronounced for depression severity and number of OCD symptoms, QoL was significantly improved in therapy responders relative to non-responders. Eisen, et al (2006), found Quality of life significantly for all domains evaluated, impaired inverse with published community norms with large effect sizes. The correlations (r) between all domain QoL measures and YBOCS score were significant, ranging from 0.40 to 0.77. Severity of obsessions and depressive symptoms, as well as marital status, was significant predictors to QoL impairment. These findings show that all aspects of QoL are significantly affected by individuals with OCD and are associated with OCD severity (particularly obsessive severity) and depression severity. Exploratory results suggest that QoL and psychosocial functioning significantly affected on YBOCS scores higher than 20. This score might be considerable as a threshold criteria for OCD in Diagnostic and Statistical Manual of Mental Disorders. Eric, et al (2011), the result shows, symptom severity on both the Y-BOCS and the CGI-Severity was negatively correlated with emotional health, social functioning and general health. But there was no significant relationship between obsessive-compulsive symptom severity and physical health QoL. There are number of limitations in this study, first, the sample contained only females and there were no men in this study, which limits generalizability, second, didn't have follow-up test for more validity, and the end, this study done in OCD Clinic in Noor hospital and we can't generalize to other OCD patients. To sum up, our results show that religious cognitive-behavior therapy can play a considerable role in severity of OCD symptoms among religious OCD patients. These training programs should be a considerable more as an important component of a comprehensive treatment program for religious OCD patients.

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