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Comparison of the effectiveness of cognitive-behavioral therapy and acceptance and commitment therapy in improving death-related disorders in male patients with liver cancer

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A B S T R A C T

Cancer can cause many psychological problems for patients and it is necessary to find effective ways to help them. Therefore, this study was conducted to compare the effectiveness of cognitive-behavioral therapy and acceptance and commitment therapy in improving death-related disorders in male patients with liver cancer. The research design was quasi-experimental and pre-test-post-test with two experimental groups and a control group. The statistical population included all men with liver cancer who referred to hospitals in Tehran in 1398. The sample consisted of 45 patients who were selected by purposive sampling and randomly assigned to three groups: cognitive-behavioral, acceptance and commitment therapy, and control group. The Death Anxiety, Death Depression, and Personal Perspectives scales were used to collect data. Data were analyzed using Mankova and Bonferroni post hoc test and SPSS-22 software. The results showed that between the cognitive-behavioral group and acceptance and commitment treatment with the control group in the post-test phase of death anxiety (F = 15.44 and p ‹0.05) and death depression (F = 21.79 and 0.05› P) .There is a significant difference. The results also showed that there is a significant difference between cognitive-behavioral group and acceptance and commitment treatment in anxiety and depression of death (p ‹0.05) and is more effective in acceptance and commitment treatment. According to the findings of this study, cognitive-behavioral therapy and acceptance and commitment therapy can be used as an effective method to improve death-related disorders in patients with liver cancer and in this regard acceptance and commitment therapy can be more effective.

Keywords: Cognitive-Behavioral Therapy, Acceptance and Commitment Therapy, Death Anxiety, Death Depression.

INTRODUCTION

Cancer is one of the most serious diseases in the world and the third leading cause of death in the world; as 18.4% of deaths in the world are due to cancer. Unfortunately, the growth of cancer in the world is accelerating and about 18.1 million people are diagnosed with cancer annually(Bray et al., 2018; Ferlay et al., 2019). Cancer is caused by the unlimited proliferation of cells in the body and there are up to 200 types of cancer(Horney et al., 2011). Breast cancer is the most common cancer among women and liver cancer is the most common cancer among men and is the leading cause of cancer mortality(Bray et al., 2018). In Iran, unfortunately, breast

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cancer is more common in women and liver cancer in men, and one in four Iranians develops one type of cancer before the age of 75 (Mohebbi et al., 2017).

Chronic cancer causes the body to weaken and increase psychological problems by weakening the body and also due to its bad mentality among people(Gregurek, Braš, Đorđević, Ratković, & Brajković, 2010). Unfortunately, people consider cancer to be a kind of end of life, and patients, after being diagnosed with the disease, find themselves closer to death, and therefore suffer from death-related disorders(Tang, Chiou, Lin, Wang, & Liand, 2011); In other words, patients suffer from anxiety and depression. Death anxiety is a persistent, irrational, and morbid fear of death or dying. This concept also refers to the fear of death and high fear of the dead(Gonen et al., 2012). Death depression also refers to depressive attitudes about death and non-existence(Templer, Lavoie, Chalgujian, & Thomas-Dobson, 1990). Research has shown that cancer patients have a high mortality rate. The prevalence of anxiety in the cancer group was 17.9% and in the healthy group was 13.9% (Mitchell, Ferguson, Gill, Paul, & Symonds, 2013; Tan, Beck, Li, Lim, & Krishna, 2014). Depression and death anxiety in cancer patients cause many problems in them and can reduce their health and quality of life(Khezri, Bahreyni, Ravanipour, & Mirzaee, 2015; Sherman, Norman, & McSherry, 2010).

It is very difficult for patients to know death is imminent and it causes them a lot of confusion; But the degree of tolerance and resistance to these difficulties varies for patients. If patients can increase their tolerance and strength, they will be less disturbed(Aghajani, Rahbar, & Moghtader, 2018; Kobasa, Maddi, & Zola, 1983). Hardship is a combination of beliefs about oneself and the world that consists of three components: commitment, control, and struggle, or challenge, and high rigidity is a sign of a healthy personality. Tough people have the power to control life events and instead of avoiding problems, they see them as opportunities for progress. In other words, difficult people not only do not consider themselves victims of change, but also see themselves as the determinants of the results of change(Maddi, 2015).

One of the interventions that has a good history in improving the psychological state of patients is cognitive-behavioral therapy (Cognitive-Behavioral Therapy) (Greer, Park, Prigerson, & Safren, 2010). Cognitive-behavioral therapy as a purposeful approach, focusing on cognitive reconstruction and change of behaviors, emphasizes on abandoning irrational behavior and dysfunctional thoughts and instead of replacing new and effective behaviors and thoughts. The basic premise of therapy is that the learning process plays an important role in creating and sustaining behaviors and habits that can de-learn learned behaviors. Cognitive-behavioral therapy, based on functional analysis and skills training, helps people to choose a wiser and healthier life(Dobson & Dozois, 2010).

It is assumed that the psychological problems that cancer patients experience are due to their dysfunctional and erroneous thoughts about the disease, and a cognitive-behavioral approach can correct such thoughts. Meta-analysis by Hoffman et al. Shows that cognitive-behavioral therapy can improve many psychological problems(Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). Tatrow and Montgomery (2006), have also pointed out in their research that cognitive-behavioral therapy can be effective in improving the disorders and pain of cancer patients. Based on his meta-analysis, Tolin (2010), states that cognitive-behavioral therapy,

contrary to popular belief, does not precede all therapies and should be the first choice of therapists for anxiety and depression.

In addition to cognitive-behavioral therapy, which is one of the therapies of modernism, there are therapies that are somewhat unusual but growing. These therapies, which are from the postmodern approach, can be effective in improving psychological problems(Lopes et al., 2014). Postmodern theorists criticize reason and objective reality and are skeptical of the foundations of modernism(Rastgari & Moradi, 2014). Narrative therapy is one of the postmodern therapies that may be effective in improving the problems of cancer patients(Sajadian, Dokanei Fard, & Behboodi, 2016). Narrative therapy sees people as experts in their lives and believes that people have skills, beliefs and values that can reduce the effects of problems in their lives. In fact, narrative therapy believes that people should rewrite their stories(Morgan, 2000). The problem is that the story has to be rewritten through therapeutic dialogue. The treatment begins with the deconstruction of the power of the individual's story and moves towards the construction of a new meaning(Rastgari & Moradi, 2014). In this method of treatment, the problem is externalized and the patient believes that he can change the problem and the environment and not consider himself a victim of the environment(Brown & Augusta-Scott, 2006). In this regard, research shows that narrative therapy can be used as an effective treatment for some psychological problems(Vromans & Schweitzer, 2011).

Given the above, cancer patients due to their illness feel disturbed by death and it is necessary to strengthen their psychological strength and have a strong spirit against the disease. Therefore, psychological interventions are important and it is necessary to choose and use the most effective types of psychological interventions; therefore, this study was performed to compare the effectiveness of cognitive-behavioral therapy and narrative therapy in improving death-related disorders in male patients with liver cancer.

METHODOLOGY

In this study, a quasi-experimental research design of pretest-posttest type with two experimental groups (cognitive-behavioral therapy group; narrative therapy group) and a control group were used. The statistical population of the study included all men with liver cancer who referred to hospitals in Tehran in 1398. Since it was not possible to accurately estimate the number of populations, the selection of large samples in experimental designs makes it impossible to accurately control the intervention variables and it is stated that in experimental studies the volume of each group can be at least 15 people(Delavar, 2015). Inclusion criteria were selected by purposive sampling method and 15 people in the cognitive-behavioral therapy group, 15 people in the narrative therapy group and 15 people in the control group were randomly replaced. Inclusion criteria included diagnosis of liver cancer, having at least 6 months of disease history, being in the age range of 30 to 45 years, no psychiatric illness and also the use of psychiatric pills in patients based on psychological interview and consent to attend treatment. . Exclusion criteria included absenteeism for more than one session, use of other psychotherapy and counseling services during the sessions, as well as dissatisfaction and willingness of the subject to continue participating in the sessions and, consequently, the need to exclude the subject from the researcher. It is noteworthy that fortunately there was no

decline in the groups studied. In order to observe the ethical aspects, the subjects were told that this research is in fact to help and provide them with practical information, their information is kept secret and if they do not want to, they cannot participate in this research, which was finally obtained orally. The control group did not receive any treatment.

Cognitive-behavioral therapy group, the training course based on the protocol of Mosalanejad, Koolaee, and Jamali (2012), and narrative therapy group, the training course based on White, White, Wijaya, and Epston (1990), in 8 sessions of 1 hour and at the discretion of psychology professors in one session in They received the week. The summary of the sessions is as follows:

Summary of cognitive-behavioral therapy, Session 1: Introducing and getting acquainted with the patient, performing pre-test, determining the goals of treatment, mentioning the rules of the session, introducing cognitive-behavioral therapy, examining cancer and related problems, relaxation training. Session 2: Writing down negative and inefficient thoughts and beliefs, using relaxation techniques, presenting homework. Session 3: Feedback from the previous session and homework review, training of vertical downward arrow technique to identify central schemas and beliefs, use of relaxation technique. Session 4: Preparing the main list of beliefs, testing the beliefs of the clients with objective analysis (judgment and judgment), using the technique of calming. Session 5: Using different methods of cognitive analysis and encouraging clients to re-evaluate beliefs, using relaxation techniques. Session 6: Opposing automatic thoughts, stopping thinking, using relaxation techniques. Session 7: Emphasis on Cognition to Emotions, Cognition and Emotions Related to Cancer, Use of Relaxation Technique. Session 8: Review of conditioning, antecedents and postpositions, questions and answers, receiving feedback, post-test and saying goodbye.

Narrative therapy summary. Session 1: Introducing and getting acquainted with the patient, performing a pre-test, determining the goals of treatment, mentioning the rules of the session, examining cancer and related problems, introducing narrative therapy, work samples and descriptions of problematic stories. Session 2: Objectification and externalization of the problem, naming the problem, identifying the problematic words and starting metaphorization. Session 3: Continuation of metaphorical construction, study of problematic metaphors and their relation to life narrative and taking a position on the problem, beginning of deconstruction. Session 4: Destruction phase: deconstruction of the problem by life exceptions, narrative analysis, attitude towards the problem and the interaction of the person and the problem. Session 5: Reconstruction phase: new metaphors, mental representations of life situations with new metaphors, creation of reality by the individual and the beginning of narration. Session 6: Enriching the New Story Using Unique Strategies, Examining the Story and Its Meaning to the Future. Session 7: Consolidation Phase: Living in a New Story, Answering Questions, and Rewriting Past Stories. Session 8: Examining the meaning of life, external documents, enriching and encouraging the person to continue the story, questions and answers, receiving feedback, post-test and saying goodbye.

Death Anxiety Scale (DAS): This questionnaire was developed by Templer (1970), and consists of 15 items that measure the subject's attitude toward death. Subjects mark their answers to each question as yes or no. The answer yes indicates the presence of anxiety in the

person. Thus, scores on this scale range from zero to 15, and high scores indicate anxiety. Reliability and validity of this scale have been reported in the country as a composition reliability coefficient of 0.60 and internal consistency coefficient of 0.73. Also, two tests of death anxiety scale and overt anxiety scale were used to evaluate the validity of the scale. Cronbach's alpha coefficient of this scale in this study was 0.81.

Death Depression Scale (DDS): This questionnaire was developed by Templer et al. (1990), And consists of 17 items that measure depressive attitudes toward death. This questionnaire has two forms, two-choice and Likert, the Likert form of which has been used. The subject determines his / her answer in a five-point Likert scale from completely agree (score 4) to completely opposite (score zero), whose scores vary from zero to 68, and higher scores mean more depression (7). In internal standardization, the death anxiety test was used to check the validity of the scale, which is at an acceptable level with 0.73. In order to evaluate the reliability of this scale, the retest method and Cronbach's alpha coefficient were used, which were 0.92 and 0.90, respectively, with good reliability(Mohammadzadeh, Rezaei, & AGHAZADEH, 2016). Cronbach's alpha coefficient of this scale in this study was 0.87.

To analyze the research data, descriptive mean index and standard deviation and at the inferential level, in order to control the effect of the pretest, multivariate analysis of covariance (MANCOVA) and Bonferroni post hoc test were used. Data were also analyzed by SPSS software.

RESULTS

In the descriptive part of the research samples, the mean and standard deviation of age were 37.46 ±4.37 in the cognitive-behavioral experimental group, 39.20±4.12 in the narrative therapy group and 38.86± 3.85 in the control group.

Table 1: Results of descriptive indicators of research variables by group

Variable	group	pre-exam		Post-test	
		Average	Sd	Average	Sd
death anxiety	Cognitive-behavioral	10.46	1.80	8.66	1.67
	Narrative Therapy	11.86	2.33	6.73	2.01
	Control	11.06	1.83	10.53	1.64
Death Depression	Cognitive-behavioral	45.53	6.24	42.26	6.19
	Narrative Therapy	47.13	5.70	36.03	6.06
	Control	49.26	5.49	50.93	6.19

The table above shows the mean and standard deviation of the variables of death-related disorders (anxiety and death depression) in the two experimental groups of cognitive-behavioral therapy and narrative therapy and the control group in the pre-test and post-test stages.

In examining the assumptions of covariance analysis, the obtained results indicated that the assumptions of covariance were established, so the results of the covariance test were reported, the results of which are as follows:

Table 2. Results of covariance test to evaluate the effects of intergroup on death-related disorders

Source	Variable	SM	Df	MS	F	P	Eta
group	death anxiety	104.27	2	52.13	15.44	0.001	0.442
	Death Depression	1711.46	2	855.73	21.79	0.001	0.527
	Psychological stubbornness	599.77	2	299.88	4.63	0.016	0.192
Error	death anxiety	131.65	39	3.37			
	Death Depression	1531.24	39	39.26			

Based on the obtained results, it can be seen that F-statistic with a value of 15.44 is significant for death anxiety and 21.79 for death depression (P <0.05). This result shows that there is a significant difference between the groups under study in death-related disorders. In order to compare the pairs of groups, Bonferroni post hoc test was used, the results of which are as follows:

Table 3. Results of Bonferroni post hoc test to compare pairs of groups in the post-test stage of death-related disorders

Source	Variable	SM	Df	MS	F	P	Eta
group	death anxiety	104.27	2	52.13	15.44	0.001	0.442
	Death Depression	1711.46	2	855.73	21.79	0.001	0.527
	Psychological stubbornness	599.77	2	299.88	4.63	0.016	0.192
Error	death anxiety	131.65	39	3.37			
	Death Depression	1531.24	39	39.26			

The table above shows the results of Bonferroni post hoc test for pairwise comparison of groups. Based on the obtained results, there is a significant difference between the cognitive-behavioral experimental groups and narrative therapy with the control group in death-related disorders (P <0.05). There is also a significant difference between the cognitive-behavioral group and the narrative therapy group in death-related disorders (P <0.05).

CONCLUSION

The aim of this study was to compare the effectiveness of cognitive-behavioral therapy and narrative therapy in improving death-related disorders in male patients with liver cancer. In the study of the effect of cognitive-behavioral therapy, the obtained results showed that cognitive-behavioral therapy was effective and was able to reduce anxiety and depression in patients. This finding is consistent with some research. In their study, Greer et al. (2010), Showed that cognitive-behavioral therapy can reduce anxiety in patients with advanced cancer. van de Wal, Servaes, Berry, Thewes, and Prins (2018), Also showed that cancer recurrence can cause disorders in patients and cognitive-behavioral therapy can be effective in improving these disorders. Hofmann et al. (2012), meta-analysis showed that cognitive-behavioral therapy can not only be effective in treating a wide range of clinical problems and disorders but can also lead to the development of positive traits.

Cancer patients experience death-related turmoil because of their beliefs about cancer and because they consider cancer to be a very frightening and deadly disease, and they start ruminating about death(Tang et al., 2011). Cognitive-behavioral therapy targets these thoughts

and constant rumination and teaches patients how to deal with these thoughts. First, when patients are disturbed, the relaxation techniques at the heart of cognitive-behavioral therapy allow patients to remain calm and then be able to identify and deal with disturbing thoughts(Dobson & Dozois, 2010). Cognitive-behavioral therapy reduces depression and death-related anxiety in cancer patients by providing skills such as coping with death, cognitive assessment of dysfunctional thoughts, increased enjoyment of life, and a health-oriented lifestyle(Furer & Walker, 2008).

Cognitive-behavioral therapy teaches patients not to find themselves trapped by cancer and thus to be able to endure the problems associated with it and be strong in fighting it. Explaining this result, it can be said that cognitive-behavioral therapy taught cancer patients to avoid exaggerated and catastrophic thoughts about cancer and replace it with positive thoughts. Fighting and challenging distorted beliefs causes them to cultivate a tenacious spirit and become more determined to heal and challenge disease.

In the study of the effects of narrative therapy, the obtained results showed that narrative therapy has also been effective in improving anxiety and depression in patients with liver cancer. In their research, Lopes et al. (2014), and Rastgari and Moradi (2014), showed that narrative therapy can improve depressive disorders in patients. In a study, Rodríguez Vega, Bayón Pérez, PalaoTarrero, and Fernández Liria (2014), Showed that narrative therapy can improve the disturbances of cancer patients.

Narrative therapy taught the patients in the study to rewrite their life narratives in a different way(Morgan, 2000). Instead of telling the story of a depressed, anxious, troubled, miserable, and tired person, they learned to change their story to a hopeful, combative, energetic, and happy person. Such a change of narrative enabled them to get rid of the turmoil associated with death and to be able to fight the disease more vigorously. Sajadian et al. (2016), Showed that narrative therapy can improve the physical and mental health of cancer patients by changing their narratives.

Narrative therapy teaches patients to take responsibility for their behaviors and increases their motivation for action and effort(Sajadian et al., 2016). This treatment teaches patients that the control and responsibility of their lives is in their own hands and the disease cannot take them, but it is the patients themselves who take the disease. In fact, they learned that the disease could be under their control and that they could overcome the problems of the disease stubbornly(Brown & Augusta-Scott, 2006). They learned to live in the moment and not be afraid of the future. Narrative therapy teaches people that by gaining self-knowledge and introspection, they move toward change, which can increase their stubbornness and reduce death-related turmoil(Changizi & Panahali, 2016).

Another result of this study was that there is a difference between cognitive-behavioral therapy and narrative therapy in reducing death-related disorders and narrative therapy is more effective in this regard. This finding contradicts Tolin (2010), claim that cognitive-behavioral therapy may be the first choice for depression and anxiety. Explaining this conclusion, it can be said that this difference may have been made because this study was on depression and anxiety related to death. However, it seems that changing narratives rather than changing thoughts can improve the turmoil associated with death. In fact, due to the available evidence, cancer is a

nasty disease that causes patients to experience death-related thoughts and disturbances that are somewhat normal and correct(Bray et al., 2018; Gregurek et al., 2010), and this reduces the ground for cognitive-behavioral interventions; But on the other hand, in the treatment process, mainly men with cancer revealed their narratives and provided the ground for more narrative therapy interventions by expressing narratives such as miserable, miserable and trapped. Both treatments were equally effective in improving cognitive toughness, indicating that both therapies can raise patients' morale equally. However, this study, like other studies, has its limitations; Despite efforts to homogenize groups and control the effects of disturbing variables, the biases that may exist in response to research tools, as well as the amount and type of medication used by patients, should be used with caution in generalizing the results.

In general, the results of this study showed that both cognitive-behavioral therapy and narrative therapy are effective in improving death-related disorders; But narrative therapy is better at curing death-related disorders than cognitive-behavioral therapy. The results of this study can pave the way for interventions to help patients with liver cancer. It is suggested that physicians and psychotherapists use cognitive-behavioral therapy and narrative therapy interventions to improve the disturbances of cancer patients in order to increase the health of these patients.

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