Comparing the Effect of Cognitive-Behavioral (CBT) Religious- Based Therapy, and Treatment-Based Admission and Commitment (ACT) on Resilience, Inefficient Attitude, and Coping Styles of Women with MS in Tehran

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Abstract:
The present study compares the effectiveness of cognitive-behavioral (CBT) religious- based therapy, and treatment-based admission and commitment (ACT) on resilience, inefficient attitude, and coping styles of women with MS in Tehran. The research methodology was an experimental research method with pre-test and post-test designs. The statistical population included all women referring to Kahrizak outpatient department with MS, low resilience, and ineffective coping styles in 2017. The statistical sample consisted of two experimental groups (15 people each) and a control group (15 people) selected by targeted sampling and two experimental groups received cognitive-behavioral religious-based therapy and treatment-based admission and commitment. The control group did not receive any intervention. Research instruments included the Lazarus and Fleckmann coping styles scale, and the Connor and Davidson resilience scale. The results of multivariate analysis of covariance (MANCOVA) show a significant effect of both treatments on increasing resilience (P = 0.0001 and F = 20.61) and problem-oriented coping styles (P = 0.0001 and F=55/571) in women with MS. According to the results, cognitive-behavioral religious-based therapy (CBT) was more effective than treatment-based admission and commitment (ACT) on resilience and problem-oriented coping styles. But no difference was seen in relation to the emotion-oriented coping style variable.
Keywords: Cognitive-Behavioral Religious-Based Therapy (CBT), Treatment-Based Admission and Commitment Therapy (ACT), Resilience, Problem-Oriented and Emotion-Oriented Coping Styles.

1. Introduction:

The present study compares the cognitive-behavioral (CBT) religious-based therapy, and treatment-based admission and commitment (ACT) on resilience, and coping styles of women with MS in Iran. The first treatment used was called cognitive-behavioral religious-based therapy. Cognitive-behavioral religious-based therapy is in accordance with the protocol of cognitive-behavioral therapy based on the teachings of Islam. In other words, in cognitive-behavioral religious-based therapy, in addition to cognitive therapy that its goal is to change a person's misconceptions and turn negative automatic thoughts into logical thoughts, during the sessions, individuals are helped to strengthen their spiritual beliefs and religious beliefs and to focus on the order of existence, the existence of the absolute power of God and divine mercy.

Also, citing verses of the Holy Quran and hadiths and their effect on healing is emphasized in this therapeutic approach.

Therefore, in general, the cognitive-behavioral religious-based therapy protocol is based on Beck's cognitive-behavioral therapy protocol and the use of hadiths and verses of the Holy Quran. Combining spiritual and religious approaches with different methods of psychotherapy can improve the effectiveness of these methods. Studies show the effectiveness of cognitive-behavioral therapy with religious and spirituality on improving coping styles in generalized anxiety disorder (Pukertet al, 2009), anxiety disorder in the elderly people (Barrera et al, 2012), and reducing symptoms and adjustment in schizophrenia patients (Weisman et al., 2010). Livneh et al. (2006) showed that spirituality plays an important role in adapting to stressful conditions caused by chronic diseases. The second treatment used in the present study is acceptance and commitment therapy. Acceptance and commitment therapy is a behavioral therapy that uses mindfulness, acceptance, and cognitive failure skills to increase psychological flexibility. Act changes the connection between problematic thoughts and feelings so that people do not perceive them as symptoms and even learn to perceive them as harmless (even if it is upsetting and unpleasant) (Hayes, 2006). Act is a context-oriented approach that challenges clients to accept their thoughts and feelings and commit to the necessary changes. Core of change in act is a change in internal and external verbal behaviors. Act believes that engaging with emotions makes them worse (Hayes, 2006). It does not mean that we should ask the authorities to accept any situation (such as abusive relationships), but, in any case, some conditions must be accepted eventually, because we can do practically nothing else. For example, if past memories and events have disturbed the client, they must accept that these events occurred and must accept them and change their feelings about the events. The first step in treatment is to identify the changeable and unchangeable domains. Past traumas are examples of immutable cases that it is better to accept them (Flecher, 2005). Researches have shown that treatment based admission and commitment have been effective in various areas such as increasing resilience (Mahishka, 2010; Amanda, 2015); Depression (Kanter et al, 2006); Psychoses (Bach and Hayes, 2002); drug abuse (Gifford et al, 2004) and pain relief (Keogh et al, 2005). In addition, treatment based admission and commitment has found a good place in improving psychiatric problems caused by physical illnesses (A-tjak et al, 2015). In addition, over the past few decades, the role of spirituality and religious as a treatment method has attracted the attention of psychologists and mental health professionals (Aten and Vasshang, 2007; Aten and Worthington, 2009; Kezdy, 2010). The first dependent variable on which the effect of the two treatments was examined was resilience. Resilience is a personality trait that can affect the course of MS. Resilience is how a person successfully copes with life's challenges when dealing with stress or injury; Resilience theory is based on the strong aspects of coping with injuries and the individual's ability to cope with danger and problems (Meyers, 2011). Improving resilience leads to the growth of individuals in acquiring their own thinking and better management skills and knowledge. Friedman defines resilience as the ability to overcome difficulties and overcome living conditions (Friedman, 2013). Due to the emphasis of experts on learning of various resilience skills and also considering that teaching positive psychological interventions, in addition to increasing happiness, causes more satisfaction in life. It increases meaning in life, leads to optimistic thinking and reduces depression. It can be found that counseling and psychological interventions can alleviate the symptoms of the disease, slow its progression, maintain and enhance a person's abilities, and allow the patient to follow a normal course in life. The second dependent variable in this study is coping styles

which is divided into two types of problem-oriented coping style and emotion-oriented coping style.

The role of coping styles and which coping styles patients use the most and which of these strategies will be most effective are important, too. Perceived social support, coping strategies and resilience of patients with inflammatory bowel disease can affect their mental and physical health (Ziaian, Anstiss, Georgia, Baghurst & Sawyer, 2012).

Health psychology gives great importance to coping style in physical and mental health and considers it as the most extensive subject of study in contemporary psychology and one of the most important psychological and social factors that are the link between stress and illness. Folkman and Lazaros consider coping styles as a complex process that changes according to one's assessments of the stressful situation and its pressures, and involves active cognitive-behavioral efforts (Folkman and Lazaros, 1998). Researchers believe that most people prefer to use special coping styles in stressful situations, which in fact, the sum of these strategies, forms a person's coping styles. Coping styles are a set of cognitive and behavioral efforts that are used to interpret and correct a stressful situation and leads to a reduction in the resulting suffering. Based on the model of Lazarus and Folkman, Higgins and Andler have divided coping styles into three types: problem-oriented, emotion-oriented, and avoidance-oriented. Problem-oriented coping style refers to behaviors and cognitions that aim to change a situation or a stressful variable. This coping style has two components: The first component is preparation, in which information is searched and planned, and the second component is called action; Problem solving and active confrontation take place and include strategies such as collecting, organizing and interpreting information. Emotional coping styles include behaviors and cognitions in which the goal is to change the individual's response to the stressful factor. Its strategies include self-engagement, daydreaming, and focusing on the emotional dimension. In the style of avoidance confrontation, the person escapes from the stressful issue and seeks emotional support and delegating the coping responsibility to others. Some classifications have conceptualized two styles of emotional and avoidance coping in one category and consider the avoidance style as an emotional coping style (Higgins and Andler, 2005). Researches have shown that non-pharmacological treats such as rehabilitation are very useful in treating anxiety and stress (Kloss and Lisman, 2002). Complementary therapies have many benefits for patients with MS disease that are widely used by these patients (Hansen, 2001). Based on this, we decided to address the effect of two complementary therapies, namely, religious-based cognitive-behavioral therapy and acceptance and commitment-based therapy on resilience and coping styles of patients with MS disease. Many treatments promote resilience. Considering the background of both treatments regarding the positive effects on resilience and coping styles, no research has been done so far that has compared both treatments and their effectiveness simultaneously in patients with MS disease. Since we live in a society that is closely related to religious in terms of culture and customs, it is important to conduct research that measures the impact of combination therapies with religious beliefs on different variables. Based on this, we decided to compare the two cognitive-behavioral religious-based therapies, and treatment-based admission and commitment to resilience and coping styles of women with MS.

2. Research Methodology:

The present study was an experiment with a pre-test and post-test design. The statistical population included all women with MS disease who referred to the outpatient department of Kahrizak Center in 2017. Sampling was done by purposive method and the subjects were

randomly divided into groups. Entry criteria were based on having a score of a lower standard deviation in the resilience questionnaire (Cooner and Davidson, 2003).

There was a lower standard deviation in the Lazarus Coping Styles Questionnaire for problem-oriented coping styles, and a higher standard deviation in the Lazarus coping styles questionnaire for emotion-focused coping styles. Exclusion criteria included two consecutive absences, non-cooperation, and worsening of the disease. Subjects were divided into three groups: cognitive-behavioral religious-based therapy (n = 15), treatment-based admission and commitment (n = 15), and control group (n = 15). Then, experimental group (a) received 10 sessions of cognitive-behavioral religious-based psychotherapy 2 sessions of 45 minutes per week, and experimental group (b) received 8 sessions of psychotherapy based on admission and commitment a session of 90 minutes per week. , But the control group did not receive any intervention. Individuals in the groups are matched in other areas, including taking medications for MS. Patients were given information about the type of treatment, their attendance in session, the number and timing of the sessions. Confidentiality was explained as the main principle in the treatment, and finally the clients who expressed their consent to participate in the groups were selected. Lazarus and Fleckmann Coping Strategies Scale (1985): The Lazarus Strategies Questionnaire, based on Lazarus and Fleckmann's list of coping strategies in 1980, was revised in 1985. Coping strategies are a set of cognitive and behavioral efforts that are used to interpret and correct a stressful situation and lead to a reduction in suffering. It also evaluates the wide range of thoughts and actions that people use when faced with internal or external stressful situations.

Validity: Cronbach's alpha coefficient ranges from 61% to 79%. Lazarus has the highest score of 100 in coping strategies.

Connor and Davidson Resilience Questionnaire (Cooner and Davidson, 2003): This scale was developed by Connor and Davidson (2003), reviewing the research resources in the field of resilience from 1979 to 1997. The reliability of this scale was obtained using Cronbach's alpha coefficient, which was equal to 89%. Its validity was calculated by factor analysis. The results showed that except for three questions, the coefficients were between 14% and 64%. 21 items were used in the final analysis.

3. Results:

Table 1: Mean and standard deviation of resilience, problem-oriented and emotion-oriented coping style in the intervention groups of cognitive-behavioral religious-based therapy (group 1), treatment-based admission and commitment (group 2) and control (group 3) in stages Pre-test and post-test

The dependent variable	Groups	Mean		Standard deviation	
		Pre-test	Post-test	Pre-test	Post-test
Resilience	Group (1)	40/07	63/93	6/27	5/7
	Group (2)	40/67	59/73	6/83	5/03
	Group (3)	42/4	42/67	4/94	4/287
Problem-oriented coping style	Group (1)	36/93	45/26	7/13	4/45
	Group (2)	42/86	49/53	9/18	5/71
	Group (3)	39/86	39/13	5/43	4/83
Emotion-oriented coping style	Group (1)	44/33	39/4	3/65	2/13
	Group (2)	45/2	41/73	7/14	6/27
	Group (3)				

	44/4	43/46	3/66	4/06

Table 1 shows the mean and standard deviation in pre-test and post-test of resilience and problem-oriented and emotion-oriented coping styles. As can be seen, after performing cognitive-behavioral religious-based therapy and treatment-based admission and commitment, resilience and problem-oriented coping styles scores increased in the post-test of both experimental groups, but scores of emotion-focused coping styles increased. Both experimental groups decreased slightly in the post-test. Significance of mean difference in pre-test and post-test will be investigated using (MANCOVA).

Assessment of covariance analysis assumptions: the Levene test of variance equality was used to examine the homogeneity of variances. According to the results, the significance level of tests related to all variables is more than (0.05). This means that the variance of the experimental and control groups in all dependent variables is not statistically significant. Therefore, the assumption of homogeneity of variances is established and the use of analysis of covariance is allowed. In addition, in order to investigate the similarity of variance and covariance matrices in this study, the box test was used, which considering that the significance of the Box s M test is equal to 0.374. Therefore, the Box s M test is not significant at the level of 0.95 (P <0.05). It can be concluded that the covariance matrix is homogeneous and the assumption is valid. The results also show the homogeneity of the regression coefficient. It is not significant because the multivariate statistic is at the confidence level (P <0.05). Therefore, it can be claimed that the assumption of homogeneity of regression coefficients is established; and analysis of covariance method can be used to analyze the data.

Table 2 - Results of multivariate analysis of covariance related to the differences between the three treatment groups

Test Name	Amount	F Hypothesis	Df Hypothesis	Df Error	Significance Level
Pillai s Test Effect	0/979	7/01	8	60	<0/001

Table 2 shows that the relevant multivariate statistics (Pillai s test effect) are significant at the confidence level of 0.99 (P <0.01). The null hypothesis is rejected. Given that the multivariate test is significant, we need to examine whether each of the dependent variables is affected separately from the independent variable.

Table 3- Results of one-way analysis of covariance

The dependent variable	Total squares	Degrees of freedom	Average of squares	F	Significance level(p)
Resilience	277/445	1	277/445	20/61	<0/0001
Problem-oriented coping style	386/84	1	386/84	55/57	<0/0001
Emotion-oriented coping style	312/66	1	312/66	50/14	<0/0001

Table 3 shows the F-ratio of one-way analysis of covariance for the resilience variable (P = 0.0001 and F = 20.61), problem-oriented coping styles (P = 0.0001 and F = 55.571) and the coping style is emotion-oriented (P = 0.0001 and F = 50.147). These findings show that there is a significant difference in the dependent variables (resilience and problem-oriented and emotion-oriented coping styles) between intervention groups, cognitive-behavioral religious-based therapy and treatment-based admission and commitment, and the control group. LSD

post hoc test was used to determine which of the three groups differed in the dependent variables.

Table 4: LSD post hoc test to determine the effect of more effective method on resilience, problem-oriented and emotion-oriented coping styles

LSD post hoc test	First group	Second group	Mean Difference	Standard Error	Significance Level
Resilience	CBT Religious Oriented	Act	4/2	1/8	0/02
		Control	21/26	1/8	0/0001
	Act	Control	17/06	1/8	0/0001
Problem-oriented coping style	CBT Religious Oriented	Control	10/4	1/83	0/002
	Act	CBT Religious Oriented	4/26	1/83	0/025
		Control	6/13	1/83	0/0001
Emotion-oriented coping style	Act	CBT Religious Oriented	2/33	1/63	0/16
	Control	CBT Religious Oriented	4/06	1/63	0/017
		Act	1/073	1/63	0/296

According to the results of Table 4, difference between the mean of the control group and the other two groups in resilience variable is significant (P <0.05). Also, the difference between cognitive-behavioral religious-based therapy group and act is significant (P <0.05). Due to the difference between pre-test and post-test means in Table 1, the effectiveness of religious-based cognitive-behavioral therapy on resilience is better than ACT treatment. According to the results of Table 4, the difference between the mean of the control group and the other two groups in the problem-oriented coping style variable is significant (P <0.05). Also, the difference between cognitive-behavioral religious-based group and act is significant (P <0.05). Due to the difference between pre-test and post-test means in Table 1, the effectiveness of cognitive-behavioral religious-based therapy on problem-oriented coping styles was better than ACT treatment.

According to the results of Table 4, the difference between the mean of the control group and the other two groups in the emotion-oriented coping style variable is significant (P <0.05). Also, no difference was observed between cognitive-behavioral religious-based group and act on emotion-oriented coping style (P <0.05).

4. Conclusion:

The results of the present study showed that religious-based cognitive therapy is effective on all three variables of research, namely resilience and coping styles (problem-oriented) and emotion-oriented coping style. Also, increases resilience and problem-oriented coping styles and decreases emotion- oriented coping style has been reported in women with MS. The results of testing the research hypotheses is consistent with (Paukert, 2009., Barra, 2012., weisman, 2010., Delgado Guay, 2011, Greaing, 2011., Rascicc et al, 2009., Bai et al, 2018 ., Mahayati et al, 2018., Rasic et al, 2011). However, there was no direct research on coping styles that shows the effect of religion-based cognitive-behavioral therapy on improving patients' coping styles. However, the results show the effect of this treatment on improving the problem-oriented coping style in MS patients. Having meaning and purpose in life, feeling of belonging to a high source, hoping for God's help and assistance in difficult life situations, having social and spiritual support, etc. are all among the resources that people can use to suffer less in the face of stressful life events. Religious beliefs are a kind of cognitive processing and finding meaning in life.

Doing religious beliefs introduces many support systems to help people. This issue strengthens effective coping strategies in them, which is consistent with the results of the present study, ie, increasing the use of problem-oriented coping style, followed by reducing emotion-oriented coping style. They believe that God supports them and loves them. This feeling gives the person a kind of control and efficiency that has divine roots and can compensate for the loss of control caused by MS. Therefore, the reason for the effectiveness of cognitive-behavioral religious-based therapy can be considered the feeling of presence and connection to the eternal divine force, according to which important cognitive assessments affect the process of effective coping. In fact, cognitive-behavioral religious-based therapy can help people evaluate negative events differently. In this way, the treatment method creates a stronger sense of control and thus helps psychological adjustment and increased resilience in patients with MS. Overall, the research findings showed the effectiveness of religion-based cognitive therapy in increasing resilience and improving the use of coping styles in patients with MS. Other results of this study are about the effect of treatment-based admission and commitment on resilience, problem-oriented coping styles and emotion-oriented coping style in patients with MS. Findings show the effect of this treatment on increasing resilience and problem-oriented coping style in these patients. The results of testing these hypotheses regarding the effect of act on increasing resilience are consistent with some researches (Mahishka, 2010, Amanda, 2015, Atajk, 2015, coholic, 2011, Sewin, 2013, Zinati & Falekar, 2016, Nordin & rozman, 2012). As mentioned earlier, many people with MS do not want to or will not be able to cope with the anxiety associated with exposure and blocking the response. Some people with MS either give up or refuse treatment during treatment. This rejection of treatment is manifested in behaviors such as absence from meetings and failure to perform behavioral tasks. Treatment-based admission and commitment seeks to teach the patient how to abandon thought control strategies, how not to mix with disturbing thoughts, and how to tolerate unpleasant emotions, such as anxiety. In fact, the use of faulting and acceptance techniques reduced the annoyance of these situations for the subjects, although this treatment did not directly aim to improve the treatment of MS disease and physical conditions. But according to Forbes (2011), reducing stress in stressful situations as a result of using fault and acceptance techniques leads to increased resilience. In this treatment, there were detailed discussions about the values and goals of the individual and the need to specify the values by the individual. Perhaps one of the reasons is the increasing resilience of specifying values and addressing important values and goals in life rather than dealing with confrontational situations. Also (Pishab et al., 2004), in their research stated that the self-regulatory aspect of attention that exists in the mind based on stress reduction leads to the elimination of dysfunctional information for the person; hence, the person has the opportunity to respond to the current experience with useful information that he has from the current experience, not resulting from conjectures and prejudices. This way of responding to problems leads to problem solving (problem-oriented coping style). In fact, treatment-based admission and commitment is a behavioral therapy that uses mindfulness, admission and cognitive failure skills to increase psychological flexibility, and increasing psychological flexibility leads to improved problem-oriented coping style. Due to the fact that act therapy has been effective in increasing the use of problem-oriented coping style in MS patients, as a result, this effect itself reduces the use of emotion-oriented coping style. In fact, this treatment emphasizes trying to accept what cannot be changed directly as a means of identifying and changing things that can be changed. In other words, ACT increases one's efforts by creating a positive meaning in one's mind by focusing on personal growth.

According to the results of testing the hypotheses of the present study, the difference between the two cognitive-behavioral religious-based therapies and treatment-based admission and commitment on the degree of resilience, the use of problem-oriented coping styles, and emotion-oriented coping styles in women with MS, the results show that cognitive-behavioral religious-based therapy is more effective than treatment-based admission and commitment on resilience and problem-oriented coping styles. There was no difference between the two treatments in relation to the emotion-oriented coping style variable. In the explanation of issue, it can be said that cognitive-behavioral religious-based therapy, in addition to cognitive therapist methods that its aim is changing the patient's misconceptions and turn negative automatic thoughts into rational thoughts, helps the patient during therapeutic sessions to strengthen spiritual and religious beliefs and pay attention to the order of the universe, the existence of the absolute power of God and divine mercy. Reliance on God and belief in divine help also increase life expectancy. In psychotherapy sessions, the patient develops the belief that every effort and suffering that occurs in life is not in vain but is accompanied by divine reflection and reward at different levels of life. By creating such a way of thinking, the patient gets rid of the feeling of emptiness and confusion. This therapeutic approach also focuses on quoting verses from the Holy Quran and hadiths and their effect on treatment. In the religious approach, there is a belief that the universe is in order and without the will of the creator of the universe, even a leaf doesn't fall from a tree. Patients' belief about the issue that the creator of the universe is the greatest protector and support is strengthened in them. In fact, establishing a spiritual connection with the only infinite power gives the person the assurance that a strong force is his supporter. Therefore, a person will go through the events, ups and downs of life more easily by relying on his faith and belief, and will be less anxious and stressed, and consequently will be more hopeful and optimistic about the future. Therefore, it can be predicted that cognitive-behavioral religious-based therapy in a country where most people believe in religion and use it to deal effectively with their problems. This type of treatment increases resilience to the problems ahead and the use of problem-solving coping styles. Consequently, the use of emotion-focused coping style reduces the problem due to its effectiveness and admission. The patient faces his illness relying on the creator of the universe, and trusting that he is a helper and supporter in all difficulties and problems, and accepts it and tries to deal effectively with his illness and use his abilities to improve issues. Also, according to the results of the present study, the effect of cognitive-behavioral religious-based therapy in comparison with treatment-based admission and commitment therapy on the emotion-oriented coping style variable was not observed and both treatments were equally effective. In fact, this result can be explained as follows: using of ACT due to the mechanism embedded in it, such as: admission, awareness raising, desensitization, presence in the moment, observation without judgment, confrontation and release in combination with traditional cognitive behavioral therapy techniques can increase effectiveness while reducing psychological symptoms. It leads to the formation of an effective coping style, dealing with the problem and solving it. In addition, religious-based CBT treatment reduces the stress of following the diagnosis and treatment of MS and plays a valuable role in the treatment and better adaptation of these patients. The results can be mentioned considering the effectiveness of both treatments in reducing the use of emotion-oriented coping style.

In general, according to the obtained results and the greater effect of cognitive-behavioral religious-based therapy in comparison to act on the two variables of resilience and problem-oriented coping style, we can use different psychotherapy approaches, especially religion-based therapies as complementary therapies alongside medical treatments. Especially in society of Iran, where religion and spirituality have a special place among the people. Also, due to the small number of studies in this field, researchers can consider the role of religion and spirituality in the treatment of various factors in incurable patients, especially MS.

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