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RESEARCH ARTICLE

Effect of Group Reality Therapy on Depression and Anxiety in Breast Cancer Patients Undergoing Chemotherapy in Ali-Ibn-Abitalib Hospital

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Abstract

The present study aims to assess the effect of group reality therapy on depression and anxiety in breast cancer patients undergoing chemotherapy in Ali-Ibn-Abitalib hospital, Zahedan, in 2017-2018. The current study is an application of research using a semi-experimental design. It employs a pretest-posttest design and separates participants into control and experiment groups. Additionally, it is a qualitative study in terms of data collection.Beck's depression and anxiety inventory (1998, 2000) was used to collect data. The statistical population of this study consists of all the breast cancer patients hospitalized in Ali-Ibn-Abitalib hospital, Zahedan. Non-probability available sampling was used to select the sample. The sample size consisted of 24 individuals randomly divided into two groups of experiment and control. The inclusion criteria were doctors' diagnosis and depression and anxiety diagnosis based on the BDI and BAI. The experiment group received reality therapy in 10 90-minutes sessions, and the control group received no intervention. Data were analyzed using univariate covariance analysis. The results showed that group reality therapy leads to less depression and anxiety in breast cancer patients undergoing chemotherapy.

Keywords: Reality Therapy, Breast Cancer, Depression, Anxiety

Introduction

Breast cancer is the most prevalent and dangerous kind of cancer in women in terms of psychological and emotional effects [1,2], and it is a serious and growing health issue in Iran. Between 1998 and 2005, breast cancer occurred in 22 out of every 100,000 Iranian women aged 15 to 85. It was more common among women between the ages of 40 and 49. 70% of Iranian women are diagnosed with advanced breast cancer. The majority of patients are under some psychological strain. This pressure subsides without causing long-term damage and is seen as a normal adaptive response in some cases. However, other individuals suffer more serious psychological issues, impairing their quality of life and ability to function in daily life [3]. This problem may result in anxiety, depression, disappointment, social exclusion, dread of the response of one's spouse, concerns regarding marriage, concern about death, and fear of sterility. Depression and anxiety are the most often encountered psychological responses in breast cancer sufferers who are confronted with a diagnosis, a prognosis, and treatment choices. Additionally, the therapy may result in stress. High amounts of stress impair the function of white blood cells and degrade immune function. Breast cancer is treated in various ways, including surgery, radiation, chemotherapy, hormone therapy, and bone marrow transplantation [4].

Cancer therapy imposes various psychological strains, some of which may impair quality of life and contribute to depression and anxiety. For example,

patients often report adverse psychological effects, including anger, anxiety, and concern, as being more severe than physical side effects, including loss of hair and nausea. Chemotherapy side effects create various difficulties for breast cancer individuals, impairing the physical, psychological, and societal functioning and perhaps causing them to forego the remainder of their treatment term [5]. Additionally, some individuals may discontinue chemotherapy due to the psychological complications associated with treatment [6]. Financial difficulties associated with therapy, illness incurability, and high death rates place additional environmental and psychological strain on patients [7]. The progression of the illness has a multifaceted effect on the patients' personal and social performance and results in a variety of psychological difficulties; thus, addressing the patients' internal issues is critical for maintaining mental wellbeing [8,9].

Several methods, including behavior therapy, cognitive therapy, and psychoanalysis, are employed to effect behavior changes in psychology. Through the use of learning principles, behavior therapy alters behavior. Based on cognitive science and theoretical concepts, cognitive therapy results in behavioral modification and psychological health improvements [10,11]. Reality therapy is intended to assist those experiencing psychological distress in resolving their issues and altering their behavior [12]. William Glasser developed this technique as a consulting and therapeutic strategy. It assists individuals in assessing their behavioral expectations, wants, and values to choose the best approach to fulfill these requirements [13]. Glasser thought that people do not get depressed; rather, they choose to be sad and exhibit depressive behaviors. Participating in an active activity enables individuals to regain control of their depressive behavior and experience more pleasant emotions, thoughts, and bodily tranquility [14].

In a clinical study called 'Comparison of the effectiveness of group reality therapy and neurofeedback therapy on depression and anxiety in breast cancer individuals,' Sabahi, and Allahinejad, Makvand Hosseini (2018) discovered that the mean post-test depression ratings of the treatment groups were substantially lower than those of the control group, demonstrating the therapy's efficacy. The reality treatment group's mean state and trait anxiety ratings were lower than the control group's. In comparison to the control group, just one method of improvement was discovered in the neurofeedback group. After a four-month follow-up, all treatment impacts were enhanced, demonstrating the long-term efficacy of both therapies. The mean depression and anxiety levels of breast cancer individuals undergoing cognitive therapy varied between 2.28 and 6.64 and were statistically significant [15].

Ghahari et al. (2012) evaluated the efficacy of behavioral-cognitive and spiritual-religious treatments in reducing depression and anxiety in patients with breast cancer. The findings indicated that the experiment group's average scores were higher than those of the control group; nevertheless, this discrepancy was not statistically significant [16]. Reality therapy is a thorough method that encompasses all aspects of therapy and may be utilized to address any condition [17]. This method stresses the most basic human needs, including acceptance of truth, accountability, and goal setting [18,19]. Psychological symptoms including depression and anxiety usually reflect a condition, not a disease. However, it is estimated that between 8% and 10% of the Iranian population over the age of ten have displayed some degree of such symptoms and suicidal inclinations, necessitating therapy [20]. The impact of this approach on depression and anxiety in breast cancer individuals receiving chemotherapy has not been extensively investigated [21]. Thus, the purpose of this research is to evaluate the effectiveness of reality therapy on depression and anxiety in breast cancer individuals receiving chemotherapy at Zahedan's Ali-Ibn-Abitalib hospital in 2017.

Study Method

The current study is an application of research using a semi-experimental design [22]. It employs a pretest-posttest design and separates participants into control and experiment groups. Additionally, it is a qualitative study in terms of data collection. This study's statistical population includes all breast cancer individuals admitted to Ali-Ibn-Abi Talib hospital in Zahedan [23,24]. Twenty-four individuals were randomly assigned to two groups of experiment and control, each with twelve people. Ten reality therapy sessions were administered to the experiment group, whereas the control group got no intervention [25,26]. The inclusion criteria were as follows: Age range of 20 to 70 years, diagnosis of depression and anxiety utilizing the BDI and BAI and confirmation by the research scientist, absence of other physical or psychological illnesses other than depression and anxiety, completion of the consent form, at least six months since breast cancer diagnosis, similar treatment process for all patients chemotherapy. The following criteria were used to exclude participants: Lack of permission to participate and diagnosis of medical or psychiatric disorders during sampling.

Beck's depression inventory and Beck's anxiety inventory were used to gather data. Ward, Aaron Beck, Mandelsohn, Erbaugh and Mark established BDI. It consists of 21 multiple choice tests evaluated on a scale of 0 to 3 that assesses the severity of depression from moderate to severe and the cognitive, behavioral, and physical symptoms associated with depression. The tool's internal reliability ranges between 0.73 and 0.92% mean=0.86%, and its Cronbach's alpha is 0.86% for patients and 0.81 % for non-patients. The validity and reliability of this instrument in Iran were determined to be 0.78 for Cronbach's alpha and 0.73 for retest validity after two weeks. BAI is composed of 21 Likert scale ratings ranging from 0 to 3. The internal reliability of this instrument was acceptable after one-week testing 0.75. BAI is valid 0.72, trustworthy 0.83, and has adequate reliability (α=0.92) for the Iranian population. SPSS was used to analyze data utilizing descriptive (mean and standard deviation) and inferential statistics univariate covariance. After the study's strategy was accepted and ethical permission was obtained, cancer patients at Zahedan's educational hospitals were identified (Table 1). The experiment was conducted in 10 90-minute sessions each Thursday at Dr. Hesabi's square and Dr. Hashemi's clinic in Zahedan. Reality therapy was administered to the experiment group.. This treatment protocol has been modified in accordance with the relevant texts and Glasser's selection theory.

Table 1. Reality therapy protocol Reality Therapy Instructions (68,69).

1nd session	familiarity among members—establishing a trustworthy connection between the consultant and the client—notification of group norms and the importance and function of good communication	To get to know one another, I ask each member of the group to spend three minutes introducing themselves in a strong, loud voice. Additionally, they should carry the page with their names on it to each session so that other members of the group may address them by name. On the whiteboard, I write what I want the group to notice throughout the session. I also create the rules that the group members want, and then we agree on group regulations. We discuss why everyone requires an identity, what identity is, and how it will be formed (success identity vs. failure identity) (the need for value and love). I describe the nature of incompatibility and communicate with clients through the inquiry technique. For example, I inquire as to what they are doing at the time. (To comprehend the inner world of wants and needs)
2nd session	Identifying the five fundamental human needs—list the members' basic requirements with their assistance and the assistance of the consultant—and evaluate the significance of fulfilling these needs	To begin, I examine the nature of wants and their universal and hereditary character in a theoretical debate. I draw each need on the whiteboard and discuss how their strength and manner of fulfillment may vary from person to person (adaptively and non-adaptively). Dr. Ali Sahebi's short-form questionnaire for evaluating the severity of requirements is used to ascertain the strength of group members' demands and comprehend these needs via focused inquiries.

3rd session	Receiving comments on the prior session - inquiring about the group members' general perspective Members discuss their present lives, and their perspectives on this topic are evaluated.	I invite each member to share their feelings on the last session and discuss their current viewpoint on life. Following that, I invite members to use a belief rating to identify the source of this opinion. In this regard, I urge members to write down their degree of belief and the reasons for their feelings. I explain why they choose unpleasant feelings (e.g., depression or anxiety) (anger management, seeking assistance from others – emotion regulation, etc.). Depression and anxiety may be triggered by a failure to fulfill fundamental needs, the most critical of which are a sense of love and worth. Additionally, we discuss the reality that a lack of responsible conduct is the source, not the consequence, of anxiety and sadness. I explain that each feeling reflects a need that has not been met (negative emotions).
4th session	Explanation of general behavior and its critical elements (activity, thinking, emotions, and physiology), as well as the reality that human beings have direct control over what happens and ideas, but not over the other elements.	We discuss how one of the primary reasons individuals seek psychotherapy is because they are dissatisfied with their existing relationships with significant people. I explain that members of the group may pick one of these things to alleviate their sense of inefficiency (1. Forget about their demand, 2. Change their behavior and attitude to achieve their demand, or forget about both alternatives). We address effective control, which is defined as fulfilling pre-existing pictures in our environment of high quality. I show how the four components of our total conduct create a strategy for self-satisfaction (satisfying the needs of the desirable world). We emphasize actions (i.e., the members' everyday activities), such as what you're doing right now, and discuss direct and indirect behaviours.
5th session	Identifying the extent to which group members have access to or are unable to utilize their current behavior to accomplish their objectives and understanding the role of their present conduct in accomplishing their goals and fulfilling their requirements.	I discuss the quality world and how it is formed and altered. Explanation of the creative power that drives a behavior – evaluation of members' activities – emphasis on everyday behavior (Does what you are doing now satisfy your needs?). We address appraisal and self-adjudication.

6th session	Receiving feedback on the previous session - assisting members in comprehending their current feelings and behaviours, demonstrating the insignificance of the past non the present, and stressing internal control	I explain that, regardless of how successful the past was, the current instant dictates the kind of behavior chosen to fulfil our requirements. I demonstrate the importance of external control in developing issues and highlight the need for internal control.
7th session	Educating group members about their duties and assisting them in gaining access to and increasing their responsibility for choosing behaviours and approaches that result in disappointment and reduced pleasure.	We examine the definition of responsibility –the characteristics of responsibility and its function in behavior selection and its influence on a person's emotional state – and we examine planning for a person that involves more effective and better conduct.
8th session	Receiving comments on the previous session, emphasizing the significance of preparing to do tasks more efficiently and effectively, and teaching proper planning for accomplishing objectives	Creating a pre-specified form for customers to use in determining a framework within which they may fulfill the majority of their requirements.
9th session	Familiarity with problems of change and commitment, as well as the provision of tasks based on the enhancement of pleasure and hopefulness, and the receipt of a signed letter of commitment to complete them without exception.	I thoroughly explain the problems to members and discuss the function of assignments and letters of commitment.
10th session	Getting feedback on previous sessions, members' re-evaluation and focus on responsibility, aiding in the substitute of internal control, ethical judgment for right and wrong behavior, dealing with reality, being here and in the current moment, behavioural change that ultimately results in depression and anxiety reduction.	I explain many hypothetical scenarios and then identify coping mechanisms with the assistance of group members to provide them with a model for resolving future problems.

Results

As demonstrated in Table 2, depression and anxiety levels in breast cancer individuals receiving chemotherapy in the experiment group reduced after treatment. The significant level and control of the protest and post-test were determined using covariance analysis, and the findings are summarized in the table. It is essential to establish the study variables' skewness, kurtosis, normality, and variance homogeneity prior to doing covariance analysis.

Table 2. Summarizes the depression and anxiety levels in the control and experimental groups before and after reality treatment.

Variable	Group	Pretest		Post-test		
		M	**SD**	**M**	**SD**	**N**

Anxiety	control	1.73	0.29	1.66	0.29	12
	experimental	1.58	0.52	0.67	0.33	12
Depression	control	1.51	0.23	1.52	0.21	12
	experimental	1.35	0.36	0.42	0.33	12

Scores of depression and anxiety in breast cancer individuals receiving chemotherapy. The mean, standard deviation, skewness, and kurtosis of breast cancer individuals' depression and anxiety ratings prior to the intervention are presented in Table 3.

Table 3. Shows the mean, standard deviation, skewness, and kurtosis of breast cancer survivors' depression and anxiety ratings.

Variable	Mean	Standard Deviation	Skewness	Kurtosis
Depression	1.43	0.312	0.146	0.849-
Anxiety	1.66	0.423	0.24	0.054

According to table 2, the skewness and kurtosis of the variable scores' frequency distributions vary between -2 and 2, which is normal. To begin, the normality and homogeneity of the variance of the scores are determined to test hypotheses and apply covariance on the mean scores. To establish the normality of the score distribution, the Shapiro-Wilk and Kolmogorov-Smirnov tests were employed. Table 4 summarizes the findings.

Table 4. Shapiro-wilk and kolmogorov-smirnov tests were used to evaluate the normalcy of depression and anxiety in breast cancer individuals.

Variable	Test	Statistics	Degree of freedom	Significance level
Depression	Kolmogorov-Smirnov	0.112	24	0.2
	Shapiro-Wilk	0.966	24	0.561
Anxiety	Kolmogorov-Smirnov	0.116	24	0.2
	Shapiro-Wilk	0.974	24	0.754

The Shapiro-Wilk and Kolmogorov-Smirnov tests have a significance level greater than 0.05; therefore, the obtained data are very confidently normal.

Variance Homogeneity Test of the Means

The variance homogeneity of the means was determined using Levene's test, and the findings are given in Table 5. This table demonstrates that Levene's test has a significance level greater than 0.05 for all variables. As a result, the variances are sufficiently homogeneous to allow for the testing of hypotheses and covariance.

Table 5. The findings of levene's test to determine the variance homogeneity of the mean depression and anxiety scores in breast cancer individuals.

Variables	Levene's statistics	1df	2df	Significance level
Depression	2.81	1	22	0/108

Anxiety	333	1	22	0/081

Tables 3 and 4 demonstrate that the dispersion of pretest scores in the experiment and control groups was nearly identical, confirming the covariance matrix's equality of variances and similarity ($p<0.05$). As the scores are normally distributed, and the number of variables in the control and experiment groups are identical, covariance may be applied.

Hypothesis 2: After reality treatment, the anxiety level of breast cancer individuals receiving chemotherapy reduces in the experiment group. This hypothesis was tested using univariate covariance analysis. Table 6 summarizes the findings.

Table 6. The findings of the univariate covariance analysis of post-test depression ratings in the experiment and control groups with pretest control.

Change source	Sum of squares	Df	Squares mean	f	Sig.	Test power
Pretest	0.472	1	0.472	7.91	0.1	0.765
Group	5.91	2	2.955	49.5	0.001	1
Error	1.254	21	0.06			

The above table summarizes the findings of univariate covariance analysis of post-test anxiety ratings in the experiment and control groups with pretest control. As demonstrated, there is a statistical difference in depression levels between breast cancer individuals receiving chemotherapy who underwent reality treatment and those who did not ($0.05<p$, $f=49.501$). As a result, the null hypothesis is rejected, and the study's first hypothesis is verified. In other words, group reality therapy alleviated depression in women receiving chemotherapy for breast cancer.

Hypothesis 3: After reality treatment, the degree of depression in breast cancer individuals receiving chemotherapy reduces. This hypothesis was tested using univariate covariance analysis. Table 7 summarizes the findings.

Table 7. The findings of the univariate covariance analysis of post-test anxiety ratings in the experiment and control groups with pretest control.

Change source	Sum of squares	Df	Squares mean	f	Sig.	Test power
Pretest	0.945	1	0.945	16.4	0.001	0.071
Group	4.973	2	2.486	43.2	0.001	0.01
Error	1.207	21	0.057			

The above table summarizes the findings of univariate covariance analysis of post-test anxiety ratings in the experiment and control groups with pretest control. As demonstrated, there is a statistically significant difference in the anxiety level of breast cancer individuals receiving chemotherapy who underwent reality treatment vs. those who did not ($0.05<p$, $f=43.249$). As a result, the null hypothesis is rejected, and the study's third hypothesis is verified. In other words, group reality therapy alleviated anxiety in people receiving chemotherapy for breast cancer.

Discussion

The findings indicate that depression and anxiety were reduced in breast cancer individuals receiving chemotherapy in the experiment group after undergoing reality therapy. These results corroborate those of Alsoalmeh and findings also indicated a substantial impact of group reality therapy on depression reduction in the experiment group. The control group's mean depression revealed no statistically significant difference. Allahinejad et al. (2018) also discovered no significant change in the mean anxiety level between the control and

experiment groups, contradicting the current study's findings. Depression and anxiety levels in breast cancer individuals decreased almost certainly as a result of reality treatment. This strategy enables breast cancer sufferers to exert more control over their life forces. Depression and anxiety are opposites. Patients benefit from reality therapy when they can avoid these external influences and regain control of their lives. Glasser's approach demonstrates that depression and anxiety are self-inflicted and self-administered. Additionally, it demonstrates to them that they may address their illness more effectively. Patients learn how to cope with various life difficulties, which helps them overcome depression and anxiety.

The current study's findings indicate that group reality therapy alleviates depression in breast cancer individuals receiving chemotherapy. This is consistent with but not with. Allahinejad et al. (2018) demonstrated that the experiment group's post-test anxiety scores were lower than the control group's. Prenzlay (2006) also discovered that reality therapy might help people overcome intrusive thoughts. Reality therapy may help cancer patients regulate their thoughts and behaviors and enhance their emotions and physiology. There are three ways to alleviate or eliminate unpleasant behaviors such as anxiety: a) Altering our ideals or ideal world, b) altering our behaviors and activities, or c) altering both (a and b) (70). When people exhibit irrational anxiety, reality therapists assist them in demonstrating behaviors and actions consistent with their ideal world. Individuals' anxiety levels will reduce if they effectively demonstrate gratifying behaviors and activities. Breast cancer individuals discovered that anxiety and despair are ineffective during reality treatment. They discovered that focusing on the current moment and meeting their fundamental needs could wash away unpleasant thoughts. Then, individuals may fill up the blank space between the actual and ideal worlds by lowering their concerns and concentrating on fulfilling their wants, thus lessening their anxiety throughout the sessions.

Additionally, the findings indicated that group reality treatment reduces anxiety in breast cancer individuals receiving chemotherapy in the trial group. These results corroborate those of that reality therapy helps patients overcome depression, improves their problem-solving abilities, and assists them in developing cognitive strategies. The current study's findings indicate that depression is likely reduced in breast cancer individuals receiving chemotherapy due to their thoughts and experiences altering throughout reality therapy sessions. During this treatment, negative ideas such as 'I am not beautiful because of my cancer.', 'cancer is a terminal illness.', 'what will my family do without me?', and 'it is not fair.' are replaced with more realistic ones in which patients take responsibility for their depression. Reality therapy educates patients that they have more options than depression when confronted with their illness. Patients may believe their sadness results from their cancer and therefore refuse to accept responsibility for their depression. If people recognize that depression is a choice, they work to overcome it. Thus, reality therapy assisted the experiment group in recognizing their issues and accepting responsibility for them, thus alleviating depression. According to selection theory, depressed behavior is a chosen behavior to address a problem. This is, though, ineffective behavior that does not resolve the issue. If a person accepts reality the current circumstance and takes responsibility for their decisions, they will feel much better and improve their quality of life.

Conclusions

The results showed that group reality therapy leads to less depression and anxiety in breast cancer patients undergoing chemotherapy.

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