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Improvement in quality of life and sexual functioning in a comorbid sample after the unified protocol transdiagnostic group treatment

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ABSTRACT

Patients with multiple mental disorders often experience sexual dysfunction and reduced quality of life. The unified protocol (UP) is a transdiagnostic treatment for emotional disorders that has the potential to improve quality of life and sexual functioning via improved emotion management. The present study evaluates changes in quality of life and sexual functioning in a highly comorbid sample treated with the UP in a group format. Forty-eight patients were randomly assigned to either a UP active-treatment group or a medication-only control group. Treatment was delivered in 14 sessions over the course of 4 months. Symptoms of anxiety and depression were assessed using the Beck Anxiety Inventory and Beck Depression Inventory. Sexual functioning was assessed by the Arizona Sexual Experience Scale (ASEX), and quality of life was assessed by the World Health Organization Quality of Life-BREF scale (WHOQOL-BREF). Quality of life, anxiety and depression all significantly improved among participants treated with the UP. Some improvement in sexual functioning was also noted. The results support the efficacy of the UP in improving quality of life and sexual functioning in comorbid patients.

1. Introduction

Comorbidity in mental disorders, in general, affects between 14% and 43% of the population in Brazil (Molina et al., 2014), and 26.2%–40% of the population in the USA (Kessler et al., 2012, 2005a, 2005b). In several studies, more than 40% of patients who received one diagnosis also met the diagnostic criteria for a second diagnosis over a 12-month period (APA, 2013; Meng & D'Arcy, 2012; Al-Asadi et al., 2014). Naturally, comorbidity is very common and can have severe consequences for mental health (Molina et al., 2014; Kessler et al., 2005a).

Generalized anxiety disorder (GAD) is characterized by excessive and persistent worrying that is hard to control, causes significant distress or impairment and occurs on more days than not for at least six months (Wittchen et al., 1994). Epidemiologic studies of nationally representative samples in the United States have found a lifetime prevalence of GAD of 5.1% (Wittchen et al., 1994) to 11.9% (Kessler et al., 2005a, 2005b, 2012). A review of epidemiological studies in Europe found a 12-month prevalence of 1.7–3.4% (Wittchen et al., 2011), and a lifetime prevalence of 4.3–5.9% (Wittchen & Jacobi, 2005).

Evidence suggests that quality of life is a measure of patients'

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perceptions that depends on their illnesses and that it should be part of the diagnostic evaluation and treatment plan for patients with depression and GAD (Al-Asadi et al., 2014; Andrade et al., 2012). Comorbid mood and GAD affect between 9.5 and 18.1% of the general Brazilian population and often contribute to a severe reduction in quality of life (Molina et al., 2014).

GAD and depressive disorders lead to a reduced quality of life across several domains (Althof, 2002; Zitman, 2012; Johansson et al., 2012; Maia et al., 2013; Aldao and Nolen-Hoeksema, 2010; Pehlivanidis et al., 2006). We can include physical, psychological, social and environmental wellbeing (Molina et al., 2014; Kessler et al., 2005a, 2005b), and sexual functioning, as well (Pehlivanidis et al., 2006).

Pehlivanidis et al. (2006) found that sexual dysfunction is reported in approximately 53%–70% of the general population. Studies indicate that patients with comorbidity can report improved measures of quality of life and decreased sexual dysfunction after cognitive behavior therapy (CBT) treatment (Johansson et al., 2012; Maia et al., 2013; Aldao and Nolen-Hoeksema, 2010; Pehlivanidis et al., 2006).

Psychoeducation and cognitive restructuring in transdiagnostic groups helps target related disorders. Systematic desensitization and assertive practice, both incorporated into CBT treatment methods, may help relieve some symptoms of sexual dysfunction (Hoyer et al., 2009; Kelly et al., 2006). Comorbid patients are often more conscious of their emotional disorders than are patients who have only one disorder. These patients typically suffer from a poor quality of life in general and often feel that their disorders impact their social, psychological and physical wellbeing.

A study by Frisch et al. (2005) showed that comorbid patients in a CBT treatment condition reported significantly higher overall levels of quality of life ($M = 2.22$, $SD = 1.52$) at post-treatment than individuals in a waitlist condition ($M = 0.93$, $SD = 1.96$). The magnitude of the between condition effect size for overall quality of life was large ($g = 0.77$) and better quality of life may reflect a range of benefits, including enhanced treatment outcomes, long-term resilience, and decreased utilization of other health care resources (Frisch et al, 1992, 2005; Gallagher et al., 2009; Donohue and Swingen, 1999).

The unified protocol (UP) for the transdiagnostic treatment of emotional disorders (UP; Barlow et al., 2011a,b) is a recently developed cognitive behavioral treatment method designed to alleviate symptoms associated with a range of emotional disorders (Aldao and Nolen-Hoeksema, 2010). The UP was developed in response to high levels of comorbidity and phenotypic overlap in anxiety, depressive and related disorders, and it targets the temperamental trait of neuroticism, i.e., the tendency to experience frequent and intense negative affect, coupled with a perception of inadequate coping (Barlow et al., 2011a,b). The UP's goal is to promote a more accepting, willing attitude toward the experience of strong emotions in order to counter the processes that cause and maintain emotional disorders (Barlow et al., 2011a,b).

Barlow et al.'s (2011a,b) research on the symptoms and dimensions of emotional disorders indicates that there is a hierarchy of affectivity negative/neuroticism and affectivity positive/extroversion. These findings demonstrate that the hyperexcitability of limbic structures and disrupted or limited inhibitory control of cortical structures is evident in people with anxiety and mood disorders.

In preliminary studies, the UP had moderate to large treatment effects on measures of temperamental affectivity, and a strong effect on positive affectivity. Since negative emotional experiences are a product of adaptive learning, an emphasis is placed on reducing affective *reactions to* negative emotions (Farchione et al., 2012; Barlow et al., 2011a,b).

Improving patients' overall quality of life contributes to positive mental health. Quality of life comprises a cognitive component (judging one's overall life satisfaction) and an affective component (reflecting the frequency of positive and negative emotions). Rationally, when people become adapted to their emotions, the positive effects include decreased mental disorders, better interpersonal functioning and functional health behaviors (Gallagher et al., 2013).

This study aimed to evaluate the quality of life and sexual function of twenty-four (24) comorbid patients with unipolar depressive disorder and generalized anxiety disorder (GAD) after 14 sessions of UP treatment.

2. Methodology

Forty-eight patients (48) with unipolar depressive disorder and anxiety disorders were assessed and diagnosed via MINI (Mini International Neuropsychiatric Interview) developed by Sheehan et al. (1998) and adapted for Brazilian population by Amorim (2000). All of the subjects sought psychological and psychiatric treatment at the Universidade Federal do Rio de Janeiro, located in Rio de Janeiro, Brazil. Of the forty-eight (48) patients, twenty-four (24) received a CBT UP group intervention, and both groups were prescribed pharmacological medication by a psychiatrist. The CBT UP patients were divided into three (3) groups of eight (8) patients. All of the subjects received the UP treatment for fourteen (14) sessions over the course of fourteen (14) weeks.

During each initial treatment session in all 3 UP groups, 2 former patients who had completed the group treatment sessions were invited to talk to the incoming patients about their positive experiences post-treatment a few weeks prior.

The inclusion of the former participants motivated new patients and demonstrated the importance of setting goals and continuing to learn about the disorders outside the treatment sessions. The therapists prepared handouts to be given to participants to be read after the sessions.

3. Statistical analysis

The Kolmogorov-Smirnov normality test revealed that the data had a normal distribution. Thus, we used the means and standard deviation as measures in this study. Next, descriptive statistics were used as the method for data analysis, which evaluated the means and standard deviations between the 2 groups in this study, the UP intervention group (N = 24) and the control group (N = 24).

A test t was used because it tests whether a mean of a sample with a normal distribution significantly differs from a hypothesized value. The P value represents the probability that any observed difference between two groups is due to chance. Then, there is the underlying assumption that the data are from a normal distribution sampled randomly. The flowchart below shows the enrollment, evaluation and follow up of patients who participated in this randomized study.