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Effectiveness Of Cognitive-Behavioral Therapy In The Treatment Of Anxiety Disorders And Obsessive-Compulsive Disorders In Adults: About A Study

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Abstract:
Background*: Anxiety disorders and obsessive-compulsive disorders (OCD) are common mental health problems that can have a major impact on the lives of sufferers and those around them. Indeed, the effectiveness of cognitive-behavioral therapy (CBT) with people suffering from these disorders has been repeatedly demonstrated in various meta-analyses. This psychotherapy helps prevent relapse. With this in mind, we conducted an experiment on the practice of CBT for anxiety disorders and OCD in our Algerian institutions, with the main aim of evaluating the comparative efficacy of CBT + pharmacotherapy and pharmacotherapy alone in the treatment of adult patients suffering from anxiety disorders and OCD over a two-year post-therapy observation period.*
Materials and methods: This was *a prospective, comparative, randomized study. 98 patients were recruited, of both sexes, aged between 18 and 65, followed up in psychiatric consultations at the Specialized Psychiatric Hospital Establishments DRID Hocine and NADOR, Tipaza. The study period was spread over four years, from January 2020 to December 2023, taking into account the different periods of the study up to the period of assessment of the impact of CBT. All patients suffering from substance-induced anxiety disorders, general medical conditions and psychiatric pathologies other than anxiety disorders and OCD were excluded from the study. All patients had received antidepressant treatment. To evaluate the efficacy of CBT, the ninety-eight patients will be randomized into two groups of forty-nine, according to the type of treatment: 1er control group: pharmacological treatment 2eme CBT + pharmacological treatment + CBT group. Confirmation of cases by dsm-5 criteria for all types of anxiety disorders and OCD. Clinical evaluation using scales specific to each clinical form. The experimental group was divided into two subgroups and then into small groups of 8 to 9 participants to ensure proper management of the CBT sessions. Monitoring parameters were relapse, duration and intensity of remission, and quality of life. Post-treatment follow-up was 24 months.*
Results: *Overall, our population showed no sociodemographic, clinical or therapeutic differences between the CBT and control groups. Our overall sample comprised 98 patients, forty-five men and fifty-three women. The average age was 35.8±12.6 years, 48% of patients were single, 42.9% married and the remainder divorced. 40% had a university education and the remainder between intermediate and primary. The majority (40.80%) had a diagnosis of panic disorder, 19% (OCD), 18% generalized anxiety disorder, 11% social phobia, 9% agoraphobia and only one case of simple phobia. The clinical assessment for each disorder prior to the start of CBT workshops was judged to be moderate to severe. There were no significant differences between the two groups in terms of socio-demographic, clinical or therapeutic characteristics. With regard to CBT, the average number of CBT workshop sessions was 17±12. Most patients attended their appointments regularly. Participation in the group was generally good for the majority of participants, as was performance of tasks at home. The impact of CBT 24 months after the program on the relapse rate in the CBT versus control group, respectively 5/49 versus 14/49, was significant (p= 0.021). The time to relapse was significantly shorter in the control group versus the CBT group (p= 0.041. Relapse intensity was significantly severe in the control group versus the CBT group (p= 0.002). Overall, CBT had a significant impact on improving the quality of remission (p=0.000) and quality of life (p=0.002) compared with the control group.*
Conclusions: *At the end of our research study, the overall evaluation of the effectiveness of the CBT program after 24 months of observation on anxiety disorders and OCD was satisfactory and significant compared with the control group. The impact of this therapy was notable on several variables, namely the rarity of relapses, the good quality of remission and quality of life.*
Key Word: *efficacy, Cognitive-behavioral therapy, anxiety disorder, obsessive-compulsive disorder*

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I. Introduction

Anxiety and obsessive-compulsive disorders (OCD) are common mental health problems, affecting around 7.5% of the population [1]. When left untreated, these disorders tend to become increasingly severe, recurrent and chronic, and are associated with depressive decompensation and high suicidal risk [2-3]. What's more, these disorders affect to varying degrees not only the sufferer, but also those around him or her. They also have a major impact on healthcare costs and lost productivity for sufferers. Given the prevalence of anxiety disorders and their impact on sufferers, numerous studies have been carried out to identify interventions that can be used to treat them, including medication and psychological interventions. Indeed, the effectiveness of Cognitive Behavioural Therapy (CBT) with people suffering from anxiety disorders and OCD has been repeatedly demonstrated in various meta-analyses [4-7].

CBT employs cognitive, behavioral and interpersonal emotional methods to modify maladaptive behaviors, dysfunctional cognitive patterns and promote emotional regulation. In general, all research studies show that CBT remains the treatment of choice for most people with anxiety disorders and OCD, and contributes significantly to improving the functioning and quality of life of these individuals [6, 8-10]. Furthermore, data from several studies in the literature show similar efficacy of CBT and pharmacotherapy in patients suffering from these disorders [11]. However, the benefits of CBT are maintained longer after the end of treatment than those of medication [11]. Most clinical practice guidelines recommend CBT for the treatment of these disorders, and have found it to be an effective treatment or adjunct to medication [11-14]. Indeed, some studies have preferred the use of CBT in combination with medication to enable better management of the physical symptoms of anxiety and better maintenance of long-term therapeutic gains and increased protection against relapse compared with those of pharmacological treatments [15-16]. To this end, we have conducted an experiment in the practice of CBT for anxiety disorders and OCD in our Algerian institutions, with the main aim of evaluating the comparative efficacy of CBT + pharmacotherapy and pharmacotherapy alone in the treatment of adult patients suffering from anxiety disorders and OCD, over a two-year post-therapy observation period.

II. Material And Methods

This is a prospective, comparative, randomized study.

1. Study population :

In our study, we recruited 98 patients, of both sexes, aged between 18 and 65, followed up in psychiatric consultations at the Specialized Psychiatric Hospital Establishments DRID Hocine and NADOR, Tipaza. The study period was spread over four years, from January 2020 to December 2023, taking into account the different periods of the study up to the period of assessment of the impact of CBT:

- Patient recruitment period ;
- Timing of the CBT program;
- The 24-month follow-up period after the program.

Inclusion criteria: panic disorder (PD), agoraphobia, specific phobia, social phobia, generalized anxiety disorder and OCD.

Exclusion criteria: all patients suffering from substance-induced anxiety disorders or general medical conditions and psychiatric pathology other than anxiety disorders and OCD were excluded from the study. All patients received antidepressant treatment.

2. Data collection method :

All patients were assessed after they had been informed of the study's objectives, the medium to be used and how it would be conducted. Patients were not recruited for the study until they had given their informed consent. Data collection was carried out with respect for the anonymity and confidentiality of all information, and in particular of patients in the CBT group**.**

The methodological procedure:

To evaluate the effectiveness of CBT in patients with anxiety disorders and OCD, ninety-eight patients will be randomly divided into two groups of forty-nine, according to the type of treatment:

1er Control group: Pharmacological treatment alone for the same duration;

2me experimental group or CBT: Pharmacological treatment + CBT.

The data collection procedure involved administering the research study questionnaire to all patients in both groups, assessing sociodemographic, clinical and therapeutic characteristics, as well as disease progression and relapse rates. A final section relating to post-treatment CBT data. The questionnaire was identical for each patient. At the end of the interview, an average of 45 min was needed for each patient to :

1). Diagnostic confirmation according to the criteria of the Diagnostic Statistical Manual of Mental Disorders 5ème version (dsm-5) [17] for all types of anxiety disorders and OCD;

2). A clinical assessment using specific scales validated by the psychometric measurement instruments used, enables us to assess the intensity and frequency of anxiety-related symptoms, and thus to evaluate the repercussions on the patient's overall functioning (changes in scores over time). These include
- Generalized anxiety disorder (GAD): the Hamilton Anxiety Rating Scale (explores anxious cognitions, physiological feelings and anxious mood), Beck Inventory and Worry Questionnaire.
- Agoraphobia and simple phobia: Chambless Scale (Bouvard & Cottraux, 2010) or Anxiety Mobility Inventory (AMI). They explore several behavioral, cognitive and interoceptive dimensions of agoraphobia
- Social phobia: social thinking from the Tapis scale (Self-Assessment Test of Thoughts in Social Interaction) and the Liebowitz Social Anxiety Scale (EASL) (separately assesses anxiety and avoidance in social interaction and performance situations);
- Obsessive-compulsive disorder (OCD): the Yale-Brow Obsessive Compulsive Scale (BOCS, Bouvard & Cottraux, 2010) is used to assess the severity of symptoms.
- The Spilberger Trait Anxiety Scale distinguishes between symptoms related to a current, transient state of anxiety and the lasting symptoms of chronic anxiety.

3) Measuring quality of life using the WHO *Systemic Quality of Life Inventory (SQLI)*: This interactive clinical instrument assesses participants' overall quality of life, based on their ability to achieve personal goals in different spheres of their daily lives.

Measurements are taken at the start and end of the program.

In order to unify and globalize the results of the clinical evaluation tests, we rated our patients at the end of each of the different specific tests for each clinical form with three assessments: no improvement (same score as at inclusion), slight improvement and improvement.

The duration of post-treatment follow-up was 24 months, and was deemed sufficient to allow measurement of the effect of psychotherapy (according to the scientific literature) with a control rhythm of one consultation every 3 months.

3. <u>Organization of the CBT program and proposed techniques</u>

The number of sessions varied, depending on the nature of the disorder being treated. It ranged from 12 to 25 sessions, each lasting 45 min to 1 hour, either individually or in a group. The CBT group was divided into 2 subgroups A and B (comprising 24 and 25 patients respectively). And each subgroup was divided into three smaller groups of 8 or 9 patients, to manage the CBT sessions. The 24 patients in subgroup **A** CBT were divided into three (3) subgroups with a number of participants ranging from 8 to 9 patients. The groups were facilitated by a pair of doctors (project leader and project member). All sessions are interactive. One of the aims is to encourage patients to share their experiences, both in terms of their conceptions and representations of the disease and its treatment, and in terms of the situations they have experienced, the actions they have envisaged and possible strategies. One patient's words can be echoed by other patients, and can in some cases be integrated into the representations and prior knowledge of other patients, more easily than any information given by caregivers. In fact, role-playing or role-playing about managing one's illness and medication in "real life" helps to assess the skills acquired by patients.

In general, the therapeutic framework of CBT addresses several themes, which unfold in several stages. Some of these stages require several sessions:

The TCC program:

The number of sessions varies, depending on the nature of the disorder being treated. It can range from 8 to 25 sessions. In general, the therapeutic framework of CBT covers several themes, which unfold in several stages:
- Motivational analysis: what does the patient want to change? Definition of treatment goals with the therapist;
- Establishing a collaborative therapeutic relationship: the therapeutic alliance must be right for therapy to work well;
- Identifying dysfunctional behaviors ;
- Functional analysis: defining problem behaviors; relating behaviors to emotions and thoughts;
- Explanation of the psychopathological problem and the therapeutic techniques that will be used to bring about changes in behaviour, emotions and thoughts;
- Development of self-healing and self-management skills; ongoing assessment of therapeutic effects achieved against a baseline recorded before starting;
- Maintenance program, monitoring progress over the medium and long term (12 to 24) months after the end of the active treatment phase) and, if necessary, carrying out therapeutic "booster shots" to consolidate therapeutic results and monitor their generalization to other areas in order to reduce the likelihood of relapses and recurrences.

<u>Monitoring parameters</u> will be statistically comparable between the two groups at inclusion.

The primary observational parameters used to evaluate CBT at the end of the study were: quality of remission, relapse, duration of remission, intensity of remission and overall quality of life.

Statistical analysis:

Data entry and statistical analysis were carried out using SPSS version 26 software. Qualitative variables were expressed as percentages or effectives. Quantitative variables were expressed by their means, standard deviations and extremes. Qualitative variables were compared using Pearson's chi-square test. Comparisons between qualitative and quantitative variables were made using Student's T-test. The significance level was set at 5% ($p \leq 0.05$).

III. Result

Descriptive results for the entire sample at inclusion

Our sample comprised 45 men and 53 women (sex ratio=0.85). The average age of the participants was 35.8 ± 12.6 years, with a minimum of 18 years and a maximum of 65 years. Nearly half (48.0%; n=47) were single and 42.9% married. In terms of educational level, almost 40% of our participants had a university education, 29.6% a secondary education, 24.5% an intermediate education and only 6.1% a primary education. On the professional front, almost 30% of participants had no professional activity, 21.4% were students, 36.8% of patients belonged to the middle and low management professional categories, with an equal share (18.4%), and only 12.2% in the upper management category. With regard to addictive behaviors, we noted that 13.3% of our patients used benzodiazepines, 5.1% used cannabis. Alcohol 2% and 6.1% used combinations (alcohol + benzodiazepines or alcohol + cannabis or all three). 31.6% of our patients had a 1st-degree family history of anxiety disorders.

In terms of clinical diagnosis, the majority (40.8%) of patients suffered from panic disorder (PD), 19.4% from Obsessive Compulsive Disorder (OCD), 18.4% from Generalized Anxiety Disorder (GAD), 11.2% from social phobia, 9.2% from agoraphobia and only 1% from simple phobia (Fig. 1).

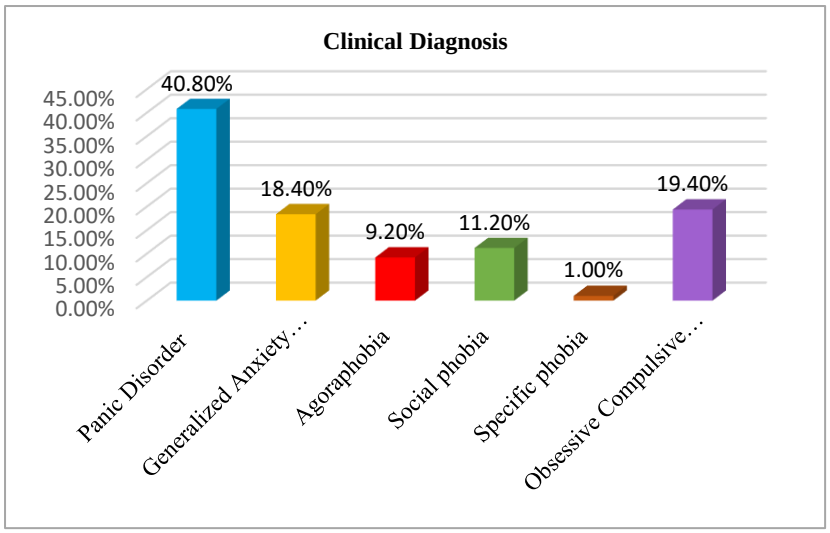

Figure 1: distribution of the clinical diagnosis of the global sample

Comparative description of the CBT group versus the Control group at inclusion

Comparative description of groups according to socio-demographic characteristics and history

There was no difference in socio-demographic profiles between the CBT and control groups (Tab.1).

Professional front, almost 30% of participants had no professional activity, 21.4% were students, 36.8% of patients belonged to the middle and low management professional categories, with an equal share (18.4%), and only 12.2% in the upper management category. With regard to addictive behaviors, we noted that 13.3% of our patients used benzodiazepines, 5.1% used cannabis. Alcohol 2% and 6.1% used combinations (alcohol + benzodiazepines or alcohol + cannabis or all three). 31.6% of our patients had a 1st-degree family history of anxiety disorders.

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Table 1. Breakdown of socio-demographic characteristics and medical history of the CBT versus Control group

Variables	TCC Group (n=49)	Control group (n=49)	Chi-square
Gender			
Woman	57 % (n=28)	51 % (n=25)	**0,543**
Men	43 % (n= 21)	49 % (n= 24)	
Family situation			
Single	41% (n=20)	55% (n=27)	
Married	49% (n=24)	37% (n=18)	**0,407**
Divorced	8% (n=04)	4% (n=02)	
Widowed	2% (n=01)	4% (n=02)	
Education level			
Primary	8% (n=04)	4% (n=02)	
Medium	22,5% (n=11)	26% (n=13)	**0,506**
Secondary	24,5% (n=12)	35%(n=17)	
University	45% (n=22)	35% (n=17)	
Socio-professional category			
Senior executive	18,5% (n=09)	6% (n=03)	
Medium frame	16,5% (n=08)	20,5% (n=10)	**0,230**
Weak frame	22,5% (n=11)	14,5%(n=07)	
Student	16,5% (n=08)	26% (n=13)	
No profession	26% (n=13)	33% (n=16)	
Family history			
Anxiety disorders	37% (n=18)	26% (n=13)	
Other disorders	6% (n=03)	11% (n=05)	**0,482**
No antecedents	57% (n=28)	63% (n=31)	
Toxic comorbidities			
Benzodiazepine	16,5% (n=08)	11% (n=05)	
Alcohol	0% (n=00)	4% (n=02)	**0,095**
Cannabis	0% (n=00)	11% (n=05)	
Associations	6% (n=03)	6% (n=03)	
No consumption	77,5% (n=38)	68% (n=34)	

Comparative description of groups according to clinical diagnosis and duration of evolution

There was no significant difference in the profile of clinical diagnosis or duration of disorder between the CBT and control groups (Tab. 2).

Table 2. Comparative distribution of clinical diagnoses and duration of evolution in the CBT versus Control group

Variables	TCC Group (n=49)	Control group (n=49)	Chi-square
Clinical diagnosis			
TP	37% (n=18)	45% (n=22)	**0,678**
TAG	16,5% (n=08)	20,5% (n=10)	
Agoraphobia	08% (n=04)	11% (n=05)	
Social phobia	12% (n=06)	11% (n=05)	
Specific phobia	2% (n=01)	00% (n=00)	
TOC	24,5% (n=12)	14,5% (n=07)	
Duration of disorder			
Less than 3 months	12% (n=06)	11% (n=05)	
3 - 6 months	8% (n=04)	11% (n=05)	**0,949**
6-9 months	6% (n=03)	8%(n=04)	
Over 6 months	74% (n=36)	70% (n=35)	

Comparative description of groups according to specific clinical assessments of each disorder and quality of life

In our series, there was no significant difference in the intensity of clinical symptoms before the start of CBT therapy workshops (p=0.573).The global assessment of quality of life using the ISQV scale was judged to be moderate to severe for the majority of patients in both groups. There was no significant difference, with chi-square = 0.567 (Tab.3).

Table 3. Breakdown of overall ratings on clinical scales in the CBT versus Control group

	Global evaluation scale			
	Slight damage	Medium damage	Severe damage	Chi-square
TCC Group	1	20	28	0,573
Control group	0	22	27	
	ISQV scale: quality of life			

Slight damage	Slight damage	Medium damage	Severe damage	Chi-square
TCC Group	3	30	16	0,567
Control group	5	32	12	
Total	8	62	28	98

Description of the results of the cognitive-behavioural therapy programme
Description of the results of the CBT workshops
1. Breakdown by number of CBT workshop sessions

The majority of patients had received an average of 17±12 CBT sessions. It should be noted that 11 patients had received more sessions (25 sessions) due to the slow assimilation of certain CBT program themes. Eighteen patients benefited from 18 sessions and 20 patients from only 12 sessions.

2. Breakdown by attendance and participation in CBT workshop sessions

The majority of participants (n=40) in the CBT workshops had a good attendance record.

And good participation in the various activities included in the program. Twelve patients, on the other hand, had difficulty communicating, either because of shyness or performance anxiety. The majority of patients (n=41) were able to carry out tasks at home within the framework of the therapy program, while three patients were not always able to do so, and five patients were unable to do so at all. (Tab.4).

Tab.4: Distribution of patients according to attendance and participation in CBT sessions

CBT group (n=49)	Good	Average	Wrong
Session attendance	40	6	3
Attendance	36	1	12

Comparative description of the results of the CBT versus Control group, 24 months after the CBT program
1. Impact of CBT on relapse rate compared with control group
Relapse rate

The impact of CBT was highly significant on the relapse rate of the CBT group at the end of our study (p=0.021) (Tab.5; Fig. 2).

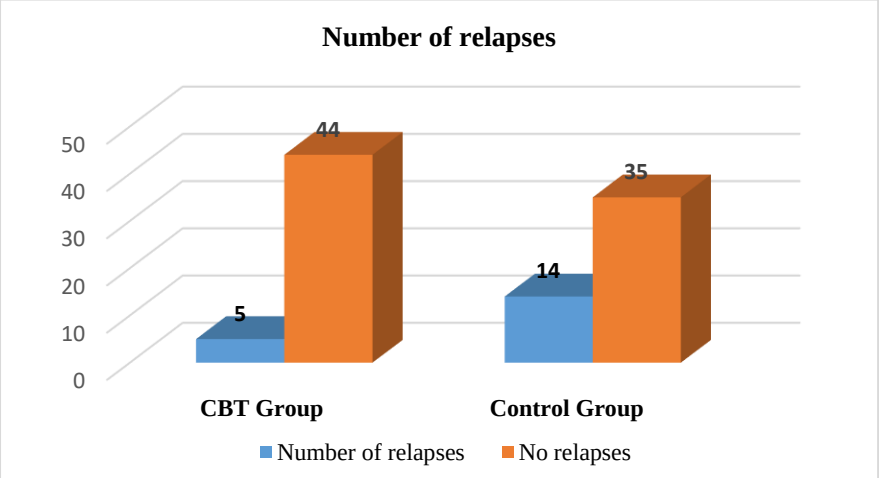

Figure 2: Relapse rate distribution, CBT versus control group

Relapse time

Note that the time to relapse was significantly faster in the control group, with the majority relapsing within 3-6 months (p=0.041) (Tab.5; Fig. 3).

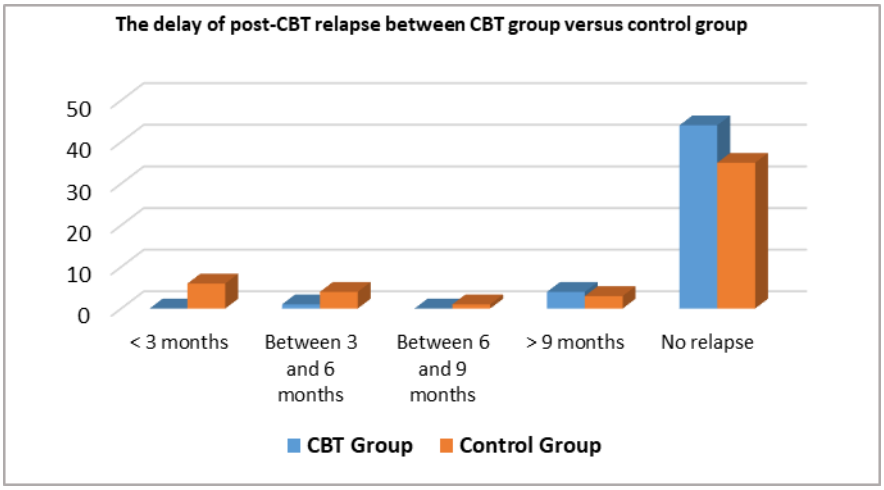

Figure 3: Distribution of patients by time to post-CBT relapse between CBT and control groups

Intensity of relapse

The intensity of relapse was moderate to severe in the control group despite pharmacological treatment, and therefore highly significant compared with the experimental group (p=0.025) (Tab.5; Fig. 4).

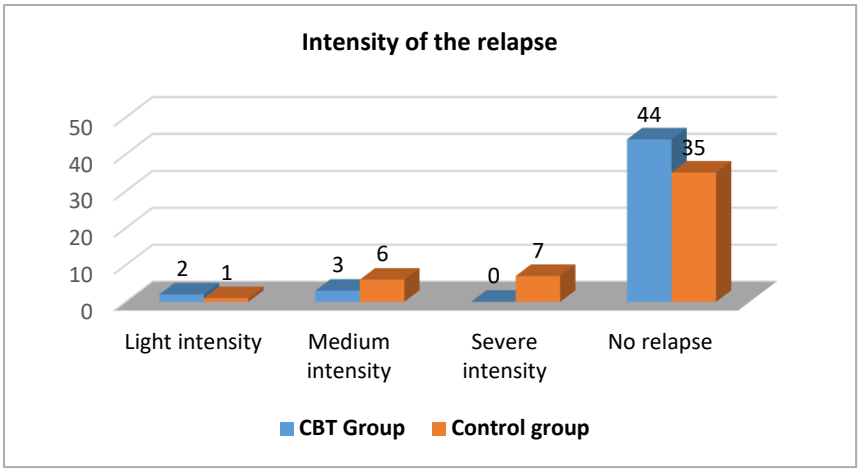

Figure 4: Distribution of patients by intensity of post-CBT relapse between CBT and control groups

Causal factors for relapse

It should be noted that stressful events were not the cause of relapses in the control group, whereas in the CBT group, event-related stress was the cause of relapses in five patients (p=0.000) (Tab.5; Fig. 5).

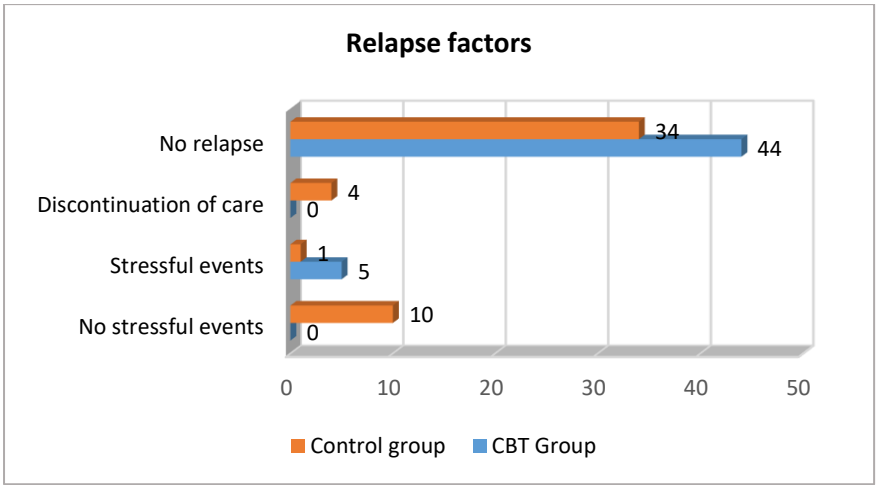

Figure 5: Distribution of patients by post-CBT relapse factors between CBT and control groups

Tab. 5: Distribution of patients according to the impact of CBT on relapse rate, delay, intensity and relapse factors at 24-month follow-up between CBT group versus Control group

	CBT Group	Control Group	Chi-square
Number of relapses			
Relapse	5	14	**0,021**
No relapse	44	35	
Time to relapse after therapy			
Less than 3 months	0	6	**0,041**
Between 3 and 6 months	1	4	
Between 6 and 9 months	0	1	
Over 9 months	4	3	
No relapse	44	35	
Intensity of relapse			
Light intensity	2	1	**0,025**
Medium intensity	3	6	
Severe intensity	0	7	
No relapse	44	35	
Relapse factors			
No stressful events	0	10	**0,000**
Stressful events	5	1	
Discontinuation of care	0	4	
No relapse	44	34	
Total	49	49	

Impact of CBT on quality of remission compared with control group

At the end of our study, CBT had a considerable impact on the quality of remission, since our results were globally significant in the CBT group compared with the control group on improved scores on specific evaluation tests of clinical symptomatology of the different clinical forms (p=0.000) (Fig.6).

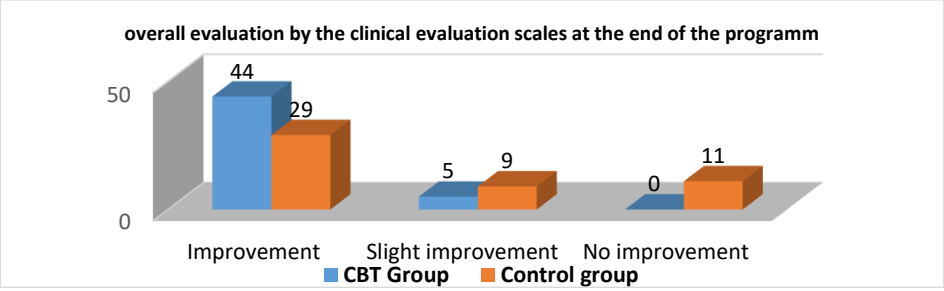

Figure 6: Distribution of patients by the clinical evaluation scales at the end of the CBT program, CBT versus control group

Impact of CBT on quality of life compared with control group

CBT had a significant impact on improving participants' quality of life scores (ISQV scale) compared with the control group (p=0.002) (Fig. 7).

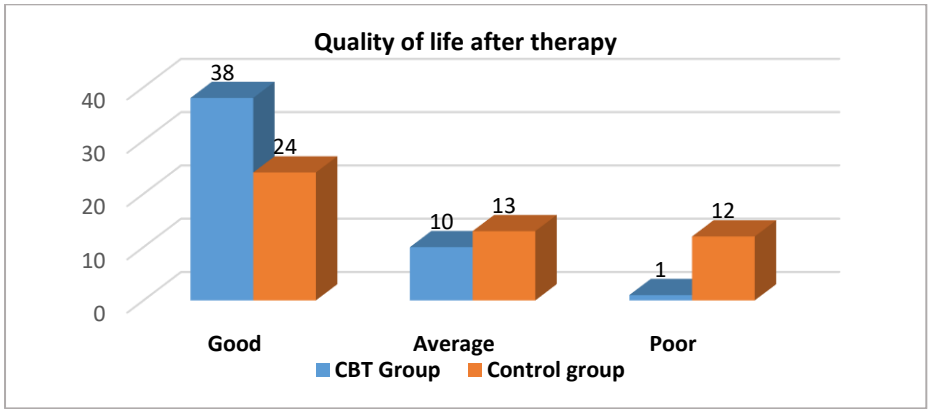

Figure 7: Distribution of patients according to improvement in quality of life between CBT and control groups

IV. Discussion

Socio-demographic and clinical profile data

On the whole, our population showed no particular socio-demographic, clinical or therapeutic differences between the CBT and control groups, compared with what has been described in the literature [5-7]. In our sample, the average age of onset of anxiety disorders and OCD was 35.8 years. Overall, these figures are in line with the literature, since the age of onset is around 35 years [18-19]. In terms of sex ratio, the prevalence of anxiety disorders and OCD is around twice as high in women as in men, according to some results in the literature [18-20]. Which does not agree with our study, since the sex ratio was close to one, This can be explained by the fact that data collection from the study population took place during the first two waves of the COVID-19 pandemic, when the level of anxiety-related decompensation was equally present in women and men.

In our results, we found a moderate to severe impairment of quality of life induced by the severity of anxiety at inclusion for both groups, which seems to be in line with some studies [21-22]. Beyond the impact of the anxiety disorder symptoms themselves, international data indicate that the presence of an anxiety disorder and OCD is associated with the subsequent risk of suffering from a medical condition, notably cardiovascular and respiratory diseases, with an increased risk of sudden death [23-24]. Our population was free of any somatic comorbidity, which could constitute a bias in our study. The presence of a high level of anxiety also has an impact on depressive complications and on the efficacy of CBT or other psychotherapies [24-25]. As for the meta-analysis by *Kanwar and al* (2013), they report a significant association between anxiety disorders and suicidality [2]. In our sample, there were no psychiatric complications, including depression and suicidal behavior.

Data on CBT and its impact on anxiety disorders and OCD

CBT has proved effective for a wide variety of mental disorders, including anxiety and OCD, since its introduction and initiation by the early work of psychologists such as *Albert Ellis and Aaron T. Beck.* CBT has also been associated with improvements in quality of life in these patients. It targets the modification of anxious thoughts and behaviors, as well as the reduction of unpleasant physical sensations caused by anxiety, through the learning of different techniques. Several meta-analyses [5-8] and systematic reviews [6, 26] have demonstrated the efficacy of these psychological interventions, which is why we have chosen CBT as our psychotherapeutic option. Studies directly comparing medication and psychological interventions are less conclusive. Indeed, according to a *Cochrane* systematic review, clinical trials directly comparing medication and psychological interventions for panic disorder failed to find a significant difference between the two [27]. Conversely, in a systematic review of the cost-effectiveness of various treatments for all anxiety disorders and OCD, four out of five studies directly comparing psychological interventions and medication concluded that the former was superior [28].

However, evidence suggests that psychotherapy (CBT) combined with pharmacotherapy is more effective than psychotherapy alone in treating patients with severe anxiety disorders, sometimes complicated by depression [15-16, 29]. Indeed, given the moderate impairment of our participants, we opted for a combination of CBT with antidepressants in the experimental group and antidepressants alone in the control group. It should also be noted that the Canadian CPG (Canadian Practice Guidelines) indicate that the combination of CBT and medication may be preferable for people whose symptoms or functional impairment are of such intensity as to justify aiming for rapid relief [14]. Furthermore, these research data show the benefits of CBT, which are maintained longer after the end of treatment than those of medication, and are therefore superior to them in terms of relapse prevention, which oscillates between 22 and 46% for anxiety and OCD sufferers [15-6,29]. CBT has also been shown to be effective when administered in group or individual formats [6, 26], as in the case of our research, where a third of patients had benefited from an individual CBT program and the remainder from a group program.

Analysis and interpretation of the 24-month post-CBT data can be summarized as follows:

The average number of CBT workshop sessions was 17±12, with a minimum of 12 and a maximum of 25 sessions depending on the clinical forms of anxiety disorders or OCD, which is a correct norm and described by the literature with notably the systematic review by *Cuijpers and al.*, 2013, sessions vary between six and twenty [15]. The majority of patients attended their sessions regularly. As for participation within the group, it was generally good for the majority of participants, as well as for the execution of tasks (exercises) at home, the majority performed them except, eight participants who had quite severe disorders. The organization of our program was in line with most meta-analyses of this issue [5-7, 26].

The impact of CBT over 24 months on the relapse rate in the CBT versus control group, 5/49 versus 14/49 respectively, was significant. Relapse time was significantly shorter in the control group than in the CBT group, which was longer. As for the intensity of relapse in the assessment tests for each clinical form of anxiety disorder and OCD, it was significantly severe in the control group versus the CBT group. Overall, there was a significant impact of CBT on improving the quality of remission and quality of life compared with the control group. This is fully in line with the literature.

It should be noted that the impact of the CBT program on anxiety disorders and OCD was significant compared to the control group on the individual's quality of life. Indeed, remission lasted at least two years after

CBT treatment for the majority of participants. These findings have been reported in most of the research literature [6-7, 26]. Indeed, James and al (2015) meta-analysis of the efficacy of CBT in the treatment of anxiety disorders in adolescents and even children showed that 59% of participants who received CBT went into remission following treatment, compared with 18% who did not [6]. What's more, between 65% and 95% of participants reported significant positive effects following CBT, such as reduced anxiety and improved overall functioning, which could persist for up to nine years after treatment [30-31]. Indeed, our study showed good results over 24 months of observation after the CBT program.

Conflict of Interest

The authors declare no conflicts of interest.

Authors' Contributions

All authors contributed to the completion of this work and have read and approved the final version of the manuscript.

V. Conclusion

At the end of our research study, the overall evaluation of the effectiveness of the CBT program after 24 months of observation on anxiety and OCD disorders was satisfactory and significant compared to the control group. The impact of this therapy was notable on several variables:

- Good remission quality;
- Relapses are rare. If a relapse does occur, it's only after a long period of remission of mild to moderate intensity, manageable by the patient and thanks to the learning of stress management methods during the CBT program;
- Normal resumption of social, professional and leisure activities, with the disappearance of anticipatory anxiety and anxious ruminations in favor of well-being and improved self-esteem, offering a better quality of life.

This program is strongly recommended without pharmacotherapy for patients suffering from anxiety disorders and obsessive-compulsive disorders at the initial consultation stage, before the disorders become chronic and the anxiety of apprehension sets in, leading to maintenance of the disorders, relapses and depressive complications, necessitating long-term, high-dose medication.

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