Journal of Asian Scientific Research
ISSN(e): 2223-1331/ISSN(p): 2226-5724
URL: www.aessweb.com

# EFFECTIVENESS OF MULTI-MODAL LAZRAVS AND MULTI-MODAL SPIRITUAL - RELIGIOUS, OF PHYSICAL SYMPTOMS AND QUALITY LIFE IN PATIENTS WITH FUNCTIONAL DYSPEPSIA

**Niloofar Mikaeili[1] --- Nader Hajloo[2] --- Mohammad Narimani[3] --- Sobhan Pournikdast[4†]**
[1,2]*Associate professor of psychology; University of Mohaghegh Ardabili, Ardabil, Iran*
[3]*Professor of psychology; University of Mohaghegh Ardabili, Ardabil, Iran*
[4]*Ph.D student of psychology; University of Mohaghegh Ardabili, Ardabil, Iran*

## ABSTRACT

*Introduction: this study aimed to compare the effectiveness of several Lazarus multimodal therapy and spiritual-religious multimodal on specific physical symptoms and quality of life in patients with functional dyspepsia was designed and implemented. Method: the study is a quasi-experimental and functional study which is done with pretest-posttest control group. The population includes all gastrointestinal patients whom are sent to clinics in Tehran district5, and samples consisted of 54 patients with FD, they will be selected using available Non Probability Sampling and random assignment. Instrument of the study are index of physical symptoms and quality of life in patients with functional dyspepsia (NDI) and data are analyzed using analysis of covariance and using SPSS software . Results: findings show that in the experimental groups, there is a significant difference in life quality and physical symptoms at the time of subjects entering the study and after treatment; however, there was no significant difference for the control group. Also, there is no significant difference among treatment groups in terms of effectiveness of physical symptoms and quality of life in post-test and the follow-up in the majority of components. According to the above results and consistent with other studies, the possibility of benefiting from above interventions in patients with functional dyspepsia was provided.*



**Keywords:** Lazarus multimodal therapy, Treatment of spiritual-religious multimodal, Functional dyspepsia, Psychosomatic, Digestion, Spirituality Therapy, Functional disorders.

## Contribution/ Originality

This study is one of the few studies to examine the effectiveness of treatment of psychosomatic disorders, focused on the psychological multifaceted. Due to the lack of research related to the society and history variables, this study would reinforce the theoretical and research literature from the increasing point of view in this area.

† Corresponding author
DOI: 10.18488/journal.2/2015.5.12/2.12.534.544
*ISSN(e): 2223-1331/ISSN(p): 2226-5724*

## 1. INTRODUCTION

Todays, most researchers of cognitive psychology believe that deficiencies of body can bring psychological problems, and they can worsen medical problems [1]. In DSM-V the psychological effective factors on the medical events with an unclear rate of approach have been placed in somatic symptom disorders chapter [2]. Functional dyspepsia is among somatic symptom disorders which is related to irritable bowel syndrome. Moreover, the studies have placed some disciplines of psychodynamics in this class of patients [3]. The chronic fatigue syndrome in upper digestive has some symptoms such as: upper abdominal pain, early satiety after eating a small amount of food, feeling of satiety in stomach, tympanites and vomiting which do not determine its common physical and biochemistry symptoms [4]. The prevalence of FD in the western countries is 17 to 29 percent [5]. For the Tehran's population it is estimated as 8.5 percent [6]. There is evidence which shows that there is a relation between pyshcological factors, sensory receptors and the perfomance of the syptomes of indigestion. In the FD, the perfomance of the hypothalamus pituitary adrenal axis controling the body responce to stress is disrupted. Also, the disorder of sympathetic system performance in the AD patiants affects the syndrom of functional dyspepsia [7]. Since psychological factors and disorders have affected the acuteness of symptoms of these patients, the researchers have shown more tendency towards utilizing psychological treatments in such patients [8].

A group of psychological therapies which their significance in somatic symptom disorder diseases received little attention are multimodal and integrative therapies. Lazarus therapy is one the most major multimodal protocols because the patients have different problems, and for treating the patient, several approaches should be used [9]. Lazarus therapy has been successfully utilized in a wide range of disorders and problems. Also, according to reports by Lazarus [10] the results of three-year longitudinal study in which the Lazarus multimodal therapy was put into practice showed that out of 20 patients (obsessive-compulsive disorder, panic disorder, anxiety and acute panic disorders, depression, addiction to alcohol, and conjugal and familial problems) 14 ones had been treated successfully [10] cited in Rahimian Bouger & Share, 2008).

But, in this research the multimodal cognitive behavioral therapy has been stressed, which is reliant on religion and spirituality. By reviewing the literature, it can be understood that the efficacy of this therapy in reducing psychological problems like acute anxiety, dysthymia, and sleeping and eating problems has been confirmed in a verity of studies [11-15]. Even short-time spiritual meditation has been reported efficient in increasing the control of feeling and its positive effects on self-esteem. Despite a growing body of evidence in the key role of psychological processes in the functional dyspepsia [16]. There are very few reported studies showing the effects of psychological interventions in symptoms of functional dyspepsia. Thus, by considering the low quality of life, the direct medicinal and health expenses, drug taking without prescriptions and indirect expenses like leave of absence and a decrease on the efficiency of work which generate many individual and social problems and enormous expenses of the FD illness, this study aims to enrich the existing literature in this scope and to investigate the efficacy of multimodal Lazarus and religious-spiritual

therapy on the physical symptoms and the life quality and finally this research intends to compare the efficacy of these two interventions in the FD patients.

## 2. METHODOLOGICAL CONSIDERATIONS

This study enjoys a quasi-experimental design in which a pretest and post-test randomized group design was taken into account. To put it differently, the dependent variables in three groups (two treatment groups and one control group) were evaluated after three rounds of pretesting and post-testing (one month after intervention).

The population of the study is composed of all the patients with gastrointestinal disease who referred to the gastrointestinal problems clinics in Tehran's region five in the second half of the year 1393 (2014). After the biochemistry, endoscopy and sonography examinations and rejecting any structural and organic factors and diseases in the digestive system, the doctor confirmed the functional dyspepsia. For each group, the sample consist of 18 patients so that it is possible to control the quality indexes of the sample if they decreased in terms of number. Thus, the whole population is made up of 54 FD patients, which were chosen using (non-random) available sampling but those available samples were chosen randomly. The patients with organic intestinal disorders, including duodenal ulcers, gastroesophageal reflux disease, gastritis, colorectal cancer, gallstones disorders and anemia were excluded from the study. Patients with medical record of thyroid problems or those take corticosteroid medications in the last six months were not considered for the research. It is also vital that all the subjects during the intervention period follow the programs and they are not expected to make any changes in their medicines or also not attend the psychotherapy sessions like relaxation and meditation.

### 2.1. Instruments

**The evaluation criterion for the physical symptoms and the quality of life in the FD patients:**

This criterion was first designed by to evaluate the physical symptoms in the AD patients Tally, et al. [4].

The score of criterion in this questionnaire is evaluated by the following symptoms: upper abdominal pain, stomach disorders, nausea, vomiting, heartburn, tympanites, early satiety after eating a small amount of food and excessive belching. The score for nine symptoms of the disease is obtained by the sum of mean, acuteness and being problematic, and the score of each is graded on a Likert scale.

The score of life quality is evaluated in this questionnaire as: This part holds 25 questions about the life quality of the patients addressing the anxiety, stress, intervention in the life affairs, eating, drinking, knowledge and familiarity with the diseases control.

In the study by Tally, et al. [4] the reliability of NDI questionnaire was acquired with Cronbach's alpha which was 70 to 76 percent. Its validity was reported as 71 to 81 percent with correlation coefficient in score of the symptoms. Also in Iran and in the research by Zargar, et al. [17] the reliability of the questionnaire was reported as 84 percent for the symptoms part and 94 percent for the life quality part using Cronbach's alpha.

The structure of the sessions of multimodal religious-spiritual therapy: the self-designed protocol for the multimodal religious-spiritual therapy is made up of the integrative therapy [18]. and the multimodal spiritual therapy by Barrera, et al. [19] as the third generation of cognitive-behavioral therapy. In addition to techniques and theoretical frameworks of the therapy, the researcher also made use of the domesticated Iranian-Islamic therapy, this protocol was presented in nine, ninety minute sessions.

Session 1: The group therapy considerations like introducing the members and the therapist, brief introductions on psychosomatic disorders with functional dyspepsia syndrome, consultation and the characteristic features of multimodal religious therapy, introducing the biological, psychological, social and spiritual dimensions with an emphasis on the significance of the spiritual dimension, encouraging the members in stating their related personal experiences, the therapist's duties and the patient by categorizing the therapy and assignments.

Session 2: Reviewing the assignments, teaching how to remove the tensions (without muscular contraction) with spiritual mediation, and giving assignments

Session 3: Reviewing the assignments, teaching participation techniques and practices of physical confronting with an emphasis on religious evidence, giving assignments.

Session 4: Reviewing the assignments, behavioral activation based on the religion (attending the religious gatherings, praying and uncommon benediction, mentioning to the non-material events in the personal life, and considering the personal time, giving assignments.

Session 5: Reviewing the assignments, teaching generosity with religious points of view, giving the assignments on generosity.

Session 6: Reviewing the assignments, teaching approaches to enhance the self-esteem based on the religion (the skills of efficient communication, and skills of managing time), giving assignments.

Session 7: Reviewing the assignments, teaching steps of solving a problem based on the spiritual approaches (plan (the principles of solving the problem), appeal and trust), giving assignments.

Session 8: Reviewing the assignments, instructions on the style of life with a spiritual approach (communications, nourishment, sleep, exercise, health), giving assignments.

Session 9: Reviewing the assignments, presenting the summaries of the earlier sessions, receiving the feedback of the members, announcing the end of sessions, acknowledging the members, advising on keeping the communications and doing the assessments, and performing after the test.

The structure of Lazarus multimodal therapy: In the current study, the multimodal therapy was done in ten, ninety minute sessions using the multimodal approach, evaluating the members and their personality through drawing the dimensional and structural profile of the group in the face-to-face meetings and in a group way [20].

Session 1: 1. Familiarizing the members with the nature of consultation and the characteristic features of Lazarus multimodal therapy, 2. The discussion about mental well-being, 3. Determining the seven dimensions on the initiation and continuance of medical disorders and 4. Members' familiarity with their assignments and duties, filling in the questionnaire of life records as an assignment.

Session 2: Reviewing the assignments, group discussions on the communicating manner of seven dimensions according to filled out questionnaires, buying Forty Poisonous Thoughts by Lazarus as an assignment.

Session 3: Reviewing the assignments, putting in discussion the dimensional and structural profile of the group prepared by the therapist, choosing the healthiest dimension in enhancing the motivation for initiating the intervention, and drawing the structural profile by members as an assignment.

Session 4: Reviewing the assignments, the functional techniques in the scope of imagination (the whiteboard technique and highest possible imagination technique) giving assignments,

Session 5: Reviewing the assignments, practicing the skills of assertiveness (ambiguity, breaking records, negation, playing the role) as an interpersonal dimension, giving assignments,

Session 6: Reviewing the assignments, behavioral techniques (record, positive enhancement, self-supervision, punishment by penalty) giving assignments.

Session 7: Reviewing the assignments, the sensorial perception (muscular relaxation of 21 groups), giving assignments.

Session 8: Reviewing the assignments, cognitive techniques (confronting cognitive distortion, motivational self-talk), giving assignments.

Session 9: Reviewing the assignments, the biological techniques or the style of life (regular exercising, the principles of nourishment and sleep, and decreasing tobacco smoking and alcohol consumption), buying We Can if We Want by Lazarus as an assignment.

Session 10: Reviewing the assignments, presenting the summaries of the previous sessions, answering the questions regarding persistence in the period after the therapy, receiving the feedback from the participants for the whole process of therapy, thanking and acknowledging, completing the post-test questionnaire.

## 3. FINDINGS

In Table 1, the descriptive indexes regarding the scores of pre-test, post-test and follow-up stages have been presented. The comparison of the means of each group in the case of physical symptoms and life quality in the post-test and follow-up stages shows that there is a decrease in the means of the treatment groups. Since the physical symptoms and life quality items are different; thus, the total factor of the questionnaire is not calculated.

In the inferential part and with the comparison of the efficacy of Lazarus and religious-spiritual multimodal therapy on the dependent variables, first all the assumptions of the post-test (p-0.411 F-0.618, p-0.565 F-0.578) and follow-up (p-0.411 F-0.814, p-0.434 F-0.849) showed that the variances of the two groups in all the items do not have any significant differences with each other ($p>0.05$); thus, a parametric test is required.

Also in the analysis the two stages of post-test (p- 0.001 F-11.16) and follow-up (p-0.001 F-6.007) showed that p was significant ($p<0.01$), thus, according to homogeneity of covariance matrix, to interpret the results the Pillai trace test was used.

According to Table 2, the results of analysis of MANCOVA for the two stages of post-test (Pillai trace-1.44, p<0.001 F-63.22) and follow-up (Pillai trace-1.35, P<0.001 F-8.05) showed that the three groups significantly differed. Also, in terms of one of the dependent variables there was significant differences in the studied groups. The Beta showed that the difference between the groups according to dependent variables is significant, and around 72% of the variance is associated with the difference between the groups in the post-test and 67% in the follow-up stages is the result of the efficiency of the interventions.

To investigate the secondary hypotheses and group differences, the univariate analysis of variance was conducted (Table 3). In the post-test and follow-up stages, a significant difference was observed (P<0.001), and the Beta also showed that the maximum standardized difference in the two said stages is related to life quality (0.97 and 0.97).

Finally, the results of Bonferroni tests for the comparison of the groups have been elaborately presented in Table 4 showing that the treatment groups (Lazarus and religious-spiritual) in comparison with the control groups in terms of life quality in the post-test and follow-up stages have shown significant differences (p<0.001). But in the treatment groups in terms of the efficacy of the therapy on the life quality no significant difference was found (p>0.05). With regard to the physical symptoms of indigestion, the findings illustrated the efficacy of the treatment groups for this variable after the post-test as opposed to the control group (P<0.001). But the Lazarus group post-test showed a significant difference with the religious-spiritual group (p<0.001). At last in the follow-up stage the difference between the efficacy of the Lazarus therapy and the religious-spiritual group was significant (p<0.001) but the religious-spiritual groups did not show any difference with the control group (p>0.05).

**Table-1.** The mean and standard deviation of indigestion symptoms and life quality variables in different groups and stages

| Follow up | after | pre | Follow up | after | pre | Follow up | after | pre | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 52/50 | 56/16 | 51/16 | 46/66 | 44/33 | 52/16 | 21/05 | 20/38 | 53/55 | M | Physical symptoms |
| 7/16 | 4/14 | 4/23 | 6/84 | 7/01 | 8/47 | 3/31 | 1/91 | 8/56 | SD | |
| 68/77 | 67/66 | 64/77 | 21/33 | 22/33 | 66/22 | 22/61 | 20/55 | 65/83 | M | Quality of Life |
| 3/40 | 4/52 | 7/43 | 4/82 | 4/35 | 8/82 | 4/31 | 4/20 | 10/84 | SD | |

**Source:** From Thesis Ph.D

**Table-2.** The MANCOVA analysis of life quality and physical symptoms in the post-test and follow-up stages.

| Statistical power | Eta | P | Error df | Hypothesis df | F | value | Dependent variable |
|---|---|---|---|---|---|---|---|
| 1 | 0/72 | 0/001 | 98 | 4 | 63/22 | 1/44 | Pillais trace |
| 1 | 0/87 | 0/001 | 96 | 4 | 166/56 | 0/01 | Wilks lambda |
| 1 | 0/94 | 0/001 | 94 | 4 | 390/22 | 32/21 | Hotelling trace |
| 1 | 0/97 | 0/001 | 49 | 2 | 791/80 | 32/31 | Roys largest root |
| | | | | | | | *Continue* |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | 0/67 | 0/001 | | 4 | 80/5 | 1/35 | Pillais trace |
| Follow up | | | | | | | |
| 1 | 0/86 | 0/001 | | 4 | 159/12 | 0/01 | Wilks lambda |
| 1 | 0/94 | 0/001 | | 4 | 419/95 | 35/74 | Hotelling trace |
| 1 | 0/97 | 0/001 | | 2 | 860/71 | 35/13 | Roys largest root |

**Source:** From Thesis Ph.D

**Table-3.** The output results of univariate analysis of variance of the studied variables in the post-test and follow-up stage

| power | Eta | P | F | Mean square | DF | Sum of squares | Dependent variable |
|---|---|---|---|---|---|---|---|
| 1 | 0/97 | 0/001 | 780/37 | 12827/46 | 2 | 25654/93 | Quality of Life |
| | | | | | | | After the test |
| 1 | 0/69 | 0/001 | 54/41 | 5676/91 | 2 | 11353/83 | Physical symptoms |
| 1 | 0/97 | 0/001 | 858/37 | 13184/40 | 2 | 26368/81 | Quality of Life |
| | | | | | | | Follow up |
| 1 | 0/49 | 0/001 | 23/72 | 4767/79 | 2 | 9535/58 | Physical symptoms |

**Source:** From Thesis Ph.D

**Table-4.** The Bonferroni test, the comparison of the groups in the studied variables in post-test and follow-up stages

| P | Std.Error | mean difference) I-J( | Group) J( | Group) I( | Dependent variable |
|---|---|---|---|---|---|
| 0/001 | 1/36 | 47/59 | Lazarus | Control | Quality of Life |
| 0/001 | 1/35 | 45/71 | Religious spiritual | | After the test |
| 0/001 | 1/36 | -47/59 | Control | Lazarus | |
| 0/17 | 1/35 | -1/87 | Religious spiritual | | |
| 0/001 | 1/35 | -45/71 | Control | Religious spiritual | |
| 0/17 | 1/35 | 1/87 | Lazarus | | |
| 0/001 | 3/44 | 35/22 | Lazarus | Control | Physical symptoms |
| 0/001 | 3/41 | 11/61 | Religious spiritual | | |
| 0/001 | 3/44 | -35/22 | Control | Lazarus | |
| 0/001 | 3/41 | -23/60 | Religious spiritual | | |
| 0/001 | 3/41 | 11/61 | Control | Religious spiritual | |
| 0/001 | 3/41 | 23/60 | Lazarus | | |
| 0/001 | 1/32 | 46/76 | Lazarus | Control | Quality of Life |
| 0/001 | 1/31 | 47/82 | Religious spiritual | | Follow up |
| | | | | | *Continue* |

| | | | | | |
|---|---|---|---|---|---|
| 0/001 | 1/32 | -46/76 | Control | Lazarus | |
| 0/42 | 1/31 | 1/06 | Religious spiritual | | |
| 0/001 | 1/31 | -/47/82 | Control | Religious spiritual | |
| 0/42 | 1/21 | -1/06 | Lazarus | | |
| 0/001 | 4/77 | 30/82 | Lazarus | Control | Physical symptoms |
| 0/24 | 4/74 | 5/55 | Religious spiritual | | |
| 0/001 | 4/77 | -30/82 | Control | Lazarus | |
| 0/001 | 4/74 | -25/27 | Religious spiritual | | |
| 0/24 | 4/74 | -5/55 | Control | Religious spiritual | |
| 0/001 | 4/74 | 25/27 | Lazarus | | |

**Source:** From Thesis Ph.D

## 4. DISCUSSION

One of the areas of disorders which has not sufficiently benefited from multimodal and integrative therapies is physical disorders affected by psychological factors like indigestion in the upper digestive; therefore, by considering the significance of the identifying new therapies in this area of research, this study intended to compare the efficacy of Lazarus and religious-spiritual multimodal therapies on the physical symptoms and life quality of the FD patients.

In sum, the results indicated that there was a significant difference between the treatment groups (Lazarus and religious-spiritual) and the control group in terms of life quality in the two stages of post-test and follow-up ($p<0.001$). But, between the treatment groups in terms of the efficacy of life quality in the post-test and follow-up stages, no significant difference was found ($p>0.05$). As to the physical symptoms of indigestion, the results confirmed the efficacy of the treatment groups in this variable in the post-test stage as opposed to the control group ($p<0.001$). But the scores of the post-test and follow-up stages in the Lazarus group showed a significant difference with the religious-spiritual group; hence, it was more efficient ($p<0.001$).

As it was mentioned previously, no similar research has been conducted on the efficacy of the aforementioned therapies on the psychosomatic disorders; consequently, the efficacy of multi-modal therapies including Lazarus on many disorders such as psychosomatic disorders is in line with the findings of the current study [21-23]. It is worth mentioning that with regard to said hypothesis, no research with opposite or contradictory results were found.

In determining the achieved results on confirming the efficacy of Lazarus therapy on the quality of life and physical symptoms in comparison with the control group, mentions could be made of the complex nature of medical disorders affected by the psychological states like FD as well as the multiple performances of Lazarus therapy in the seven-dimensional levels. Stress and neurotransmitter, endocrine and immune response to it alongside the daily stress, depression, and conscious and unconscious excitement, personality features, coping style, excessive denial, health behaviors and weak self-care [1] are among the main routs which affect the medical disorders like FD from the psychological state of the patient. Integrative and multimodal therapies such as Lazarus therapy also affect the behavioral, cognitive, sensorial, interpersonal, biological states as well as the life style of the patient by the various and comprehensive patterns and techniques in different levels. Lazarus also clearly states that integrative and hybrid approaches have a higher

applicability in the general populations and in a wide range of medical disorders [24]. In the previous research also cognitive-behavioral and multimodal therapies based on the religion and decreasing the level of stress and anxiety [15] on decreasing the generalized anxiety disorder in the elderly [18] short-term meditation over control feeling and self-concept and in increasing the risky behaviors and tobacco smoking in the minorities [25] as an effective therapy in line with the current research have been reported as efficient which are in line with the obtained results of the current study on the efficacy of religious-spiritual therapies. Therapy intervention based on the spirituality as an intermediary process affects the humans' evaluation of events, and the believer could obtain a more positive excitement with faith when facing with the up and downs of life. In fact, the spiritual orders and ceremonies continually- by means of the multimodal interventions driven from behavioral and cognitive principles with an increase in self-esteem and decreasing the social alienation and loneliness, feeling of having a purposes in life, increasing endurance, facing by means of faith, appeal and plan and finally preserving the mental health of subjects- act like a shield in the face of acute adversities like psychosomatic disorders, and at last brings about compatibility and consistency for the patient in various levels [23]. But in regard to the return of physical symptoms in the treatment group of religion-spirituality in the follow-up stage and also the higher efficacy of treatment of Lazarus as opposed to the religious-spiritual therapy in terms of the physical symptoms of functional dyspepsia, one can mention to the biological and acute nature of these symptoms. Probably in the protocol of integrative spiritual therapy, the physical dimensions and particular interventions in this area have not sufficiently been taken into account by the researcher; as a result, the fourth hypothesis was rejected.

Concerning the comparison of the two therapies as mentioned before, apart from the physical dimension in the follow-up stage in the other variables in this study, no significant difference between the religious and Lazarus multimodal therapies was found, in response to this lack of difference we could refer to the similarities of the two methods: both approaches work with the process of thoughts and believes, and both put an emphasis on the emotional and behavioral aspects, and they consider humans as a complex and multimodal creature [26].

## 5. CONCLUSION

Here it is safe to claim that utilizing multimodal therapies with an emphasis on the society's cultural and faith aspects on the medical disorders affected by the psychological state is the main finding of this study.

## 6. LIMITATIONS

Due to partially filled out questionnaires or illegible questionnaires because of the high number of the items or fatigue of the participants, utilizing self-reporting approach, purposive and available sampling techniques, the geographical position near to the subjects, and the possible increase of cultural and socio-economic similarities, the results cannot be generalized.

## 7. THEORETICAL AND APPLIED SUGGESTIONS FOR FURTHER RESEARCH

Replication of the study in different cultural, geographical and faith contexts to enhance the external credits, employing longitudinal study in identifying the factors causing the HD patient to have early satiety, controlling the effects of some variables like duration, the acuteness of the diseases and time duration of medicine taking in patients through comparable hypotheses are recommended. Also, the introduced therapies in this research can be compared with other psychological interventions, at last, the future researchers can make use of the results of this study as new research hypotheses.

## REFERENCES


[1] H. Kaplan and B. Sadock, *Based on (DSM5), translated by Mahdi Ganji*, 11th ed. vol. 2nd. Tehran: Savalan Press, 2015.

[2] American Psychiatric Association, *Diagnostic and statistical manual of mental disorders dsm-5. Translated by Shamloo, Mohammad; Framand, Atousa; Rezaei, Farzin; Niloofari, Ali; Fakhraee, Seyed Ai and Hashemi Azar, Janet*. Tehran: Arjmand Press, 2013.

[3] P. Porcelli, M. De-Carne, and G. Fava, "Assessing somatization in functional gastrointestinal disorders: Integration of different criteria," *Psychother Psychosom*, vol. 11, pp. 198-204, 2000.

[4] N. J. Tally, M. Verlinden, and M. Jones, "Quality of life in functional dyspepsia: Responsiveness of the Nepean dyspepsia index and development of a new 10-item short form," *J. Gastroenterol Hepatol.*, vol. 26, pp. 49-52, 2011.

[5] R. M. Zagari, G. R. Law, L. Fuccio, V. Cennamo, M. S. Gilthorpe, D. Forman, and F. Bazzoli, "Epidiemiology of functional dyspepsia and subgroups in Italian general population: A endoscopic study," *Gastroenterology*, vol. 138, pp. 1302-1311, 2010.

[6] M. Bazrkar, M. Pourhoseingholi, M. Habibi, D. B. Moghimi, A. Safaee, and A. Pourhoseingholi, "Uninvestigated dyspepsia and its related factors in an Iranian community," *Saudi. Med. J.*, vol. 30, pp. 397-402, 2009.

[7] T. Tanaka, N. Manabe, and J. Hata, "Characterization of autonomic dysfunction in patients with irritable bowel syndrome using fingertip blood flow," *Neurogastroenterol Motil*, vol. 20, pp. 498-504, 2008.

[8] K. Kroenke and J. G. Rosmalen, "Symptoms, syndromes, and the value of psychiatric diagnostics in patients who have functional somatic disorders," *Med. Clin. North Am.*, vol. 90, pp. 603-626, 2006.

[9] S. Palmer, *Multimodal counseling and therapy. In: Palmer S, editor. Introduction to counseling and psychotherapy: The essential guide*. London: Sage Publications, 2000.

[10] A. A. Lazarus, *Multimodal therapy. In: Corsini RJ & Wedding D, editors. Current psychotherapies*, 8th ed. Belmont, CA: Brooks Cole, 2007.

[11] A. P. Spira, K. Stone, S. A. Baudreau, S. Ancoli-Israel, and K. Yaffe, "Anxiety symptoms and objectively measured sleep quality in older women," *American Journal of Geriatric Psychiatry*, vol. 17, pp. 136-143, 2009.

[12] D. L. Spangler, "Heavenly bodies: Religious issues in cognitive behavioral treatment of eating disorders," *Cognitive and Behavioral Practice*, vol. 19, pp. 358-370, 2010.

[13] D. H. Rosmarin, K. I. Pargament, S. Pirutinsky, and A. Mahoney, "A randomized controlled evaluation of spiritually integrated treatment for subclinical anxiety in the Jewish community, delivered via the internet," *Journsl of Anxiety Disorders,* vol. 24, pp. 799-808, 2010.

[14] M. A. Stanley, A. L. Bush, M. E. Camp, J. P. Jameson, L. L. Phillips, C. R. Barber, and J. A. Cully, "Older adults preference for religion/spirituality in treatment for anxiety and depression," *Aging and Mental Health*, vol. 15, pp. 334-343, 2011.

[15] A. L. Paukert, L. Phillips, J. A. Cully, C. Romero, and M. A. Stanley, "Systematic review of the effects of religion-accommodative psychotherapy," *Journal of Cognitive and Behavioral Practice,* vol. 41, pp. 99-108, 2011.

[16] C. Crescentini, C. Urgesi, F. Campanell, R. Eleopra, and F. Fabbro, "Effects of an 8-week meditation program on the implicit and explicit attitudes toward religious/spiritual self-representations," *Consciousness and Cognition,* vol. 30, pp. 266–280, 2014.

[17] Y. Zargar, Z. Dehghanizadeh, Z. H. Mehrabi, and K. A. Mahnaz, "The efficacy of stress management on physical symptoms and life quality in patients with functional dyspepsia," *Govaresh,* vol. 17, pp. 148-155, 2012.

[18] M. Sharifinia, *Integrated treatment of mental models by introducing integrated monotheistic therapy*, 1st ed. Qom: University Press, 2013.

[19] T. L. Barrera, V. A. Bush, C. R. Barber, and M. A. Stanley, "Integrating religion and spirituality into treatment for late-life anxiety: Three case studies," *Journal of Cognitive and Behavioral Practice,* vol. 19, pp. 346-358, 2012.

[20] B. I. Rahimian and H. Share, *Arnold Lazarus and multimodal therapy*. Tehran: Danjeh Press, 2008.

[21] S. G. Hofmann, "The importance of culture in cognitive and behavioral practice," *Cognit. Behav. Pract.,* vol. 4, pp. 243-254, 2006.

[22] E. B. Blanchard, J. M. Lackner, K. Sanders, S. Krasner, L. Kefer, and A. Payne, "A controlled evaluation of group cognitive therapy in the treatment of irritable bowel syndrome," *Behave. Res. Ther.,* vol. 45, pp. 633-648, 2007.

[23] S. Purnikdast, F. Maghsoud, M. Assareh, K. Khorramdel, and S. Rajabi, "Efficacy of mindfulness-based therapy efficacy in reducing physical symptoms and increasing specific quality of life in patients with functional dyspepsia," *Bulletin of Environment, Pharmacology and Life Sciences,* vol. 3, pp. 8-11, 2014.

[24] A. A. Lazarus, *Multimodal therapy: A seven-point integration. In G. Stricker & J.Gold (Eds). A casebook of psychotherapy integration*. Washington, DC: APA Books, 2006.

[25] D. J. Beckstead, M. J. Lambert, A. P. Dubose, and M. Linehan, "Dialectical behavior therapy with American Indian/Alaska native adolescents diagnosed with substance use disorders: Combining an evidence based treatment with cultural, traditional, and spiritual beliefs," *Addictive Behaviors,* vol. 51, pp. 84–87, 2015.

[26] H. W. Jesse, R. B. Monica, and E. T. Michael, *Learning cognitive- behavior therapy: An illustrated guide*: American Psychiatric Publishing. Inc, 2006.