Research Paper
The Spiritual Coping Model of Patients with Chronic Back Pain According to Mood/Anxiety Symptoms Mediating by Emotional Schemas

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ABSTRACT

Background and Objectives: Spiritual coping strategies of patients are influenced by their mood/anxiety symptoms and emotional schemas. Therefore, the present study aimed to develop a conceptual model of spiritual coping in patients with chronic back pain, considering the role of mood/anxiety symptoms and emotional schemas.

Methods: The research method was descriptive correlational. The statistical population included all women and men 25 to 55 years old with chronic back pain referring to the orthopedic and neurology clinics of Torbat Heydarieh City, Iran, in 2021-2022, of whom 400 people were selected considering the inclusion criteria using the convenience method. The tools used were the mood and anxiety symptoms questionnaire (MASQ-D30), a brief version of the Leahy emotional schema scale II-(LESS II), and the religious coping scale. The data were analyzed by structural equation modeling by SPSS software, version 24 and LISREL software, version 8.8.

Results: The fitted model showed a direct relationship between mood/anxiety symptoms and emotional schemas (β=0.740), an inverse relationship between mood/anxiety symptoms and spiritual coping (β=-0.480) at the significant level of 0.05, and an indirect relationship between mood/anxiety symptoms and spiritual coping through emotional schemas (β=-0.488), which was significant at the 0.05 level.

Conclusion: The results of the study supported the mediating role of emotional schemas in the relationship between mood/anxiety symptoms and spiritual coping strategies of patients with chronic back pain. Therefore, developing therapeutic interventions to reduce emotional schemas and improve spiritual coping strategies along with medical treatments is useful in adapting and improving chronic pain sufferers.

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Introduction

C hronic pain has many undesirable consequences on the quality of life (social, occupational, and family), and leads to a sense of hopelessness, loss of meaning in life, and feeling abandoned by everyone, including God [1]. The most common location of chronic pain is the back [2]. The experience of chronic back pain affects coping with injuries, diseases, and psychological distress caused by pain in life [3]. Religious and non-religious people experience psychological stress at the same level; however, religious people can better use religious resources, such as prayer, reliance, and appeal to God and imams to cope [4]. Religious coping is the reliance on religious beliefs and activities to control stress and physical discomforts [5]. Under two general approaches, positive and negative coping can be considered [6]. Most patients believe that they can control the pain to some extent and reduce it with spiritual coping strategies [7]. People with chronic pain experience more anxiety and depression and less self-compassion than healthy people [8], and with increasing the intensity of negative emotions, patients with chronic back pain experience more pain [9]. Spiritual health is related to people's physical health [10]. Therefore, we examined the relationship between emotional symptoms and spiritual coping strategies in patients with chronic back pain. Since anxiety and depression have common characteristics [11], we used mood/anxiety symptoms to examine these common characteristics [12].

A significant number of patients with chronic pain suffer from maladaptive primary schemas affecting their current pain status [13]. Also, mood/anxiety symptoms lead to increased people's emotional schemas [14, 15]. As a result, in terms of interpretation of their emotional experiences, they use different strategies to deal with their emotions [16]. Because spiritual schema therapy is effective in increasing mental health [17], performing psycho-spiritual interventions to reduce emotional symptoms and improve the level of spiritual health of people in society seems to be a crucial step in preventing pain or reducing the intensity of pain in patients with chronic pain. Therefore, it seems necessary to conduct more studies in this field [10]. Considering the role of emotional schemas and the difficulty in regulating emotions in people's understanding of pain, it seems necessary to pay attention to these factors in the field of educational and therapeutic interventions [18]. Therefore, the question is raised whether the conceptual model of the relationship between mood-anxiety symptoms and spiritual coping strategies of patients through emotional schemas exhibits a good fit or not.

Methods

This study is applied objectively and in terms of data collection, it was descriptive correlational. As men and women aged 25-55 years are among the active forces and chronic back pain is also seen in this group [19], the sample was selected from patients with chronic back pain referring to the orthopedic and neurology clinics of Tarbat Heydarieh City from September 2021 to May 2022 using convenience sampling.

It is appropriate to consider 15 cases for each predictor variable in multiple regression analysis using the standard least squares theory [20]. However, in the confirmatory factor analysis, 100 or 200 cases are suitable for two or four factors (latent variable) [20]. Therefore, the appropriate sample size was 400 people with a probability of 5% dropout, which were selected by convenience sampling according to the inclusion criteria. The inclusion criteria included age between 25 and 55 years, having back pain despite receiving treatment for at least six months, diagnosis of chronic back pain by a physician, no acute trauma, ability to participate in the research, and willingness to participate in the study. The exclusion criteria were the lack of satisfaction with participating in the project and having psychological disorders, pain, and acute trauma.

According to the conditions of the COVID-19 epidemic, while maintaining the conditions of personal protection, the samples were identified in the clinics, and after explaining the design, confidentiality, ethical issues, and people's consent, the questionnaires were distributed and completed online through the Internet.

Questionnaires

Mood and anxiety symptoms questionnaire (MASQ-D30)

MASQ-D30 was created by Wardner et al. in 2010. This questionnaire has 30 questions and its three main factors are general distress (GD), anhedonia (AD), and anxiety arousal (AA), which are scored on a five-point Likert scale from not at all (1) to very much (5) and each component has ten questions. Its internal consistency for all three scales in the short form is 0.87 to 0.93 by Izadi Dehnavi et al. and its reliability is also reported as 0.91. In the study conducted by Ardalani et al. Cronbach's α for the entire questionnaire was 0.929 and in examining

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the validity, its factors were confirmed [14]. The validity of this construct in the present study was confirmed through confirmatory factor analysis with a three-factor structure. The goodness of fit index (GFI) of the measurement model of emotional symptoms showed that the ratio of Chi-square to the degree of freedom (χ^2/df) was 2.01 and less than three, which is desirable. GFI, comparative fit index (CFI), and normed fit index (NFI) were 0.93, 0.92, and 0.94 respectively, which is more than 0.9 and confirms the good fit of the measurement model.

Leahy emotional schema scale-II (LESS-II)

The short form of the LESS-II with ten questions was extracted from a 28-question questionnaire (Jang Ho et al. 2019) and has options on the Likert scale scored from one to six. A high score on the scale indicates that a person has more negative schemas. Cronbach's α in the ten-question form is 0.893 and the correlation between two questionnaires of 28 questions and ten questions is 0.933. In the study conducted by Ardalani et al. Cronbach's α value for the entire questionnaire was calculated as 0.929 and its factors were confirmed [14]. The validity of this scale in the present study was confirmed via confirmatory factor analysis with a two-factor structure, and the GFI, CFI, and NFI indices were higher than 0.9 and indicated the appropriate fit of the measurement model. Cronbach's α coefficient of each of these factors was higher than 0.79, which indicates good internal con-

sistency for them. The χ^2/df ratio was 2.13, which was less than three and evaluated as desirable.

Religious coping scale

The short form of this scale has 14 questions extracted from the original and long form and was validated by Etemadi. Its scoring is done on a Likert scale with four options from "always" to "never" (0 to 3). The correlation between the scores obtained from the simultaneous use of two scales is 0.6 and to evaluate the validity of the test, Cronbach's α coefficient was calculated, which was 0.86 for the subscale of "positive religious coping" and 0.65 for the subscale of "negative religious coping". These results are consistent with the results of Etamadi in 2015 [21]. The validity of this scale in the present study was confirmed through confirmatory factor analysis, and the GFI, CFI, and NFI indices were more than 0.9, which indicated the appropriate fit of the measurement model. Cronbach's α coefficient was higher than 0.7, which indicates good internal consistency of the scale. Also, the χ^2/df ratio was 2.08, which is less than three and is considered desirable.

The data were analyzed using descriptive and inferential statistics. To verify the assumptions, the correlation matrix was used, and to fit the model, the structural equation modeling was used via SPSS software, version 25 and LISREL software, version 8.8.

Table 1. Descriptive indices of the variables

Variables	Mean±SD	Medium	Mode	Minimum	Maximum
Mood and anxiety symptoms	78.88±18.64	76.50	70	34	138
Emotional schemas	31.15±11.84	33	41	10	57
Positive spiritual coping	14.48±4.67	15	15	1	21
Negative spiritual confrontation	14.82±4.48	15.50	10	0	21

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Table 2. Examining the normality of research variables (df=352)

Variables	Descriptive Indices		Shapiro-Wilk Test	
	Skewness	Kurtosis	Statistics	P
Mood and anxiety symptoms	0.957	1.337	0.966	0.259
Emotional schemas	-0.134	-1.300	0.976	0.301
Spirituality coping	0.760	1.162	0.969	0.273

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Results

Based on the demographic results, 182 cases (51.7%) were men and 170 cases (48.3%) were women.

Concentration and dispersion indices in Table 1 present that these indices are close to each other, which indicates the relative symmetry of the data.

Table 2 presents that the values of skewness and kurtosis of all variables are in the range of +2 and -2 and indicates that the distribution of data did not deviate from the normality of a single variable. Also, the significant level for mood and anxiety symptoms, emotional schemas, and spiritual coping was 0.259, 0.301, and 0.273, respectively, which is more than 0.05 and indicates the null hypothesis based on the normality of these variables.

Based on Table 3, there was a correlation between the dependent variables and the independent variable. Considering the normality of research variables, Pearson's correlation coefficient was used to check the relationship between them.

To check the answer to question 1 and the fit of the conceptual model, the goodness of fit indices were studied. Table 4 presents that all the GFIs of the model were in the acceptable range and evaluated as desirable. It means confirming all the items and no need to remove any of them.

According to the coefficients of the direct paths of the model in Table 8, it can be seen that the relationship between mood/anxiety symptoms and emotional schemas ($\beta=0.74$) and the inverse relationship between mood/anxiety symptoms and spiritual coping ($\beta=-48$) were significant at a significant level of 0.05.

By examining the indirect paths of the model through the Sobel test in Table 9, the indirect relationship between mood/anxiety symptoms and spiritual coping via emotional schemas ($\beta=-0.488$) was significant at the level of 0.05.

To investigate the effect of mood/anxiety symptoms via emotional schemas on spiritual coping, the Sobel test was used. Table 9 shows that the significance level for the Sobel test was less than 0.05, which indicates a significant effect and this value resulted from the coefficients related to the emotional signs to emotional schemas (0.86) and emotional schemas to spiritual confrontation (-0.96) paths.

Discussion

This study was conducted to develop a spiritual coping model, and mood/anxiety symptoms could explain the spiritual coping strategies of patients with the mediation of emotional schemas. Consistent with our research, Ardalani et al. indicated that the effect of mood/anxiety symptoms on increased emotional schemas in patients suffering from chronic pain was significant and effective in the quality of spiritual life [14]. Addressing spiritual coping strategies is necessary because spiritual-religious intervention methods are effective as interactive interventions in reducing stress, anxiety, and depression [22]. Praying, hoping, and statements to deal with pain are often used among patients, and people can control and reduce pain to some extent [7].

Table 3. Correlation matrix of variables

Variables		1	2	3	4	5	6	7	8
Mood and anxiety symptoms	General distress	1							
	Anhedonia	0.82**	1						
	Anxiety arousal	-0.38**	-0.23**	1					
Emotional schemas	Negative evaluation of emotions	0.62**	0.59**	-0.49**	1				
	Negative cognitive reaction to emotions	0.61**	0.56**	0.47**	0.80**	1			
Spirituality coping strategies	Positive spiritual coping	-0.56**	-0.57**	0.17**	-0.38**	-0.36**	0.37**	1	
	Negative spiritual coping	-0.57**	-0.44**	0.50**	-0.64**	-0.53**	0.07	0.28**	1

*Significant at the level of 0.05, **Significant at the level of 0.01 (n=352)

Table 4. Correlation coefficients between research variables

Variables	Correlation	Mood and Anxiety Symptoms	Emotional Schemas	Spirituality Coping
Mood and anxiety symptoms	The correlation coefficient P Number	1 0.000 352		
Emotional schemas	The correlation coefficient P Number	0.382** 0.000 352	1 352	
Spirituality coping	The correlation coefficient P Number	-0.478** 0.000 352	-0.626** 0.000 352	1 352

Table 7. Goodness-of-fit indices (GFI) of the relationship between mood and anxiety symptoms and spiritual coping via emotional schemas

Fit Index	X²/df	SRMR	RMSEA	CFI	GFI	AGFI	NFI	NNFI	IFI	ECVI	90% Confidence Interval for ECVI	ECVI for the Saturated Model
Acceptable range	1-5	<0.05	<0.1	>0.9	>0.9	>0.9	>0.9	>0.9	0-1			
Index value in the model	2.434	0.058	0.075	0.92	0.94	0.92	0.91	0.89	0.92	0.113	(0.120), (0.106)	0.099

Abbreviations: SRMR: Standardized root mean squared residual; RMSEA: Root mean square error of approximation; CFI: Comparative fit index; GFI: Goodness of fit index; AGFI: Adjusted Goodness of Fit Index; NFI: Normed fit index; NNFI: Non-normed fit index; IFI: Incremental fit index; ECVI: Expected cross-validation index.

Table 8. Estimation of the standardized coefficients of the direct effects of the research model using the maximum Likelihood method

Direct Paths	β	Non-standardized Coefficients	R²	T	P
The direct effect of mood/anxiety symptoms on emotional schemas	0.74	0.78	0.55	13.70	<0.05
The direct effect of mood/anxiety symptoms on spiritual coping	-0.48	-1.08	0.23	-08.63	<0.05

Table 9. Estimation of the standardized coefficients of the indirect effects of the research model using the maximum likelihood method

Indirect Paths	β	Non-standardized Coefficient	R²	Sobel Statistics	P
The indirect effect of mood/anxiety symptoms on spiritual coping via emotional schemas	-0.488	-0.842	0.392	-7.76	<0.05

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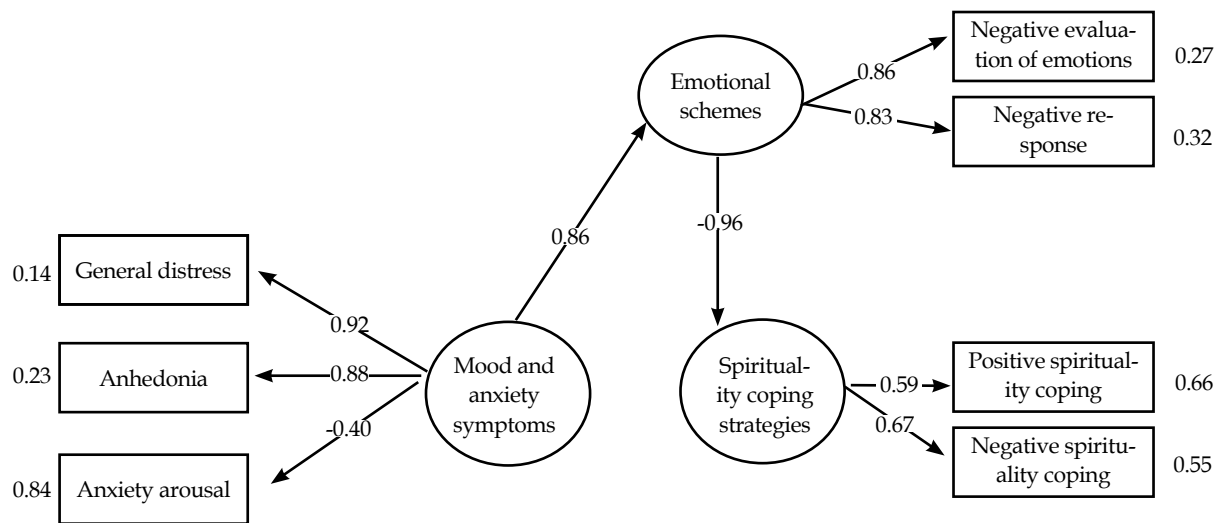
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Figure 1. The standard research model of the standardized coefficients of the path and factor load of the conceptual model of the relationship between mood/anxiety symptoms and spiritual coping via emotional schemas

Chi-square=97.37, df=40, P=0.09232, Pemsa=0.075.

The results showed that patients' negative emotions are associated with emotional schemas, which is consistent with the results of Ardalani et al. [13] and Bishop et al. [23]. Also, Edward and Wallpepperman [24] confirmed the mentioned relationship. Based on Leahy's theoretical model, when negative emotions occur, emotional schemas in the form of emotional interpretations are created and cause to intensify and create negative troublesome emotions [16].

The results of the present study showed that mood/anxiety symptoms have an inverse and significant relationship with spiritual coping, which is consistent with the results of Pargament [25] and Sharifi et al. [28]. It is concluded that negative religious coping predicts more depression [26], while negative religious coping has adverse consequences for people's health by creating higher levels of anxiety, depression and reduced self-esteem [27]. Positive religious coping methods have a negative and significant relationship with depression and care exhaustion [28]. Therefore, the spiritual-religious intervention method is effective in reducing stress, anxiety, and depression [22].

Also, the results showed that emotional schemas harm the selection of spiritual coping strategies, which is consistent with the results of Temple [29] and Leahy [16]. According to the "emotional schema model", people differ from each other in terms of their interpretation of their emotional experiences and they use different strategies to deal with their emotions [16]. For example, a person who considers himself incompetent, when faced with a stressful situation, may think that he cannot cope with it and, as a result, avoid related stressful situations or thoughts [30].

According to our results, based on the biological-psychological-social-spiritual model of pain, the understanding and expression of pain by each person is influenced by psychological, social, and spiritual factors in addition to biological factors. Since there is currently no definitive cure for some diseases in medical science, religious beliefs can be effective in reducing anxiety and depression [6]. Performing psycho-spiritual interventions to improve the level of spiritual health of people in society can be a crucial step in preventing pain or reducing the intensity of chronic pain [10] and in contrast, life's stressful factors help the individual's coping strategies [25].

The current research had limitations, such as conducting research during the COVID-19 epidemic, which was accompanied by the limitation of clinics and patients. Second, the stress during the epidemic might have affected the patient's behavior. Also, this research was limited to a geographical region with its culture. Therefore, it is necessary to be cautious in generalizing the results to all.

Conclusion

Performing psycho-spiritual interventions to reduce mood and anxiety symptoms and improve the level of the spiritual health of the community can be a crucial step in preventing the consequences of pain or reducing the intensity of pain in patients with chronic pain with medical treatments.

Ethical Considerations

Compliance with ethical guidelines

This study was approved by the Ethics Committee of Birjand University of Medical Sciences (Code: IR.BUMS.REC.1401.181).

Authors' contributions

All authors contributed equally to the preparation of the article.

Conflict of interest

The authors declared no conflict of interest.

References

[1] Eccleston C, Morley SJ, Williams AC. Psychological approaches to chronic pain management: Evidence and challenges. Br J Anaesth. 2013; 111(1):59-63. [DOI:10.1093/bja/aet207] [PMID]

[2] Mozafari Comeshtappeh A, Esmaeilnejad Ganji S, Bahrami Feridoni M, Falsafi M. [Prevalence of musculoskeletal pains and the demographic factors related to the pain locations in patients with chronic trauma (Persian)]. J Babol Univ Med Sci. 2018; 20(7):21-27. [DOI:10.18869/acadpub.jbums.20.7.21]

[3] Babaee Z, Dehghani M, Babakhani B, Najafi-Mehri S. [Challenges and lived experiences of patients who suffer from chronic back pain: A phenomenological study (Persian)]. Iran J Nurs Res. 2020; 15(4):43-57. [Link]

[4] Pourghane P, Sharif Azar E, Zaer Sabet F, Khorsandi M. Survey the effect of religious beliefs in stress reduction in students of Langroud Faculty of Medical Sciences . J Holistic Nurs Midwifery. 2010; 20(1):10-5. [Link]

[5] Khoshtinat V. [Survey of religious coping style in PNU students with an emphasis on spiritual elevation (Persian)]. 2015; 8(30):135-56. [DOI:10.22037/mej.v8i30.7611]

[6] Trankle TM. Psychological well-being, religious coping, and religiosity in college students. Encyclopedia Qual Life Well-Being Res. 2006; 1(5):53-6. [Link]

[7] Andruszkiewicz A, Basińska MA, Felsmann M, Banaszkiewicz M, Marzec A, Kędziora-Kornatowska K. The determinants of coping with pain in chronically ill geriatric patients - the role of a sense of coherence. Clin Interv Aging. 2017; 12:315-23. [DOI:10.2147/CIA.S118136] [PMID] [PMCID]

[8] Narimani M, Ghasemkhanlo A, Sabri V. [The comparison of self-compassion, anxiety and depression in patients with chronic pain and normal people (Persian)]. J Anesth Pain. 2020; 11(3):57-65. [Link]

[9] Dehghan M, Ahmadi A, Jalili S. [A study of pain and anxiety/ depression severity on patients with nonspecific chronic low back pain (Persian)]. J Shahrekord Univ Med Sci. 2018; 20(3):9-19. [Link]

[10] Shaygan M, Mozafari M, Zahedian Nasab N, Shaygan L, Bagheri S. [Comparison of depression and spiritual well-being in chronic pain patients and healthy control group (Persian)]. J Pizhūhish dar dīn va salāmat. 2020; 6(2):100-14. [DOI:10.22037/jrrh.v6i2.23258]

[11] Clark DA, Beck AT, Stewart B. Cognitive specificity and positive-negative affectivity: Complementary or contradictory views on anxiety and depression? J Abnorm Psychol. 1990; 99(2):148-55. [DOI:10.1037/0021-843X.99.2.148] [PMID]

[12] Watson D, Clark LA, Weber K, Assenheimer JS, Strauss ME, McCormick RA. Testing a tripartite model: II. Exploring the symptom structure of anxiety and depression in student, adult, and patient samples. J Abnorm Psychol. 1995; 104(1):15-25. [DOI:10.1037/0021-843X.104.1.15] [PMID]

[13] Saariaho THJ, Saariaho ASI, Karila IA, Joukamaa MI. Early maladaptive schemas in Finnish adult chronic male and female pain patients. Scand J Pain. 2010; 1(4):196-202. [DOI:10.1016/j.sjpain.2010.09.003] [PMID]

[14] Ardalani Farsa F, Shahhabizadeh F, Hashemi M, Dadkhah P. [Mood/anxiety symptoms and emotional schemas in the model of quality of spiritual life of patients with chronic low back pain mediated by role of multidimensional perfectionism cognitions (Persian)]. J Anesth Pain. 2021; 12(3):115-28. [Link]

[15] Mears GS. Examining the relationship between emotional schemas, emotional intelligence, and relationship satisfaction [PhD dissertation]. Lynchburg: Liberty University; 2012. [Link]

[16] Leahy RL, Tirch D, Napolitano LA. Emotion regulation in psychotherapy: A practitioner's guide. New York: Guilford press; 2011. [Link]

Ebrahimbai Salami AA, et al. The Spiritual Coping Model of Patients With Chronic Back Pain. Health Spiritual Med Ethics J. 2022; 9(4):241-248.

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[17] Ghaseminejad Rinie F, Golparvar M, Aghaei A. [Comparison of the effectiveness of emotion-focused therapy based on attachment injuries and eclectic spirituality based schema therapy on hopelessness and mental health of women affected by husband's infidelity (Persian)]. Shenakht J Psychol Psychiatr. 2022; 9(3):151-66. [DOI:10.32598/shenakht.9.3.151]

[18] Khanzadeh M, Aminimanesh S, Taheri M, Aghamohammadi S. [The relationship between emotional schema and pain perception in the elderly: The mediation role of emotional regulation (Persian)]. Aging. 2021; 7(4):331-43. [DOI:10.22126/JAP.2021.6351.1525]

[19] Parno A, Sayehmiri K, Nabi Amjad R, Ivanbagha R, Hosseini Ahagh MM, Hosseini Foladi S, et al. [Meta-analysis Study of work-related musculoskeletal disorders in Iran (Persian)]. Arch Rehabil. 2020; 21(2):182-205. [DOI:10.32598/RJ.21.2.2444.4]

[20] Haidar Ali H. [Multivariate data analysis in scientific research (Persian)]. Tehran: Paykefarhang; 2006. [Link]

[21] Etemadi, Shahrazad. [The relationship between religious confrontations, problem-solving styles and rumination with the mental health of parents with children with cancer (Persian)] [Msc. thesis]. Tehran: Kharazmi University; 2014.

[22] Taghavi M, Hashemian K, Bolhari J. [Comparison of the Effectiveness of Two Religious–Spiritual and Hope Interventions on Reducing Stress, Anxiety and Depression of Spouses of Veterans with PTSD (Persian)]. Iran J War Public Health. 2020; 12(3):165-72. [Link]

[23] Bishop A, Younan R, Low J, Pilkington PD. Early maladaptive schemas and depression in adulthood: A systematic review and meta-analysis. Clin Psychol Psychother. 2022; 29(1):111-130. [DOI:10.1002/cpp.2630] [PMID]

[24] Edwards ER, Wupperman P. Research on emotional schemas: A review of findings and challenges. Clin Psychol. 2019; 23(1):3-14. [DOI:10.1111/cp.12171]

[25] Pargament KI. The psychology of religion and coping: Theory, research, practice. New York: Guilford press; 2001. [Link]

[26] Herrera AP, Lee JW, Nanyonjo RD, Laufman LE, Torres-Vigil I. Religious coping and caregiver well-being in Mexican-American families. Aging Ment Health. 2009; 13(1):84-91. [DOI:10.1080/13607860802154507] [PMID] [PMCID]

[27] Pargament KI, Smith BW, Koenig HG, Perez L. Patterns of positive and negative religious coping with major life stressors. J Sci Stud Relig. 1998. 37(4):710-24. [DOI:10.2307/1388152]

[28] Sharifi M, Fatehizadeh M. (2011). [The relationship of religious coping with depression and caregiving burnout (Persian)]. Mod Care J. 2012; 9(4):327-35. [Link]

[29] Temple SD. Schema therapy: A practitioner's guide. American J Psychiatry. 2003; 160(11):2074-a-5. [DOI:10.1176/appi.ajp.160.11.2074-a]

[30] Ehlers A, Clark DM. A cognitive model of posttraumatic stress disorder. Behav Res Ther. 2000; 38(4):319-45. [DOI:10.1016/S0005-7967(99)00123-0] [PMID]

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