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The Impact of Life Quality Therapy on Tolerating Distress, Stress, Anxiety and Depression in Women Suffering from Tension Headache

Mohammad Bagher Kajbaf[1], Fariba Hosseini[2], Amir Qomrani[1] & Nazanin Razzazian[3]

[1] Department of Psychology, Faculty of Psychological and Educational, University of Isfahan, Iran

[2] PhD Student in Psychology, Faculty of Psychological and Educational, University of Isfahan, Iran

[3] Scientific Advisory Board of University of Kermanshah, Kermanshah, Iran

Correspondence: Mohammad Bagher Kajbaf, Department of Psychology, Faculty of Psychological and Educational, University of Isfahan, PO Box: 8179949413, Iran. E-mail: m.kajbaf2006@gmail.com

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Abstract

Introduction: Present study is about determining the effectiveness of life quality therapy on tolerating distress, stress, anxiety and depression in women suffering from Tension Headache.

Methods & Materials: Study design is semi-experimental through pre-test, post-test with control group. population includes all the women suffering from tension headache in Kermanshah city during 2014, 30 people have been chosen through random sampling and they have been put in two groups of experiment and Control (each group has 15 members). In pre-test, the members of both groups have applied the questionnaires of Distress Tolerance (Simons & Gaher, 2005), Questionnaire of Distress, Anxiety and Stress Scale (Lavibond & Lavibond (1995) and the questionnaire of the researcher designed for demographic information. Then experiment group have passed eight 90-minute sessions of life therapy quality while there happened no any intervention for control group. Both groups have been assessed through the mentioned questionnaire again in post-test and follow-up steps. Collected data have been analyzed through Variance Analysis in repetitive ranges.

Results: The results have indicated that quality therapy have been effective on improving stress, anxiety, depression and tolerating distress in women suffering from tension headache during post-test and follow-up ($P<0.05$).

Discussion: It can use life quality therapy as one of the effective therapies for resolving psychological disorders.

Keywords: life quality therapy, distress tolerance, stress, anxiety, depression, tension headache

1. Introduction

Psychosomatic or psychological – physiological disorders are referring to those physical modes that the meaningful psychological incidents are closely in connection with physical signals. Such problem and disorders are including cardiovascular diseases - cardiovascular, respiratory, gastro - intestinal, musculoskeletal, skin and headaches. Generally, the term “Psychosomatic” is used when an individual is having physical signs which are seemed to be intensified due to psychological factors (Aruna et al., 2005).

Headache is one of the most common complaints within Neurological clinics. Most of such headaches are Migraine or Tension Type Headache (TTH). Severe and repetitive headaches can restrict daily life activities; decrease the life quality and cause productivity reduce (Kvrt & Kaplan, 2008). Most of chronic headaches are involving with psychological and behavioral issues and depression and anxiety are the reasons for hospitalizing patients within hospitals, depression and anxiety are having connection with the continuity of headache more than the severity of headache (Holroyd, Stensland, & Lipehik, 2000).

Theoretical progress and increasingly growth of studies have provided the required principles for conceptualizing headache, as a psychosomatic disorder. Also biological factors cannot explain the vulnerability to headache disorder experience, its attack time, its stream, severity of the attacks or the disabilities relating to disorder (Rains, Penzien, Mccrory, & Gray, 2005). Psychological stress and negative mood are called as the factors of intensifying TTH, which are the result of headache increase and cause the intension of TTH (Kikuchi et al., 2015). The results of the studies have indicated that Tension Type Headache is caused and intensified by stress (Cathcart et al., 2010).

Stress is usually accompanied with prolonged contraction of the muscles of the head and neck that may cause contraction of blood vessels during several hours. Usually an obscure pain is felt at the back of head and it will be distributed in all head and sometimes it is felt as a tight belt round the skull (B. J. Sadock & V. A. Sadock, 2007). Physical consequences of stress and its impact on health have been studied comprehensively. Studies are indicating that stress causes physical inaction and also increases disease severity (Ogdon, 2007). Due to individuals' disability in controlling their distress in stressful situation, stress is known as one of the main intensifying factors of headache (Galego, Moras, Cordeiro, & Tagnola, 2007).

Anxiety is an unpleasant and vague feeling which is defined as a doubtful sense towards an unknown factor (Black & Hawks, 2005). Such unpleasant sense can be accompanied with physiological and emotional signs and can be manifested in form of a severe emotional feeling (Smeltzer & Bare, 2010). There is a significant relation between the headaches that are beginning from childhood and adolescence and depression will appear in next years. The people who are suffering from depression, are at risk of suffering TTH two times more than normal people and the feeling depression during adolescence who has no any complaint from headache, shows the start of headache in future, we can conclude that there is a neurochemical and drug-cognitive between depression and headache (Brasla, Lipton, Stewart, Schultz, & Velch, 2003). For the individuals who are suffering from non-organic chronic headaches, depression is defined as one of the variables of chronic headache (Maro, 2000). Black & Hawk (2008) have indicated that there is a positive relation between headache severity and depression severity among individuals suffering from initial headaches. Also one third of clients of Arizona medical centers complaining initial headaches had the symptoms of moderate depression (Smeltzer & Bare, 2009).

Depression is a common and world disease in its mild and moderate forms and it can be considered in different forms as a paralyzing disorder. Depression is almost not alone and in %50 of cases, the depressed patient is a suffering from anxiety disorder (Fennell, Bent-levy, & Watsbrok, 2004). Depression is one of the common emotional diseases that causes lack of feeling of joy from life and it indicates itself with symptoms of Depressed mood, loss of feeling, absurdity, slow mental and motor, guilt and inability to concentrate, and thoughts of death (B. J. Sadock & V. A. Sadock, 2007). Such disorder is usually accompanied with higher levels of anxiety and it can be accompanied with simple and complicated phobia which threatens the life quality of an individual (Chew, 2006). Distress tolerance (turbulence) is referring to the ability of experiencing and tolerating negative psychological situations. Turbulence may be the result of physical and cognitive processes. Individuals with low level of distress tolerance cannot tolerate excitement and cannot manage their distress and turbulence, such individuals ignore the existence of excitement and they feel ashamed and distressed towards it since they underestimate their abilities to cope with emotions and they highly attempt to prevent such negative issues and they look for a quick relief for them (Simons & Gaher, 2005).

Depression and anxiety is more in connection with repetitive and continual headache rather than its severity. Therefore, in order to determine, find and treating the chronic headaches we shall consider its mental aspects more and we shall consider psychological treat as a complimentary since successful treatment of chronic headaches is depending on determining depression and anxiety moods (Harlroyd et al., 2000).

Frisch believes that medical study on individuals and societies and its improvement is the biggest scientific challenge after increase and progress in technology (Frisch, 2006). This s the reason that today's treatments must focus on modification and changing life quality and developing abilities and providing life satisfaction for individuals. Since, in fact, happiness and depression (positive and negative emotions) are not two opposite sides and treating negative feelings cannot provide us happiness and life satisfaction automatically (Joseph & Lindley, 2006).

Quality of life therapy (QOLT) has integrated and utilized a combination of newest researches and theories relating happiness, positive psychology and managing negative feelings accompanying with insight due to effective Clinical work and positive psychology. Such approach can be utilized for clinical and non-clinical clients. Such treatment is one of the rare comprehensive treats (Magyar-Moe, 2009) and it is based upon experimental theory and witnesses (Diener-Biswas, 2010) which is harmonized with Formulation of cognitive therapy and depression cognitive theory and Psychopathology. The quality of life therapy includes an approach for increasing life satisfaction. Life satisfaction is described as an individual assessment from his/her own different aspects of life. Frisch believes that such therapy, like positive Psychotherapy, is seeking for studying and improving human happiness through exploring abilities and better life quality (Frisch, 2006). Sanjuan, Ruiz and Perez (2011) in a research have indicated that life satisfaction and other positive compatibility indexes can be a keen predictor for emotional compatibility (depression and anxiety) for men suffering from heart disease.

The purpose of QOLT is to increase professional self-protection or internal richness and it is defined as a sense

of deep calmness, comfort, concentration, affection, awake and preparedness for coping with daily life challenges and protecting self in an intellectual, lovely, and sympathetic and comprehensive way. Such approach is the coherent of cognitive therapy and positive psychology that is matched with the latest cognitive therapy and cognitive theory of depression and mental pathology; three principles of interventions of QOLT are internal richness, time with quality and fining meaning (Frisch, 2006).

Vostanis (2010) in order to assess treatment based on life quality for the parents of the children suffering from obsession disorder have indicated that such treatment (QOLT) causes reduction of OCD symptoms, anxiety and increases overall satisfaction and the status of the children suffering from OCD. Also, the life quality status of mothers has been totally changed. In other study by Rodrigve et al. (2010) in a study named psychological intervention in order to improve life quality and decrease of mental sadness among adults waiting for kidney surgery have compared the effectiveness of three kinds of treatments. 62 patients have been divided into three groups of receiving treatments based on life quality, supportive treatment and normal cares. Results have indicated that the individuals of life quality therapy group have achieved higher scores in scale of life quality and social intimacy in comparison with other two groups. Regarding the significance deceasing stress, anxiety, depression among patients suffering from psychosomatic diseases like tension type headaches that the disease is having mental root and it is influenced by stress, and also the significance of increasing tolerance among such patients and since few studies have reviewed the effectiveness of life quality therapy among such patients, the purpose of this research is to review the effectiveness of life quality therapy on improving stress, anxiety, depression and distress tolerance among patients suffering from TTH.

2. Method and Materials

Designing semi-experimental research and it is kind of a study design with pre-test, post-test and follow up with group control. The population of this research is including all the women patients suffering from TTH in Kermanshah City in 2014.

Inclusion criteria included: Research sampling, they have been chosen from health centers, treatments and clients of medical clinics suffering from chronic tension headache.

Conditions to enter the research are the age requirement 18 to 60 years; desire to improve without medication, level of education at least reading and writing, neurologist confirmation about disease (chronic tension-type headache) patient agreement to participate in therapy sessions. Conditions to enter the research were included , the absence of more than one session of therapy sessions, suffering from psychotic disorders, mental preoccupation, suicidal thoughts or idea making or suicidal, the unwillingness of the patient to continue treatment

Patients participated in the study with informed consent and also it was emphasized that they are free to leave the participation in the study at any stage and confidentiality of the study (Polit & Beck, 2006).

Method: sample have been divided into groups of test and control (each groups with 15 members) according to research ethics and therapy logic. After that, the questionnaires of tolerating distress, anxiety, depression and stress have been executed on clients within pre-test step. Then, test group has participated in eight 90 minutes sessions of life quality therapy and there were no interventions for control group. Then, both groups have been post-tested and they have been followed up two months later with the same tools. Implementation of questionnaire by the method of becoming unnamed and using a code, the mentioned action is done in order to build trust for clients that the results are confidential and to prevent the mistakes from social desirability in execution of research questionnaires from periodic rotation in order to prevent the impacts of questionnaire execution order. Data have been analyzed from statistics methods of variance analysis with repetitive ranges. Titles and brief content of the training sessions is presented in Table 1. Data collecting tool: Distress tolerance scale questionnaire is designed by Simons J, Gaher R. (2005). This questionnaire considers distress tolerance as a meta-emotional construct including assessment and expectations of an individual from experiencing negative emotional moods about 1) Tolerability Aversiveness 2) assessment 3) tendency to absorb attention and performance desultory 4) adjustment, and specifically the force resulted from the tendencies of action in order to prevent or quick weakening of experience (Simons & Gaher, 2005). This questionnaire is having 15 questions testing 4 minor scales of distress, absorbing by negative emotions, mental assessment of distress and adjusting attempts for distress remedy. Such scale is scored based on 5 degree Likert scale, in a way that, score 1 means completely agree with the intended choice and score 5 means completely disagree. Alpha coefficients for such scales are respectively 0.82, 0.78, 0.7 and for whole scale is 0.82. Also it is determined that such scale is having adequate validity and initial convergence (Simons & Gaher, 2005). The questionnaire Depression Anxiety Stress Scale is designed by Lavibond and Lavibond (1995) and it includes two forms. The main form is having 42

phrases that each one of them assesses the mental structures of depression, anxiety and stress by 14 different phrases. Its short form includes 21 phrases that each one of 7 phrases are measuring one mental structure. Individual shall mark the severity of mentioned symptom frequency experienced during the previous week. Each one of the questions is having Likert scale of 0 to 3. Lavibond and Lavibond (1995) have indicated that the credit of re-testing for sub-secondary scales is 0.71 for depression, 0.81 for stress, and 0.79 for anxiety. For validity of the scale, correlation coefficient or the questionnaire of Anxiety and depression are respectively 0.81 and 0.74, therefore, such scale is having the adequate reliability for using within research activities.

Table 1. Title and Summary content of training sessions

Sessions	Description of Sessions
1	communication and introducing members, expression of the rules of the group, objectives and introducing training courses, obtaining the commitment of the participants to attend meetings, Introduce and discuss the quality of life, life satisfaction, happiness
2	Review of the previous session, the definition of quality of life, health, quality of life dimensions, introducing of 16 domains of life that make up a person's overall quality of life, detecting problematic issues of members, summarizing the discussion, feedback
3	Review of the previous session, introducing CASIO The as the five root, starting with one of the aspects ,introducing C as the first strategy and its 16 aspects application of quality of life
4	Review of the previous session, Introducing CASIO, Introducing as the second strategy in 16 aspects application of quality of life
5	Review of the previous session discuss the CASIO, Introducing S as the third strategy to increase life satisfaction, teaching quality of life
6	Review of the previous session, discuss the principles of quality of life, Introducing I as the fourth strategy and application of this principle for increase the satisfaction
7	Review of the previous session, continuing the discussion the principles, Introducing O as the fifth strategy
8	Providing a summary of the issues identified in the previous sessions, Conclusions and CASIO training in the application of the principles of life in different aspects of life, application of CASIO in in 16 aspects of quality of life

3. Results

The analysis of demographic characteristics revealed that the mean of age and education in the experimental group were 36.33 and 13.12 and it was 30.53 and 14.15 in control group. In both groups, the largest number of participants were married that experimental and control groups, respectively are included60 and 53 percent.

The descriptive indexes of research variables have been presented in table 2 based on assessment and group membership steps

Table 2. The descriptive indexes of research variables based on two groups and three researches

Variable		Experiment			Control		
		Pre- test	Post-test	Follow up	Pre- test	Post –test	Follow up
Stress	Mean	27.83	22.5	24	31.07	30.4	29.87
	sd	8.3	8.14	7.43	7.4	8.14	4.62
Anxiety	Mean	32.17	23.17	20.83	34.4	33.33	33.2
	sd	5.8	5.3	5.4	7.7	6.3	6.6
Depression	Mean	30.66	20.17	22.33	34.67	34.93	34.53
	sd	8.7	8.4	8.5	7.07	8.6	6.02
Distress tolerance	Mean	26.17	42.08	39.83	25.47	24.67	25.33
	sd	6.07	6.43	7.06	4.9	4.3	5.05

Totally, it is observed within descriptive findings that the average of scores in all research variables have been improved in pre-test and follow up level on test group in comparison with control group. In order to doe variance analysis with repetitive ranges, some pre-assumptions are needed that such pre-assumptions have been approved. The purpose of doing Mauchly test is to review the pre-assumption of co-variances monotony or equality of co-variances with the overall covariance. If the significance level in Mauchly is higher than 0.05, therefore we usually use Kruit test and in case of rejection, conservative test of Greenhouse-Geisser will be utilized for repetitive measure of variance analysis The results of Mauchly test is indicated in table 3.

Table 3. Mauchly test

Variable	Value	Chi square	df	sig
Stress	0.812	4.991	2	0.082
Anxiety	0.499	16.67	2	0.001
Depression	0.464	18.45	2	0.001
Distress tolerance	0.709	8.26	2	0.016

As it is written in Table 3, the pre-assumption of co-variances monotony through Mauchly test is not approved except for stress variable. Therefore, we shall use Greenhouse-Geisser in review of anxiety, depression and distress tolerance variables and Kruit coefficient for stress. The results of variance analysis test with repetitive ranges are written in Table 4.

Table 5, the results of variance analysis through repeatedly measurements of variables in pretest, posttest and tracking in both control and experimental group.

Table 4. Analysis of repeated measures

Variable	source	Sum of Squares	df	Mean square	F	sig	Partial Eta Squared	Observed Power
Stress	factor1	138.375	2	69.188	5.874	.005	.190	.855
	group	642.222	1	642.222	4.587	.042	.155	.540
	factor1*goroh	72.993	2	36.495	3.099	.064	.110	.521
Anxiety	factor1	587.793	1.333	441.078	19.765	.000	.442	.998
	group	1363.084	1	1363.084	15.099	.001	.377	.962
	factor1*goroh	378.805	1.333	284.254	12.738	.000	.338	.970
Depression	factor1	398.948	1.302	306.457	6.691	.009	.211	.782
	group	2130.965	1	2130.965	19.174	.000	.434	.988
	factor1*goroh	421.664	1.302	323.906	7.072	.008	.221	.804
Distress tolerance	factor1	920.381	1.549	594.175	40.384	.000	.618	1.000
	group	2364.104	1	2364.104	33.039	.000	.569	1.000
	factor1*goroh	1063.098	1.549	686.308	46.646	.000	.651	1.000

Based on the obtained findings in Table 5, the difference among the scores of stress (P=0.005), Anxiety (P=0.001), Depression (P=0.009) and Distress tolerance (P=0.001) are significant in three steps of research. Also the average of scores of stress (P=0.042), Anxiety (P=0.001), Depression (P=0.001) and distress tolerance (P=0.001) are having significant difference in both groups of test and control. The results have indicated that respectively near to %15.5, %37.7, %34.4 and %56.9 of individual differences in variables of stress, anxiety, depression and distress tolerance are relating to the difference of two groups. In addition to such interaction among the research steps and group membership, except in stress variable, in other variables it was also significant. in other words, the difference among scores of anxiety, depression and distress tolerance are

significant in three steps of study for both groups. The range of such differences for variables of anxiety, depression and distress tolerance are respectively 0.338, 0.221 and 0.651. it means that %33.8, %22.1 and %65.1 of variance or individual differences in such variables are relating to differences among three steps of test and group membership. Therefore, we can conclude that quality therapy is effective on improving stress, anxiety, depression and distress tolerance for women suffering from TTH. Regarding the obtained results in above table, the difference among the steps of pre-test, post-test and follow up in all four variables are significant, therefore, the results of paired comparisons of averages in three steps of study have been achieved by using LSD testing Table 5.

Table 5. Paired comparison of mean scores of cognitive symptoms in three phases of the research

Variable	groups		Mean Difference	Std. Error	sig	95% Confidence Interval for Difference	
						Lower Bound	Upper Bound
Stress	Pre-test	posttest	3.000	.910	.003	1.126	4.874
	Follow up		2.517	1.113	.033	.224	4.809
	posttest	Pre-test	-3.000	.910	.003	-4.874	-1.126
	Follow up		-.483	.764	.533	-2.056	1.089
Anxiety	Pre-test	posttest	5.033	1.246	.000	2.467	7.599
	Follow up		6.267	1.211	.000	3.773	8.760
	Pre-test	posttest	-5.033	1.246	.000	-7.599	-2.467
	Follow up		1.233	.572	.041	.055	2.412
Depression	Pre-test	posttest	5.117	1.643	.005	1.733	8.501
	Follow up		4.233	1.834	.030	.456	8.011
	Pre-test	posttest	-5.117	1.643	.005	-8.501	-1.733
	Follow up		-.883	.802	.281	-2.536	.769
Distress tolerance	Pre-test	posttest	-7.558	.825	.000	-9.257	-5.860
	Follow up		-6.767	1.145	.000	-9.125	-4.408
	Pre-test	posttest	7.558	.825	.000	5.860	9.257
	Follow up		.792	.757	.305	-.766	2.350

($p<0.05$).

The results of paired comparisons indicate averages difference in three steps of test in Table 6, in variable of stress, the difference of two steps of pre-test with post-test were (P=0.003) and with follow up (P=0.033) which it was significant but the difference of post-test and follow-up was insignificant. In variable of anxiety, the difference of two steps of pre-test with post-test were (P=0.001) and with follow up (P=0.001) and also post-test with follow-up was (P=0.041) are significant. In variable of depression, the difference of two steps of pre-test with post-test were (P=0.005) and with follow up (P=0.03) which it was significant but the difference of post-test and follow-up was insignificant. In variable of distress tolerance, the difference of two steps of pre-test with post-test were (P=0.001) and with follow up (P=0.001) which it was significant but the difference of post-test and follow-up was insignificant.

4. Discussion

The purpose of this study is to review the impact of life quality therapy on improving stress, depression, anxiety and distress tolerance in women suffering from TTH. The results of variance analysis with repetitive ranges have been indicated in table 5 that such treatment could decrease the stress of patients in test group in both steps of post-test and follow-up. Such results are similar to the finding of Abedi and Vostanis (2010) and Rodrigo et al., (2010) based on the effect of positive psychological interventions, including quality of life therapy on patients improvement.

Regarding the strong theoretical background of life quality therapy and previous studies, it seems this method

can help people to manage their stress. Life quality therapy which is the coherent coherence of cognitive therapy and positive psychology and it is matched with cognitive therapy of Beck. The purpose of this therapy method is to increase happiness by focusing on issues and difficulties that are existing in field of achieving satisfaction in all aspects of life. The therapy insist of such method is that it has an overall viewpoint on life and life goals in which each level of intervention are relating with the overall goals of life in valuable and significant aspects of life. In a way that, the clients observe a direct elation among intervention and achieving the most important needs, goals and demands.

Assessment and conceptualizing difficulties and abilities of clients accepts an overall vision towards life which is based on the performance in 12 aspects of daily life accompanying with any kind of psychological, physical problems, disorders and disabilities. Such approach is a kind of concept therapy, in a way that it helps clients to find the happiest thing for their health and happiness right now and also during their lifetime. Meaningfulness in life causes decrease of depression and increase of happiness. Findings have indicated that the people who conceptualize for their own situation within challenging and stressful situation will usually experience less negative emotion and they are more satisfy with life. It indicates that conceptualization can have higher impact on life satisfaction rather than having only positive emotions. This factor causes the people to improve their life quality by kindling with getting involved in activities including social integration, social coherence and significant relation (Hughes, 2006). On the other hand, in quality of life therapy in two cases of therapy strategies, change in attitude (A) and change in goals and standards (S), have changed the recognitions and standards of people by using cognitive techniques and it helps people to decrease their depression.

Sin and Lyubomirsky (2009) have indicated that positive psychotherapies is effective on increasing mental welfare of clients. Therefore, the quality of life therapy can be effective on increasing mental welfare of people.

Mental feeling of welfare is an overall concept and it is rooted from the way of perceiving cognition and emotion from whole life. Mental happiness has two aspects of cognitive and emotional. Cognitive happiness dimension is cognitive assessment of people from life satisfaction status. Emotion dimension means having the maximum positive emotion and least negative emotion. Positive emotions indicates how a person feels about being the agent of actions while negative emotion indicates a common internal sadness and unpleasant involvement dimension (Eid & Larsen, 2008). People with high mental happiness experience more positive emotions and they positively assess the events and occurrences around them and they consider them pleasant. Such people are having higher sense of control and manage and they experience more feeling of success and life satisfaction (Bradwin & Hedor, 2010). Moreover, such people are having healthier immune system and more creativity, while people with low mental feeling of happiness assess their events and occurrences in their life inappropriate (Diener, 2003). In explanation of effectiveness of quality therapy on improving anxiety, stress and depression, Tay and Diener (2011) explains that life quality therapy causes mental happiness increase for clients and it decreases negative emotion and increases positive feelings.

Howell, Keren, and Lyubomirsky (2007) by doing a super-analysis from 150 studies in field of psychological happiness have indicated that happiness positively impacts on long-term and short-term consequences of health and disease and syndromes control. Since, higher happiness, in addition to lead them for better performance in health, by strengthening the response of immune system and pain tolerance, helps people to cope with illness through psychological reactions. In life quality therapy, we teach clients to consider mental happiness as a necessary psychic health and to achieve beyond from this vision that psychic health is not only having no any disease, also we shall permanently try for increasing life satisfaction. For this reason, people learn through a cognitive approach to improve their mental happiness and life satisfaction by adjustment among valuable aspects of life according to their ideals and after that not only they decrease stress, anxiety and depression but also they increase their tolerance.

On the other hand, life quality therapy, in addition to work on documents, they provide solutions and principles for increasing ability of resolving issues and strengthening it in different aspect of life, therefore it can help clients to improve their distress tolerance. In other words, we can state that life quality therapy is comprehensive that can consider the ability of problem-solving in all 16 aspects of life and it is tried to modify all related aspects with problem-solving ability in this field and it provides mental health increase for individuals. Also WHO considers mental health as a form of happiness that individuals have an actual perception from their own abilities and can cope with daily life stresses and can work effectively and they have role in their society.

5. Conclusion

Based on the obtained results in research, life quality therapy is effective on improving psychological distress and distress tolerance among patients suffering from TTH and it can be an appropriate and effective model for

improving problems for Psychosomatic patients and it is recommended to use it as a therapy model for treating such patients.

Competing Interests Statement

The authors declare that there is no conflict of interests regarding the publication of this paper.

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