



**COMPARING EFFICACY OF METACOGNITION TREATMENT IN THE LIFE
QUALITY OF PATIENTS WITH DEPRESSION AND OCD****RAHIMEH HAMEDI^{*1}, ISMAIL SOLEIMANI²**¹ Department of Psychology, Science and Research branch, Islamic Azad University, Ardabil,
Iran² Assistant Professor, Urmia University, Urmia, Iran***Corresponding Author: E Mail: r.hamed6231@gmail.com****ABSTRACT**

The present study aims at comparing efficacy of metacognition in the life quality of patients with depression and OCD –the quasi –experimental study was performed in the form of a pre-test-post –test plan. The population of this study include all depressed and obsessed women referring to consulting services of Imam Khomeini committee in Ardabil city of which 50 people were selected by convenience sampling and were randomly put into two groups of depressed and obsessed patients .The two groups experienced well's metacognitive therapy for 8 weeks (14 sessions).We used second edition of Beck's depression questionnaire ,Yale-Brown obsession scale and life quality questionnaire to collect the data .The data were analyzed by descriptive indices ,covariance analysis test and multi-variety Turkey test .The results showed that applying well's metacognitive pattern on patients with depression and obsession is efficient in improving their life quality .Also the result from mean comparison test indicate that the efficacy of metacognition therapy was significantly effective for obsessive patients compared to depressed ones. This approach deepens the clinical function of therapy and allows us to create a new set of guidelines to help patients to shape a new relationship with their minds .Therefore, this approach is considered in treatment intervention of patients with obsession and depression.

Keywords: Metacognition, Life Quality, Obsession and Depression**INTRODUCTION**

Obsessive –compulsive disorder is an impulses or images are recurrent and anxiety disorder in which thoughts, persistent which are experienced as

annoying and unwanted .The prevalence of 12 months of this disorder is 1.2 in America which is similar to the international outbreak (1.1 to 1.8). Women are more affected than men in adulthood, though men are usually affected in childhood (American psychiatric Association 2013, Translated by Sayyed Mohammadi, 1393). The most common result of this disorder is its adverse effect on relationship with others ,especially with family members and this has other implications ,too like creating feeling of depression and generalized anxiety in patient and even underlies worse personal relationship in one (Davison ,Neale and kring ,1943 ,translated by Dehestani ,1383).In the other hand ,the extreme responsibility of people with OCD make them experience more anxiety ,stress and disability which ,in turn ,this is identified by apparent confusion in family and social relationships.

However ,depression is a common disorder with symptoms such as sadness ,nihilism irritable mood and physical and cognitive changes which are considerably effective on 's ability to act (American Psychiatric Association ,2013 ,translated by Sayyed Mohammadi ,1393).All of these factors are detrimental for welfare of people with this kind of disorder and at last potentially leads to a decrease in life satisfaction and problems of marriage and choosing a

spouse, social relationships and their employment ,as a result ,lowers their living standards .Life quality which is the first variable in question in this study is a concept with a wide range which is influenced by a wide set of individual's physical health ,psychological states ,independence level of social relationships and their relation with a prominent manifestation in one 's life environment .Therefore ,in total ,life quality has different physical ,mental and social aspects which covers a wide range of one's life range (Momeni Moshtaque and Poor Shahbaz ,1392).Depression and anxiety can have a negative impact on all aspects of life quality and lead to a reduction in life quality level.

In recent three decades regarding life quality as a main factor in evaluating therapy result and treatment efficacy in physical and mental diseases has increased (Karow, Reimer, Schafer, Krasz Hassan et al, 2010, according to Momeni et al ,1392).

Quality, in relation to the objectives is regarded as expectations, criteria and affairs. Life quality is a concept with a wide range which is influenced by a wide set of one's physical health ,psychological states and indolence level of social relationships and their relation has been put in one's living environment with a prominent manifestation .Thus ,totally .life quality has different physical ,mental and social aspect

which encompass a wide range of one's life quality. According to Falaeyan (1997) (quoted by Katschnig, 2006) the impact of these aspects on whole life quality is dependent on individual realization of each person. Life quality based on various evidence in its related parts is considered as a multi-dimension structure. Studying life quality as a part of therapy results enable the therapist find the trivial differences between people response to treatment. Norbeg, Calamari, Cohen and Reiman (2008) have reported a weaker life quality in patients with mental –physical OCD especially in areas such as self –esteem and work. Also, results from researches by Albert, Maina, Bogetto, Chiarle and Mataix –Coles (2009) showed that compared to Italian published norms, patients with physical –mental OCD exhibit insufficiency in most different aspects of life. Eisen, Mancebo, Pinto, close and Pagno et al (2006) have also similar results.

Metacognition therapy is a new approach which has been suggested in recent years about distending and treatment of emotional disorders. The results from various studies show that interventions such as metacognition therapy concentrating on a change in patient's communication with inefficient and dysfunctional thoughts and feelings is far more useful than an attempt to change the content of thought and

belief (Teasdale, Scott, Moore, Hayhurst and pope et al, 2001). So it seems that the approach can compensate the defections of cognitive theories (Roelofs, Papageorgiou, Gerbera, Huibers and Peters et al 2007). In fact, metacognition deals with studying processes and structures of cognition that review and control different aspects of cognition. Metacognition is a phase of Information processing system that review interpreted and evaluate its own contents and processes (Clark, 2000).

Wells and Matthews, for the first time, introduced metacognition pattern based on executive functioning model of self – regulation to explain and executive functioning model of self–regulation of emotional disorders with the combination of scheme approach and information processing. This system influences on reducing the gap between goals and reality (Shirinzade, 1387).

This the apical approach believes that people are caught in the trap of emotional distress because their meta cognitions against responding to internal experiences lead to a pattern that there by a negative emotion continues and negative beliefs are strengthened in these people. This pattern is called cognitive –attention syndrome which includes anxiety, rumination, stabilized attention and self –regulation guidelines or maladaptive coping behaviors. This pattern

is based on the fundamental theory of executive function self-regulation. This model considers the vulnerability to emotional disorders as a pattern paying attention to itself activity of maladaptive cognitive beliefs and special reflection processes (Wells and Cartwright-Hatton, 2004, quoted by Dargahiyan et al, 1390). This process is activated when one feels a mismatch between the internal objectives and external conditions. In these conditions special guidelines such as absorbing information into beliefs, thought suppression, obsessive rumination, and anxiety are applied to prevent entering annoying stimuli into awareness or solving problems resulted by discordance, monitoring mental-physical states and readiness against dangers, to reduce the discordance by executive function of self-regulation (Wells, 2009). Many different studies have evaluated metacognitive model of anxiety and depression disorders, the studies show that there is a positive constant relationship between metacognitive beliefs, emotional vulnerability and a wide range of psychological disorders (Papageorgiou and Wells, 2000).

Massive amount of resulted data from a wide range of methods, on patient and problem's in the area of mental health, physical health, social relationships and satisfaction with social environment which

is in life quality of all people, thus evaluating these components can be effective in efficacy of therapeutic result of metacognition. Based on what mentioned above we can say that the present study is looking for a response to this question: what kind of impacts can a short-term treatment concentrating on metacognition have on life quality of obsessive people compared to depressed people?

MATERIALS AND METHODS

Since the present study aims at comparing the efficacy of metacognition treatment on life quality of patients with obsession and depression, it a pre-test-post-test design research. The subject of the present study includes all female patients with obsession and depression having diploma and higher education degrees ranging from 18 to 45 years old refer to consulting center of Imam Khomeini committee in Ardabil city. The samples are 50 women with OCD and depression who were selected in convenience sampling method and were randomly put into two groups. Notably, the sample size in the pilot studies is 15 people for each subgroup (Delavar, 1382). But due to increased research funding and the risk of participants loss we regarded 25 people for each sub group's the studied sample includes 25 women with OCD and 25 women with depression. Entry criteria for participants are: female, having no other disorders

,having diploma and higher education degree and using no medicine to treat the disorder .The tools for data collection are: semi –structured clinical interview based on DSM -5 to diagnose depression and OCD by an expert psychologist ,Beck 's depression Inventory ,second edition (BDI-II).The BDI-II is also consisted from 21 items like first edition ,each item has a score between zero to 3 so the entire list ranges from zero to 63 scores. Beck, steer and Brown (1996) have reported the internal consistency of the instruments from 0.73 to 0.92 with 0.86 mean and alpha coefficients for patient group as 0.86 and non-patient group as 0.81. In a study on 125 university students in Tehran University and Allameh Tabatabaee university studying the reliability and validity of "Beck Depression Inventory Revised ", the results indicated a total score with 0.79 mean , standard deviation as 7.96 Cronbach alpha as 0.78 and re-test reliability within two weeks was 0.73 (Mojtabaee and Qasemzade ,quoted by Gharaee ,1382).Y-BOCS :This inventory is a part of Yale-Brown compulsive scale that was made by Goodman et al in 1989 .In this inventory ,there are two sub-scale for measuring compulsive which in both 5-item scale ,the severity of symptoms is evaluated upon frequency , caused anxiety period for action damage and intervention in the life of the patient ,resistance and the degree of

control in 7 days before interview .This test has shown a good reliability and validity in evaluating the severity of symptoms(Goodman ,Ward ,Kablinger and Murphy ,1989).Inter-rater reliability in 40 patients was 0.98 and the internal consistency coefficient (alpha coefficient) was 0.89 for this test. In Iran, Mohammad Khani (1372) has reported the reliability coefficient of this scale within two weeks with 5-people sample as 0.84. Life quality questionnaire of WHO (world Health organization): This questionnaire after emerging some areas and eliminating some of the items the life quality of WHO was created (as 100 items) and was translated and was simultaneously designed in more than 15 countries .Thus the concepts of items are the same in different cultures (Bonomi, 2000, according to Momeni, et al, 1387). The 26-item questionnaire is formed of four areas: physical health mental health, social relations and environmental conditions and a total score. The reliability of this scale is 0.92 and its validity has been reported as 0.86 (Masaeli, 1390).

The participants were classified into two groups of 25 people observing entrance standards after completing consent form based on participating in the design .The two groups were pre-tested in early stages of study, and at the end after treatment intervention were post-tested for 14 sessions

of 1 hour within 8 weeks, and the therapy sessions were formed based on study and includes review assignments, treatment, and assignments for next session based on wells metacognition therapy. In the present study ,in addition to using descriptive statistics test such as frequency ,frequency percentage

,mean standard deviation ,the multivariate covariance analysis test was used to study the research items(MACOVA).Also a single sample Klomograph –Smirnov test assuming normality, Levine test and Box test were used to observe statistical actuarial assumptions of MACOVA.

Therapy sessions

Sessions	Treatment	Homework
1st	Completing the questionnaires (pre-test) and planning session	-
2nd	Design and formulation ,introducing meta –cognitive model	-
3rd	Performing the thought suppression teaching and practicing detachment awareness attention ,attention training techniques	Practicing the techniques
4th	Continuing introducing meta –cognitive model, main problem ,patient orientation beliefs more practice on detachment awareness attention and introduction and confrontation and response performance	Confrontation performance and reply performance
5th	Nore practice on detachment awareness attention and confrontation and response performance ,identifying triggers of worry and copying and dealing	Practicing the technique of attention training
6th	Continuing verbal challenge with related beliefs TOF TAF TEF	Performing the detachment awareness attention
7th	Performing behavioral experiments in sessions on beliefs and continuing challenging with positive metacognition beliefs related to worry	Performing behavioral tests and attention technique
8th	Implementing other behavioral test in treatment and identifying related beliefs and identifying and challenging with negative beliefs related to emotion and depression	Implementing specific behavioral test
9th	Continuing verbal challenges with beliefs related to TOF TAF TEF and related –beliefs and identifying and coping with fear, anxiety and depression.	Practicing attention training technique and delaying worry and continuing activities
10th	Continuing studies on related –beliefs using confrontation test and correcting related beliefs	Practicing attention training techniques and postponing worry and continuing activities
11th	Continuing to change stopping symptoms and alternative criteria and planning new process plan to deal with annoying thoughts	Strengthen new process plan and increasing confrontation
12th	Continue to change stopping symptoms and alternative criteria and planning new processing program to cope with annoying thoughts	The patient is asked to work on outline, strengthening the new processing program
13th	Stabilization new processing programs for future and completing treatment outline	Defining continued application
14th	Continuing homework and performing post-test	-

FINDINGS

Demographic characteristics show selected samples.

There are 35% single and 65% married .Participants are 41% diploma ,37.5% association ,17.5% bachelor and 4% masters.

Among OCD participant, around 53% had more than 5 years of disease and this is 44% for depressed patients.

Table 4-4 shows the mean and standard deviation of depression and OCD scores of subjects in both pre-test and post –test stages.

As the results show mean and standard deviation of post-test for depressed patients

are: 10.88 and 1.69 and these are 11.24 and 0.77 for OCD patients.

As it can be seen in table 2-4:

Mean and standard deviation of post –test physical health for OCD patients is 90.76 (3.23) and for depressed patients is 87.40 (3.64) .Mean and standard deviation of post-test mental health is 89.88 for OCD (2.58) and 83.96 (2.89) for depressed subjects.

Mean and standard deviation of post-test of social relations is 88.72 (4.05) for OCD and 88.60 (5.42) for subjects with depression.

Mean and standard deviation of post-test for environmental health is 88.60(3.42) for subjects with OCD and 85.40(2.87) for depressed subjects.

One of the conditions using analysis of multivariate variance, is the normality of related variable .For this ,the Kolmogrov test in table 3-4 shows a significant level for all variables of this study higher than 0.05 which indicate normality of variables in this research ,thus parametric statistics can be used.

As it can be seen in table 4-4 level of statistics (F) based on life quality components is not significant ($P>0.05$) and this shows that the error variance of components is not different among subjects and variance are equal. Also Box test was used to study the homogeneity assumption

of variances and the results showed the amount of Box test is not significant(Box =56.587, $F=1.051$, $P=0.31$).

And as a result of default, there is a difference between covariances.

The results from table 4-5 shows that significant levels of all tests enables usability of multivariate covariance analysis .These results show that there is a significant difference between three group of OSD ,depressed and control in one of the related variables (Lambda=0.773 and $F=6.989$, $P<0.00$).

As it can be observed in table 4-6 there is a significant difference between groups of OSD, depressed and normal in physical health, mental health, social relations and environmental health. In the other hand, mean values of life quality components of depressed and OSD groups are different that of control group.

The results from Tukey test to compare mean values in table 4-12 shows that mean values of life quality components of depressed and OCD group is significantly higher than that of control group ($P<0.001$) and OCD group is significantly higher than that of depressed group ($P<0.001$), and this means that metacognition therapy in life quality of OCD patients is more effective than patients with depression.

Table (1-4): Descriptive components of OCD and depression scores of subjects in two pre-test and post-test measurement stages:

Variable	Stage	N	M	SD
Depression	<i>pre – test</i>	25	41.34	5.03

		25	10.88	1.69
OCD	<i>pre – test</i>	25	24.68	2.56
	<i>post – test</i>	25	11.24	0.77

Table (2-4): Mean and standard deviation of life quality components in both pre-test and post-test stage:

			Physical health	Mental health	Social relations	Environments health
Pre-test	OCD	M	31.40	24.04	20.16	28.84
		SD	2.73	3.87	7.26	3.41
	depressed	M	6.72	24.04	17.28	28.72
		SD	3.27	4.36	9.42	4.17
Post –test	OCD	M	90.76	89.88	88.72	88.60
		SD	3.23	2.58	4.05	3.42
	depressed	M	87.40	83.96	80.76	85.40
		SD	3.64	2.89	5.42	2.87

Table (3-4): Kolmogrov- Smirova test (studying normality of data)

Sig	Z	
0.29	0.979	Physical health
0.61	1.32	mental health
0.72	1.88	social relations
0.12	1.45	environmental

Table (4-4): The results from Levine test for consistency of variances between components of life quality.

Sig	Df2	Df1	F	Sizes
0.068	48	1	2.487	Physical health
0.687	48	1	2.365	mental health
0.587	48	1	2.031	social relations
0.071	48	1	2.698	environment health

Table 4-5: Results of reliable indices of test significance of covariance analysis of multivariate on life quality of components.

Source	Test	Amount	F	df assumption	df error	Sig	Eta
Group	Pilae effect test-	0.227	6.98	3	46	0.00	0.975
	wilks Lambda test	0.773	6.98	3	46	0.00	0.975
	effect of Hoteling test	0.294	6.98	3	46	0.00	0.975
	the biggest root productivity test	0.294	6.98	3	46	0.00	0.975

Table 4-6: Results from multivariate covariance analysis on life quality components

Source	Related variable	SS	Df	Ms	F	P	Eta
Group	Physical health	18238.1	1	18238.1	22.93	0.000	0.8
	mental health	12150	1	12150	14.13	0.000	0.91
	social relation	9712.32	1	9712.32	9.59	0.000	0.96
	environment health	15443.2	1	15443.22	21.32	0.000	0.91

Table 4-7: Results from Tukey test for comparing mean values of life quality components between two groups

Components	Groups (post – test)	<i>difference of mean value between group and significacant level mark</i>	
		<i>depressed</i>	<i>pre – test group</i>
Physical health	<i>OSD</i>	60.68*	1.32*
	<i>depressed</i>	59.36*	-
Mental health	<i>OSD</i>	65.84*	5.92*
	<i>depressed</i>	59.92*	-
Social health	<i>OSD</i>	68.56*	5.08*
	<i>depressed</i>	63.48*	-
Environment health	<i>OSD</i>	59.76*	3.08*
	<i>depressed</i>	56.68*	-

Note: P<0.05: and P<0.01:**

DISCUSSION AND CONCLUSION

The present study aims at studying and comparing efficacy of metacognition therapy in life quality of people with OCD and patients with depression. According to the findings of present study it was clear that the efficacy of metacognition therapy in life quality of people with OCD is significantly different than depressed people. The results from Tukey test for comparison showed that mean values of life quality components in derided and OCD group is significantly higher than that of control group ($P < 0.001$) and OCD group is significantly higher than depressed group ($P < 0.001$). And this means that metacognition therapy in life quality of patients with OCD is more effective than patients with depression. So approving the above question shows a compatibility between the results of this study with that of wells et al (2003). Also the results from this research is in consistent with that of Hashemi et al (1389), Parhoon et al (1391), Firooz Abadi and Shareh (1388), Hassan Vandi et al (1392), Taba Tabayi (1392), Entezari and Mojtabayi (1392), Bergsan et al (2011), Andoose (1385), Farhmand et al (1393). In explaining this effect is worth mentioning that metacognition has a major impact on beliefs and thinking and forms basis of normal and abnormal emotion experiences and our awareness, so that

metacognition forms what we consider and enter into the realm of our consciousness, all evaluations and impact of kinds of guidelines that we apply to regulate our feelings and thoughts. The fundamental premise of traditional cognitive-behavioral therapy (CBT) such as Beck's scheme theory and its rational-emotional and behavioral therapy shows that which disorder or bias in thinking bring about psychological disorder. Both these approaches emphasize on the central role of dysfunctional beliefs: metacognition therapy as a general principle agrees with this attitude and this puts it among cognitive therapies. AS the central idea of therapeutically metacognition is that metacognition factors play a decisive role in creating inutility intellectual styles which lead to the persistence of negative emotions in psychological disorders and people with OCD are constantly facing with annoying thoughts and worry and based on metacognition therapy this approach includes eliminating worry, dropping threat strategies and helping people to experience annoying thoughts without avoiding or reacting against them, so it is more effective.

This study like other design researches is of limitations and the accuracy interpretation

of the results will be possible in terms of these restrictions:

Short training course, lack of long –term follow –up rareness of literature on comparing efficacy of metacognition therapy on a variety of mental disorders, limitation of research sample to referring female clients in Ardabil .Thus it is suggested that the following –up period should be done within 3 to 6 months and even 1 year, to ensure of sustainability of training results. The efficacy of this therapeutically approach is studied in a variety of mental disorders (fear, generalized anxiety, PTSD...).It is advised to repeat research in bigger samples and more balanced sex ratio.According to the findings of present study which show the efficacy of therapy concentrating on metacognition, it is suggested that this therapeutic approach is used in all kinds of psychological disorders such as OCD and depression in consulting medical centers.

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