Specific and nonspecific role of vulnerability factors in emotional disturbances: “Triple vulnerability model”

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Abstract

Aim: The aim of this study was to investigate specific and nonspecific role of vulnerability factors in emotional disturbances based on triple vulnerability model. Methods: The sample of study included 400 people of general population of Qazvin. The method of sampling was quota. In order to collect data, we used a number of questionnaires. The methods of data analysis were Pearson correlation coefficient and path analysis. Results: We designed two models for each of studied emotional disturbances (GAD, SAD, DEP and OCD)\(^1\) based on Barlow’s theory. Final models suggested that IOU may be considered as a specific vulnerability factor for GAD and SAD but it had more specific role for GAD. TAF was a specific factor for OCD. DAS is a specific factor for depression but in comparison to specific role of TAF for OCD, it has a less specific role for depression. Conclusions: IOU is greatly considered a transdiagnostic factor but TAF and DAS have more specific roles in EDs.

Keywords: emotional disturbances, specific vulnerability factors, transdiagnosis, triple vulnerability model.

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1 Abbreviations: OCD: obsessive-compulsive disturbance; GAD: generalized anxiety disturbance; SAD: social anxiety disturbance; DEP: depression; IOU: intolerance of uncertainty; TAF: thought-action fusion; DAS: dysfunctional attitudes; EDs: emotional disturbances; PC: perceived control; NEURO: neuroticism; EXTRA: Extraversion; PC: Perceived control.
Introduction

The main feature of EDs is that the afflicted person experiences negative, aversive and intense affects or emotions such as anxiety, depression or fear in response to the environmental stimuli. The person interprets these experiences harmful and traumatic. These emotions result in problems in person’s life. The person may display some behaviors and avoids specific situations. EDs consist of various types of anxiety and depression such as social anxiety, major depression, panic, generalized anxiety, obsessive-compulsive disturbances and disturbances such as anxiety related to health or hypochondriasis (Brown & Barlow, 2009; Barlow & colleagues, 2011).

Recently, to explain etiology of EDs, various structural models have been developed. The models mainly are cognitive behavioral oriented and disturbance-specific. These models include factors which are more specific. Nowadays, however, researchers and clinicians conclude that these models no longer help to understand psychopathology of EDs and their value has been decreased. On the other hand, the numerous models themselves leads to problems in training and learning as well as hinders services offer to the patients. Many clinicians are concerned about the correct choice for comorbid conditions (Farchione, Fairholme, Ellard, Boisseau, Thompson-Hollands, Carl, 2012; Harvey, Watkins, Mansel, and Shafran, 2004). These reasons suggest that there is latent same trait or traits between EDs resulted in similarities. Therefore, to resolve problems with specific models of disturbances, we need models accounted for latent same traits and similar factors in explaining of pathology of EDs, that is, to achieve these aims, we need transdiagnostic or unified models (Craske, 2012).

In this regard, Barlow (2000, 2002) developed a transdiagnostic model named “triple vulnerability model”. It was assumed that a set of interactional vulnerability factors contribute in development of EDs. Based on this model, there is a common general genetic factor in EDs. Results of studies suggest two genetic temperamental dimensions: neuroticism and extraversion. Next dimension is psychological vulnerability factor referred to person’s perception about controllability and predictability of events and emotions related to life experiences. Third dimension is specific to each disturbance and resulted from learning experiences. In other words, the person learns how to overcome on genetic and psychological dimensions by specific factor (Brown and Barlow, 2009; Brown and Naragon-Gainey, 2013). Some of these specific factors are: intorolerance of uncertainty (IOU), thought-action fusion (TAF) and dysfunctional attitudes (DAS). TAF refers to a cognitive bias which can increase persons responsibility related to intrusive thoughts. For this reason, TAF considered as a specific vulnerability factor to develop obsessive thoughts (Shafran, Thordarson, and Rachman, 1996). First time, it was used the concept of IOU to explain of development and maintainance of GAD (Dugas, Buhr and Ladouceur, 2004). Dugas, Gagnon, Ladouceur, and Freeston (1998) claim that IOU results in a chain of worry, negative orientation to problem and cognitive avoidance as well as influences directly on orientation to problem and degree of cognitive avoidance. Accordingly, people with high level of IOU are more susceptible to engage in worry process. Beck proposed dysfunctional attitudes (DAS) and attributed the cause of EDs to person’s misinterpretation about himself, irrational beliefs and false assumptions about reality instead of attributing the cause to unconscious and uncontrollable forces (weissman and Beck, 1978). He first proposed DAS related to depression.
Theories of EDs suggest that TAF, IOU and DAS play specific roles in OCD, GAD and DEP respectively. However, in recent years, there have been contradictory results related to specific roles of these factors. Results of some studies suggest that these factors have no longer as specific roles in EDs as past (Sutton and et al, 2001; Muris, meesters, Rassin, Merckelbach and Campbell, 2001; Gentes and Ruscio, 2011; Brown and Naragon-Gainey, 2013). In this regard, Brown and Naragon-Gainey (2013) examined “triple vulnerability model” by structural equation modeling. In this study, 700 patients with DEP, SAD, GAD and OCD recruited. In the level of specific vulnerability, TAF specifically related to OCD. DAS and IOU were not significant predictors for DEP and GAD respectively, instead, they correlated to other disturbances.

Because of contradictory results in the field of specificity of vulnerability factors in EDs and according to recent transdiagnostic models about EDs included specific factors of disturbances, the main question of this study was whether these factors are specific in the models or they have a transdiagnostic entity. As a result, the aim of this study was to investigate the specific and nonspecific role of vulnerability factors of emotional disturbances based on triple vulnerability model.

**Methods**

*Sample*: Statistical society consists of general population of Qazvin. We used quota method to sampling regarding age, sex and education. We used data of Iran statistics center. the sample consist of 400 people. Demographic characteristics of sample have been presented in table 1.

**Table 1: Demographic characteristics of sample**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Male</td>
<td>200</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>200</td>
<td>50</td>
</tr>
<tr>
<td>Age</td>
<td>20-30</td>
<td>171</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>30-40</td>
<td>129</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>40-50</td>
<td>100</td>
<td>25</td>
</tr>
<tr>
<td>Education</td>
<td>Associate’s degree and lower</td>
<td>113</td>
<td>28.29</td>
</tr>
<tr>
<td></td>
<td>Bachelor’s degree</td>
<td>244</td>
<td>60.87</td>
</tr>
<tr>
<td></td>
<td>Master’s degree and upper</td>
<td>43</td>
<td>10.80</td>
</tr>
</tbody>
</table>

**Instruments**

*Thought- action fusion scale*: this scale developed by Shafran, Thordarson, and Rachman (1996) in order to assess 3 subscale named as TAF-moral, TAF-likelihood-self and TAF-likelihood-others. It has 27 items with likert scoring method from 0 (disagree strongly) to 4 (agree strongly). Shafran and colleagues reported internal consistency by Cronbach alpha ranging from 0.85 to 0.96. Pourfaraj, Mohammadi, and Taghavi (2008) reported internal consistency by Cronbach alpha and test-retest reliability 0.81 and 0.61 respectively in Iranian population. We acquired Cronbach Alpha 0.79 for 19 items in our study.

*Intolerance of uncertainty scale*: This questionnaire developed by Freeston, Rheumae, Letarte, Dugas, and Ladouceur (1994) to assess people tolerance confronting uncertain situations. It has 27 items scored by 5 points likert scale from 1 (not at all) to 5 (entirely). Buhr and Dugas (2006)
reported Cronbach alpha and test-retest reliability 0.94 and 0.78 respectively. It has been acquired Cronbach alpha 0.88 and test-retest reliability 0.76 in iranian population (Fahimi, Aliloo, Poursharifi, Fakhar, Akbari, and Khanli, 2014). We acquired Cronbach alpha 0.91 in this study.

Dysfunctional attitudes scale (DAS): this scale developed by Weissman and Beck (1978) in order to assess beliefs, attitudes or negative schemas. The scale consists of 40 items with 7 points likert scale. It has been reported Cronbach alpha 0.9 and test-retest reliability 0.73 by Oliver & Baumgart (1985). This scale has been translated and revised by Yazdandoost, Rezvantalab, Payrovi, and Peyrovi (2001) in Iran. They acquired test-retest reliability 0.72 in an Iranian sample. It was acquired Cronbach alpha 0.85 in present study.

Penn State Worry Questionnaire (PSWQ): This scale consists of 16 items to assess intense, excessive and uncontrollable worry. The scale developed by Meyer, Miller, Metzger, and Borkovec (1990). Its scoring method is a 5 points likert scale. It has been acquired Cronbach alpha and test-retest reliability 0.88 and 0.79 respectively in Iranian population (Dehshiri, Golzari, Borjali, and Sohrabi, 2010). We acquired Cronbach alpha 0.81 in present study for this scale.

Beck depression inventory (BDI-II): this scale developed by Beck, Steer, and Brown (1996) to assess intensity of depression. Based on Beck and colleagues’ research, the scale has high internal consistency. It has been reported Cronbach alpha and test-retest reliability 0.87 and 0.73 respectively (Stefan-Dabson, Mohammadkhani, and Massah-Choulabi, 2007). We acquired Cronbach alpha 0.90 in our study.

NEO-Five Factor Inventory (NFFI): Costa and McCrae (1992) developed this scale in order to assess 5 main traits which neuroticism and extraversion are two of them. We used this scale to assess neuroticism and extraversion. We used 60 items version of this scale. Its scoring method is a 5 points likert scale. Roshan Chesly, Shaeri, Atrifard, Nikkhah, Ghaem Maghami, Rahimierad (2006) reported Cronbach alpha for subscales ranging from 0.35 to 0.83 and rest-retest reliability from 0.61 to 0.82. We acquired Cronbach alpha for neuroticism and extraversion 0.73 and 0.77 respectively.

Obsessive-Compulsive Inventory–Revised (OCI-R): this scale developed by Foa and his colleagues (2002) to assess 6 subscales: washing, obsessions, hoarding, ordering, checking and neutralizing. The scale consists of 18 items with 5 points likert scale. Foa and colleagues reported Cronbach aloha 0.9 and test-retest reliability ranging from 0.74 to 0.91. Mohammadi, Zamani and Fata (2008) reported Cronbach alpha for this scale. We acquired Cronbach alpha 0.87 for the scale.

Anxiety Control Questionnaire (ACQ-R): this scale developed by Rapee, Craske, Brown, and Barlow (1996). It has 30 items to assess 3 subscales as emotional control, threat control and stress control with 6 points likert scale. Rapee and colleuges acquired appropriate psychometric properties. We acquired Cronbach alpha 0.72 for this scale.

Social Interaction Anxiety Scale (SIAS): this scale developed by Mattick and Klarke (1998) to assess social anxiety in two person or group interactions with 20 items scoring 5 points likert scale. Its Validity and test-retest reliability is reported 0.84 and 0.91 respectively (Hope, Heimberg, Turk, 2006). We acquired Cronbach alpha 0.84 in present study.
Procedure: we used some questionnaires to assemble data. After estimating sample size with quota sampling method regarding to main demographic indices such as age, sex and education, we asked people to complete scales in public places. First, we described aim of study and method of responding scales. The questionnaires administered by trained persons. We had many questionnaires but whole items were 215. Data analysis methods were Pearson correlation coefficient and path analysis.

Results
It has been presented some descriptive indices such as mean, standard deviation, and minimum, maximum, skew and kurtosis of studied variables in table 2.

<table>
<thead>
<tr>
<th>Variables</th>
<th>M</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>skew</th>
<th>kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuroticism</td>
<td>33.23</td>
<td>7.12</td>
<td>16.86</td>
<td>52.78</td>
<td>0.13</td>
<td>-0.24</td>
</tr>
<tr>
<td>Extraversion</td>
<td>39.60</td>
<td>5.86</td>
<td>22.08</td>
<td>54.85</td>
<td>-0.03</td>
<td>-0.25</td>
</tr>
<tr>
<td>Perceived control</td>
<td>80.62</td>
<td>17.12</td>
<td>29.81</td>
<td>133.9</td>
<td>-0.09</td>
<td>0.06</td>
</tr>
<tr>
<td>Depression</td>
<td>28.89</td>
<td>11.05</td>
<td>0</td>
<td>63</td>
<td>-0.01</td>
<td>-0.02</td>
</tr>
<tr>
<td>Worry</td>
<td>15.19</td>
<td>4.60</td>
<td>2.26</td>
<td>27.06</td>
<td>-0.03</td>
<td>-0.41</td>
</tr>
<tr>
<td>Obsessive-compulsive</td>
<td>34.86</td>
<td>11.13</td>
<td>0</td>
<td>72</td>
<td>0.08</td>
<td>0.21</td>
</tr>
<tr>
<td>Social anxiety</td>
<td>33.23</td>
<td>12.82</td>
<td>2</td>
<td>76</td>
<td>0.12</td>
<td>0.09</td>
</tr>
<tr>
<td>Thought-action fusion</td>
<td>41.29</td>
<td>12.32</td>
<td>5</td>
<td>70</td>
<td>0.009</td>
<td>0.02</td>
</tr>
<tr>
<td>Intolerance of uncertainty</td>
<td>62.47</td>
<td>21.51</td>
<td>3</td>
<td>134</td>
<td>0.15</td>
<td>0.11</td>
</tr>
<tr>
<td>Dysfunctional attitudes</td>
<td>141.2</td>
<td>27.07</td>
<td>59.06</td>
<td>229.42</td>
<td>-0.008</td>
<td>0.07</td>
</tr>
</tbody>
</table>

As presented in table 3, there are significant relationships between all specific factors (IOU, TAF, and DAS) and EDs. To determine specific role of vulnerability factors, we used path analysis relied on literature, Barlow’s theory and results of present study. We depicted separate models for each disturbance. At first, all specific factors placed concordantly in model. Each non-significant path of specific factor to ED deleted from model and that specific factor excluded from model. Then it was applied modification indices and final model developed.

Table 3: Zero-order correlations between variables
Table 4: Fitness indices of social anxiety model

<table>
<thead>
<tr>
<th></th>
<th>$\chi^2$</th>
<th>$d$</th>
<th>$P$</th>
<th>GFI</th>
<th>TLI</th>
<th>CFI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-modification</td>
<td>368.68</td>
<td>12</td>
<td>0.0001</td>
<td>0.805</td>
<td>0.164</td>
<td>0.335</td>
<td>0.315</td>
</tr>
<tr>
<td>Post-modification</td>
<td>13.11</td>
<td>4</td>
<td>0.011</td>
<td>0.983</td>
<td>0.938</td>
<td>0.975</td>
<td>0.078</td>
</tr>
</tbody>
</table>

It has been presented fitness indices in table 4 and relationships between main components of triple vulnerability model of SAD in model 1. The $\chi^2$ is significant but its proportion to $d$ is acceptable to fitness of model. Root mean square errors of approximation (RMSEA), comparative fit index (CFI), Tucker-Lewis index (TLI), goodness of fitness (GFI) suggest that the model is fit. However, IOU to SAD path is not significant ($p>0.74$) and explain low variance.
Model 1: Triple vulnerability model of SAD

Table 5: Fitness indices of obsessive-compulsive model

<table>
<thead>
<tr>
<th></th>
<th>$\chi^2$</th>
<th>d.f.</th>
<th>P</th>
<th>GFI</th>
<th>TLI</th>
<th>CFI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-modification</td>
<td>142.47</td>
<td>12</td>
<td>0.0001</td>
<td>0.89</td>
<td>0.64</td>
<td>0.80</td>
<td>0.19</td>
</tr>
<tr>
<td>Post-modification</td>
<td>7.29</td>
<td>3</td>
<td>0.06</td>
<td>0.99</td>
<td>0.97</td>
<td>0.99</td>
<td>0.06</td>
</tr>
</tbody>
</table>

It has been presented fitness indices in table 5 and relationships between main components of triple vulnerability model of OCD in model 2. The $\chi^2$ is significant but its proportion to d.f is unacceptable range to accept fitness of model. Root mean square errors of approximation (RMSEA), comparative fit index (CFI), Tucker-Lewis index (TLI), goodness of fitness (GFI) suggest the model is fit.
Model 2: Triple vulnerability model of OCD

Table 6: Fitness indices of generalized anxiety model

<table>
<thead>
<tr>
<th></th>
<th>$\chi^2$</th>
<th>$d_f$</th>
<th>P</th>
<th>GFI</th>
<th>TLI</th>
<th>CFI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-modification</td>
<td>133.05</td>
<td>12</td>
<td>0.0001</td>
<td>0.89</td>
<td>0.34</td>
<td>0.62</td>
<td>0.18</td>
</tr>
<tr>
<td>Post-modification</td>
<td>8.6</td>
<td>3</td>
<td>0.03</td>
<td>0.99</td>
<td>0.93</td>
<td>0.98</td>
<td>0.08</td>
</tr>
</tbody>
</table>

It has been presented fitness indices in table 6 and relationships between main components of triple vulnerability model of GAD in model 3. The $\chi^2$ is significant but its proportion to $d_f$ is unacceptable range to accept fitness of model. Root mean square errors of approximation (RMSEA), comparative fit index (CFI), Tucker-Lewis index (TLI), goodness of fitness (GFI) suggest the model is fit.
Model 3: Triple vulnerability model of GAD

Table 7: Fitness indices of depression model

<table>
<thead>
<tr>
<th></th>
<th>$\chi^2$</th>
<th>df</th>
<th>P</th>
<th>GFI</th>
<th>TLI</th>
<th>CFI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-modification</td>
<td>350.71</td>
<td>12</td>
<td>0.0001</td>
<td>0.80</td>
<td>0.10</td>
<td>0.36</td>
<td>0.30</td>
</tr>
<tr>
<td>Post-modification</td>
<td>0.61</td>
<td>2</td>
<td>0.73</td>
<td>0.98</td>
<td>0.99</td>
<td>0.99</td>
<td>0.0001</td>
</tr>
</tbody>
</table>

It has been presented fitness indices in table 7 and relationships between main components of triple vulnerability model of DEP in model 4. The $\chi^2$ is not significant suggesting fitness of model. Root mean square errors of approximation (RMSEA), comparative fit index (CFI), Tucker-Lewis index (TLI), goodness of fitness (GFI) suggest the model is fit. However, DAS to DEP path is not significant.
Discussion and conclusions
In the first place, because of assembling data from general population, we can conclude that triple vulnerability model and its components are dimensional, in other words, EDs and their underlying etiological dimensions have dimensional and continuous entity. Brown and Barlow (2009) have proposed suggestions to classify EDs. They claim there are some high order dimensions such as neuroticism/negative affect and behavioral inhibition/behavioral activation explaining conditions such as comorbidity of disturbances and covariance between anxiety and affective disturbances. They believe that classification should include both underlying, dimensional and common elements and specific clinical criteria of each disturbance. In other words, EDs are dimensional and such a classification can resolve problems and deficits of categorical classification. For example, using dimensional classification, we can identify intensity of disturbance. Also, sometimes there are people have symptoms of EDs but do not meet full criteria of the disturbance or their disturbance is not clinically significant because of low intensity of symptoms. Dimensional classification accounts for non-significant clinically features, symptoms comorbid conditions (for example, symptoms of generalized anxiety in affective disturbances), under threshold or subclinical as well as NOS diagnosis. Using such classification and considering dimensions such as neuroticism/behavioral inhibition and behavioral activation/positive affect in classification because they stand for general vulnerability constructs, we can pave the way to interventions related to primary and secondary preventions in
mental disturbances. For example, it will be possible to identify people with high neuroticism/behavioral inhibition and intervene on time to prevent afflicting disturbances. Because these people are at risk to psychopathology if they confront to other vulnerability factors such as psychological and life stressors and specific factors related to each disturbances.

Results of study based on table 3 suggest that there are significant relationships between all specific vulnerability factors and EDs. However, to determine specific role of these factors in EDs, we relied Barlow’s model using path analysis. We depicted separate models for each disturbance. All specific factors located in the first models. We applied modification indices and deleted non-significant paths. Therefore, in the model 1 related to social anxiety, only significant factor was IOU. Final model of SAD was fit but the path of IOU to SAD was non-significant. Some of past studies showed that there was relationship between SAD and IOU (for example, Boelen and Reijntjes, 2009; Whiting, Jenkins, May, Rudy, Davis, and Reuther, 2014).

As we know, one of the variables related to SAD is worry about others’ evaluations about own self. This worry appears as anticipating anxiety before situation, as situational anxiety experience in the situation and as rumination about performance, dissatisfaction about own performance and self-evaluation after situation (Hofmann and Otto, 2008). In other words, we can say that people with SAD cannot tolerate others’ uncertain views about themselves and when they do not know what impression may others will have about them; they become intensely anxious and worried. Probably, these people see these worries well because they result in vigilance to avoid situations with high possible negative evaluations and escape from uncertainty.

It was only path of TAF to OCD significant in model 2 and remained in the model. Fitness indices suggested this model was fit. Although there were significant relationships between TAF and other EDs based on Pearson coefficient, TAF was not significant in other models and explained little variance. These results suggest that although TAF plays a role in other EDs, it has a little contribution to explain development and maintenance of other EDs when places aside of other vulnerability factors. However, results showed that TAF has more specific role for OCD. This result is consistent to some results of past studies (for example, Brown and Naragon-Gainey, 2013).

Literature suggest that OCD is different from other EDs in some aspects such as phenomenology, symptoms and criteria, course of disturbance, comorbidity, neural paths and circuits, family, genetic, and environmental factors, temperamental antecedents, personality correlates, cognitive and emotional processes, biological indicators and treatment response (Stein and et al, 2010). Phenomenologically, other anxiety disturbances are indicated with physical and psychological anxiety manifestations. Therefore, anxiety or fear is apparent in anxiety disturbances. In OCD, obsessions and their intrusive and ego dystonic entity and rituals are different from ruminations in generalized anxiety and symptoms of other EDs (Langlois, Freeston, Ladouceur, 2000). OCD has more common aspects with obsessive-compulsive spectrum disturbances such as body dimorphic, trichotillomania, tic and so on.

Intrusive cognitions occur in many disturbances but people with OCD specifically see these mental processes uncomfortable and dangerous (Dias-Ferreira and et al, 2009). Although there are similarities between compulsions and avoidant behaviors of other EDs, intense stereotypic, repetitive and dysfunctional entity of compulsions differentiate them from other behaviors. There
are many cognitive deficits common between OCD and other EDs. However, OCD has specific and different profile of executive functions engaging in inhibitory processes such as shifting attention set which explain cognitive inflexibility and inhibitory problems of impulsive behavioral responses (Chamberlain, Fineberg, Blackwell, Robbins, and Sahakian, 2006). In other hand, there are cognitive-neural deficits related to frontal-striatal circuits in OCD which there are not in other EDs. Cognitive-neural evidence suggest that compulsions in OCD are indications of basal ganglia dysfunction.

It was only IOU to GAD path significant in model 3. Final model of GAD was fit. As seemed in model of SAD, IOU was related to SAD, although its path to SAD was not significant in final model. As a result, although IOU had strong relationship with GAD, it may be considered as a vulnerability factor in SAD. In other words, IOU had a more specific role in GAD. Based on IOU model, people with GAD consider uncertain and ambiguous situations stressful and disturbing (Dugas and Koerner, 2005) and experience chronic worry in response to such situations. These people believe that worry helps them to more effective coping with horrible events or prevent their occurrence (Borkovec & Roemer, 1995). This worry and anxiety result in negative orientation to problem and cognitive avoidance which cause to maintain worry. Dugas, Gagnon, Ladouceur, and Freeston, (1998) say that IOU starts a chain of worry, negative orientation to problem and cognitive avoidance and affect directly on orientation to problem and degree of avoidance. Accordingly, people with high IOU are more susceptible to engage in worry process.

It was only DAS to DEP path significant and explained more variance. As a result, it remained in final model. Fitness indices suggested this model is fit. These results are inconsistent with some past results (for example, Brown and Naragon-Gainey, 2013). Brown and Naragon-Gainey found that DAS is not specific to DEP but was related to other ED. Using interview to record of depressive and non-depressive patients, Beck found out that depressive people tend to distort their experiences in a specific way. In other words, they misinterpret events as failure, deprivation or rejection or tend to exaggerate and overgeneralize negative events. Accordingly, Beck proposed that specific cognitive schemas become so strong during depression and dominate on thinking processes and result in cognitive distortions (Weissman and Beck, 1978). Accordingly, he decided to develop a questionnaire using negative thoughts content of depressive patients. It seems that Beck and his colleagues’ questionnaire (1996) focuses more on depressive thought content and has been aimed more specifically to assess dysfunctional beliefs in depressive people.
References


