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Research Article

COMPARISON OF EMOTIONAL SCHEMA AND COPING STRATEGIES IN PATIENTS WITH OBSESSIVE-COMPULSIVE DISORDER (OCD) AND HEALTHY PEOPLE

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ABSTRACT
Obsessive-compulsive disorder is chronic, neurotic and debilitating which has been noteworthy of psychologists and psychiatrists. This study compares emotional schema and coping strategies in patients with obsessive-compulsive disorder and healthy people. For this purpose, 60 healthy people and 60 patients of obsessive-compulsive disorder from Hospital Psychiatry of Iran are chosen by voluntary sampling. Collecting data was done by Leahy Emotional Schema Scale (LESS), Lazarus' ways of coping questionnaire (WOCQ). Descriptive and inferential statistics of variance and t-test was used. Results showed there is a significant difference between emotional schema in obsessive rumination and attempting for being reasonable and coping strategies in components of encountering, solving the problem, responsibility of healthy people and patients of obsessive-compulsive disorder.

Keyword: *Obsessive-compulsive Disorder, Emotional Schema and Coping Strategies*

INTRODUCTION
Based on the concept of emotional process and by revelation of ultra-cognition model of emotional, Leahy presented his emotional schema model in 2002; an explanatory shows how people differ in their concept of emotion. Most of researches point that emotional schemas are related with many disorders such as: anxiety, depression, addiction and wedlock conflicts. So, therapeutic ways will be found by comparing the schemas of patients with healthy individuals (Leahy, 2002). Leahy believes individuals differ in strategies of opposing with emotion. According to the schema of Beck (1976) anxiety specifies with distorted negative thought in interpretation of stimulus's and events. Thus, when an unpleasant emotion is activated person may react with negative behavior or thoughts, and this may be the infrastructure of vulnerability against varieties of diseases. During three recent decades we observed tremendous development in the role of schema in forming, steadiness and treatment of many psychiatry disorders such as obsessive-compulsive disorder.
Cognitive variables emphasize on the way people perceive the content and incident of disturbance thought. To the present time many questions about the way of formation, performance, backwash, treatment, pictures and disturbance thoughts of obsessive thought have remained without solution. Mirzaei and Asgharnezhad (2014) in a study named" comparison of emotional schema and examination of anxiety relevancy with emotional schema in patients of obsessive-compulsion disorder, social anxiety disorder and normative group" indicated that some dimensions of emotional schema in patients of obsessive-compulsive disorder and social anxiety disorder was different with normative group and intensity of anxiety and worry was relevant with some dimensions of emotional schema. Leahy (2007) in a study "emotional schema and individual supports: self support in homework of patients of obsessive-compulsive disorder" examined the patients of obsessive-compulsive disorder and represented some solution for avoiding obsessive-compulsive disorder by family supports. He emphasized that individual can change their emotions by reminding emotional positions of his/her childhood and writing a letter to his/her parents. Considering recent changes about the role of cognitive factor, beliefs and inefficient assessments of obsession as necessary factors in making obsession, it's necessary to do a research in the field of cognitive factors such as schemas. From Leahy point of view, emotional schemas are effective on obsessive patients and using these schemas can help in treatment of obsessive patients. So the first step in

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treatment of obsession by schema is having cognition about their schemas. According to the fact that Leahy questionnaire was designed in 2002 and because of its reliability in Iran in 2012s, quantitative researches done for emotional schemas. This research is the first step for treatment and cognition of emotional schemas and its purpose is to respond the question" is there any difference between emotional schemas healthy people and patients with obsessive-compulsive disorder? Is there any difference between coping strategies of healthy people and patients with obsessive-compulsive disorder?

Literature Review

Emotional Schemas

All people experience different modes of emotions such as: anxiety, anger, envy, sadness and remorse in their life and cannot find one who lives without these emotions (James *et al.,* 2011). Goleman (1995) applied emotion in referring to a feeling, thought, psychological and biological state and range of interest to act according that. Definitions of emotion are various and often contradictory. Leahy *et al.,* (2010) believe that emotion is formed from set of processes and each of them alone cannot cause an experience of "emotion". Emotions like anxiety include components such as assessing, intention, feeling, and physical behavior. But from some theorists point of view emotion is set of universal emotions such as: anger, grief, fear, happiness, love, excitement, hate and shame. Each of the emotions has a single core, it means that the original form of emotion in different people is the same, but the form of revelation is different in different societies and under specific cultural conditions. Generally, emotion can be applied to a vast range of responses. These emotions are examinable in some dimensions like intensity, period and direction (Gross and Thompson, 2007). In the fields of Psychopathology, many researchers know different role and positions for emotion On account of mental disorder. Emotional problems including depression, anxiety, hostility and interpersonal sensitivity involve high percent of people in society. Anxiety include vast range of clinical depression symptoms, such as depressed mood, loss of interest in relation to the pleasures of life, lack of motivation and the loss of vital energy, feelings of helplessness, thoughts of suicide. Anxiety, symptoms such as nervousness, and tremor felt in parts of the body, sudden fear, feelings of panic, fear and worry about the future and it takes some physical aspects. Hostilities, including thoughts, feelings or actions that represent the mood of anger and negative feelings of inadequacy and inferiority means of interpersonal sensitivity, especially in comparison with others (Fathi, 2009). However, emotions have biological base, but people are able to affect the way they express these emotions (Tamson, 1994). Thus, seeking order in emotion is a basic principle in beginning, assessing, organizing adaptive behavior and preventing expression of negative emotions and maladaptive behaviors (Cicchetti *et al.,* 1995). Psychological literature review shows that order-seeking emotion is an important factor in determining the health and performance of successful social interactions (Tamson, 1994; Cicchetti *et al.,* 1995). Every default in systematizing emotions can make the person pathologic in psychological disorders like depression and anxiety (Karnfski and Kraj, 2003). Using cognitive processes is one of the most common strategies for encouraging information, managing and seeking order in emotion (Mashhadi *et al.,* 2011). Folkman and Lazarus (1988) presented eight strategies for emotion seeking-order such as encountering the condition, staying away from the situation, self-control, seeking social support, accountability, escape, avoidance, problem solving and positive evaluation. Large portion of theories and cognitive pathologic patterns focused on determining the emotional disorder based on cognitive processes of emotional information (Clark *et al.,* 1999). These studies in general found that cognitive structures are the agent of active construction of perception and experience and emotional experience are the resultant of this activity (Ingram, 1984). But researchers do not have agreement in details of this process. Some of them believe that the original factor in cognitive processing is emotional states. For example, link network theory (Bower, 1981) a dominant theory in determining the relationship between mood and memory believe that emotional states have a basic role in processing information. According to this theory when a person memorize something in special condition of mood, he can remember that more easily when he be in that situation again. In other sides, there are theories that believe the key elements in cognitive processing of emotional information are fundamental characteristics, beliefs and basic emotional experiences of the person. For instance the theory of making significant structures of

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schema believes that cognitions and schemas were the origin of initial process and cognitive process direct by aid of existing schemas in person (Beck, 1967; Ingram, 1984). Both of link network theories and theories of making significant structure have been confirmed in different researches. Schema theory calls this assumption "specific content". According to this theory depression-related knowledge associate with failure, loss; anger-related knowledge associate with assessment of injustice and positive emotions-related knowledge associate with assessing the profit.

Model of Emotion-focused Therapy

Model of Leahy Emotional Schemas

Leahy (2002) believes that problem-making emotional schemas is associated with higher levels of, depression, anxiety, cognitive concerns, experiential avoidance, marital maladjustment, personality disorders and reduced Mindfulness (Leahy *et al.,* 2011). Leahy (2002) presented model of emotional schemas based on emotional processing concept and by inspiring from meta-cognitive model of emotions. According to model of emotional schemas, people may differ in conceptualization of their emotions or in other words they have different schemas about their emotions. These schemas reflect the way people experience their emotions and is a belief that they have in mind in immediate provocation of unpleasant emotions to act (or how to act when unpleasant emotions provoke) (Leahy, 2002; Leahy, 2010).

This model tries to integrate models of emotion-centered with meta-cognitive modes to cure patients with anxiety disorder who resist the treatment (Leahy, 2002). One advantages of this integrated model is recognizing the value of attention and expressing emotion paid by person in significant context for his/her emotions. It's clear that all people experience anger, agony and anxiety or other emotions, but these emotions create disorder in some people. These are witnesses to the fact that cognitive schemas about emotions may be affective in creating and developing these disorders (Leahy, 2002; 2007; 2010).

Leahy (2002) defined a scale for assessing emotional schemas. He designed this scale based on 14 factors, including seeking approval (others understand how I feel), comprehensibility (my emotion is nonsense to me), guilt and shame (I should have my feelings), a simplistic view of emotions (I should not have mixed emotions), higher values (values reflect my feelings), control (I scare my feeling go out of my control), trying to be rational (I should be a logical and rational person rather than emotional person), period (my emotion will continue for a long time), agreement (others experience the same feeling that I've experienced), acceptance of feelings (I cannot accept my feeling), rumination (I sit in a corner and think how bad feeling I have), tool of emotions (I cannot let myself cry) and blame (others make me to feel like this).

Cognitive theories of emotional disorders like schema theory (Beck, 1976) are based on this principle that psychological disorders are associated with disorder in thought. Especially, anxiety and depression determine by negative thought and distortion in events. It is assumed that dynamic interpretation and negative thought or distorted interpretation originated from activation of stored negative thought in long-term memory. According to this theory, emotional disorder associate with activation of dysfunctional schemas. Schemas are memory structures which contain two types of information: beliefs and assumptions. Beliefs are central core of structures with unconditional nature accepted as facts about themselves and the world. Assumptions are conditions and show dependencies between events and self assessing (Beck, 1976). Dysfunctional schemas which signify emotional disorder are more flexible, serious and objective than schemas of common persons (Beck, 1976).

Obsessive Compulsive

Define anxiety as painful emotion with a threatening situation or with expectation of a danger dependent on indefinite object (Sadouck and Sadouck, 2008). As well, anxiety is an unpleasant feeling accompanied by stress, fear, Concerns and feelings of impending danger. When anxious states intensify or continue for a long time and become chronic it can be said that Phobic anxiety has occurred, so two factor of intensity and period are characteristics of Phobic anxiety. Anxiety disorder is the disease of emotional people (Barlow, 1991) and links them to direct role of emotions. Obsession disorder is on components of anxiety divide into two components of "obsession thoughts and beliefs" and "practical obsession". Obsession thoughts and beliefs are provoking mental images manage life and dominate it. Practical obsessions are

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repetition of set of unreasonable actions and internal rules form its base. Side effects of obsessive disorder are so huge that world health organization has recognized this disorder as one leading causes of disability. Obsessive-compulsive disorder is a complex and debilitating disorder has long been of interest to psychiatrists and psychologists. Obsessive-compulsive disorder is primarily a disorder of cognitive processing (Stekti, 1997) in which obsessions in forms like thought, beliefs and mental images and unwanted impulses annoy the person. Practical obsession is in the form of repetition behavior or mental activities that person feels he have to act or respond to obsession (Tourneur, 1997). Obsessive-compulsive disorder is a debilitating disorder and its original characteristic is occurrence of obsession and applying compulsion. Obsessions are thought, mental images and unwanted impulses occur without the intention of patient. Patient persists against obsession and knows that obsessions are the product of mind. Obsessive thought often have hostile, sexual or religious content or experience in the form of doubts and ruminations. Practical obsessions are repetitive behaviors done in response to obsessions. The goal of these behaviors is decreasing agony and distress by preventing some terrible events (Wels, 2009). The main characteristics of obsessive-compulsive disorder are regressive obsessive thought and compulsory acts. Obsessive thoughts are beliefs or impulses occur continuously as stereotype behaviors in the mind of patient. Obsessive behavior is stereotype behaviors that patient repeat them continuously. In obsession signs of automatic anxiety often exist and signs of depression occur by increasing the obsession. Obsessive-compulsive disorder causes chaos in patients and mainly causes disorder in their performance and social compatibility (Sadouk and Sadouk, 2005). These signs of obsession exist especially in form of depression and obsessive thoughts. Obsessive thoughts continuously causes chaos in patient and the patient by unsuccessful attempts tries to oppose them. This disorder exists in men and women equally, but the beginning of signs is not clear and sometimes occurs in childhood or adulthood. Depression, anxiety and paying much attention to optional processing of information is related to the clinical phenomenon of this disorder.

Coping Strategies

In 80s, a structure named opposition entered the literature of psychology and has been interesting as a mediator of relationship between stress and physical-psychological disorder. Lazarus and Folkman (1984) believe that managing demands (external or internal) point to difficulty or beyond the individual resources. From their point of view, opposition includes attempts such as action oriented internal mental health for managing and control of internal-environment demands and challenges between them (Lazarus and Latter, 1978). Folkman and Lazarus (1991) know opposition as cognitive attempts and individual behavior for overcoming stress or decreasing its effect. lack of single pattern in considering strategies and coping skills is a problem in measurement of strategies and coping skills, because there are different patterns and based on them many tools are presented. Investigations show that personal and coping strategies are associated with each other. For example, Koror and et.al concluded that optimistic, high self-esteem and continence persons rely more on active opposition and planning, while less desirable qualities of character relate to more inefficient opposition. Many researches related neurotic with avoidance confrontation (Mouse, 2003). Lazarus (1993) believed that opposition has two functions: regulation of adverse emotions and adopting action for changing and improvement of the annoying problem. So they identified two classes of opposing ways which include opposition using problem solving and emotion-centered opposition.

Opposition strategies using problem include: active methods of solving the problem used for solving the stressful relationship between self and environment (Compass *et al.,* 2001). The most important of these strategies include: encountering opposition such as militant attempts for changing the situation, seeking social support, attempt to attain emotional support and information of others and strategy of problem solving with plan such as weighed-centered attempts to solve the problem. In other hand, emotion-centered strategies include ways based on people attain optimal level of emotional regulation, ability to face situations and intense emotions. Most important of these strategies are continence, attempt to be apart from situation, reassessment, attempt to perceive the positive meaning in experience by personal growth, avoidance strategy and try to escape the situation.

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Hypothesis of the Research

1. There is a significant difference between emotional schema of patients of obsessive-compulsive disorder and healthy people.
2. There is a significant difference between coping strategies of patients of obsessive-compulsive disorder and healthy people.

MATERIALS AND METHODS

Present study is descriptive and retrospective. Population of this research includes two groups of patients of obsessive-compulsive disorder and healthy people from Farvardin to Tir 2014 in Iran Psychiatric Hospital. The total population of patients of under treatment is 145 and 60 of them chosen by voluntary sampling.

To examine the emotional schema and coping strategies orderly the questionnaires of Leahy emotional schema (2002) and Folk man and Lazarus coping strategies was used.

In this study the normality of data was done by Colmograv-Smirnov test. In condition that data is normal, the comparison of emotional schema and coping strategies in patients and healthy people will be done by t-test, otherwise Man-within test will be used. Variance analysis is used to estimate the impact of sex on emotional schema and coping strategies in patients and healthy people. SPSS software is used for analyzing the data.

Data Analysis

Table 1: Result of components of emotional schema of Colmograv-Smirnov test

Sig	Statistics of the test	Number	Variable
.752	.675	120	Seeking confirmation
.234	1.036	120	Perceivable
.611	.760	120	Feel guilty
.374	.913	120	Simplistic view toward excitement
.508	.823	120	Higher values
.718	.696	120	Excitement of self-consciousness
.456	.856	120	Attempt
.684	.717	120	A reason for being reasonable
.320	.956	120	Agreement
.349	.933	120	Accepting sensation
.170	1.110	120	Rumination
.591	.771	120	Tool of excitements
.873	.593	120	Blame

Table 2: Result of coping strategies of Colmograv-Smirnov test

Sig	Statistics of the test	Number	Variable
.322	.954	120	Encountering
.353	.930	120	Avoidance
.511	.820	120	Continence
.268	1.002	120	Seeking
.021	1.509	120	Responsibility
.701	.706	120	Escape
.440	.867	120	Problem solving
.558	.791	120	Positive feedback

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First hypothesis: there is a significant difference between patients with obsessive-compulsive disorder and healthy people.

Table 3: Result of t-test (comparison of emotional schema in both groups of patients and healthy people)

t-test for mean equation of two groups							**Loin variance equality test**			**Variable**
reliability 95%		**Standard deviation difference**	**Mean difference**	**sig**	**df**	**t**	**Sig**	**F**		
High	**Low**									
.41507	-.09597	.12903	.15955	.219	118	1.237	.069	3.362	equality of variance	Seeking Non-confirmation
.41528	-.09618	.12903	.15955	.219	109.194	1.237			Non-equality of variance	
.57827	.03344	.13757	.30586	.028	118	2.223	.000	26.240	equality of variance	Conceivable
.57876	.03295	.13757	.30586	.028	100.580	2.223			Non-equality of variance	
.64044	.11318	.13313	.37681	.005	118	2.830	.000	32.014	equality of variance	Feeling guilty
.64132	.11230	.13313	.37681	.006	89.208	2.830			Non-equality of variance	
.77241	.27079	.12665	.52160	.000	118	4.118	.003	9.491	equality of variance	Simplistic view Toward emotion
.77274	.27046	.12665	.52160	.000	104.589	4.118			Non-equality of variance	
.72027	.18609	.13488	.45318	.001	118	3.360	.002	9.868	equality of variance	Higher values
.72062	.18574	.13488	.45318	.001	104.829	3.360			Non-equality of variance	
.76937	.24151	.13328	.50544	.000	118	3.792	.001	11.907	equality of variance	Emotional self knowledge
.76977	.24111	.13328	.50544	.000	102.881	3.792			Non-equality of variance	
.66676	.18814	.12085	.42745	.001	118	3.537	.039	4.344	equality of variance	Attempt
.66700	.18791	.12085	.42745	.001	107.713	3.537			Non-equality of variance	
.85418	.38061	.11957	.61739	.000	118	5.163	.215	1.552	equality of variance	A reason for being reasonable
.85427	.38052	.11957	.61739	.000	113.908	5.163			Non-equality of variance	
.82213	.27134	.13907	.54673	.000	118	3.931	.000	19.226	equality of variance	Agreement
.82268	.27079	.13907	.54673	.000	98.914	3.931			Non-equality of variance	
.86927	.34942	.13126	.60935	.000	118	4.642	.000	15.300	equality of variance	Accepting emotion
.86971	.34898	.13126	.60935	.000	101.573	4.642			Non-equality of variance	

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.93111	.42594	.12755	.67853	.000	118	5.320	.005	8.134	equality of variance	Rumination
.93152	.42554	.12755	.67853	.000	102.188	5.320			Non-equality of variance	
.75571	.26981	.12269	.51276	.000	118	4.179	.295	1.107	equality of variance	Expressing emotion
.75582	.26970	.12269	.51276	.000	113.208	4.179			Non-equality of variance	
.79585	.32458	.11899	.56021	.000	118	4.708	.041	4.265	equality of variance	Blame
.79604	.32438	.11899	.56021	.000	109.320	4.708			Non-equality of variance	

Result of compared mean of emotional schema between patients and healthy people show that there is a significant difference in components of coping strategies between patients and healthy people. Since the significance of the mean comparing test is lower than 0.05 we can say that hypothesis of equality of mean in both groups with reliability of 95% is rejected.
A comparison will be done between the mean of components of emotional schema, considering the existing difference of emotional schema between healthy people and patients to reveal that in which one of components of emotional schema there is a high difference between two groups of patients and healthy people. The result is given bellow.

Table 4: Result of grading the mean difference of components of emotional schema in healthy people and patients

Grade	Difference	Healthy	Patient	Component
12	0.3058	3.5523	3.8581	Conceivable
11	0.3768	3.5444	3.9212	Feeling guilty
6	0.5217	3.3356	3.8573	Simplistic view toward emotion
9	0.4532	3.4726	3.9258	Higher values
8	0.5054	3.4434	3.9488	Self emotional knowledge
10	0.4274	3.5996	4.027	Attempt
2	0.6174	3.491	4.1084	A reason for being reasonable
5	0.5467	3.5499	4.0966	Agreement
3	0.6093	3.3694	3.9787	Accepting the feeling
1	0.6785	3.3913	4.0698	Rumination
7	0.5128	3.4851	3.9979	Expressing emotion
4	0.5602	3.4851	4.0453	blame

Result of grading the difference mean of components of emotional schema between healthy people and patients indicate that significance between variables of rumination and a reason for being reasonable is more rather than other components. It shows that obsessive people are challenging with themselves and review their past more than healthy people and tend to be reasonable and not to behave emotionally.
Second hypothesis: there is a significant difference between coping strategies in patients of obsessive-compulsive disorder and healthy people.

Table 5: Result of –test (comparison of coping strategies in both groups of patients and healthy people)

Equality of t-test for both groups							Loin variance equality test		Variable	
Reliability 95% High	Low	Difference of standard deviation	Difference of mean	sig	df	t	sig	F		
1.09320	.56431	.13354	.82876	.000	118	6.206	.000	13.682	Equation variation	Encountering
1.09355	.56396	.13354	.82876	.000	104.483	6.206			Non-equality of variance	
.66667	.13358	.13460	.40012	.004	118	2.973	.000	14.985	equality of variance	Avoidance
.66705	.13319	.13460	.40012	.004	103.598	2.973			Non-equality of variance	
.82743	.28706	.13644	.55724	.000	118	4.084	.002	10.127	equality of variance	Continence
.82782	.28666	.13644	.55724	.000	103.567	4.084			Non-equality of variance	
.72743	.17619	.13918	.45181	.002	118	3.246	.001	12.338	equality of variance	Seeking social support
.72778	.17585	.13918	.45181	.002	105.220	3.246			Non-equality of variance	
1.02452	.49501	.13370	.75977	.000	118	5.683	.000	27.292	equality of variance	Responsibility
1.02513	.49441	.13370	.75977	.000	96.763	5.683			Non-equality of variance	
.78518	.23786	.13819	.51152	.000	118	3.701	.000	21.823	equality of variance	Avoidance
.78575	.23728	.13819	.51152	.000	98.232	3.701			Non-equality of variance	
.86304	.32699	.13535	.59502	.000	118	4.396	.000	30.545	equality of variance	Problem solving
.86388	.32615	.13535	.59502	.000	90.588	4.396			Non-equality of variance	
.55294	.01447	.13596	.28370	.039	118	2.087	.001	11.853	equality of variance	Positive feedback
.55344	.01397	.13596	.28370	.039	100.220	2.087			Non-equality of variance	

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Result of comparison of coping strategies mean between patients and healthy people prove that there is a significant difference between coping strategies mean in patients and healthy people. In another word, because the significance of the test is lower than 0.05 we can say that mean equality hypothesis is rejected in both groups with reliability of 95%.
Considering the present difference between coping strategies in two groups of patients and healthy people, a comparison was done between the mean of variables in two groups to see in which group components of coping strategies are more. The mean of components will be estimated in patients and healthy people and then the difference between them will be graded.

Table 6: Result of grading the difference mean of components of coping strategies in patients and healthy people

Grade	Difference	Healthy	Patient	Variable
1	0.8288	3.2905	4.1193	Encountering
7	0.4001	3.518	3.9181	Avoidance
4	0.5572	3.3772	3.9344	Continence
6	0.4519	3.5495	4.0014	Seeking social support
2	0.7597	3.4017	4.1614	Responsibility
5	0.5115	3.4046	3.9161	Avoidance
3	0.5951	3.502	4.0971	Problem solving
8	0.2837	3.6522	3.9359	Positive feedback

Result of grading the difference mean of components of coping strategies in healthy people and patients indicate that difference between encountering variable is more than other components in patients and healthy people, and after it there stand variables of responsibility and problem solving. It reveals that obsessive people attempt more than healthy people to change the position. Also obsessive people try more to refine the present position and they accept their error.

RESULTS AND DISCUSSION

Result

First Hypothesis

Result indicated that there is a significant difference between components of emotional schema in healthy people and patients. Result of grading the mean of components of emotional schema in patient and healthy people show that the difference between variables of rumination and attempt for being reasonable is more than the other components. It implies that patients are challenging with themselves and review their past. This people are eager to behave reasonably and not to show emotion.

Second Hypothesis

Results showed that there is a significant difference between patients and healthy people in components of coping strategies. Results of classifying the mean of components of coping strategies also indicate that the difference between variables of encountering in patients and healthy people is more than other components. After encountering, variables of responsibility and solving the problem stand in next rating. This shows that obsessive-compulsive patients attempt more than healthy people for changing the position and also patients represent degrees of risk and hostility.
As well, considering the variable of responsibility and solving the problem, obsessive patients attempt continuously for adjustment of present position and have thoughtful and weighty attempting based on the problems for changing the position.

Suggestion

Accepting the existence of difference between emotional schemas and coping strategies of healthy people and patients with obsessive-compulsive disorder, we can say that patients with obsessive-compulsive disorder need instruction in field of recognizing emotions, arranging emotion, controlling thoughts and problem centered disturbance. As much as knowledge about emotional schema and cognition increase,

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avoidance of emotion decrease. So patient feeling of ability in facing with future threatening position will increase.

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