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# Metacognitions And Psychological Flexibility Among The Patients With Generalized Anxiety Disorder, Obsessive And Compulsive Disorder, And Healthy Controls

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***Abstract***
*Objective: The present study aimed to explore metacognitions and psychological flexibility among the patients with generalized anxiety disorder, obsessive-compulsive disorder and healthy peoples and other objective was to determine the relationship among the variables metacognitions and psychological flexibility. Methods: Purposive sampling technique was used to select 60 participants from different hospital settings and community. For this, purpose 20 GAD, 20 OCD from different hospital settings of Kota (Raj) and 20 healthy peoples from community were selected and they were administered Generalized Anxiety Disorder – 7, Yale Brown Obsessive Compulsive Scale, Metacognitions Questionnaire (MCQ) and The Acceptance and Action Questionnaire II (AAQ II). The ANOVA and Post hoc were applied to analyze the data. The results as follows: Patients with GAD obtained significantly greater mean score on metacognitive beliefs than other two groups. Similarly, patients with OCD obtained significantly greater mean score on psychological flexibility than other two groups. The study aims in making the people aware of the various anxiety disorder and their psychological symptom and different coping strategies that can help them deal with the anxiety disorder in a better way, and thus maintaining their emotion. The review concludes with a summary of major research findings, as well as a consideration of future directions and implications for practice and policy.*

***Keywords:*** *Metacognitions and Psychological Flexibility, Generalized Anxiety Disorder, Obsessive and Compulsive Disorder, And Healthy Controls*

## INTRODUCTION

In the field of Clinical psychology, neurotic diseases are a subset of internal health diseases characterized by an incapability to manage everyday life. Neurotic diseases are a particular order of common internal diseases that includes anxiety diseases and depressive diseases, as well as compulsive- obsessive complaint (OCD). Generalized anxiety complaint (GAD) is a habitual condition, characterized by patient, inordinate, and unrealistic solicitude, generally associated with depressive symptoms, which vitiate everyday life of its victims and has a low probability of robotic recovery( Wittchenn & Hoyer, 2001). Over the once many decades, experimenters have shown adding exploration interest in GAD population. Up to 20 of grown-ups are affected by anxiety diseases each time ( Grenier,S., Desjardins,F., etal., 2019). Compulsive obsessive complaint (OCD) is characterized by prepossessions, which are ego- dystonic and unwanted studies or impulses, and forces, which are repetitious actions or internal acts. Metacognition refers to the cerebral structures, knowledge, events, and processes that are involved in the control, revision, and interpretation of thinking ( Fisher,PL. & Wells,A. 2008). Given the growing focus on studies in GAD and OCD, it has been proposed that dysfunctional appraisals of protrusive studies have an important part in the etiology and conservation of prepossessions and forces and anxiety ( Wells,A. & Papageorgiou,C. 1998). People living with neurosis have forcefully established in- reality, but they may have difficulty in managing with stressful situations or certain feelings and allowed processes and pattens which may

beget disabled capacity for being in contact with the present and acting on long- term pretensions rather than short- term urges. Unlike utmost studies, studies of emotional complaint are extended and reclaimed and are delicate to control. The metacognitive model of general psychopathology (Wells & Matthews, 1994; Wells, 2008) proposes that this style of thinking is a general unproductive factor. The process is comprised largely of perseveration in the form of solicitude and/ or reflection and results from metacognition. Metacognitions are pivotal factors for the development and conservation of pathologic anxiety. Metacognitions that aren't specific to any psychiatric complaint can be called "general metacognitions. " general metacognitions can be seen both in OCD and GAD. Cognitive propositions have varied in the stresses placed on the part of colorful aspects of beliefs about studies. While many studies have delved OCD specific metacognitions, including study emulsion beliefs, beliefs about rituals, and internal stop signals ( Hansmeier, Exner, Rief, & Glombiewski 2016) general metacognitive beliefs may also be useful in understanding the processes involved in the colorful symptom confines of OCD. It's anticipated that metacognitive processes, including compulsive- obsessive ( O- C) beliefs, will contribute differentially to the symptom confines of OCD. Such an understanding is anticipated to be useful in perfecting the effectiveness of personalized cognitive- behavioral interventions for different symptom donations in OCD and GAD. Gundogmus, Tekin, Aydin, Ucar, & Uzun,( 2022) compare the metacognitions in OCD, GAD and healthy controls. According to the comparison of OCD and GAD cases, 'positive belief ', and BAI scores were set up to be statistically different (p0.05). Other study was set up that metacognition was the strongest middleman of this relationship, indeed when counting for state and particularity anxiety (Gutierrez, Hirani, Curtis, etal. 2020). Metacognitive beliefs could contribute to cerebral dysfunction if they support unreasonable interpretations of studies, unattainable pretensions, or bias cognitive coffers. Metacognitive beliefs and allowed control strategies could therefore be marvels that uphold increased perceptivity to stress, and contribute to emotional symptoms and complaint (Wells, Matthews, 1996; Wells, 2000, 2006). Several recent studies have examined styles of study control in individualities with colorful anxiety diseases. Two studies have set up that individualities with compulsive – obsessive complaint use the study control strategies of discipline and worry more and use distraction lower thannon-clinical actors (Coles, Heimberg, 2005; Abramowitz, Whiteside, Kalsy, & Tolin, 2003; Amir, Cashman, & Foa, 1997). Coles, Heimberg( 2005) were the first study that individualities with GAD use different styles for controlling their unwanted studies thannon-anxious individualities. Specifically, individualities with GAD reported lesser use of solicitude and discipline strategies, and lower use of distraction and social control strategies than did NACs. Further, solicitude and discipline strategies were appreciatively identified with depressive symptoms and inordinate solicitude, while distraction and social control strategies were negatively identified with these measures of psychopathology. Eventually, advanced situations of life satisfaction were identified with lesser use of distraction and social control strategies, and lower use of solicitude and discipline strategies. People with OCD also employ lesser sweats to control studies than those with GAD (Morillo etal., 2007). Abramowitz and Foa( 1998) set up that people with OCD with comorbid GAD reported more generalised solicitude than those without, but no difference in the inflexibility of OCD symptoms. Research findings concluded that poor study control strategies and negative metacognitive beliefs prompt the cerebral inflexibility. Cerebral inflexibility is defensive against negative passions and can promote positive internal health (Masuda etal., 2011). That is, cerebral inflexibility can act as a buffer between stress and negative cerebral issues ( Gloster, Meyer, & Lieb, 2017). Those who are more psychologically flexible generally report lower situations of depression, anxiety, and torture during stressful life events (Masuda etal., 2011). Research has constantly set up that poverties in cerebral inflexibility are related to OCD symptoms ( Bluett etal., 2014) as well as the broader development and conservation of a range of mood and anxiety diseases( Spinhoven, Drost, de Rooij, van Hemert, & Penninx, 2014). Two studies reported a significant reduction in AAQ scores as well as the Yale- Brown compulsive- obsessive Scale scores during ACT treatment (Dehlin etal., 2013, Twohig etal., 2006, 2013, 2015) delved the part of cerebral strictness as a middleman in a sample of 41 cases treated with ACT. A agreement analysis of the AAQ values showed that the position of the AAQ at the time of discharge (post) intermediated the change in Y- BOCS between the launch values ( pre) and follow- up. In addition, a change in their tone- designed variable, 'cerebral inflexibility related to preoccupation, prognosticated a reduction in compulsive- obsessive symptoms.

In summary previous studies have shown that only few researches have been done on these variables on such population. Thus, the aim of the present work is to explore the metacognitive beliefs, thought control and

psychological flexibility among the patients with generalized anxiety disorder, obsessive compulsive disorder, and healthy.

**Hypothesis-1:** There would be significant differences on metacognitive beliefs among patients with generalized anxiety disorder, obsessive compulsive disorder, and healthy control.

**Hypothesis-2:** There would be significant differences on psychological flexibility among patients with generalized anxiety disorder, obsessive compulsive disorder, and healthy control.

**METHOD :**

**Participants:**

Present study is exploratory in nature. Data were collected on a total of 60 participants fulfilled DSM-V criteria to be mainly diagnosed with GAD, OCD and healthy control participants. Out of which 20 participants were diagnosed with GAD kept in group I, 20 participants were diagnosed with OCD similarly kept in group II and 20 were healthy control participants also kept in group III. Further the age group of the participants is 17-27 years of age. The availability basis sampling technique was used to select the participants of the study. Patient inclusion criteria were age and a primary diagnosis of GAD and OCD. Healthy control participants were selected from community. Exclusion criteria for all participants were a history of any other psychiatric disorder, neurological or developmental disorder and severe head injury. Control participants were further excluded if they reported current symptoms of any mental illness in need of treatment.

**MEASURES**

**Generalized Anxiety Disorder – 7** (GAD-7; Spitzer et al., 2006). The GAD-7 is a screening and severity measure of GAD according to the diagnostic criteria of the DSM-IV-TR (American Psychiatric Association, 2000). It consists of 7 items with a 4-point Likert-type scale (3 = *nearly every day*; 0 = *not at all*). The score ranges for mild, moderate, and severe levels of GAD are 5–9, 10–14, and 15–21, respectively. We used the Spanish translation of the GAD-7 for Colombia distributed by Pfizer, which showed good psychometric properties in initial studies in our laboratory with clinical ($\alpha$ = 0.87) and non-clinical samples ($\alpha$ = 0.90), and a one-factor structure.

**Yale Brown Obsessive Compulsive Scale** (Y-BOCS; Goodman et al., 1989). The YBOCS is a 10 item assessor-rated measure of OCD symptom severity that is commonly used as a primary outcome in clinical trials for OCD. Total scores on the Y-BOCS range from 0 to 40. The Y- BOCS has demonstrated both good interrater reliability for the total score (rs between .80 and .97) and two week test-retest reliability (between .81 and .97). In the current study, Cronbach's $\alpha$ at pretreatment was .79.

**Metacognitions Questionnaire –MCQ-** (Wells and Cartwright-Hatton, 2004). The MCQ-30 is a short version of the original MCQ and assesses individual differences in five factors important in the metacognitive model of psychological disorders. In particular, unhelpful metacognitions may contribute to obsessive and compulsive symptoms, pathological worry and underpin trait anxiety. The five subscales of the MCQ-30 are: cognitive confidence, positive beliefs about worry, cognitive self-consciousness, negative beliefs about uncontrollability of thoughts and danger, and beliefs about the need to control thoughts. Reliability of MCQ is good enough, with alpha coefficients ranging from 0,73 in "Cognitive self-awareness" and 0,93 in "Negative beliefs about uncontrollable worries and their danger". Construct validity is also good, rating a CFI of 0,91 (Wells and Cartwright-Hatto, 2004).

**The Acceptance and Action Questionnaire II** (AAQ II Bond et al., 2011). The AAQ -II
is a 7 -item self-report measure of psychological flexibility on a scale of 1 ("never true") to 7 ("always true") with lower scores reflecting greater psychological flexibility.Internal Consistency ranges from .78 -.88, and it has acceptable test - retest reliability (3 months = .81; 12 Journal Pre-proof Journal Pre-proof PSYCHOLOGICAL FLEXIBILITY 10 months = .79; Bond et al., 2011 ) . It is a widely used measure in ACT research; however, researchers have more recently questioned the discriminative validity of the AAQ -II Ong, Lee, Levin, & Twohig,

2019).

**Procedure:**
A full description of the study was rendered to the participants. A written informed consent was obtained from them. After the diagnostic interview, the interviewer filled out the demographic and clinical data form, the scales used for the severity ratings of OCD and GAD. Following this, the patients were screened for exclusion and inclusion criteria. Then finally various assessment tools were administered and scored according to the standardized procedures set for each tool. Total time spent in filling all the questionnaires was around 30 minutes to 50 minutes. However, most of the participants were able to complete the questionnaires without any help.

**STATISTICAL ANALYSES:**
Data was analyzed using Statistical Package for the Social Sciences (SPSS) to examine the comparability of participants in the GAD and OCD and healthy control. Mean scores, Standard Deviations were computed. To find out the significance of the difference among means of three different groups under study ANOVA was applied. Further, to study the pair groups difference the Post hoc analysis was applied.

**RESULTS AND DISCUSSION:**

**Table no. 1:** Mean and SDs of different patients with generalized anxiety disorder, obsessive compulsive disorder, and healthy control on metacognition.

| Disorder | | Cognitive Confidence | Positive Beliefs About worry | Cognitive self consciousness | Negative beliefs about uncontrollability and danger | Need to control thought | Metacognition |
|---|---|---|---|---|---|---|---|
| GAD (group-I) | Mean | 15.80 | 13.55 | 16.15 | 18.90 | 17.35 | 84.90 |
| | N | 20 | 20 | 20 | 20 | 20 | 20 |
| | SD | 3.592 | 3.236 | 4.133 | 4.154 | 3.964 | 7.993 |
| OCD (group-II) | Mean | 14.15 | 12.05 | 13.45 | 17.10 | 15.00 | 71.75 |
| | N | 20 | 20 | 20 | 20 | 20 | 20 |
| | SD | 2.978 | 2.929 | 3.426 | 3.999 | 3.960 | 9.727 |
| Healthy control (group-III) | Mean | 13.85 | 16.55 | 14.05 | 11.25 | 11.35 | 68.00 |
| | N | 20 | 20 | 20 | 20 | 20 | 20 |
| | SD | 3.150 | 4.883 | 3.576 | 2.447 | 3.703 | 8.033 |

From the above table it was evident that patients with generalized anxiety disorder were higher in metacognition than two groups. The mean of the generalized anxiety disorder group (M=84.90), obsessive compulsive disorder group (M=71.75) and healthy control (M=68.00) respectively. Dimension wise analysis also revealed that the mean score of generalized anxiety disorder group was higher in cognitive confidence dimension than other two groups. The mean scores were 15.80, 14.15 and 13.85 for group I, II and III respectively. While for the mean revealed that generalized anxiety disorder group was higher in Cognitive self-consciousness dimension than other two groups. The mean were 16.15, M=16.32, 13.45 and M=14.05 for group I, II & III respectively, similarly, the mean revealed that generalized anxiety disorder group was higher in the negative beliefs about uncontrollability and danger dimension than other two groups. The mean and the 18.90, 17.10 and 11.25 for I, II & III respectively, and the mean score generalized anxiety disorder group was higher in the Need to control thought dimension than other two groups. The mean score were 17.35,
17.10 and 11.25 for I, II & III respectively. Whereas, the mean score revealed that Healthy people was higher in positive beliefs about worry dimension than other two groups. The mean score were 13.55, 12.05 and 16.55 for group I, II & III respectively. The table shows that there seems a difference in metacognitive beliefs, and its dimensions among the patients with generalized anxiety disorder, obsessive-compulsive disorder and healthy

peoples but these differences may be due to chance factors, hence, to see that whether the differences are real or due to the chance factors, ANOVA was applied. The results are shown in the following table:

**Table no. 2:** showing ANOVA on metacognitions score among the three different groups of patients with generalized anxiety disorder, obsessive compulsive disorder, and healthy control

| | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| **Cognitive Confidence** | Between Groups | 44.100 | 2 | 22.050 | 2.087 | .133 |
| | Within Groups | 602.300 | 57 | 10.567 | | |
| | Total | 646.400 | 59 | | | |
| **Positive Beliefs About worry** | Between Groups | 210.000 | 2 | 105.000 | 7.345 | .001 |
| | Within Groups | 814.850 | 57 | 14.296 | | |
| | Total | 1024.850 | 59 | | | |
| **Cognitive self-consciousness** | Between Groups | 80.400 | 2 | 40.200 | 2.899 | .063 |
| | Within Groups | 790.450 | 57 | 13.868 | | |
| | Total | 870.850 | 59 | | | |
| **Negative beliefs about uncontrollability and danger** | Between Groups | 639.900 | 2 | 319.950 | 24.468 | .000 |
| | Within Groups | 745.350 | 57 | 13.076 | | |
| | Total | 1385.250 | 59 | | | |
| **Need to control thought** | Between Groups | 365.633 | 2 | 182.817 | 12.158 | .000 |
| | Within Groups | 857.100 | 57 | 15.037 | | |
| | Total | 1222.733 | 59 | | | |
| **Metacognition** | Between Groups | 1958.033 | 2 | 979.017 | 9.201 | .000 |
| | Within Groups | 6064.700 | 57 | 106.398 | | |
| | Total | 8022.733 | 59 | | | |

From table 2 clearly indicate that ANOVA dimension wise analysis of metacognition beliefs score among the three different groups of patients. The metacognition overall difference among the three different groups of patients were found statistically significant ($F=9.201$, $p<.001$). On the positive beliefs about worry dimension ($F= 7.345$, $p=.001<.001$), control thoughts dimension ($F=12.158$, $p= .000<.001$), on the negative beliefs about uncontrollability and danger dimension the difference among the three different groups of patients were found statistically significant ($F=24.468$, $p= .000<.001$), these sub variables difference among the three different groups of patients were found statistically significant. Whereas, the difference among three different groups of Cognitive Confidence dimension ($F=2.087$, $p=.133>.05$) and cognitive self-consciousness dimension ($F= 2.899$, $p=.063<.01$) were not found significant at any level of confidence.

**Table no. 3:** Showing the difference between the possible pairs of groups.

| Dependent Variable | (I) Sample | (J) Sample | Mean Difference (I-J) | Std. Error | Sig. |
|---|---|---|---|---|---|
| **Cognitive Confidence** | GAD | OCD | 1.65000 | 1.02794 | .252 |
| | | Healthy Participants | 1.95000 | 1.02794 | .149 |
| | OCD | Healthy Participants | .30000 | 1.02794 | .954 |
| **Positive Beliefs About worry** | GAD | OCD | 1.50000 | 1.19564 | .427 |
| | | Healthy Participants | -3.00000* | 1.19564 | .039 |
| | OCD | Healthy Participants | -4.50000* | 1.19564 | .001 |
| **Cognitive self consciousness** | GAD | OCD | 2.70000 | 1.17761 | .065 |
| | | Healthy Participants | 2.10000 | 1.17761 | .184 |
| | OCD | Healthy Participants | -.60000 | 1.17761 | .867 |
| **Negative beliefs about uncontrollability and danger** | GAD | OCD | 1.80000 | 1.14352 | .265 |
| | | Healthy Participants | 7.65000* | 1.14352 | .000 |
| | OCD | Healthy Participants | 5.85000* | 1.14352 | .000 |
| **Need to control thought** | GAD | OCD | 2.35000 | 1.22625 | .143 |
| | | Healthy Participants | 6.00000* | 1.22625 | .000 |
| | OCD | Healthy Participants | 3.65000* | 1.22625 | .012 |
| **Metacognition** | GAD | OCD | 9.80000* | 3.26187 | .011 |
| | | Healthy Participants | 13.55000* | 3.26187 | .000 |
| | OCD | Healthy Participants | 3.75000 | 3.26187 | .488 |

Tukey test was used for post hoc analyses and the results were given in table 3. The table showed that dimension-wise analysis of metacognition of mean difference between groups. It shows that the group difference in metacognition beliefs between I and II was found 9.80 which was statistically significant (P= .011<.01). Similarly, the mean differences between group I and group III was found 13.55 and it was also found to be statistically significant (p=.098>0.05), whereas, the difference between-group II and group III was found 3.75 and it was not found statistically significant (p=.500>0.05) at any level of confidence.

From the table 1, 2 and 3 clearly indicated that findings of ANOVA and Post hoc analysis suggest that generalized anxiety disorder, obsessive compulsive disorder, and healthy control have different levels of metacognitive beliefs. Finding revealed that generalized anxiety disorder patients had significantly greater amount of metacognitive belief than two other groups (obsessive compulsive disorder and healthy control). Hence, the hypothesis-1 which states that "there would be significant differences on metacognitive beliefs among patients with generalized anxiety disorder, obsessive compulsive disorder, and healthy control" was proved true by the finding of the study. Metacognitive beliefs were linked to pathological concern and symptoms of generalised anxiety disorder (Barahmand 2009; Cartwright-Hatton and Well s 1997; Davis and Valentiner 2000; McEvoy and Mahoney 2013; Sica et al. 2007; Thielsch et al. 2015). For instance, Thielsch et al. (2015) observed in an ecological assessment research that negative metacognitive beliefs predicted adolescents' daily concern, and Nassif (1999) found that negative metacognitive beliefs predicted the subsequenton set of GAD. There is evidence that persons who fit the criteria for generalised anxiety disorder (GAD) also report much greater levels of maladaptive metacognitive beliefs about concern than do those with other anxiety disorders or those who are not worried (Wells and Carter 2001). However, metacognitive views have been linked to increased anxiety (Van der Heiden et al. 2010; Ramos-Cejudo and Salguero 2017). other anxiety disorders (Bailey and Wells 2015; Sassaroli et al. 2015; Yoris et al. 2015).

**Table no. 4:** Mean and SDs of different patients with generalized anxiety disorder, obsessive compulsive disorder, and healthy control on psychological flexibility.

| **Disorder** | | **Psychological flexibility** |
|---|---|---|
| GAD **(group-I)** | Mean | 35.85 |
| | N | 20 |
| | Std. Deviation | 4.511 |
| OCD **(group-II)** | Mean | 38.00 |
| | N | 20 |
| | Std. Deviation | 4.577 |
| Healthy control **(group-III)** | Mean | 26.40 |
| | N | 20 |
| | Std. Deviation | 4.160 |

From the above table-4 it was evident that patients with obsessive compulsive disorder were higher in psychological flexibility than two groups. The mean of the generalized anxiety disorder group (M=35.85), obsessive compulsive disorder group (M=38.00) and healthy control (M=26.40) respectively. The table shows that there appears to be a difference in psychological flexibility between patients with generalized anxiety disorder (GAD), obsessive-compulsive disorder, and healthy people, but these differences may be due to chance factors; thus, ANOVA was used to determine whether the differences are real or due to chance factors. The findings are presented in the table below:

**Table no. 5**: showing ANOVA on psychological flexibility score among the three different groups of patients with generalized anxiety disorder, obsessive compulsive disorder, and healthy control.

| | | Sum of Squares | Df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| **Psychological flexibility** | Between Groups | 1523.233 | 2 | 761.617 | 38.992 | .000 |
| | Within Groups | 1113.350 | 57 | 19.532 | | |
| | Total | 2636.583 | 59 | | | |

From table-5 clearly indicate that ANOVA dimension wise analysis of psychological flexibility score among the three different groups of patients. The psychological flexibility overall difference among the three different groups of patients were found statistically significant (F=38.992, p<.001). These finding suggest that psychological flexibility was work different in patients with GAD, OCD and health control. The findings of the present study confirm the hypothesis -3 which states that "there would be significant differences on psychological flexibility among patients with generalized anxiety disorder, obsessive compulsive disorder, and healthy control."

**Table no. 6:** Showing the difference between the possible pairs of groups

| | (I) Sample | (J) Sample | Mean Difference (I-J) | Std. Error | Sig. |
|---|---|---|---|---|---|
| **Psychological flexibility** | GAD | OCD | 2.15000 | 1.39759 | .281 |
| | | Healthy Participants | 9.45000* | 1.39759 | .000 |
| | OCD | Healthy Participants | 1.60000* | 1.39759 | .000 |

Tukey test was used for post hoc analyses and the results were given in table 6. The table showed that analysis of psychological flexibility of mean difference between groups. It shows that the group difference in metacognition beliefs between I and III was found 9.45 which was statistically significant (P= .000<.001). Similarly, the mean differences between group II and group III was found 1.60 and it was also found to be statistically significant (p=.000<0.001), whereas, the difference between-group I and group II was found 2.15 and it was not found statistically significant (p=.281<0.001) at any level of confidence.

From the table 4, 5 and 6 clearly indicated that findings of ANOVA and Post hoc analysis suggest that generalized anxiety disorder, obsessive compulsive disorder, and healthy control have different levels of psychological flexibility. Finding revealed that OCD patients had used small amount of psychological flexibility than two other groups (GAD and healthy control). Hence, the hypothesis-3 was proved true by the finding of the study.

In light of this, psychological flexibility is crucial for life's pleasure since difficult circumstances and change are a constant in our existence. Well-developed psychological flexibility is linked to improved mental health and a decreased chance of having a mental disease, according to a meta-analysis conducted by Hayes et al. (2006). Wersebe et al. (2018) found that throughout a self-help session aimed at enhancing psychological flexibility, a sizable sample saw a reduction in stress and an uptick in well-being. This conclusion is consistent with the fact that many mental diseases are associated with considerable impairments in flexibility processes (Allen and Barlow, 2009; Twohig et al., 2006). Research has also revealed that individuals with obsessive compulsive symptoms have lower levels of cognitive flexibility compared to those in good health (Paast et al., 2016; Sternheim et al., 2014). The lack of psychological flexibility in OCD sufferers is apparent when one examines the diagnostic criteria for the disorder as outlined in DSM-5 and ICD-10, which include avoidance, rigidity, and adherence to unduly superior assumptions (American Psychiatric Association, 2013; Dilling and Freyberger, 2006). Studies show that OCD patients struggle more than healthy individuals to appropriately control their emotions (La Cruz et al., 2013; Whitehead and Suveg, 2016). According to Allen and Barlow (2009) and Twohig et al. (2006), flexibility or embracing one's beliefs and feelings seems to be crucial for OCD therapy to be successful.

**CONCLUSION:**

The present study aimed to investigate the differences in metacognitive beliefs and psychological flexibility in GAD and OCD with healthy controls. In present study, results showed that dysfunctional metacognitive beliefs and psychological inflexibility were mostly elevated in patients with GAD and OCD when compared with the healthy control. In addition, the healthy control subjects showed higher cognitive flexibility, as expected. These results provide evidence for the transdiagnostic characteristics of the psychological processes under investigation and reject the priori hypotheses. The current study adds to previous prospective studies by demonstrating that metacognitive beliefs and psychological flexibility are important factor of vulnerability to psychopathology. As per the cognitive model of GAD; individual who develops GAD have a metacognitive dysfunction, characterized by negative beliefs about the effects of engaging in active worry. Therefore, in the present work, we decided to focus on GAD and OCD to explore that specific metacognitive beliefs and psychological inflexibility that would favors these anxiety disorders. Metacognitive beliefs impaired self-knowledge about the own cognitive operations therefore it results in the sense of threat and perseverance in worrying. Present study results pointed out a "high negative beliefs about uncontrollability and danger and need to thought control" as the main metacognitive beliefs involved in the long-time maintenance in GAD and OCD. These dysfunctional metacognitive beliefs play significant role in pathological worries in GAD and OCD. Which may impaired daily functioning and increase the avoidance in individual. Poor psychological flexibility impacts the psychological wellbeing and valued actions of the individual. Thus, it needed a therapeutic intervention (CBT, ACT mindfulness-based CBT, ERP and others) to enlarge the awareness of one's cognitive processes and to make a person able to detect maladaptive Mata beliefs replace them with more adaptive Mata beliefs and increase the psychological flexibility in the individual. However more studies are needed to generalize the present result.

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