J. Appl. Environ. Biol. Sci., 4(2)57-65, 2014

ISSN: 2090-4274
Journal of Applied Environmental and Biological Sciences
www.textroad.com

Cross Cultural Comparison Role of Early Maladaptive Schemas and Coping Styles between Women with Depressive Symptoms in Iran and India

Maryam Khajouei Nia[1*], Anuradha Sovani[2]

[1]PhD of Psychology, University of Mumbai, Department of Applied Psychology, Mumbai, India
[2]Associate Professor, Department of Applied Psychology, University of Mumbai, India

Received: November 22 2013
Accepted: December 16 2013

ABSTRACT

The main goal of this study was to investigate the relationship between Early Maladaptive Schemas and Coping Style in Iran and India and to compare mild & moderately depressed, young & older women.
The tools of this research were Beck Depression Inventory, Young Schema Questionnaire, Young-Rygh Avoidance Inventory, and Young Compensation Inventory were administered to depressed women residing in Iran and India that were randomly selected n = 200. The age group of sample was 16-60 India (M=30.26 SD=11.45) and Iran (M=31.92 SD=10.08). Data analyses comprised of the methods of descriptive statistics and deductive statistics.
Pearson Correlation was obtained between the Subjugation, Failure to achieve, and Unrelenting Standards schemas and compensation subscales in the total group. In addition, the comparison between two countries showed that the correlation between compensation subscales in women from India was higher than women from Iran. In the total group, it was showed a correlation between the Denial Unhappiness, the Psychosomatic Symptom, the Avoidance through sleeping and lack of energy subscales in Avoidance and Maladaptive Schema $P<0.05$& $P<0.001$). Likewise, the results indicated differences within Iran and India among mild & moderately depressed, young & older women in overcompensation as coping style as opposed to avoidance.

KEYWORDS: Coping Style, Cross Cultural, Depression, Early Maladaptive Schemas.

1. INTRODUCTION

The World Health Organization cited that by 2020, depression will be the second most prevalent non-infectious disease, and secondary only to ischemic heart disease. It is also estimated that the prevalence of disability caused by depression is on the rise. Nearly twice as many women (12.0 percent) as men (6.6 percent) are affected by a depressive disorder each year. These figures are translated to 12.4 million women and 6.4 million men in the U.S (WHO) [1]. This is one of the reasons for the motivation of selecting the women for the present study.

In stages of development, adolescence is a particular time of stress for girls due to the pressures to adopt increasingly inflexible gender roles that emphasize appearance, dependency, and passivity [2, 3, 4]. Epidemiological data shows that the mid to late 20s is the age of the most frequent onset of depression [5, 6]. In 2010 a study predicted that gender differences in life events prior to Major Depressive Disorder (MDD) onset would emerge in the younger age groups (adolescence and young adulthood) but not in the older age groups [7]. Investigations done by researchers found that negative life events predict MDD and general emotional maladjustment more strongly in girls than in boys[8, 9, 10,11, 12,13].

Regarding the prevalence of depression in women, a cross sectional study was conducted on general population to determine the characteristics of depression in Kashmir (India). The difference in the prevalence of depression among males and females is significant. Depression is much higher in rural areas (84.73%) as compared to urban areas (15.26%). In rural areas the prevalence of depression among females is higher (93.10 %) as compared to males (6.8%) [14]. Likewise, an attempt was made to determine the prevalence of depressive disorders and some associated factors in Rasht City (Northern part of Iran). It was revealed that the prevalence of dysthymic and minor depressive disorder were more than major depressive disorder, and low socio-economic class was the most significant risk factor associated with depression [15].

In the fields of psychology, each of the paradigms has their views to the etiology of depression. In this connection, in cognitive theory a number of assumptions have been discussed, one of which is schema. Schema is cognitive structures that allot meaning to perception. Schemas are basically the representations of early childhood experiences, and serve as patterns for processing and defining

*** Corresponding Author:** Maryam Khajouei Nia, PhD of Psychology, University of Mumbai, Department of Applied Psychology, Mumbai, India, Email: araad0098@yahoo.com

behaviours, thoughts, feelings, emotions, and relationships with others in following one's life [16]. Hence, a schema can be positive or negative, adaptive or maladaptive; dysfunctional in a significant degree, it can be formed in childhood or later in life [17]. Young who has innovated Schema Therapy Approach in 1992, defined maladaptive or dysfunctional schemas as enduring, pervasive, unconditional, negative beliefs about oneself, others, and the environment that are learned in childhood and perpetuated and elaborated in adulthood. Furthermore, it is believed that unmet core emotional needs in childhood lead to dysfunctional schemas. Negative experiences were labelled as Early Maladaptive Schema. According to Schema approach, three factors are of significance; early childhood experiences, the innate temperament of the child, and cultural influences. There are 18 maladaptive schemas in schema therapy approach, which are grouped into five broad categories of unmet emotional needs called schema domains [18, 19].

Over time, deep beliefs about self and others become dysfunctional to a significant degree and highly resistant to change in persons. Individuals typically develop behavioural strategies to cope with the distressing thoughts, overwhelming emotions, and impulses associated with early maladaptive schema. These long standing, usually unrecognized maladaptive coping styles are often effective in reducing the schema- evoked distress [20, 21].

According to schema therapy, there are three coping styles as: 1) Surrender, referring to a process whereby perceptions and behaviours are changed so that they comply with the schema. 2) Avoidance, referring to the ways in which people avoid activating schemas. It includes both conscious and automatic processes3) Overcompensation Schema compensation, referring to the processes of overcompensating for early maladaptive schemas [22].

2. METHODS

2.1. Sampling

The comparative subjects for the present study were selected from Iran and India. The sample was selected randomly and consists of 200 females diagnosed with (mild- moderate) depression. A sample of 100, each selected from Indian and Iranian metropolitan cities, Pune (India) and Tehran (Iran), respectively. The age group of sample was 16-60 years (India M=30.26, SD=11.45) and (Iran M=31.92, SD=10.08).

2.2. Tools:

2.2.1. Beck's Depression Inventory (BDI II, 1996)

The test is created by Aaron T. Beck in 1961. It is a 21- question multiple choice self- report inventory about how the subject has been feeling in the last week. This scale reliably measures the severity of affective, cognitive, motivational, and physical (vegetative) symptoms of depression. Each question has a set of at least four possible answer choices, ranging in intensity and each answer being scored on a scale value of 0 to 3. A study reported that the BDI-II had good internal consistency ($\alpha = .90$) and that the total score was not significantly correlated with gender, age, or ethnicity of the patients [23]. It was also noted the BDI-II appears to have strong psychometric support as a screening measure for depression among older adults in the general population [24].

2.2.2. Young Schema Questionnaire-Short Form (YSQ-SF, 2003)

It is a self – report measure containing 90 items to assess schemas. Patients rate themselves on how well each item describes them on a 6-point Likert scale. Items on the questionnaire are clustered according to specific schemas. To measure EMSs in 18 subscales including in 5 domains as Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation, Defectiveness/Shame, Social Isolation/Alienation, Dependence/ Incompetence, Vulnerability to harm or Illness, Enmeshment/ Undeveloped Self, Failure, Entitlement/Grandiosity, Insufficient Self-Control, Subjugation, Self-Sacrifice, Approval-Seeking/Recognition-Seeking, Negativity/Pessimism, Emotional Inhibition, Unrelenting Standards, Punitiveness. A study showed that the Young Schema Questionnaire possesses very good internal consistency and that its primary factor structure is stable across clinical samples from two different countries and for different diagnoses [25]. In the present study, Cronbach's coefficient alpha in Iran was 0.80 and in India 0.84

2.2.3. Young-Rygh Avoidance Inventory (RYAI, 1994)

The instrument is used to assess this variable is the Young-Rygh Avoidance Inventory. The Young – Rygh Avoidance Inventory (1994) is a 41- item questionnaire that assesses schema avoidance. The patients rate responses on a 6-point scale. To score this inventory, we simply circle all items with a high rating of "5" or "6". According to a study, the split half value was 0.79 [26]. In the current study, the split half (Cronbach's coefficient alpha) in Iran was 0.58 and 0.78 in India.

2.2.4. Young Compensation Inventory (YCI, 1995)

The Young compensation inventory (1995) is a 48- item questionnaire that assesses schema overcompensation. The inventory uses a 6-point scale. To score this inventory, the therapist circles all items with a high rating of "5" or"6". There is not a one –to-one correspondence between each item on the YCI and any schema. In a study reliability coefficient through splitting was yielded 0.79 [26]. In this study Cronbach's alpha, obtained in Iran, was 0.89 and in India was 0.88.

3. PROCEDURE

The client was informed of the various instruments to be administered. The researcher first used to illustrate about the instructions of the questionnaires. After taking patient's consent, they were assured that all the information will be kept confidential and will be used only for research purpose. Then, they were requested to answer all the questions. The time of answering questionnaires was not limited and it depended on the participants.

4. RESULTS

The analysis of data was conducted by SPSS 17.0. For the purpose of comparing two groups t-test was selected and for the aim of correlation, Pearson correlation was executed. Firstly, Kolmogorov-Smirnov test was conducted for the aim of making normality of data. Also, linearity test was used for assessment of linear correlation. The results of both tests revealed normality and linear correlation.

Table 1 reveals 31% of the population is mildly depressed while 62% was moderately depressed. 28% young and 22% was older in Iranian population and 25% is young and older age group in India.

Table 1: Sample Demographics variables

		percent
Iran	Mild	31%
	Moderate	69%
	Young	56%
	Old	44%
India	Mild	45%
	Moderate	55%
	Young	50%
	Old	50%

Table 2 reveals the correlation between Early Maladaptive Schemas and Compensation Subscales as a coping style. The second column demonstrates the correlation for the total group. Column three shows the Iranian group and the last column presents the same correlations for the Indian group .It indicates a relationship between the compensation subscales and the Subjugation schema(r=.46), Failure to Achieve (r=.34), and Unrelenting Standards (r=.33) in Indian and Iranian women together. Approval Seeking (r=.44), and Subjugation (r=.42) in the compensation style are highly associated with corresponding Maladaptive Schemas in the Iranian group.

There is correlation between Subjugation (r=.50), Insufficient Self-Control (r=.47), Entitlement (r=.42), Mistrust/Abuse (r=.41), Defectiveness/Shame (r= .40), Failure to Achieve (r=.38), Self-Sacrifice (r=.37). Overall, these correlational findings are very interesting since they reveal a significant relationship ($p<0.01$) between Early Maladaptive Schemas and Compensation, particularly among Indian women. These findings could yield pointers for intervention, particularly in this country.

Table 2: The correlation between Compensation subscales and Early Maladaptive Schemas

Compensation Subscales	Maladaptive Schemas		
	Total	Iran	India
Mistrust/Abuse	.32**		.41**
Defectiveness/Shame	.31**		.40**
Failure to Achieve	.34**	.30*	.38**
Subjugation	.46**	.42**	.50**
Self-Sacrifice			.37**
Unrelenting Standards	.33**	.29*	.36**
Entitlement	.29**		.42**
Insufficient Self-Control	.27**		.47**
Approval Seeking	.30**	.44**	

**p< 0.01*p< 0.05

Table 3 shows correlation between Maladaptive Schemas and Avoidance in Indian and Iranian groups together. The table indicates that few significant relationships emerged from this correlational analysis, largely in the subscales of Social Isolation, Vulnerability to harm, Mistrust/Abuse, Subjugation, and Defectiveness/ Shame. Interestingly, the results of this study show significant negative correlations between Denial Unhappiness (DUN) subscale as a coping style and Maladaptive Schemas such as Social Isolation schema (r= -.50), Defectiveness/Shame (r= -.38),Vulnerability to Harm (= -.35) and Emotional Deprivation (r= -.32).

Table 3: The Correlation between the Avoidance subscales and the Early Maladaptive Schemas (EMSs) - the Total Group (India & Iran)

EMSs	Avoidance					
Subscales	DNU	PS	WP	AVS	SES	PDF
Emotional Deprivation	-.32**	.29**	.24**	.18*	.32**	
Mistrust/Abuse	-.30**	.39**	.29**	.27**	.25**	.22**
Social Isolation	-.50**	.37**	.35**	.29**	.26**	.19**
Defectiveness/Shame	-.38**	.26**	.23**	.36**	.29**	.21**
Failure to Achieve	-.22**	.19**	.23**	.35**	.15*	.20**
Vulnerability to Harm	-.35**	.44**	.23**	.28**	.23**	.23**
Subjugation	-.23**	.31**	.39**	.30**	.21**	.21**
Entitlement	-.28**	.30**	.34**	.20**	.30**	.17*
Insufficient Self-Control	-.28**	.16*	.27**	.38**	.28**	.28**

**p< 0.01 *p< 0.05

Table 4 indicates the correlation between the Avoidance subscales and the Early Maladaptive Schemas for Indian group. Similar to the results of the total group, Denial of Unhappiness (DUN) is the only subscale in this group which correlates significantly negatively with the Maladaptive Schemas. The highest negative correlation for the Indian group in this subscale is found with the Social Isolation (r= -.52 p<.0.01). This negative correlation with Denial of Unhappiness (DUN) shows that the women admit easily to being unhappy; i.e. they do not deny it. Indian women who are depressed may not feel so isolated since they live in a collectivistic society and can find support.

Suppression of Anger (SUA) associates significantly with Self-Sacrifice (r=.39). In Indian women it might be due to social and cultural reasons. In the joint family system, a woman may compromise with the situation for her family members at the cost of own wishes. Psychosomatic symptoms (PS) subscale significantly correlates with Vulnerability to Harm (r=.45), Pessimism/Worry, Mistrust/Abuse (r= .42), Punitiveness (r= .40), and Social Isolation (r= .40). Withdrawal from people subscale (WP) has a correlation with Subjugation (r= .46), unrelenting Standards (r= .41), Entitlement/ Superiority (r= .38), and Social Isolation (r= .37). Avoidance through sleep / lack of energy (AVS) correlates significantly with Insufficient Self-Control (r= .46), Failure to Achieve (r= .40), Subjugation (r= .39), and Dependence Incompetence (r= .37). Self-Soothing (SES) has correlation with Defectiveness/ Shame (r= .36), and Social Isolation schema (r= .35. Passive distraction: Fantasy, daydreaming, television (PDF) associates with Approval Seeking (r= .36). Avoidance of upsetting situations (AUS) correlates with Unrelenting Standards (r= .36).

Table 4: The correlation between Avoidance subscales and Early Maladaptive Schemas (EMSs)-the Indian group

EMSs	Avoidance							
Subscales	**DUN**	**SUA**	**PS**	**WP**	**AVS**	**SES**	**PDF**	**AUS**
Emotional deprivation	-.29**		37**	.29**	.21*	.29**		.23*
Abandonment	-.37**	.22*	.31**	.29**	.21*		.32**	.33**
Mistrust/ Abuse	-.33**	..23*	.42**	.33**	.30**	.32*	.25*	.27**
Social Isolation	-.52**		.40**	.37**	.26*	.35**	.30**	.33**
Defectiveness / Shames	-.40**		.39**		.27**	.36**	.30**	.25*
Failure to Achieve	-.35**		.29**	.21*	.40**		.29**	.22*
Dependence Incompetence	-.29**		.33**		.37**			.22*
Vulnerability to Harm	-.30**	.29**	.45**	.26*	.31**	.24*	.26*	
Subjugation	-.25**	.35**	.38**	.46**	.39**		.27**	.22*
Self-Sacrifice		.39**	.24*	.33**				.22*
Unrelenting Standards	-.29**	.34**	.36**	.41**	.30**	.21*	.34**	.36**
Entitlement	-.38**		.31**	.38**	.26**	.25*	.25*	.35**
Insufficient Self-Control	-.43**		.29**	.36**	.46**	.21*	.26*	.31**
Approval Seeking	-.32**					.27**	.36**	
Pessimism		.28**	.42**	.33**	.29**	.22*	.30**	.25*
Punitiveness	-.22*	.25*	.40**	.32**	.36**	.22*	.22*	30**

**p<0.01 *p<0.05

Table 5 exhibits the correlation between the Maladaptive Schema and Avoidance in the Iranian group. The analysis of data shows negative correlation between Denial of unhappiness subscale and the Social Isolation (r= -.42), Vulnerability to Harm and Emotional Deprivation (r= -.39), Defectiveness/Shame(r= -.38). This means that women in this group with these schemas rely on the opposite of the Denial of unhappiness avoidance strategy that is; they accept their unhappiness and admit to it. In addition, there is negative correlation between Intentionally not Thinking about Upsetting things (ITU) and Abandonment schema (r= -.35). Psychosomatic symptoms (PS) associate with Vulnerability to Harm (r= .42), Self-Sacrifice (r= .39), and Mistrust/Abuse (r= .37). There is also a significant correlation between Avoidance through sleep / lack of energy (AVS) and Defectiveness/Shame schema (r= .45), and Social Isolation (r= .36). Iranian women who feel flawed and defective or believe themselves to be different from others tend to use Avoidance as a coping strategy. Self-soothing (SES) shows correlation with Emotional Deprivation (r= .37). Self-soothing was relied on as a coping strategy by Iranian women who feel emotionally deprived. Passive blocking of upsetting emotions (PBU) associates with Emotional Inhibition (r= .39). In this group, Excessive rationality and control (EXR) does not have any correlation with maladaptive schemas. Mean scores- Indian/ Iranian samples, mildly-moderately depressed, and young -older age groups.

Table 5: The correlation between Avoidance subscales and Early Maladaptive Schemas (EMSs)-the Iranian group

EMSs	Avoidance					
Subscales	**ITU**	**DUN**	**PS**	**AVS**	**SES**	**PBU**
Emotional deprivation		-.39**	.22*		.37**	
Abandonment	-.35**	-.22*	.31**	.24*	.30**	
Mistrust/ Abuse	.26*	-.30**	.37**	.25*	.20*	
Social Isolation	.29**	-.42**	.34**	.36**		.34**
Defectiveness/ Shames	.25*	-.38**		.45**	.23*	.29**
Vulnerability to Harm		-.39**	.42**	.28**	.21*	.21*
Self-Sacrifice			.39**		.23*	
Emotional Inhibition		-.29**	.28**	.25*		.39**

**p< 0.01 *p< 0.05

Table 6 presents the analysis of data obtained from both countries combined is, N=200. This table clearly shows that there was no significant difference across coping styles (Avoidance and Compensation) across both countries, or even between younger and older groups. Interestingly, moderately depressed women did score significantly higher on the Compensation Inventory (t=3.50, p<.001). Interestingly, the results show mean and SD are higher in overcompensation; mildly (m=149.00, SD=33.07) and moderately depressed (m=167.46, SD=31.25) than avoidance coping style; mildly (m=125.26, SD=16.53) and moderately depressed (m=128.29, SD=20.01). Despite previous investigations showing that

depressed patients often tend to use avoidance as a coping strategy to adapt with their problems, the results of this study indicate the opposite.

Table 6: Mean scores- Indian/ Iranian samples, mildly-moderately depressed, and young -older age groups

Groups	Avoidance		t	p-value	Compensation		t	p-value
Iran	mean	125.20	1.58	NS	mean	162.38	0.81	NS
	SD	14.56			SD	30.39		
India	mean	129.83			mean	158.02		
	SD	22.11			SD	35.62		
Mild	mean	125.26	1.27	NS	mean	149.00	3.50	0.001
	SD	16.53			SD	33.07		
Moderate	mean	128.29			mean	167.46		
	SD	20.01			SD	31.25		
Young	mean	128.46	0.68	NS	mean	164.71	1.88	NS
	SD	21.08			SD	32.56		
Old	mean	126.47			mean	154.67		
	SD	16.04			SD	33.23		

Table 7 shows there is significant difference among mildly and moderately depressed (t=2.59, p<.05), younger and older groups (t=3.50, P<.001) by using compensation as a coping strategy in Iranian women with symptoms of depression. The result demonstrates that mean and SD in moderately depressed (m=168.07, SD=29.89) higher than mildly depressed (m=149.52, SD=28.02) and also, younger (m=163.00, SD=32.57) is higher than older group (m=161.56, SD=27.67) in compensation coping style.

Table 7: Mean scores-Coping styles in Iranian women with depression by segregation groups of mildly-moderately depressed and young-older age groups

Coping styles		Mild	Moderate	t	p-value	Young	Old	t	p-value.
Avoidance	mean	122.60	126.32	1.14	NS	124.29	126.23	1.27	NS
	SD	12.76	15.24			21.08	16.04		
Compensation	mean	149.52	168.07	2.59	0.05	163.00	161.56	3.50	0.001
	SD	28.02	29.89			32.57	27.67		

Table 8 indicates significant difference within Indian group between mildly and moderately depressed (t=2.29, p<.05), younger and older groups (t=2.25, p<.05) in the Compensation. Also, the table reveals mean and SD in compensation; moderately (m=166.68, SD=33.26) is higher than mildly depressed (m=148.68, SD=36) and this difference can be seen between younger (m=166.51, SD=32.86) and older (m=148.86, SD=36.63) groups. Hence, separating the data showed that in each country the latter trend was present, but was not clearly seen in pooled data.

Table 8: Mean scores- Coping style in Indian women with depression by segregation groups of mildly-moderately depressed and young-older age groups

Coping styles		Mild	Moderate	t	p-value	Young	Old	t	p-value
Avoidance	mean	126.97	122.50	1.13	NS	133.05	126.7	1.29	NS
	SD	18.51	24.92			24.99	18.66		
Compensation	mean	148.68	166.68	2.29	0.05	166.51	148.86	2.25	0.05
	SD	36.14	33.26			32.86	36.63		

5. DISCUSSION

The aim of the current study was Cross Cultural Comparison between Women with Depressive Symptoms in India and Iran-role of Maladaptive Schemas and Coping Styles. This section presents a discussion on each of the obtained results of the current study, keeping relevant theories and past researches in view.

Since in this research an attempt was made to explore the given variables on mild and moderately depressed levels, the results of this part of the study, to a certain extent, are consistent with a research, suggesting that depressed persons with high levels of depressive symptoms tend to use more avoidance

and emotion-focused coping, while problem-focused coping is correlated with lower levels of depressive symptoms [27].

The results of the present research are not in agreement with investigators suggesting avoidance coping has been found to be more usual among women than men, indicated that depressed women were engaged in more escape–avoidance coping strategies and less problem-solving controlling for the stressfulness of the event, than non-depressed female controls [28, 29, 30, 31]. In 2012 a study also showed that avoidance coping style could be considered as a good prediction for disconnection-rejection schema, vigilance and avoidance. Compensatory coping style had no relations with this area which is inconsistent with the result of the current research [26].

The results of the present study indicated Compensation coping styles and Maladaptive Schemas mostly correlate moderately. In Iranian group, the Approval Seeking and Subjugation schemas were associated with the same subscales in compensation. In Indian group Subjugation, Insufficient Self-Control, Entitlement, Mistrust/Abuse, Defectiveness/Shame, Failure to achieve, and Self-Sacrifice schemas were correlated with the corresponding subscales. Mistrust/Abuse, Defectiveness/Shame, Self-Sacrifice, Entitlement, Insufficient Self-Control showed correlation only in the Indian group and on the other hand, in the Iranian group only the Approval Seeking schema was highly correlated. It seems that Indian depressed women tend to utilize compensation as coping strategies more than Iranian depressed women.

The results of correlation between Maladaptive Schemas and Avoidance showed two common negative and positive correlations in both countries; Negative significant relationship between Denial Unhappiness subscale and Social Isolation schema. This indicated that depressed women rely on the opposite of the Denial of Unhappiness avoidance strategy i.e. Social Isolated females show their unhappiness and solitary openly. It is interesting that this pattern occurs regardless of culture or geographical location. Perhaps women are “permitted” in both cultures to express their unhappiness.

The common positive significance showed correlation between Psychosomatic Symptoms and Vulnerability to Harm. The differences were; in India depressed women rely on Withdrawal from People to cope with unhealthy Unrelenting Standards schema and Avoidance through Sleeping and lack of energy to adapt with Insufficient Self-Control. But Iranian depressed women tend to use Avoidance through Sleeping and lack of energy to adapt with Defectiveness/Shame.

The results revealed Indian depressed women do not utilize Substance abuse and Excessive rationality and control as coping styles to avoid their Maladaptive Schemas. This may be a cultural finding, since they may find it socially undesirable to admit to these coping styles. Likewise, the results in this group indicated correlation between Suppression of Anger (SUA) and Self-Sacrifice. It might be due to social and cultural reasons. Since, the system of family in India is joint family. In the joint family system, a woman may compromise with the situation for her family members at the cost of her own wishes.

It was seen that there is negative correlation between Intentionally not Thinking about Upsetting things (ITU) and Abandonment schema. People with Abandonment schema think that significant others will not be able to continue providing emotional support and practical protection. It might be due to the reasons that Iranian depressed women feel insecure because of social and economic situations.

The results lead us to infer that culture and early negative experiences influence individuals how to adapt with their Maladaptive Schemas. For example, women from different countries relied on different coping styles to cope with the same Maladaptive Schema. Furthermore, it could be also inferred that people from different society and family systems cope with the same Maladaptive Schema in different manners.

The other aim of the current study was to examine coping styles between mild and moderately depressed, young and old women from Iran and India. Differences were seen between Iran and India among mild and moderately depressed women in the Compensation. Older age group in Iranian sample scored higher than Indian. But the results were reverse with younger age group. Indian young age group scored higher than Iranian in the same group. Interestingly, the results showed that mean and SD of overcompensation style was high in both groups of mild and moderate level of depression. Consequently, it was indicated that depressed women in this study tend to use overcompensation to cope with problems which they encounter in their life. But, when they cannot solve their problems, they would be overwhelmed in their difficulties which consequently leads to depression and the vice circles will be continued.

Therefore, coping styles chose help in perpetuation of maladaptive schemas. The analysis of data, as expected, indicated a correlation between maladaptive schemas and the coping styles among two countries because of cultural differences. However, coping styles, as the results indicated, were the same within depressed women and interestingly most of the women were dependant on overcompensation as coping styles to adapt with their maladaptive schemas. Interesting insights, based on the results of this research, could be offered into the relationship between coping styles and dysfunctional core believes. In the schema maintenance process, all maladaptive coping styles, serve as elements and consequently keep

the individuals imprisoned in their negative schemas. Therefore, it is of great significance to recognize maladaptive schemas and coping style of a patient in order to break the vicious circle for assisting the patient in a therapeutic procedure to recover from troublesome situations.

This study was conducted only on females. Therefore, the researcher may attempt to extend the study which could be undertaken on a different gender group and to compare genders to identify their Early Maladaptive Schemas and Coping Style. Culture and ethnicity are important aspects of health and illness. Further research needs to take into account the role of culture, perception, and context in shaping someone's physical and mental health due to the fact that cultural differences in help-seeking behaviour may influence the treatment of depression. As each part of Iran and India has various cultures, therefore, more research could be done to investigate the effect of early negative experiences and cultures in the development of the Early Maladaptive Schemas.

To some extent, it was difficult to find a depressed person without comorbidity. Most of the time, patients used to seek professional help with symptoms of bipolar or personality disorders as well. Data collection was occasionally difficult in India, where depressed individuals might not really seek out psychiatric or mental health care for depressive symptoms because of stigmatization reasons. The last limitation is that the sample was female. Thus, the findings cannot be generalized across both genders.

Acknowledgements

My first and foremost debt is to my present supervisor, Dr.Anuradha Sovani, without whose support and guidance this research would have never been possible. I would like to express my profound gratitude to Dr. V.G. Watve, Dr. Hiamani Dighe, Mrs.Dande and all personnel of OPD section in Pune Hospital and Research Centre in Pune- India. I would like to appreciate Dr. Jafar Bolhari in Tehran Institute of psychiatry and Dr.Mojgan Salavati in Rozbeh hospital in Tehran-Iran.

REFERENCES

[1]Murray, C. J., & Lopez, A. D. (Eds**). (**1996**).**The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries and Risk Factors in 1990 and Projected to 2020. *Cambridge: Harvard University Press.*

[2]Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.

[3]Kaschak, E. (1992). *Engendered lives: A new psychology of women's experience*. New York: Basic Books.

[4]Miller, J. B. (1991). The development of women's sense of self. In J. V. Jordan, A. G Kaplan, J. B. Miller, I. P. Stiver, & J. L. Surrey (Eds.), *Women's growth in connection: Writings from the Stone Centre* (pp. 11-26). New York: Guilford.

[5]Mueller, T. I., Leon, A. C., Keller, M. B., Solomon, D. A., Endicott, J., Coryell, W.,Warshaw, M., & Maser, J. D. (1999). Recurrence after recovery from major depressive disorder during 15 years of observational follow-up. *American journal of Psychiatry*, 156, 1000-1006.

[6]Robins, L. N., &Reiger, D. A. (1991). *Psychiatric disorders in American: The Epidemiological Catchment Area Study*. New York: Free Press.

[7]Harkness, K.L., Alavi, N., Monroe, S.M., Slavich, G.M., Gotlib, I.H., &Bagby, R.M. (2010). Gender Differences in Life Events Prior to Onset of Major Depressive Disorder: The Moderating Effect of Age. *Journal of Abnormal Psychology*, 119 (4), 791–803.

[8]Bouma, E. M. C., Ormel, J., Verhulst, F. C., &Oldehinkel, A. J. (2008). Stressful life events and depressive problems in early adolescent boys and girls: the influence of parental depression, temperament and family environment. *Journal of Affective Disorders*, 105, 185-193.

[9]Ge, X., Lorenz, F. O., Conger, R. D., Elder, G.H. J., & Simons, R. L. (1994).Trajectories of stressful life events and depressive symptoms during adolescence. *Developmental Psychology*, 30, 467-483.

[10]Rudolph, K. D., & Hammen, C. (1999). Age and gender as determinants of stress exposure, generation, and reactions in youngsters: A transactional perspective. *Child Development*, 70, 660 – 677.

[11]Shih, J. H., Eberhart, N. K., Hammen, C. L., & Brennan, P. A.(2006).Differential Exposure and Reactivity to Interpersonal Stress Predict Sex Differences in Adolescent Depression. *Journal of Clinical Child and Adolescent psychology*, 35(1), 103–115.

[12]Silberg, J., Pickles, A., Rutter, M., Hewitt, J., Simonoff, E., & Maes, H. (1999).The influence of genetic factors and life stress on depression among adolescent girls. *Archives of General Psychiatry*.56, 225–232.

[13]Windle, M. (1992). Temperament and social support in adolescence: Interrelations with depressive symptoms and delinquent behaviours. *Journal of Youth and Adolescence*, 21, 1–21.
[14]Syed, A., & Khan, A.W. (2009). Life in Conflict: Characteristics of Depression in Kashmir. *International Journal of Health Sciences*, 3(2).
[15]Modabernia, M.J.**,** Tehrani, H.S., Fallahi, M.**,**Shirazi, M., &Modabbernia, A. H. **(**2008). Prevalence of depressive disorders in Rasht, Iran: A community based study.*Clinical Practice and Epidemiology in Mental Health*, 4 (20).
[16]Alford, B., & Beck, A. T. (1997).*The Integrative power of cognitive therapy*. New York: Guilford Press.
[17]Riso, L. P., Toit, P. L., Stein, D. J., & Young, J. E. (Eds.).(2007). *Cognitive Schemas and Core Beliefs in Psychological Problems. A Scientist- Practitioner Guide*. Washington, DC: American Psychological Association.
[18]Young, J.E. (1990). *Cognitive therapy for personality disorders: A schema focused approach*. Sarasota, FL: Professional Resource Exchange
[19]Young, J. E. (1999). *Cognitive therapy for personality disorders: A schema-focused approach* (Rev. ed.). Sarasota, FL: Professional Resource Press.
[20]Young, J.E., &Lindeman, M.D. (1992). An integrative schema focused model for personality disorders. *Journal of Cognitive Psychology*, 6, 11-23.
[21]Ball, A.S., & Young, J. E. (2000). Dual focus schema therapy for personality disorder and Substance dependence: Case study results. *Cognitive and Behavioral Practice*, 7 (3), 270-281.
[22]Young, J.E., Klosko, J.S., & Weishaar, M.E. (2003). *Schema therapy: a practitioner guide*. New York: Guilford.
[23]Steer, R. A., Rissmiller, D. J., & Beck, A. T. (2000). Use of the Beck Depression Inventory–II with depressed geriatric inpatients. *Behavior Research and Therapy, 38*, 311-318.
[24]Segal, L.D., Coolidge, L.F., Cahill, S.B., & O'Riley, A. A. (2008). Psychometric Properties of the Beck Depression Inventory–II (BDI-II) Among Community-Dwelling Older Adults. *Behaviour Modification*, 32 (1). DOI: 10.1177/0145445507303833
[25]Lee, C.W., Taylor, G., & Dunn, J. (1999).Factor structure of the schema questionnaire in a large clinical sample.*Cognitive Therapy and Research*, 23(4), 441-451.
[26]Bayrami, M., Bakhshipor, A,.& Esmaeili, A. (2012).The relationship between coping styles and early maladaptive schemas in disconnection-rejection and over vigilance - inhibition in young's schema model.*J.Life Sci. Biomed.*2(4):178-181.
[27]Billings, A. G., & Moos, R. H.(1981).The role of coping responses and social resources in attenuating the stress of life events. *Journal of Behavioural Medicine*, 4(2), 139-157.
[28]Barker, C., Pistrang, N., Shapiro, D.A., & Shaw, I. (1990).Coping and help seeking in the UK adult population. *British Journal of Clinical Psychology*, 29, 271-285.
[29]Kleinke, C.L., Staneski, R.A., & Mason, J.K. (1982). Depression Coping Questionnaire. *Journal of Clinical Psychology*, 44,516 - 526.
[30]Kuyken, W., &Brewin, C. R. (1994). Stress and coping in depressed women. *Cognitive Therapyand Research*, 18 (5), 403-412.
[31]Folkman, S., & Lazarus, R. S. (1988).*The ways of coping questionnaire*. Palo Alto: Consulting Psychologists Press.

Appendix: Different strategies based on Avoidance Inventory and their abbreviation

Intentionally not thinking about upsetting things.	**(ITU)**
Substance abuse.	(SUB)
Denial of unhappiness.	(DUN)
Excessive rationality and control.	(EXR)
Suppression of anger.	(SUA)
Psychosomatic symptoms.	(PS)
Withdrawal from people.	(WP)
Denial of memories.	(DM)
Avoidance through activity.	(AVS)
Self-soothing (eating, shopping, etc.).	(SES)
Distraction through activity.	(DIA)
Passive blocking of upsetting emotions.	(PBU)
Passive distraction: fantasy, daydreaming, Television.	(PDF)
Avoidance of upsetting situation.	(AUS)