

Comparison of Early Maladaptive Schemas in Depressed, Anxious, Obsessed and Normal Individuals

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ABSTRACT

Goal: the present research aims to investigate early maladaptive schemas in depressed, anxious, obsessed and normal individuals. Research methodology was of correlation type and it was a post event, comparison and cross-sectional study. Statistical population of the research included all depression, anxiety and obsession patients who had referred to Shafa Psychiatry Hospital since January 2013 to September 2014 in Rasht City. Simple random sampling method was used to pick sample members. In order to collect data, DASS-21 questionnaire and Young's schema questionnaire (short form) and Madsley's obsessive-compulsive disorder questionnaire were used. Data were analyzed by means of multivariate variance analysis using SPSS software.

Findings: $\text{sig}=0.0005$, which is smaller than $\alpha (=0.01)$. Therefore, it can be said with 99% of certainty that the compound variable is different in the four groups.

Conclusion: the above findings showed that early maladaptive schemas were different in depressed, anxious, obsessed and normal individuals.

KEYWORDS: primary incompatible schemas, depression, anxiety, obsession, normal individuals

INTRODUCTION

Mood disorders comprise a large group of disorders and depression is one of the commonest disorders. Depression is considered as the commonest disorder in psychiatry. Depression is psychological cold and relatively all people feel weak level of depression in their lives. Being bored, impatience, unhappiness, disappointment, sympathy and dissatisfaction are all common experiences of depression. In general, personality plays an important role in effective emotional performance (Sadock & sadock, 2003). Therefore, Beck et al made many studies on personality of depressed individuals and found that depressed individuals have negative thoughts about themselves, the world, experiences and their future, view others as non-supporting and rejecting and view themselves as weak and faulty individuals. This is because individuals have schemas in their childhood and these schemas are transferred to their adulthood. In fact, early maladaptive schemas are the causes for many emotional disorders. When early maladaptive schemas are activated, different levels of emotions are disseminated and cause different forms of psychological problems both directly and indirectly. Young (1994), a famous cognitive theorist, introduced 18 schemas and classified them into 5 categories: disconnection and rejection, impaired autonomy and performance, impaired limits, other directedness and over-vigilance and inhibition. Anxiety is an unwelcome feeling, a fear and worry with unknown origin which haunts an individual and includes uncertainty, misery and physiological stimulation. Anxiety occurs when stressful conditions last for a long time or occur several times or when body nervous system fail to put an end to tension resistance stage and body remains prepared for a long time. In this case, body becomes ill and vulnerable to physical and psychological diseases (like anxiety) (Cring et al, 2007). Presence of obsession is so serious that brings considerable agony for an individual and wastes time and creates considerable disorder in the natural trend of life, occupational performance, normal social activities and inter-personal relations (Kaplan and Sadouk, translated by Rezaee, 2010). The developmental origin of primary incompatible schemas is found in bad childhood experiences. When patients have their primary incompatible schemas activated in situations of their adulthood lives, they usually experience emotional experiences of their childhood. Social isolation schema is usually formed in the late childhood and may not be a reflection of core family dynamism. Emotional deprivation schema or abandonment occurs as a result of presence of defect in primary environment. in the life of such a child, there is not any sign of stability, understanding and love. In dependence/insufficiency schema, parents rarely behave towards their children seriously and the child becomes very spoiled. Therefore, the child's emotional needs are not satisfied with autonomy or realistic limitations. Patients who have

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abandonment/instability schema believe that their relationships with important individuals of their lives are not stable and these individuals do not stay with them. Such individuals are emotionally instable, unpredictable and unreliable. They expect their relatives to die or leave them. Patients who suffer from mistrust/abuse schemas believe that others will abuse them as they have the smallest opportunity and will harm them. Patients with defectiveness/shame schema feel they are valueless, small, defective and bad individuals and feel they will be rejected by others. This schema is usually accompanied by a sense of shame towards perceived defects. These defects may be personal (like selfishness, aggression impulses) or general (like unattractive appearance, social inappropriateness). Patients with social isolation/alienation schema feel they are different from other people and are not consistent with society. These patients feel no belonging to any social group. Patients who have dependence/incompetence schema feel they are not able to do their daily tasks without serious helps of others (like solving daily problems and proper decision-making). This schema is usually expressed in the form of not being active and extreme misery.

Patients who have vulnerability to loss or disease schema have an extreme fear from occurrence of a close calamity with which they cannot fight. Patients who have Enmeshment/Undeveloped self-schema are usually obsessed with their relationships with one or several important people in their lives (usually parents) and patients' social growth and individuality depends on them. An individual who suffers from enmeshment schema cannot continue his or her life without others' helps and cannot live in a happy manner. Patients who have defeat schema believe they will be defeated when they try to succeed and feel very incompetent in comparison with their peers. Individuals who have this schema feel usually unintelligent, talentless and unsuccessful. Patients who have Entitlement/Grandiosity feel they are superior to other people and think of special rights and advantages for them. These patients do not observe mutual respect which is necessary for healthy social interactions. These patients are usually very demanding and domineering and do not express empathy with others in their social relationships. Patients who have insufficient self-control/self-discipline cannot have self-control in achieving their goals and are not able to tolerate frustration sufficiently. On the other hand, they cannot control their impulses and emotion expressions. In the weakest forms of this schema, patients emphasize on avoidance of worry. They try, for instance, not to cause any conflict in their inter-individual relationships and evade taking on more responsibilities. Patients who have subjugation schema consign their control to others and yield to them because they feel they have to do so. Subjugation schema function is avoidance of anger, revenge or abandonment (Khosravi et al, 2009). Patients who have self-sacrifice schema satisfy others needs with their own tendencies even at a price of losing their personal satisfaction. They do so to reduce others' agonies and problems, to avoid sin, achieve a sense of valuableness and establishment of emotional relationship with needy individuals. Patients who have Approval- Seeking/Recognition-Seeking schema try to attract others' attention and acceptance, their senses of valuableness belongs to others' responses rather than their own responses. Patients who have Negativity/Pessimism schema pay a lot of attention to negative aspects of life (pain, death, loss, disappointment and betrayal) while they pay little attention to positive aspects. When the schema of such individuals becomes activated they make extreme predictions. These patients fear from mistakes and this kind of thinking results in financial problems. Patients who have Emotional inhibition schema restrict their self-stimulated behaviors, feelings and inter-individual relations. Patients who have Unrelenting standards/Hypercriticalness schema believe that they must try to achieve their ambitious standards and they do so for avoiding embarrassment and rejection. This schema usually results in continuous pressure and hypercriticalness. Patients who have punitiveness schema believe that individuals must be punished for their mistakes. In such a schema, there is a serious penal tendency towards those who do not behave according to patients' criteria (even the individual himself or herself). Such patients cannot usually ignore others' mistakes and forgive them because they cannot assume and accept problematic situations, defects and faults of human (Young, Klosko and Vishar; translated by Hamidpour and Andouz, 2010). Masoumeh Ahmadiyan (2008) conducted a research titled: "a comparison of early maladaptive schemas in suicide-committing and non-suicide-committing depressed individuals and non-clinical population":

a) the two clinical groups were different from non-clinical group in all early maladaptive schemas. b) the two clinical groups had significant difference with each other in three schemas: emotional inhibition, dependence/incompetence, and vulnerability to loss and disease and these differences were independent of patients' depression intensity. Results showed that treatment interventions influence significantly on emotional deprivation, dependence/incompetence and vulnerability schemas in suicide-committing depressed patients. Mohammad Nejad (2010) conducted a semi-empirical study titled: "the influence of schema-therapy approach on adjustment of early maladaptive schemas in depressed women in Marvdasht City". In the present research, 20 depressed women were selected by means of random sampling and were put into two groups (control group and experiment group). Beck's depression questionnaire and Young's schema questionnaire (short form) were used for data collection. Data analysis using T test showed that group schema-therapy is effective in reduction of women depression. Furthermore, group schema-therapy reduced early maladaptive schemas. In other words, group schema-therapy had significant influence on reduction in incompatible schemas: disconnection and rejection, other directedness, and over-vigilance. Montazeri et al (2013) conducted a research titled "influence of

schema-therapy on reduction of depression symptoms and obsessive-compulsive personality disorder. Results showed that schema-therapy influences obsessive-compulsive personality disorders and depression. Further, follow-up sessions which were held two months after therapy showed that the reduced symptoms were still there. Li (2007) conducted a study on 233 students and investigated 2 assumptive models in cognitive schemas which played a mediating role between social prescribed perfectionism and depression & anxiety. In the assumptive depression model, abandonment, defectiveness/shame, dependence/incompetence, insufficient self-control/self-discipline were considered as mediating variables. The primary assumptive model was not verified in the research. Even a revised model in which abandonment schema had been influenced by depression via indirect impacts of other schemas was not verified. To this end, the present research tries to investigate early maladaptive schemas in depressed, anxious, obsessed and normal individuals.

RESEARCH METHODOLOGY

The present research is a correlation study of type comparative and post event cross-sectional.

Statistical population

The population in this research is made up of two groups:

1. Patients group, which contained all patients who suffered from depression, anxiety and obsession and had referred to Shafa psychiatry hospital in Rasht city from February 2013 till October 2014.

Normal individuals group which was used as comparison group and contained all accompanying family members of the depression, anxiety and obsession patients who had referred to Shafa psychiatry hospital in Rasht city from February 2013 till October 2014.

120 people out of the population were selected for taking part in the research (30 anxiety patients, 30 obsession patients, 30 depression patients and 30 family members). These individuals had the following characteristics:

1. first of all, a psychiatrist conducted a structured interview and found the patients to be suffering from depression, anxiety and obsession.

2. then, the patient was introduced to the researcher to be informed about the research structure and goal.

3. the patient and his or her family member voluntarily declared their readiness for taking part in the research.

4. then, the research questionnaires were distributed among the participants.

Individuals who suffered from the aforementioned clinical disorders should have been able to write and read in Persian and should not have had similar disorders. Normal individuals who wanted to take part in the research should not have had any background in psychological/psychiatry disorders, organ disorders like head strike, epilepsy, convulsion and cerebral chronic tumor. Simple random sampling was used for picking sample members and data were collected in field. We referred to Shafa Psychiatry Hospital in Rasht City for data collection. After primary diagnosis by a psychiatrist and explanation of the importance of the research and satisfaction of the participants, obsessive-compulsive disorder questionnaire and DASS-21 depression-anxiety questionnaires were distributed among respondents. Descriptive statistical indices (mean and standard deviation) and multivariate variance analysis were conducted for data analysis. All statistical analyses in the present research were done by means of SPSS software.

Research instrument

1. Young's schema questionnaire (short form): this questionnaire contains 75 items out of 205 items of the main questionnaire which was designed in 1998 by Young for measuring early maladaptive schemas (Divandari, Ahi, Akbari and Mahdian, 2009). This questionnaire is based on 6-point Likert scale: completely true=6, approximately true=5, slightly true=4, more true than false=3, approximately false=2, and completely wrong=1. In their first comprehensive research, Young, Klosko and Vishar (1986) calculated alpha confidants (from 0.83 to 0.96) and retest coefficients in non-clinical population (0.53 to 0.82) for all primary schemas (Zargar et al, 2011). This questionnaire was normalized by Ahi, Mohammadi Far and Besharat (2007) in Tehran Universities. Its internal consistency was calculated to be equal to 0.97 for women and 0.98 for men. Furthermore, the validity of the subscales of the short form of the Young's questionnaire ranges from 0.09 to 0.49 and it has been validated by subscales of the 25-item pathological symptoms revised questionnaire which was conducted by Najjariyan and Davoudi (2001) (Ahi et al, 2007). Fatehizadeh and Abbasiyan (2003) also calculated the validity of Young's incompatible schemas test by means of correlation with illogical beliefs test ($r=0.34$). The sentences of the questionnaire have been classified according to special schemas. These sentences have been separated by means of an asterisk and two code letters which are abbreviation letters of a schema.

2. depression, anxiety and stress scale (DASS): this questionnaire was designed by Lavibond and Lavibond (1995). This scale has two forms. Its short form has 21 items. Each of the constructs depression, anxiety and stress has 7 items. The three constructs stress, anxiety and depression are evaluated by means of DASS-21. The 21-item short form of the questionnaire was validated by Sahebi et al (2005) for Iranian population. This scale is used for adults. By stress in this scale, we mean physical and psychological stresses. Studies conducted by Lovibond and Lovibond (1995) showed that retest coefficient was equal to 0.81 for stress, 0.79 for anxiety and

0.71 for depression. For validity, correlation coefficients with anxiety and depression questionnaires were equal to 0.81 and 0.74, respectively. Therefore, this scale has an appropriate validity and reliability for research.

Scoring and interpretation: each of the subscales of DASS-21 has 7 questions and each construct's total score is obtained by means of adding the scores of corresponding questions (table 1). Each questions is scored from zero (it is not at all true for me) to 3 (it is completely true for me). Since DASS-21 is the short form of the main scale (42-item), the final score of each of the subscales must be doubled (Lovibond and Lovibond, 1995).

Madsley's obsessive-compulsive disorder questionnaire: this questionnaire was designed by Hajson and Rachman (1977) in order to study the type and area of obsessive problems. This questionnaire contains 30 items, half of which have correct key and the other half has incorrect key. The four subsidiary hypotheses are: checking, cleanliness, slowness and obsessive doubts. Using simple scoring method, we can obtain a total score for obsession and four subsidiary scores. Hajson and Rachman (1977) conducted a study on 40 patients and showed that the total score of this questionnaire is sensitive to treatment changes. In general, it has been verified that Madsley's obsessive-compulsive disorder questionnaire is an appropriate instrument for therapists and researchers.

Psychometric characteristics: the reliability and validity of madsley's questionnaire have been verified in many studies in different countries. For instance, Sanavio calculated the correlation between total score of Madsley test and padova's test (0.70). the calculated reliability coefficient between test and retest was high ($r=0.89$) (Rachman and Hajson, 1977). In Iran, Estekti (1976) calculated the reliability coefficient to be equal to 0.85 by means of retest method and dadfar (1997) calculated total reliability coefficient of the test to be equal to 0.84 and convergent validity by means of Yeel-Brown obsession and compulsion scale to be equal to 0.87 (Lindzi, 2000).

Findings

Table 1: variance-covariance matrix of significant homogeneity test

test BOX	dF ₁	dF ₂	F	sig
392.314	360	2.372	0.809	0.997

As it can be seen in table 1, sig is equal to 0.997 which is greater than alpha level (0.05). therefore, it can be said with 95% of certainty that variance-covariance matrix homogeneity assumption has been observed.

Table 2: similarity of variances test

Variable	dF ₁	dF ₂	F	sig
vulnerability	3	106	0.584	0.627
self-control	3	106	4.282	0.007
Hypercriticalness	3	106	1.068	0.366
inhibition	3	106	0.091	0.965
Self-sacrifice	3	106	1.144	0.335
subjugation	3	106	0.339	0.797
enmeshment	3	106	1.51	0.216
Failure	3	106	2.25	0.086
dependence	3	106	3.37	0.021
approval-seeking	3	106	0.481	0.696
defectiveness	3	106	1.62	0.188
Alienation	3	106	0.129	0.943
mistrust	3	106	0.799	0.497
abandonment	3	106	1.68	0.176
emotional deprivation	3	106	8.74	0.000

As it can be seen in table above, sig value for self-control, dependence and emotional deprivation variables was equal to 0.007, 0.021, and 0.000, respectively. This shows that similarity of variances error has not been observed for these three variables but sig values for other variables are greater than 0.05. Therefore, similarity of variances error for these variables has been observed.

Table 3: multivariate covariance analysis for influence of matrix on compound variable

² n	sig	dF	dF	F	value	test
0/625	0/000	274/089	45	10/308	0/053	Wilks' Lambda

As it can be seen in table above, sig is equal to 0.0005 which is smaller than $\alpha=0.01$. Therefore, it can be said with 99 percent of certainty that the compound variable in depressed and anxious and obsessed individuals has significant difference with normal individuals.

DISCUSSION AND CONCLUSION

The present research aimed to investigate and compare early maladaptive schemas in depressed, obsessed, anxious and normal individuals. Results showed that early maladaptive schemas are different between depressed, anxious, obsessed and normal individuals. This result is consistent with the results of studies conducted by Ahmadiyan (2008), Mehrangiz Mohammadnejad (2010), Montazeri et al (2013), and Lee (2007). Maryam Salmani lotfAbadi (2010) conducted a research titled: investigation of the influence of cognitive group therapy concentrated on schema on reduction of students' depression symptoms. She put 26 students of Mohaghegh Ardebili University who suffered from depression in two control and experiment groups. Results of statistical analyses showed that schema-oriented cognitive group therapy reduced total score of Young's schemas questionnaire significantly in comparison with control group. Results of multivariate covariance analysis showed that treatment was effective in reducing the scores of all schemas significantly except social isolation/alienation and enmeshment/undeveloped self. Further, results of t test showed that there is a significant difference between reduction in depression score in the experiment group in comparison with control group. Results of multivariate regression analysis also showed that social deprivation, strict criteria and approval-seeking schemas can predict 65% of the variance of depression using Beck's test. Calvete et al (2005) found a significant relationship between emotional disorders symptoms (depression, anxiety and anger) and early maladaptive schemas. They investigated 407 students using beck's depression index (BDI-II), state-trait anxiety index (STAIT) and automatic thoughts revised questionnaire (ATQ-R). they found clinical relationships between these schemas and emotional, depression and anxiety disorders. It can be said that there is significant difference between maladaptive schemas in normal, depressed, obsessed and anxious individuals and this result is consistent with the results of the present study.

It can be said that individuals with schemas in disconnection and rejection area (abandonment/instability, mistrust/misbehavior, emotional deprivation, defectiveness/shame, social isolation and alienation) cannot have secure and satisfactory attachment with others. These individuals believe that their needs for stability, security, affection, love and devotion will not be satisfied. Many of them have had shocking childhoods and tend to avoid inter-individual relationships very recklessly. Individuals with schemas which are in impaired autonomy and performance area (dependence/incompetence, vulnerability to loss and disease, enmeshment/undeveloped self) cannot have an independent identity and cannot manage their lives without others' helps. They cannot set specific goals for them and get skilled. Individuals with schemas which are in impaired limits area (approval-seeking/recognition seeking, insufficient self-control/self-discipline) have problems with mutual respect and self-control. They have problems with respecting others' rights, cooperation, being committed or achieving long-term goals. Individuals with schemas which are in directedness area (subjugation, self-sacrifice, attraction of attention) try to satisfy others' needs instead of their own needs. They do so in order to achieve respect, continue emotional relationship or avoid revenge. They emphasize more on others' responses than their own needs and are unaware of their tendencies. Individuals with schemas which are in over-vigilance/inhibition area (negativism, emotional deprivation, strictness, punitiveness) suppress their feelings and self-stimulated impulses. They usually try to act according to their own internalized inflexible rules even if they lose happiness, expression of ideas, comfort of mind, friendly relations or health. These individuals usually suffer from positivism, worry and fear and believe that if they cannot be vigilant in all times, their lives may be destroyed. The results show that problems with regulating emotions, absence of toleration of unspecified conditions, worry and sense of anxiety act like mechanisms against emotions which are resulted from stressful conditions in patients who suffer from anxiety and depression. This is why the levels of these cognitive constructs are higher in this category of patients.

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