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DIFFERENCES IN EARLY MALADAPTIVE SCHEMES EXPRESSION

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Abstract: *This paper has targeted the identification of significant differences in the early maladaptive schemas endorsement according to subject's gender and diagnostic category, and the assessment of the presence and strength of the correlation between the intensity of the aforementioned schemas and the subject's age. We found significant statistical gender differences regarding the Unrelenting standards/ hypercriticalness (Us) schema and significant statistical differences regarding the Failure to achieve (Fa) schema according to the subjects' diagnosis, the effect size of the result being above average. Finally, a significant positive correlation has been found between the subject's age and the intensity of Punitiveness (Pu) schema, but the result had a below average effect size.*

Key words: *early maladaptive schemas, sex, gender, diagnosis, age.*

1. Introduction

We cannot underline enough the distinction between helping someone into getting better and assisting her/him to feel better. Thus, relapse prevention implies a change of deep ingrained pathogenic variables- early maladaptive schemas.

Early maladaptive schemas (EMS) consist of emotional and cognitive dysfunctional patterns that begin early in life and repeat themselves throughout the entire individual lifespan. These are "broad, pervasive themes regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree." They share the following traits:

- they develop in childhood and adolescence from an interplay between the child's innate temperament, and the child's ongoing damaging experiences with parents, siblings, or peers;
- they are responsible for generating intense emotional distress and negative consequences to the individual or his entourage;
- they block the normal development of autonomy, self-expression, self-acceptance and of the ability to form harmonious relationships;
- they are deeply entrenched patterns, central to one's sense of self, usually self-perpetuating;
- they erupt when triggered by everyday events (or by a biological status) relevant to the schema.

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Shorey, Ryan, Anderson, & Stuart (2012), in a study conducted on a sample of subjects diagnosed with alcohol addiction found that women reported higher levels of the following EMS: Emotional Deprivation (Ed), Abandonment/Instability (Ab), Mistrust/Abuse(Ma), Social Isolation/Alienation(Si),Defectiveness/Shame (Ds), Failure to Achieve (Fa), Dependence/ Incompetence (Di), Vulnerability To Harm Or Illness (Vh), Enmeshment/ Undeveloped Self (Em), Insufficient Self-Control/Self-Discipline (Is), Subjugation (Sb), Self-Sacrifice (Ss), Approval-Seeking/Recognition-Seeking (As), Negativity/Pessimism (Np). None of the EMS were significantly stronger endorsed by men.

Another research concentrated on the assessment of gender differences influence on the early maladaptive schemas reported by children (152 boys and 48 girls) in foster institutions from egiptian province of Dakahlia. The authors applied the EMSQ – SF-Early maladaptive schemas questionnaire-short form. Except for the Self-Sacrifice (Ss) and the Unrelenting standards/ hypercriticalness (Us) schemas, the total score average and the scales total scores were significantly higher in the female sample (El-Gilany, El-Bilsha, & Ibrahim, 2013).

As stated by Colman, following a research on a non-clinical sample of 82 college students, there were no gender differences concerning the EMS levels. However, the same study supported the existence of significant gender differences in a clinical sample (N = 456, 328 women and 128 men, most of them presenting a diagnosis of depression). Thus, men reported higher levels of Isolation/Alienation (Si) and Emotional inhibition (Ei), while women scored higher on the Enmeshment/Undeveloped Self (Em) and Self-Sacrifice (Ss) (Colman, 2010).

The vast majority of research on this topic concerns personality disorders (mainly narcisistic and borderline). The aforementioned studies are among the few regarding axis I disorders. In everyday practice, where one must adjust the assistance according to the client's needs and characteristics, age and gender can make a difference in the intensity of the client's maladaptive schemas. Her life path presents her with a multitude of experiences that streghten or relax these patterns, especially as a consequence of the supporting coping strategies.

Also, apart from basic innate needs, mainly as an effect of their distinctive socialization, men and women might differ in their sensibility to the frustration of certain more sophisticated needs and in their specific types of vulnerability. The educated counsellor /psychotherapist should be aware of these differences so he or she is able to provide the client with a specifically targeted and efficient intervention.

We intended to find whether certain EMS are diagnostic or gender specific and if their level varies with age. In order to reach the above mentioned objectives, we stated the following hypotheses:

1. Regardless of the category of diagnosis received (anxious or depressive disorder), the subject's EMS have significantly different levels according to their gender.
2. Regardless of their gender, the subject's EMS have significantly different levels according to their diagnosis category (anxious or depressive disorder).
3. The subject's age and EMS levels are significantly correlated.

2. Method

2.1. Participants

A sample of 50 subjects, 35 women and 15 men, aged 16 to 65 years, (M = 32,31, SD = 11,32), presented in a clinical setting, with various psychological issues. Either based one the PDESQ cutoffs or on the psychiatric semi-structured interview, they met the criteria for major depressive disorder, without psychotic features (N = 12,25; 5%), anxiety type disorders (N = 25; 49%) or mixed (with anxiety and depressive symptoms) disorder (N = 2; 3,9%), while some of them presented with non-clinical depressive or anxiety symptoms (N = 6; 8,8%) or psychotic type disorders (N = 4; 7,8%).

In order to test the second hypothesis, we used 37 subjects of the initial sample described above (12 subjects meeting the criteria for depressive disorder only and 25 meeting the criteria for anxiety disorders), thus narrowing the diagnostic range to two categories. In order to test the first and third hypotheses, we used the entire sample described above (N = 50).

2.2. Instruments

EMS were measured using the Young Schema Questionnaire-short form 3 (YSQ-S3) and PDSQ- Psychiatric diagnosis and screening questionnaire.

Originally, the YSQ was developed by Young in 1990 (hence the name Young Schema Questionnaire) ”for Schema Therapy, an adaptation of Cognitive Behavioral Therapy with insights from Attachment Theory, experiential approaches, and concepts of emotional core needs” (Bach, Simonsen, Christoffersen, & Kriston, 2015) The questionnaire has 114 items, assessing 18 scheme maladaptive schemas: Emotional Deprivation (Ed), Abandonment/Instability (Ab), Mistrust/Abuse (Ma), Social Isolation/Alienation (Si), Defectiveness/Shame (Ds), Failure to Achieve (Fa), Dependence/Incompetence (Di), Vulnerability To Harm Or Illness (Vh), Enmeshment/ Undeveloped Self (Em), Insufficient Self-Control/Self-Discipline (Is), Subjugation (Sb), Self-Sacrifice (Ss), Approval-Seeking/Recognition-Seeking (As), Negativity/Pessimism (Np), Entitlement (Et), Emotional inhibition (Ei), Unrelenting standards/Hypercriticalness (Us), Punitiveness (Pu). Each item is graded on a 6 point Lickert-type scale, a score of 1 meaning ”completely untrue for me”, and a score of 6 – ”completely true for me”. In the Romanian validated questionnaire, based on the respective cutoffs, all schemes can vary within the following range/levels: low, medium, high and very high. The YSQ-S3 is very reliable, with an α-Cronbach of 0.96 for the total score and with α-Cronbach ranging between 0.68 - 0.90 for the 18 subscales (David, 2006-2009).

The PDSQ consist of 125 items, with Y/N type answers. It yields a total pathology score and scale specific scores (major depressive disorder, PTSD, bulimia/binge eating, obsessive-compulsive disorder, panic disorder, psychotic disorders, agoraphobia, alcohol abuse, drug abuse, general anxiety disorder, somatization disorder and hypochondria and suicide risk. It has good internal consistency (0.68-0.94) and test-retest reliability (0.68-0.94) and good concurrent and discriminant validity (Zimmerman, 2010).

The data were processed using the SPSS.17. Since male subjects were significantly fewer that women and too few to run parametric procedures, in order to identify a significant difference in the schemes levels according to the subject’s gender, we used the

schemes levels as ordinal scale variables and applied the U Mann-Whitney test. Also, since the number of subjects within each diagnostic category (depressive and anxiety disorders type, respectively) was insufficient to use parametric statistical procedures, so, in order to identify a significant difference in the schemes levels according to subject's diagnostic type, we used the schemes levels as ordinal scale variables and applied the U Mann-Whitney test.

3. Results

Our initial objectives were partially attained. Specifically, we found two differences in EMS endorsement worth mentioning:

1. Regardless of their diagnostic category, the Unrelenting standards/ Hypercriticalness (US) scheme has significantly different levels according to the subject's gender (N1 = 15, N2 = 35, U = 187, $p < .05$). Thus, women endorse this schema with greater intensity than men do, but the effect size of this result is below average ($r = .29$). We present the outcomes of Mann-Whitney test concerning the other EMS (see Table 1). None were statistically significant.
2.

Table 1

Mann-Whitney test for gender differences in the others EMS endorsement

	ED	AB	EI	MA	DS	SI	VH	SB	DI	SS	ET	IS	AS	NP	PU
M.-W. U	282	245	244	254	270	239	277	246	269	220	134	258	248	268	258
N1	15	15	15	15	15	15	15	15	15	15	12	15	15	15	15
N 2	35	35	35	35	35	35	35	35	35	35	26	35	35	35	35

$p < .05$

2.Regardless of their gender, the Failure (FA) scheme has significantly different levels according to the subject's diagnostic category (N1 = 12, N2 = 25, U = 101, $p < .05$). Thus, subjects with depressive disorder endorse this schema stronger than those with anxious disorders and the effect size of this result is average (r = .33). We present the outcomes of Mann-Whitney test concerning the other EMS (see Table 2). None were statistically significant.

Table 2

Mann-Whitney test for diagnostic differences in the others EMS endorsement

	ED	AB	EI	MA	DS	SI	VH	SB	DI	SS	ET	IS	AS	NP	PU
M.-W. U	122	150	139	153	153	124	125	158	146	134	88	111	139	137	134
N1	13	13	13	13	13	13	13	13	13	13	13	12	12	12	12
N 2	25	25	25	25	25	25	25	25	25	25	24	25	25	25	25

$p < .05$

3. Concerning the age variation of EMS, we observed a significant positive correlation between subject's age and the level of the Punitiveness (Pu) schema ($r = .32$, $p < .05$),

with a determination coefficient of $r^2 = .10$. Thus, the connection between the two variables has a low strength, that is, only 10% of the variance in the Punitiveness (Pu) schema level is explained by a variance in the subject's age. Table 3 presents the correlations between age and the others EMS. None were statistically significant.

4. Discussion and conclusions

Concerning the US schema level, since we proved it differs significantly according to the subject's gender and the strength of this difference was below average, one can presume that it is unlikely to obtain the observed effect by chance, but, also, that this outcome is not robust enough to make a difference in everyday clinical practice.

Correlation between age and the other EMS Table 3

	ED	AB	MA	SI	DS	FA	DI	EM	VH	SS	US	ET	IS	NP
ED	1													
AB	.52***	1												
MA		.52***	1											
SI	.35**	.28*	.50***	1										
DS	.48***	.48***	.46**	.61***	1									
FA	.32*		.49***	.51***	.47***	1								
DI	.33*	.49***	.50***	.58***	.65***	.70***	1							
EM		.47**					.33*	1						
VH	.31*	.68***	.49***	.42**	.58***	.36**	.60***	.55***	1					
SS		.31*	.27*					.35*		1				
EI		.34*	.43**			.41**	.35*	.28*	.30*	49***				
US										46***	1			
ET			.32*	.52***	.30*	.27*						1		
IS	.32*	.30*	.38**	.67***	.50***	.47***	.57***		.37**			.31*	1	
AS	.33*			.39**	.29*						.31*		.43**	
NP		.45***	.42**	.49***	.43**	.51***	.61***		55***				.42**	1
SB	.32*	.45***	.44***	.45***	.53***	.49***	.60***	.50***	55***			.36**	.37**	.51***

Note: N = 5; *p < .05; **p < .01; ***p < .001

Concerning the FA schema level, since we proved it differs significantly according to the subject's diagnosis and the strength of this difference was average, one can presume that it is unlikely to obtain the observed effect by chance and this outcome is robust enough to make a difference in everyday clinical practice.

As stated by our study, FA is the only schema that makes a distinction between subjects suffering from depressive disorders and those with anxiety disorders. This scale reflects the core vulnerability to depressive symptoms- the "self-downing" attitude.

Unlike the anxiety suffering subjects, when it comes to failure, the depressive subjects have a stable, global and internal attributional style: they believe that it happened only because they did something wrong, something that reflects a global characteristic of their

personality („I am not good at doing X") and something that's not going to change.

While the anxiety suffering subjects tend to assign an unrealistically high probability of danger/failure, the depression suffering subjects are 100% certain of it, since they can only fail.

A previous study (carried on 31 of the 50 subjects involved in this research), reported that (FA) and resorting to pharmacotherapy/sport/supplements as a solution for psychological problems were negatively correlated (Neacşu, 2011). That is, the more one feels inadequate, less (socially) successful or unable to achieve, the more she will avoid psychotropic medication, probably as a consequence of self-blaming for/giving in to her psychological problems. Hence the necessity to encourage these subjects to adhere to an evidence-based treatment plan – e.g. in a severe major depressive episode.

Punitiveness (Pu) is the belief that people should be harshly punished for making mistakes. It involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards. Usually, it includes difficulty forgiving mistakes in oneself or others, because of a reluctance to consider extenuating circumstances, allow for human imperfection, or empathize with feelings (David, 2006).

Concerning the positive significant correlation between Punitiveness (Pu) and subject's age, we found that the strength of this connection was below average. Thus, one can presume that it is unlikely to obtain the observed effect by chance, but, also, that this outcome is not robust enough to make a difference in everyday clinical practice. Furthermore, since we discuss correlation, not mutual determination of the two variables, one can state the obvious requirement to identify the variable(s) that moderate this association.

Since this was not a longitudinal study, we cannot conclude that the Pu schema intensifies with age, but only that, in this sample, it is stronger in older subjects.

Upon inspecting the steam and leaf graph of age distribution, one can easily see that the majority of sample is in the 20-30-40 years range. So, the correlation we found could be a generational effect, with older subjects receiving a more severe education and assimilating a less tolerant attitude towards both their mistakes and others'.

One of the limits of this research (but also its main strength, if one considers it in the light of the effect sizes obtained) is the use of a convenience sample, caused by the difficulty to find in a non-academic/non-institutionalised setting, subjects presenting with single diagnosis, mainly without comorbid anxiety and depression symptoms. Another limit is the lack of balance between the number of subjects with anxiety (the majority of them) and depression diagnosis.

Also, the gender difference was stated according to the biological assigned sex of the subjects. One might need to consider not only this biological criterion, but the inner assumed gender role, along with all its differentiating psychological traits and attitudes. For this purpose, one may need to assess gender-role differentiation (e.g. using Bem Sex-Role Inventory).

Studies investigating this topic proved that subjects that possess both traditionally "male" and traditionally "female" psychological traits were better adjusted socially and scored lower on the neuroticism scale of EPQ, compared to men with high levels of male gender-role endorsement and women with high levels of female gender-role endorsement. (Tudose, 2005) Thus, psychological gender-specific traits may better explain our outcomes, or even produce stronger clinical implications.

As far as we would expand the study on a bigger, more gender-balanced sample, we could capture the existence of other differences or connections between the targeted variables.

To sum up, in terms of statistical significance, the most relevant outcomes were the increase of the Pu intensity with age and a higher level of the Us in women compared to their male counterparts.

In terms of practical effects, the increased intensity of Fa made the difference between depressive and anxiety disorders. So, when a subject presents with both anxiety and depression complains, the clinician should be particularly mindful of the prominence of general failure statements in the subject's discourse. As is often the case, after a number of unsuccessful attempts to cope with anxiety and/or the events that triggered it, they experience the onset of depressive symptoms.

Although (especially the somatic) symptoms of anxiety disorders can be dramatic, thus becoming the focus of the clinician's attention, he/she should remain alert to the fact that a large number of failure references on the client's part is a red flag and therefore the depressive states should be addressed immediately, in order to prevent the worsening of his condition.

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References

Bach, B., Simonsen, E., Christoffersen, P., & Kriston, L. (2015). Young Schema Questionnaire 3 Short Form (YSQ-S3). Psychometric properties and association with personality disorders in a Danish mixed sample. *European Journal of Psychological Assessment*. doi: http://dx.doi.org/10.1027/1015-5759/a000272

Colman, L. K. (2010). *Maladaptive Schemas and Depression Severity: Support for Incremental Validity When Controlling for Cognitive Correlates of Depression,* Master's Thesis, University of Tennessee, Retrieved from http://trace.tennessee.e/utk_gradthes/615.

David, D. (2006). *Tratat de Psihoterapii Cognitive şi Comportamentale* [Handobook of Cognitive and Behavioral Psycotherapy]. Iaşi: Polirom.

David, D. (2006-2009). *Chestionarul Schemelor Cognitive Young – Forma Scurtă* (YSQ-SF) [Young Cognitive Schema Questionnaire – Short Form (YSQ-SF)]. Cluj: COGNITROM.

El-Gilany Abdel-Hady, El-Bilsha, M., & Ibrahim, A. (2013). *Gender Differences in Maladaptive Cognitive Schema in Orphans in Dakahlia, Egypt*, The Scientific World Journal, Retrieved from: http://dx.doi.org/10.1155/2013/373120

Neacşu, V. (2011). Schemele dezadaptative şi teoria schimbării în intervenţia terapeutică [The maladaptive schemes and the theory of change in the therapeutic intervention]. *Revista SmartPSI*, *1*, 16-22.

Shorey, Ryan C., Anderson, S. E, & Stuart, G. L. (2012). Gender Differences in Early Maladaptive Schemas in a Treatment-Seeking Sample of Alcohol-Dependent Adults. *Substance Use and Misuse*, *47*(1), 108–116. doi:10.3109/10826084.2011.629706

Tudose, C. (2005). *Gen şi personalitate* [Gender and personality]. Bucureşti: Ed. Tritonic.

Young, J. E., Janet, K. S., & Weishaar, M. (2003). *Schema Therapy: a Practitioner's Guide*. New York: Guilford Press.

Young, J. (1990). *Cognitive therapy for personality disorders: A schema-focused approach*. Sarasota, FL: Professional Resource Exchange.

Zimmerman, M. (2010). *PDSQ: Chestionarul de Screening şi Diagnostic Psihiatric* [*PDSQ:*Psychiatric Diagnostic Screening Questionnaire]. Cluj-Napoca: Editura ASCR.