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Early Maladaptive Schemas of Substance Abusers and their Intimate Partners

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Abstract

The influence of intimate partners in the recovery of substance abuse has been increasingly recognized in the professional literature. Couples-based substance abuse treatment has demonstrated effectiveness in reducing substance abuse and increasing healthy couple functioning. Recently, research has begun to investigate enduring cognitive beliefs that may impact substance abusers and their intimate partners, which could advance our understanding of factors that may impact couple's functioning. The current study examined the early maladaptive schemas and substance use of a sample of adult substance abusers who have sought residential substance abuse treatment and their intimate partners ($N = 102$). Results demonstrated that the early maladaptive schemas of patients and their intimate partners may be interrelated and that patients scored significantly higher than their partners on 13 of the 18 early maladaptive schemas. Substance use was only associated with a few early maladaptive schemas. These findings highlight the potential importance of assessing early maladaptive schemas in couples where one partner has a substance abuse problem. Implications of these findings for future research are discussed.

Keywords

Early maladaptive schemas; substance use; intimate partners; couples

The negative consequences of substance abuse are not limited to the substance abuser, but also extend to intimate partners (O'Farrell & Fals-Stewart 2006). Thus, it is not surprising that substance abuse intervention that includes intimate partners, such as couple-based interventions (e.g., Behavioral Couples Therapy), have received extensive empirical investigation. These interventions are often designed to reduce substance abuse and improve relationship functioning, with research demonstrating their effectiveness (Powers, Vedel, & Emmelkamp 2008). Recent research has also demonstrated that enduring and pervasive, negative cognitive and behavioral patterns of viewing oneself and the world, known as early maladaptive schemas, are prevalent among substance abusers (Ball 2007). Unfortunately, there is limited research on the early maladaptive schemas of intimate partners of substance abusers. Knowing whether intimate partners of substance abusers also have negative, enduring cognitive and behavioral patterns of interacting with the world may help to improve our knowledge of factors that could be assessed in couple's therapy where one partner has a substance abuse problem. Thus, the current study cross-sectionally examined the interrelationships of, and differences between, early maladaptive schemas in a sample of adult treatment seeking substance abusers and their intimate partners.

Substance Abuse and Couple Functioning

Couples in which at least one partner is abusing alcohol or drugs are at risk of having a number of personal and relationship problems. For instance, couples with a substance abuse problem have a higher risk for divorce and/or separation, domestic violence, poor problem-solving, and poorer functioning for couple's children, relative to couples in which there is not a substance abuse problem (O'Farrell & Fals-Stewart 2006). Substance abusers are more likely to have comorbid mental health problems, including both Axis I (e.g., depression) and Axis II (e.g., borderline personality) disorders (Grant et al. 2004; 2006). Intimate partners of substance abusers may also have a higher risk of health-related problems. Psychological symptoms, such as depression and increased stress, are higher among intimate partners of substance abusers, and likely related to the increased use of health-care resources among these individuals (Copello et al. 2009; Ray, Mertens, & Wiesner 2007; Svenson et al. 1995).

Thus, it is important for researchers and clinicians to consider the mental health problems of both the primary substance abuser and their intimate partner. Substance abuse treatment is improved when concurrent mental health problems are targeted (e.g., Messina, Farabee, & Rawson 2003), and it is also possible that couples therapy for substance use could be improved if concurrent mental health issues are also targeted during treatment. Recent research (Shorey, Anderson, & Stuart 2011) and theory (Ball 1998; 2007) have advocated for the examination of enduring cognitive and behavioral patterns that likely underlie the development of mental health problems, namely early maladaptive schemas, among substance abusers and their intimate partners.

Early Maladaptive Schemas

Defined as "self-defeating emotional and cognitive patterns that begin early in our development and repeat throughout life" (Young et al. 2003; p. 7), early maladaptive schemas are ways of viewing oneself and interacting in the world that are pervasive, enduring, and resistant to change (Young et al. 2003). Similar to the concept of "core beliefs" (Riso et al. 2006), early maladaptive schemas influence how individuals encode, process, and respond to stimuli in their environment, and are believed to develop during childhood, usually through toxic or traumatic experiences that involve one's primary caretakers (Young et al. 2003). Early maladaptive schemas often generate high levels of negative affect and self-defeating behavioral patterns, which are believed to underlie the development of a range of mental health disorders (Ball 1998; Young et al. 2003). As outlined by Young, Klosko, and Weishaar (2003), there are 18 early maladaptive schemas which can be categorized into five domains: disconnection and rejection, impaired autonomy and performance, impaired limits, other directedness, and overvigilance and inhibition. Table 1 outlines each of the early maladaptive schema domains and individual schemata.

Early Maladaptive Schemas and Substance Abuse

Recent research has elucidated the importance of early maladaptive schemas to substance abuse (e.g., Brothie et al. 2004; Roper et al. 2010). Ball (1998) was the first to systematically propose how early maladaptive schemas may (1) underlie and increase the risk for substance abuse and (2) that substance abuse treatment that focuses on modifying early maladaptive schemas may result in improved outcomes (i.e., increased abstinence). Research has largely supported the suppositions of Ball (1998), demonstrating that individuals with substance abuse disorders score higher on early maladaptive schemas than non-clinical controls or individuals not in substance abuse treatment (Brothie et al. 2004; Roper et al. 2010; Shorey, Anderson, & Stuart 2012a; Shorey, Stuart, & Anderson in press). Other research has demonstrated that early maladaptive schemas are prevalent and relevant

for both young adult and adult alcohol and drug abusers (Shorey, Anderson, & Stuart 2012b; Shorey, Stuart, & Anderson 2012). Ball (2007) has also demonstrated that individuals with opioid dependence have better substance abuse outcomes when treatment concurrently focuses on treating early maladaptive schemas and substance abuse, relative to substance abuse alone.

Early Maladaptive Schemas, Couples, and Substance Abuse

Schemata influence how individuals interpret their world, including their interactions, perceptions, and emotions related to intimate partners (Dattilio 2006). Moreover, schemata are often core components of conflict between couples (Dattilio 2005). Young and Gluhoski (1997) discuss how early maladaptive schemas may cause considerable conflict between partners, as 11 of the 18 early maladaptive schemas are focused on core beliefs related to relationships. It is likely that conflict between partners activates schematic beliefs and behaviors in one partner which, since maladaptive, serves to generate continued conflict and perpetuation of schemata (Young & Gluhoski 1997). Understanding the early maladaptive schemas of each relationship partner, and how they may be related to each other and substance abuse, may advance our understanding of couples where one partner has a substance abuse disorder.

To date, only one study has examined the early maladaptive schemas of intimate partners of substance abusers, and the interrelation of schemata among couples where one partner is abusing substances. Using pre-existing patient records of a sample of couples where one partner was seeking residential treatment for substance abuse, Shorey and colleagues (2011) examined the interrelations of early maladaptive schemas among partners. Findings demonstrated that patients scored higher on 5 of the 18 early maladaptive schemas than their intimate partners (the schemata of defectiveness, failure, dependence, vulnerability, and insufficient self-control), and intimate partners scored higher than patients on the schema of self-sacrifice. Moreover, early maladaptive schemas of both partners were highly correlated to each other. However, this study had several limitations. No demographic information on intimate partners was available and no measures of alcohol or drug use were available for either patients or intimate partners. Thus, research is needed that replicates and extends these findings. If replicated, these findings could provide researchers with important information for the development of future research into the early maladaptive schemas of both partners (e.g., longitudinal studies; treatment outcome studies) and may suggest that it could be useful for clinicians to screen for the early maladaptive schemas of both partners.

Current Study

The current study cross-sectionally examined the early maladaptive schemas of a sample of treatment seeking adult substance abusers and their non-treatment seeking intimate partners. Using patient records, we examined whether patients and intimate partners differed on early maladaptive schemas. In addition, we examined the relation between substance use and early maladaptive schemas for patients and intimate partners. It was hypothesized that (1) patients would score higher than intimate partners on the majority of early maladaptive schemas; and (2) increased substance use (alcohol and drug) would be associated with increased early maladaptive schema endorsement.

Method

Procedures

Patient records from an adult substance abuse treatment facility program located in the Southeastern United States were reviewed for the current study. The data used in the current

study is a different sample than that used by Shorey and colleagues (2011). The substance abuse treatment facility is guided by the traditional 12-step model and emphasizes the identification and modification of patients' early maladaptive schemas. The adult treatment facility only admits patients who have a primary disorder diagnosis and are 25 years of age or older.

As part of the initial intake assessment, patients complete a number of self-report measures, including the Young Schema Questionnaire – Long Form, Third Edition (YSQ-L3; Young & Brown 2003), the Alcohol Use Disorders Identification Test (AUDIT; Saunders et al. 1993), and the Drug Use Disorders Identification Test (DUDIT; Stuart et al. 2003, 2004). All measures are completed after medical detoxification, when applicable. Prior to their first family therapy session, intimate partners are also asked to complete the YSQ-L3, AUDIT, and DUDIT. Substance use diagnoses, which are based on the Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition – Text Revision (DSM-IV-TR; American Psychiatric Association 2000), are made through a treatment team consultation with a psychologist, a psychiatrist, a general physician, and substance use counselors.

As part of the treatment, approximately 3-5 family therapy sessions are conducted with patients' intimate partners, parents, siblings, children, or friends, depending on the unique needs of each patient and the willingness of family members to participate in therapy. For the current study, the charts of patients were reviewed to determine whether they had an intimate partner who completed the YSQ-L3, AUDIT, and DUDIT as part of family therapy. All procedures were approved by the Institutional Review Board (IRB) of the first author.

Participants

Patient records were searched from May 2011 to November 2011 to determine whether family members who participated in family therapy also completed the YSQ-L3, AUDIT, and DUDIT. This resulted in a total of 51 dyads ($N = 102$), patients and partners, who both completed the YSQ-L3, AUDIT, and DUDIT. This time frame was chosen because May 2011 is when the treatment facility asked all intimate partners to complete the YSQ-L3, AUDIT, and DUDIT. The majority of patients were male (72.5%) with a mean age of 41.00 ($SD = 10.24$). Ethnically, 96.1% were non-Hispanic Caucasian with the remainder being African American. The majority of patients were employed full-time prior to entering treatment (64.7%), with the remainder being employed part-time (11.8%), unemployed (11.8%), or retired/on disability (11.8%). The mean number of years of education for patients was 14.19 ($SD = 2.39$). For the 51 patients, the primary substance use diagnoses derived from their charts were as follows: 45.1% had a primary diagnosis of alcohol dependence, 25.5% polysubstance dependence, 23.5% opioid dependence, and 2% each for cannabis dependence, phencyclidine dependence, and amphetamine abuse.

For intimate partners, the majority were female (70.6%) with a mean age of 40.23 ($SD = 9.98$). Ethnically, the majority were non-Hispanic Caucasian (92.2%), with the remainder being African American (3.9%), Hispanic (2%), and Indian (2%). Most of the intimate partners were employed full-time (74.5%), followed by unemployed (11.8%), employed part-time (7.8%), and retired/on disability (2%). Two partners did not indicate their employment status. The mean number of years of education for partners was 14.88 ($SD = 3.40$). Only 7.8% of partners indicated they had ever sought treatment for substance use in their lifetime. Of the 51 dyads, 80.4% were married, 11.8% were dating, 3.9% were engaged, and 3.9% were life partners. The majority of patients and intimate partners were living together prior to entering treatment (90.2%). The mean number of years of relationships was 12.74 ($SD = 8.95$).

Measures

Demographics—Both patients and intimate partners were asked to indicate their age, ethnicity, education level, employment status, relationship status, and relationship length. Intimate partners were also asked to indicate whether they had ever sought treatment for an alcohol or drug problem.

Early Maladaptive Schemas—The Young Schema Questionnaire – Long Form, Third Edition (YSQ-L3; Young & Brown 2003), a 232-item self-report measure, was used to assess early maladaptive schemas. The YSQ-L3 assesses the 18 early maladaptive schemas, which can be grouped into five schema domains, identified by Young and colleagues (2003). All items are rated on a six point scale (1 = completely untrue of me; 6 = describes me perfectly) to indicate how much they believe each item describes themselves. For each early maladaptive schema, a score of 4 or greater for each item contributes to the total score of each specific schema, since a response of 4 or greater is suggestive that that particular item may be representative of a maladaptive belief or behavior. Total scores for each early maladaptive schema are obtained by summing the number of responses rated as a 4, 5, or 6 for all items associated with each schema. Score ranges for each schema domain (and each early maladaptive schema) are: *disconnection & rejection*, 0-408 (emotional deprivation [0-54]; abandonment [0-102], mistrust/abuse [0-102], social isolation [0-60], and defectiveness [0-90]); *impaired autonomy and performance*, 0-282 (failure [0-54], dependence [0-90], vulnerability [0-72], and enmeshment [0-66]); *other directedness*, 0-246 (subjugation [0-60], self-sacrifice [0-102], and approval-seeking [0-84]); *impaired limits*, 0-156 (entitlement [0-66] and insufficient self-control [0-90]); and *overvigilance and inhibition*, 0-306 (emotional inhibition [0-54], unrelenting standards [0-96], negativity/pessimism [0-66], and punitiveness [0-90]) (Young & Brown 2003; Young et al. 2003). The YSQ has demonstrated good factor structure, validity, and reliability (Cockram, Drummond, & Lee 2010; Saariaho et al. 2009).

Alcohol Use—The Alcohol Use Disorders Identification Test (AUDIT; Saunders et al. 1993) was used to examine alcohol use in the previous 12 months. The AUDIT is a 10-item self-report measure that examines the frequency and intensity of alcohol use, symptoms that might indicate tolerance or dependence to alcohol, and negative consequences associated with alcohol use. The AUDIT has demonstrated a superior ability, when compared with other measures of alcohol use, to identify individuals with problematic alcohol use (Reinert & Allen 2002). Moreover, the AUDIT has demonstrated good reliability and validity across a wide range of populations (Babor et al. 2001). A score of 8 or greater on the AUDIT is indicative of hazardous drinking (Babor et al. 2001; Saunders et al. 1993).

Drug Use—The Drug Use Disorders Identification Test (DUDIT; Stuart et al. 2003; 2004) was used to examine drug use in the previous 12 months. The DUDIT consists of 14 questions. Modeled after the AUDIT, the DUDIT assesses the frequency and intensity of drug use across different classes of drugs (e.g., opioids, hallucinogens, stimulants) and symptoms that may be characteristic of tolerance or dependence. Unlike the AUDIT, the DUDIT does not have a standard cutoff score to indicate hazardous drug use. The DUDIT has demonstrated good reliability and validity across multiple samples (Stuart et al. 2008).

Results

All analyses were conducted using SPSS version 18.0. We first examined whether there were any differences in demographic characteristics among patients and their partners. Patients and partners did not significantly differ on any of the demographic variables. Patients ($M = 16.68$; $SD = 11.94$) did score higher on the AUDIT than their intimate partners

($M = 4.13$; $SD = 3.59$), $t(100) = 7.18$, $p < .001$. In addition, patients ($M = 15.13$; $SD = 14.25$) scored higher on the DUDIT than their intimate partners ($M = .90$; $SD = 2.41$), $t(100) = 7.03$, $p < .001$. For patients, 68.6% had a score of 8 or higher on the AUDIT. For intimate partners, 17.6% had a score of 8 or higher on the AUDIT, indicating the presence of hazardous alcohol use.

We next examined correlations among patient and intimate partners' early maladaptive schemas and substance use (see Table 2). All early maladaptive schema domains were highly correlated with each other for both patients and intimate partners. For patients, increased drug use was associated with increased scores on the schemata domains of disconnection and rejection and other directedness. Alcohol use was not significantly associated with schemata for patients. Impaired autonomy and alcohol use were positively associated with each other for intimate partners. Patients' drug use, disconnection and rejection, and other directedness schema domains were all significantly associated with higher scores for intimate partners' impaired limits domain.

Lastly, we examined differences in scores on early maladaptive schemas among patients and intimate partners using a Multivariate Analyses of Covariance (MANCOVA). Because patients and intimate partners significantly differed on alcohol and drug use, scores on the AUDIT and DUDIT were entered as covariates when examining differences in early maladaptive schemas. All schemata domains were entered as dependent variables. As displayed in Table 3, patients scored significantly higher on each early maladaptive schema domain. We next examined each individual early maladaptive schema, again using a MANCOVA, to determine which early maladaptive schemas within each domain were significantly different among patients and their partners. As displayed in Table 3, patients scored significantly higher than their intimate partners on 13 of the 18 early maladaptive schemas. This included the schemata of abandonment, mistrust/abuse, social isolation, defectiveness, failure, dependence, vulnerability, emotional inhibition, entitlement, insufficient self-control, approval-seeking, negativity/pessimism, and punitiveness.

Effect size differences between patient and intimate partner schemata were computed by comparing the mean scores of patients and intimate partners, divided by their pooled standard deviations (Cohen 1988). Cohen (1988) recommended that a small effect size be interpreted when the d is equal or less than .20, a medium effect size is equal to a d of .50, and a large effect size is equal to a d of .80. Based on these recommendations, differences in three individual schemata, and one schema domain, fell into the large range, including the individual schemata of insufficient self-control, approval-seeking, and defectiveness, and the schema domain of impaired limits. The majority of the other effect size differences fell into the medium range.

Discussion

The current study examined the early maladaptive schemas of a sample of adults seeking treatment for substance abuse and their non-treatment seeking intimate partners. Expanding upon previous research, we examined whether these two groups differed in early maladaptive schemas while controlling for differences in substance use. This is only the second study to investigate early maladaptive schemas among couples where one partner has a substance abuse problem.

Correlation analyses demonstrated that the schema domains of disconnection and rejection and other directedness for patients were associated with higher scores on the schema domain of impaired limits for their intimate partners. The schema domain of other directedness is characterized by an excessive focus on meeting the needs, desires, and responsibilities of

other people, usually in an attempt to gain love and approval from significant others (Young et al. 2003). The schema domain of disconnection and rejection is characterized by a fear that one's needs for security, safety, stability, and nurturance will not be met in a predictable manner (Young et al. 2003). Finally, the impaired limits domain is characterized by a lack of responsibility to others, deficiencies in internal limits, and a lack of long-term goals. This schema domain is also associated with a limited ability to cooperate with others (Young et al. 2003). Additional research using longitudinal designs is needed that replicates and extends these findings, while also determining how these interrelations of schemata affect couples functioning

Consistent with our hypothesis, patients scored significantly higher on the majority of early maladaptive schemas than their intimate partners. Specifically, patients scored higher on all five schema domains and 13 of 18 early maladaptive schemas. Although the pattern of patients scoring higher than their partners on early maladaptive schemas was found in previous research (Shorey et al. 2011), the present study also controlled for the effects of alcohol and drug use and had a larger sample than the previous study. While most differences fell into the medium effect size range, a few differences in schemata between patients and partners were considered large effect size differences. For instance, there were large effect size differences between patients and partners on the schemata of defectiveness and approval-seeking. The defectiveness schema involves the feeling and belief that one is bad, unwanted, inferior, or an invalid person across multiple domains of life (Young et al. 2003). The approval-seeking schema involves the belief that one must gain approval, recognition, or attention from close others, which usually comes at the expense of forming a sense of self and self-esteem that is independent of approval from other people (Young et al. 2003). It is possible that individuals may use substances to avoid their feelings of defectiveness or to facilitate social interactions due to fear of negative self-evaluation (approval-seeking). Feelings of defectiveness could further be perpetuated by being involved with an intimate partner who does not have a substance abuse problem, as individuals may compare themselves to their partners and believe something is wrong with them for abusing alcohol and/or drugs. It is also possible that substance abuse impacted the development and/or maintenance of these schemata.

Consistent with previous research (Shorey et al., 2011), the largest difference between patients and intimate partners was for the schema of insufficient self-control. This schema is characterized by an omnipresent difficulty in exerting healthy self-control and frustration tolerance, or "fail to" restrain excessive expression of emotions and impulses to achieve personal goals. Some individuals with this schema also seek, in an over-exaggerated manner, to avoid discomfort (e.g., physical pain, conflict, responsibility; Young et al. 2003). It is not surprising that this schema would be higher among individuals with substance abuse disorders, as it is similar to the concept of impulsivity, which is associated with increased risk of substance abuse disorders (Verdejo-Garcia, Lawrence, & Clark 2008), and a lack of self-control which has been shown to predict a range of deviant behavior (Jones & Quisenberry 2004). Couples in which one member of the dyad has a substance abuse disorder often have a number of interpersonal difficulties, such as poor communication and problem-solving (O'Farrell & Fals-Stewart 2006), and it is possible that this schema in particular may be partly responsible for the development of these interpersonal problems due to its impulsive nature and discomfort avoidance.

Finally, our results only partially supported our second hypothesis, that increased substance abuse would be associated with increased schema endorsement. Increased drug use was associated with higher scores on the schema domains of disconnection and rejection and other directedness for patients. For intimate partners, increased alcohol use was associated with higher scores on the impaired limits schema domain. These findings provide

preliminary support for the notion that increased substance use severity/frequency may be associated with greater schema endorsement. It is possible that individuals are using alcohol and/or drugs to avoid the negative cognitive and emotional aspects of early maladaptive schemas, which would be consistent with both theory and previous research (Ball 1998; Brotchie et al. 2007). However, it is also possible that substance use is contributing to the development or perpetuation of early maladaptive schemas, and carefully conducted longitudinal research is needed to address this question.

Clinical Implications

This study, and others, suggest that early maladaptive schemas are more prevalent among individuals seeking treatment for substance abuse when compared to individuals not seeking treatment, and increased substance abuse may be related to increased early maladaptive schema endorsement. Thus, it is possible that targeting and modifying early maladaptive schemas in substance abuse treatment may improve outcomes, since early maladaptive schemas are theorized to be an underlying vulnerability to the development, or maintenance, of mental health problems (Young et al. 2003). By teaching individuals more consistent and adaptive ways of coping with their early maladaptive schemas, it is possible that they would turn to substances less when facing negative cognitive and emotional components of schemata. It should also be noted that the present study, and that of Shorey and colleagues (2011), indicate that clinicians should be aware that intimate partners of substance abusers who seek individual therapy may also have early maladaptive schemas that could be contributing to their current personal and relationship difficulties and clinicians may want to assess for such schemata during treatment.

Limitations

The cross-sectional nature of the current study prevents the assessment of causality among study variables. For instance, we are unable to determine whether patient and partner schemata were present and stable prior to their relationship formation, or whether they influenced the schemata of their partners. Longitudinal research is needed to determine whether the relationship had an influence on early maladaptive schemas. The sample was also primarily comprised of non-Hispanic Caucasian participants, which limits the generalizability to more ethnically diverse samples. In addition, employing a substance abuse treatment-seeking sample limits the generalizability to non-substance abusing samples. The sample of substance abusers were primarily male and it is possible that a larger sample of female substance abusers may have produced different findings, since previous research has demonstrated that early maladaptive schemas may be more relevant for female substance abusers (Shorey, Anderson, et al. 2012). Future research should compare early maladaptive schemas in samples of female substance abusers and their intimate partners to samples of male substance abusers and their intimate partners.

The lack of standardized diagnostic interviews for assessing substance abuse diagnoses among patients represents a limitation of the current study, and future research should employ structured interviews to confirm diagnoses, such as the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID; First et al. 1995). Larger sample sizes should also be employed in future research, as this would allow researchers to examine specific diagnostic groups individually (e.g., opioid; alcohol), since it is possible that results may vary depending on the primary substance being used. Additionally, the number of analyses may have inflated our Type I error, although we felt our approach was justified given the preliminary and descriptive nature of the current study.

In summary, our results demonstrated that substance abuse patients scored higher than their non-treatment seeking partners on 13 of 18 early maladaptive schemas, even after

controlling for substance abuse. In addition, patients' schemata, and drug use, were related to the impaired limits schema domain of their intimate partners. These findings further contribute to the literature on early maladaptive schemas and substance abuse in general, demonstrating that schemata may be highly relevant to the treatment of substance abuse. In addition, these findings suggest that couples therapy where one partner has a substance abuse problem may benefit from assessing early maladaptive schemas. Research is needed to determine whether modifying early maladaptive schemas during couple's therapy where one partner has a substance use disorder leads to reduced substance use and improved couple functioning.

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Table 1

List of Early Maladaptive Schemas

Early Maladaptive Schemas	Description
Disconnection & Rejection	Expectation that safety, stability, security, empathy, nurturance, and sharing of feelings will not be predictably met.
Emotional Deprivation	Expectation that close others will not be able to meet one's emotional needs or provide emotional support.
Abandonment	A perceived inability or instability of close others to provide support and connection.
Mistrust/Abuse	The expectations that other people will abuse, manipulate, or take advantage.
Social Isolation	A feeling that one is different from other people and isolated from the world.
Defectiveness	A feeling that one is not lovable or significant because one feels they are being bad, inferior, or invalid.
Impaired Autonomy & Performance	Expectation that one is unable to survive, perform successfully, and function independent of other people.
Failure	A belief that one has failed in important areas of life or the expectation that one will eventually fail.
Dependence	The expectation that one is not able to handle everyday responsibilities without significant help from other people.
Vulnerability	The expectation that bad things will happen and that there is nothing one can do to prevent it or cope with it.
Enmeshment	A feeling that one cannot survive or be happy in life without being consistently and constantly supported by other people.
Impaired Limits	A lack of internal limits, ability to form long-term goals and a lack of responsibility to others.
Entitlement	The expectation that one deserves special rights and is better than other people.
Insufficient Self-Control	A pervasive difficulty refraining from impulsive behavior, low frustration tolerance, and thinking of long-term consequences.
Other-Directedness	An extreme focus on meeting the needs, feelings, and desires of other people at the expense of one's own needs.
Subjugation	A feeling that one is controlled by other people and that one's own feelings/opinions are not important.
Self-Sacrifice	The expectation that one must meet the needs of other people.
Approval-Seeking	Excessive focus on gaining the approval or attention of other people at the expense of developing a true sense of self.
Overvigilance & Inhibition	Expectation that one must suppress feelings and impulses; rigid standards of performance and behavior.
Emotional Inhibition	Excessive inhibition of thoughts, feelings, and behavior to avoid feelings of shame.
Unrelenting Standards	Expectation that one must meet high internalized, rigid standards of behavior.
Negativity/Pessimism	A pervasive focus on negative aspects of life.
Punitiveness	The expectation that people should be punished for mistakes.

Note: Schema domain names are bolded

Table 2

Correlations among Study Variables

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.
1. DRp	---	.78***	.74***	.64***	.75***	-.17	.33*	.16	.13	.31*	.17	.05	.01	.03
2. IAp		---	.63***	.62***	.65***	-.12	.24	-.00	.06	.16	.01	-.16	.01	.14
3. ILp			---	.66***	.74***	.02	.24	.13	.04	.10	.10	.02	.03	.14
4. ODp				---	.80***	-.16	.30*	-.02	-.02	.28*	.04	-.01	.04	.07
5. OIp					---	-.10	.18	-.01	-.06	.14	-.04	-.02	-.06	.01
6. AUDITp						---	-.48***	.11	.08	-.11	-.05	.06	.03	-.06
7. DUDITp							---	.13	.06	.32*	.12	-.01	.04	.02
8. DRi								---	.67***	.45***	.65***	.66***	.15	.03
9. IAI									---	.56***	.69***	.45***	.37***	.15
10. ILi										---	.51***	.48***	.21	-.11
11. ODi											---	.69***	.14	.01
12. OIi												---	.04	-.16
13. AUDITi													---	.13
14. DUDITi														---

Note: DR = Disconnection and Rejection; IA = Impaired Autonomy; IL = Impaired Limits; OD = Other Directedness; OI = Overvigilance and Inhibition; AUDIT = Alcohol Use Disorders Identification Test; DUDIT = Drug Use Disorders Identification Test;

"p" = Patient; "i" = Intimate Partner.

*
p < .05

**
p < .01

p < .001

Table 3

Mean Differences between Patients and Intimate Partners on Early Maladaptive Schemas

Schema	Patients (<i>n</i> = 51) <i>M</i> (<i>SD</i>)	Intimate Partners (<i>n</i> = 51) <i>M</i> (<i>SD</i>)	<i>F</i>	<i>p</i>	<i>d</i>
Disconnection & Rejection	73.39 (81.91)	29.56 (49.17)	6.32	< .01	.64
Emotional Deprivation	8.17 (12.21)	7.58 (12.80)	1.98	> .05	.04
Abandonment	14.58 (20.41)	6.37 (11.00)	7.58	< .001	.50
Mistrust/Abuse	20.52 (25.70)	10.17 (17.85)	3.98	< .05	.46
Social Isolation	9.29 (14.24)	4.05 (9.91)	3.17	< .05	.42
Defectiveness	17.43 (22.50)	3.52 (9.00)	7.07	< .001	.81
Impaired Autonomy and Performance	34.41 (44.73)	11.43 (28.98)	5.05	< .01	.60
Failure	7.05 (11.53)	2.35 (8.25)	2.87	< .05	.46
Dependence	11.68 (18.81)	2.33 (8.89)	4.92	< .01	.63
Vulnerability	10.25 (14.71)	4.68 (11.24)	3.80	< .05	.42
Enmeshment	5.41 (10.41)	2.05 (6.12)	2.01	> .05	.39
Impaired Limits	42.64 (38.35)	9.00 (12.64)	15.34	< .001	1.17
Entitlement	13.92 (17.44)	4.43 (7.42)	5.36	< .01	.70
Insufficient Self-Control	28.72 (24.39)	4.56 (9.70)	18.96	< .001	1.30
Other Directedness	64.49 (55.53)	48.07 (41.46)	2.98	< .05	.33
Subjugation	9.78 (14.76)	5.27 (10.69)	2.62	> .05	.34
Self-Sacrifice	33.86 (27.42)	36.54 (28.46)	1.77	> .05	.09
Approval-Seeking	20.84 (22.42)	6.25 (10.32)	6.88	< .001	.83
Overvigilance and Inhibition	90.35 (66.40)	50.64 (51.36)	4.33	< .01	.66
Emotion Inhibition	11.54 (12.78)	5.43 (9.93)	2.69	< .05	.53
Unrelenting Standards	33.52 (24.35)	23.76 (23.24)	1.68	> .05	.41
Negativity/Pessimism	17.90 (20.06)	7.96 (14.64)	3.67	< .05	.56
Punitiveness	27.37 (23.84)	13.49 (16.13)	5.27	< .01	.68

Note: Schema domain names are bolded; *d* = effect size differences in patient and intimate partner early maladaptive schemas.