Published in final edited form as:

Addict Res Theory. 2015 July 1; 23(4): 280–286. doi:10.3109/16066359.2014.981810.

Trait mindfulness and early maladaptive schemas in women seeking residential substance use treatment: A preliminary investigation

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Abstract

Mindfulness has received an abundance of research attention in recent years, largely due to mindfulness-based interventions demonstrating positive mental and physical health outcomes. However, less research has examined individual's trait levels of mindfulness and how it is related to mental health, particularly among individuals seeking substance use treatment. Therefore, in the current study, we examined the relation between trait mindfulness and early maladaptive schemas (EMS), which are dysfunctional cognitive and behavioural patterns that theoretically underlie the development of mental health problems, among women seeking residential substance use treatment. Pre-existing, adult female, patient records from a residential substance abuse treatment facility were reviewed ($N = 67$). Results demonstrated that higher trait mindfulness was negatively associated with 12 of the 18 EMS. Moreover, patients who endorsed multiple EMS reported lower trait mindfulness than patients who endorsed zero (or one) EMS. These findings are the first to examine the relation between trait mindfulness and EMS among women seeking substance use treatment. Findings suggest that EMS and trait mindfulness are robustly related and future research should examine whether mindfulness-based interventions reduce EMS.

Keywords

Early maladaptive schemas; mindfulness; substance use; treatment

Introduction

Substance use and its associated disorders are a serious and growing problem among women. Although alcohol continues to be the most widely abused substance among women (Gabbard, 2001), the use and the abuse of opioids and other drugs (e.g. stimulants) are increasing at alarming rates (Veilleux, Colvin, Anderson, York, & Heinz, 2010). Moreover,

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Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

women with a substance use disorder are more likely to have associated mental health problems, such as mood, anxiety and personality disorders, than non-substance abusing women (Grant et al., 2004, 2006). In addition, there is research to suggest that women who seek substance use treatment have more comorbid mental health problems than their male counterparts (Foster, Peters, & Marshall, 2000). Because problematic substance use is preventable and treatable (Marlatt & Donovan, 2005), there is a need for continued research on comorbid mental health factors among individuals seeking substance use treatment, particularly women. Such variables could be targeted in treatment programs in an effort to improve outcomes. Toward this end, the current study examined the relationship between trait mindfulness and early maladaptive schemas, two factors related to mental health that have received increased attention with substance use, in a sample of women in residential substance use treatment.

Mindfulness and substance use

Mindfulness can be defined as “paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally” (Kabat-Zinn, 1994, p. 4). Rather than being a state-like quality or a set of techniques to be learned, mindfulness is a “way of being” (Kabat-Zinn, 2003). Mindfulness is believed to help individuals be more open to experience feelings, thoughts and behaviours with an open awareness, non-judgmentally and non-defensively (Heppner et al., 2008). Moreover, mindfulness is present-moment based, and it can, therefore, help individuals to decrease rumination and worry and allow experiences to naturally rise and fall away without struggling to avoid or escape unpleasant emotions/ thoughts or engage in reactive behaviour (Segal, Williams, & Teasdale, 2002). Research has demonstrated that the qualities of mindfulness (e.g. non-judgment, acceptance, curiosity of experience) are enhanced with appropriate training (e.g. mindfulness meditation) and practice (Baer, 2003). A large literature has demonstrated the positive effects of mindfulness-based interventions for mental and physical health disorders (see reviews by Eberth & Sedlmeier, 2012; Keng, Smoski, & Robins, 2011). Research also demonstrates that mindfulness-based interventions increase levels of trait mindfulness (also referred to as “dispositional mindfulness”) (e.g. Birnie, Speca, & Carlson, 2010; Bowen et al., 2014; Kearney, McDermott, Malte, Martinez, & Simpson, 2012).

Research has begun to investigate trait mindfulness among individuals seeking substance use treatment. Individuals who seek substance use treatment report lower levels of trait mindfulness relative to healthy comparison groups (Brooks, Kay-Lambkin, Bowman, & Childs, 2012; Dakwar, Mariani, & Levin, 2011; Shorey, Brasfield, Anderson, & Stuart, 2014a,b) and trait mindfulness is negatively associated with mental health symptoms (e.g. PTSD) (Garland & Roberts-Lewis, 2013; Shorey, Brasfield, Anderson, & Stuart, 2014a,b) and the severity of substance dependence (Bowen & Enkema, 2014) among treatment-seeking adults. In addition, Mindfulness-Based Relapse Prevention (MBRP; Bowen et al., 2014), an 8-week outpatient group therapy for substance use, has been shown to produce reduced cravings and relapse to substance use to a greater degree than a 12-step, process-oriented outpatient program, and traditional relapse prevention, 12-months after treatment. Other mindfulness-based interventions have shown initial promising in increasing positive substance use outcomes (Chiesa & Serretti, 2014; Garland et al., 2014).

Thus, the initial research evidence suggests that trait mindfulness is lower among individuals seeking substance use treatment, is related to mental health and substance use severity and that training in mindfulness may be a helpful component of substance use treatment by decreasing risk for relapse. It is, therefore, important for research to continue to investigate how trait mindfulness is related to factors that may complicate substance use treatment, such as mental health problems. Specific to the current study, we examined whether trait mindfulness was associated with early maladaptive schemas.

Early maladaptive schemas and substance use

Early maladaptive schemas (EMS) can be defined as a “broad, pervasive theme or pattern comprised of memories, emotions, cognitions, and bodily sensations regarding oneself and one’s relationships with others ... [that] are dysfunctional to a certain degree” (Young, Klosko, & Weishaar, 2003, p. 7). Early maladaptive schemas interfere with healthy self-expression, autonomy and interpersonal relationships, result in high levels of negative affect and distress and are central themes that help to comprise one’s sense of self (Young et al., 2003). Moreover, because early maladaptive schemas are core themes through which individuals interpret their environments, they often define how individuals process experiences and stimuli throughout their lives (Young et al., 2003). EMS are theorised to underlie the development of psychopathology, particularly chronic and pervasive disorders, such as substance use (Ball, 1998; Young et al., 2003). Young et al. (2003) have conceptualised 18 EMS, grouped into five EMS domains, which have been reviewed elsewhere (Shorey, Anderson, & Stuart, 2014; Young et al., 2003). It is also believed that EMS are highly pervasive and resistant to change (Ball, 2007; Young et al., 2003) and also maintain persistent clinical disorders (Young et al., 2003). Indeed, EMS are stable across multiple years (Riso et al., 2006).

Specific to the current study, a growing body of research has demonstrated that individuals in substance use treatment report greater levels of EMS than non-clinical comparison groups (Brotchie, Meyer, Copello, Kidney, & Waller, 2004; Roper, Dickson, Tinwell, Booth, & McGuire, 2010; Shorey, Stuart, & Anderson, 2013a, 2014) and that EMS are associated with mental health problems among individuals seeking substance use treatment (Shorey, Stuart, & Anderson, 2013b). Moreover, findings indicate that the majority of EMS (i.e. 14 of the 18) are higher among women relative to men who are in substance use treatment (Shorey, Anderson, & Stuart, 2012). Research also suggests that substance use treatment that concurrently focuses on reducing EMS may result in better substance use outcomes relative to 12-step focused treatment (Ball, 2007).

Mindfulness and early maladaptive schemas

To date, only one study has examined the relation between trait mindfulness and EMS. Shorey, Brasfield, Anderson, and Stuart (in press) demonstrated that trait mindfulness was negatively associated with 15 of the 18 EMS among men seeking substance use treatment. Moreover, men who endorsed multiple EMS had lower trait mindfulness than men endorsing fewer EMS. Research has also demonstrated trait mindfulness to be negatively associated with constructs similar to EMS, such as negative self-schemas (Oliver, O’Connor, Jose, McLachlan, & Peters, 2012) and that constructs similar to trait mindfulness

(i.e. psychological mindedness) are negatively associated with EMS (Cecero, Beitel, & Prout, 2008). Thus, there are empirical reasons to suspect an association between trait mindfulness and EMS. However, it is important for research to replicate the findings of Shorey et al. (in press) in women seeking substance use treatment since women report higher levels of EMS in substance use treatment (Shorey et al., 2012) and enter substance use treatment with more mental health problems than men (Foster et al., 2000).

There are also theoretical reasons to support the relation between EMS and trait mindfulness. First, it is theorised that avoidance is one of the primary coping mechanisms for EMS (Ball, 1998; Young et al., 2003), such as avoidance through substance use. In contrast, mindfulness is theoretically believed to be the opposite of avoidance, as all experiences are naturally allowed to come and go and not be avoided (Baer, 2003). Thus, theoretically, high levels of trait mindfulness would be associated with less EMS endorsement, likely due to reduced avoidance of painful experiences. Second, a component of mindfulness is non-judgment and compassion toward the self (Baer, 2003). In contrast, EMS are often composed of negative, self-defeating views and beliefs (Young et al., 2003). Theoretically, then, individuals higher in trait mindfulness would also have greater levels of self-compassion, which has been proposed as one factor that would be associated with reduced EMS (Germer, 2009). Finally, mindfulness-based interventions have recently been proposed as one type of intervention that may be effective in the reduction of EMS (e.g. Germer, 2009; McKay, Lev, & Skeen, 2012). It is believed that the enhanced awareness and acceptance attained through mindfulness-based interventions will allow individuals to become more aware of their EMS, more accepting of their struggles, and better able to engage in behaviours based on conscious decisions instead of automatic behaviours often driven by EMS (McKay et al., 2012). Therefore, there are theoretical reasons to suspect an association between trait mindfulness and EMS, although to our knowledge only one empirical study exists on this potential relationship.

Current study

The purpose of the present study was to examine the relationship between trait mindfulness and EMS in a sample of women in residential substance use treatment. Because mindfulness-based interventions are known to increase trait mindfulness, and theory would suggest EMS and trait mindfulness should be inversely related, examining the relationship between EMS and trait mindfulness in a substance abuse treatment seeking sample of women could help researchers and clinicians to determine whether mindfulness-based interventions could be implemented to target and reduce EMS. This could, therefore, help to improve long-term substance use outcomes. Based on the previous research and theory, we hypothesised that (1) trait mindfulness would be negatively associated with EMS and (2) individuals with greater EMS endorsement would report lower trait mindfulness relative to individuals with less EMS endorsement.

Methods

Procedure and participants

Patient records from an adult residential substance abuse treatment facility, which is located in the Southeastern United States, were reviewed for the current study. To be admitted into this facility, patients must have a primary substance use disorder and be 25 years of age or older. The treatment facility includes medical detoxification (if needed) and is a 28–30-d program that is guided by the traditional 12-step model. Once admitted into the treatment facility, and after medical detoxification if necessary, patients are administered an extensive intake assessment, which includes both interviews and self-report measures (discussed below). Substance use disorder diagnoses are based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Text Revision (DSM-IV-TR) criteria (American Psychiatric Association, 2000). All diagnoses are determined through a treatment team consultation, with the support of the intake assessment, which includes a licensed psychologist, a psychiatrist, a general physician and substance abuse counsellors. All procedures for the current study were approved by the Institutional Review Board of the first author.

We reviewed patient medical records from May 2012 to May 2013. All female patient records during this time were included in the current study, which resulted in 67 patients. The primary substance use diagnosis for this sample was alcohol dependence (59.7%), followed by opioid dependence (23.8%), polysubstance dependence (9%), sedative/hypnotic/anxiolytic dependence (3%), cocaine dependence (3%) and amphetamine dependence (1.5%). The majority of patients were non-Hispanic Caucasian (91%). The mean age of patients was 43.10 ($SD = 11.49$) and the mean years of education completed was 14.26 ($SD = 2.39$).

Measures

Trait mindfulness—The 14-item version of the Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003; Brown, West, Loverich, & Biegel, 2011) was used to examine trait mindfulness. The 14-item version does not contain the item “I drive places on ‘automatic pilot’ and then wonder why I went there,” which was included in the original 15-item version of the MAAS (Brown & Ryan, 2003). The substance use facility where patient charts were reviewed did not include this item because (1) patients cannot drive during residential treatment and (2) the treatment facility wanted the option to eventually examine pre-post treatment changes in trait mindfulness. The MAAS is designed to capture a receptive state of mind, one in which awareness of what is taking place in the present moment is observed, without appraising or evaluating experience (Brown & Ryan, 2003). Example items include “I find it difficult to stay focused on what’s happening in the present” and “I rush through activities without being really attentive to them.” All items are rated on a 6-point scale (1 = *Almost always*; 6 = *Almost never*) and a mean score is obtained by adding all items and then dividing by the total number of items. Higher scores on the MAAS correspond to higher levels of trait mindfulness. The 14-item version of the MAAS has demonstrated good reliability ($\alpha = 0.88$) and validity (Brown et al., 2011).

Early Maladaptive Schemas—The Young Schema Questionnaire – Long Form, Third Edition (YSQ-L3; Young & Brown, 2003) was used to measure Young et al.'s (2003) conceptualisation of EMS. The YSQ-L3 consists of 232 self-report items that assess 18 EMS. All items are rated on a six-point scale (1 = *completely untrue of me*; 6 = *describes me perfectly*). A score of 4 or greater on each item contributes to the total score for each specific EMS (Young & Brown, 2003). That is, total scores for each EMS are obtained by summing the number of responses rated as a 4, 5, or 6 (scores of 1–3 are recoded into “0”). Score ranges for the 18 EMS are emotional deprivation (0–54), abandonment (0–102), mistrust/abuse (0–102), social isolation (0–60), defectiveness (0–90), failure (0–54), dependence (0–90), vulnerability (0–72), enmeshment (0–66), subjugation (0–60), self-sacrifice (0–102), emotional inhibition (0–54), unrelenting standards (0–96), entitlement (0–66), insufficient self-control (0–90), approval-seeking (0–84), negativity/pessimism (0–66) and punitiveness (0–90; Young & Brown, 2003; Young et al., 2003).

The YSQ-L3 also has established cutoff scores for each EMS (Young & Brown, 2003), such that each EMS can also be categorised into clinically interpretive categories that reflect low, medium, high and very high EMS endorsement. A score in the *low* range indicates that a particular EMS is not a problem for an individual; a *medium* score indicates that a EMS may be a problem for an individual and should be given further consideration; scores of *high* and *very high* indicate that a particular EMS is a problem for an individual (Young & Brown, 2003). For ease of interpretation, we combined *high* and *very high* scores into one overall “high” category, and scores of *low* and *medium* into one overall “low” category. The YSQ-L3 has demonstrated good psychometric properties, including internal consistency ($\alpha = 0.89\text{--}0.94$), good factor structure and validity (e.g. Cockram, Drummond, & Lee, 2010; Saariaho, Saariaho, Karila, & Joukamaa, 2009).

Results

All statistical analyses were conducted using SPSS version 21.0 (SPSS Inc., Chicago, IL). We first examined all study variables for positive skew and kurtosis. Results demonstrated that all variables had a skew of less than 1.6 and kurtosis of less than 1.8. Values greater than 2.0 and 5.0 for skew and kurtosis, respectively, are considered non-normally distributed (Hildebrand, 1986). Thus, all variables were normally distributed. Means, standard deviations and score ranges among study variables are presented in Table 1.

We next examined our first hypothesis that trait mindfulness and EMS would be negatively associated. Bivariate correlations among study variables are presented in Table 2. As expected, trait mindfulness was negatively associated with the majority of EMS (12 of the 18). The six EMS that were not significantly associated with trait mindfulness were abandonment, emotional deprivation, entitlement, enmeshment, negativity/pessimism and emotional inhibition. The strongest correlations were between the trait mindfulness and the EMS of unrelenting standards ($r = -0.38$) and insufficient self-control ($r = -0.36$).

Lastly, we examined whether patients who endorsed having multiple EMS reported lower trait mindfulness than patients who reported only one (or zero) EMS. To examine this, we first categorised each EMS into high or low endorsement (Young & Brown, 2003) and then

combined EMS into a single variable to reflect the total number of schemata endorsed. The average number of EMS rated as high by patients was 6.41 ($SD = 5.13$; range = 0–15). An independent samples t -test was employed to examine group differences. Results demonstrated that patients who had more than one EMS rated as high ($n = 54$; $M = 3.52$, $SD = 0.77$) scored significantly lower on trait mindfulness than patients who scored high on only zero or one EMS ($n = 13$; $M = 4.21$, $SD = 0.88$), $t = 2.76$, $p < 0.01$, Cohen's (1988) effect size $d = 0.87$.

Discussion

Recent research has demonstrated the importance of both early maladaptive schemas (EMS) and mindfulness among women seeking substance use treatment. Due to the high rates of relapse to substance use among individuals who seek treatment, there is a strong need for research to investigate factors that could be targeted during treatment to reduce the risk for relapse. Toward this end, both EMS and mindfulness are theoretically believed to be important factors to target during substance use treatment, and preliminary empirical research has supported these claims (e.g. Ball, 2007; Bowen et al., 2014). However, no known research has examined the relationship between EMS and trait mindfulness among women in substance use treatment. Knowledge of this relationship could inform substance use interventions, as it is possible that mindfulness-based interventions could be effective in reducing EMS. Thus, we examined these relationships in a sample of adult women in residential substance use treatment.

Findings from the current study provide preliminary support for a relationship between trait mindfulness and EMS among women seeking residential substance use treatment, consistent with the theoretical literature on both EMS and mindfulness. Consistent with research on men seeking substance use treatment (Shorey et al., in press), findings demonstrated that 12 out of 18 EMS were negatively associated with trait mindfulness. It is interesting to note that the two strongest relations between EMS and trait mindfulness were with the EMS of unrelenting standards and insufficient self-control. Indeed, these EMS are consistently two of the highest endorsed EMS in substance abuse treatment seeking samples (e.g. Shorey et al., 2012). Insufficient self-control is characterised by impulsivity, low self-control, poor frustration and anger tolerance, and the avoidance of discomfort (Young et al., 2003). Unrelenting standards is characterised by the belief that one must continually strive to meet high internalised standards of behaviour (Young et al., 2003), resulting in intense anxiety and pressure to perform well. In essence, both these EMS are opposite of higher trait mindfulness, which supports conscious behaviour and adaptive emotion regulation (Baer, 2003).

Our findings also demonstrated that women with more than one EMS reported lower trait mindfulness than women with one, or zero, EMS. It is possible that as each EMS increases in intensity, individuals will become more fused with the negative cognitions and emotions associated with each EMS, thus reducing the ability to remain focused on the present moment, and increasing maladaptive coping behaviours (e.g. substance use) to temporarily reduce the pain associated with EMS. Thus, the more the EMS that are present for an individual, the greater the fusion with negative emotions and cognitions, and thus the lower

trait mindfulness will be. Of course, it is also possible that lower trait mindfulness is a risk factor for developing EMS, and additional research is needed to disentangle the directionality of these relationships.

It is important to note that six EMS were not associated with trait mindfulness, including abandonment, emotional deprivation, enmeshment, entitlement, emotional isolation and negativity/pessimism. However, all these associations were in the expected direction and were approaching significance, which may suggest that the small sample size precluded the detection of these less robust associations. Still, it is also possible that there indeed is no association between trait mindfulness and these specific EMS. Future research that attempts to replicate these findings with larger samples will be able to provide a more definitive conclusion regarding these associations.

Directions for future research

There are a number of directions for future research on the relationship between EMS and trait mindfulness. First, these findings should be replicated in larger samples of women in substance use treatment, as well as other clinical populations (e.g. individuals with Axis II disorders). It would also be useful to examine the factors that may moderate the relationship between trait mindfulness and EMS. For instance, it is possible that comorbid mental health disorders, such as depression or generalised anxiety, may moderate and increase the relationship between EMS and trait mindfulness. Given the high rates of comorbid mental health problems among individuals in substance use treatment, this will be an important question for future research.

Given the robust relations between EMS and trait mindfulness identified in this study and that of earlier research (i.e. Shorey et al., in press), it is possible that an underlying deficit common to EMS is the inability to remain present focused, non-judgmental, and accepting of experiences. Indeed, this would be supported by the high levels of avoidance coping seen among individuals with EMS, including substance use treatment seekers (Brotchie, Hanes, Wendon, & Waller, 2007). Young et al. (2003) and Ball (1998) have hypothesised that substance use is a common coping mechanism for the emotional pain associated with EMS. This raises the possibility, then, that mindfulness-based interventions could help to increase awareness of EMS, enhance acceptance of emotions and thoughts associated with EMS, and, in turn, reduce substance use as a means of coping with EMS. Although this remains an empirical question, recently researchers have discussed how mindfulness-based interventions may be helpful for reducing EMS (e.g. Germer, 2009). Moreover, given the research suggesting that mindfulness-based interventions enhance levels of trait mindfulness (e.g. Kearney et al., 2012), and findings from this study demonstrated a negative association between trait mindfulness and EMS, this provides further support for the possibility that mindfulness-based interventions could positively impact EMS. Thus, future research should examine whether mindfulness-based interventions for substance use have the concurrent benefit of reducing EMS endorsement.

Limitations

There are a few notable limitations that should be considered. Our sample size was small, which may have limited our ability to detect significant associations among study variables. Larger samples would also allow for more complex and sophisticated statistical analyses to determine which EMS best predict trait mindfulness (e.g. multiple regression analyses with all EMS predicting trait mindfulness simultaneously). Larger samples would also allow for the inclusion of control variables that may confound the association between EMS and trait mindfulness (e.g. coping styles, severity of substance use). It is likely that multicollinearity existed among the EMS scales, which have been shown in previous research to be highly associated with each other (Shorey et al., 2012). In addition, we did not utilise a Bonferroni correction for our statistical analyses due to our small sample size and preliminary nature of this study. Future research with larger samples and more sophisticated statistical analyses should adjust their alpha level accordingly. The cross-sectional nature precludes determining whether trait mindfulness and EMS are associated over time. The generalisability of findings is limited to primarily non-Hispanic Caucasian women seeking substance use treatment. Additionally, the substance use treatment facility where charts were reviewed does not administer structured diagnostic interviews to confirm substance use diagnoses. This also hinders our ability to determine whether comorbid mental health disorders would have influenced our results, and future research should examine this possibility. Our use of the MAAS to examine trait mindfulness also has limitations. The MAAS, one of the most widely used measures of trait mindfulness, only captures one aspect of mindfulness, and other self-report measures of trait mindfulness assess mindfulness as a multidimensional construct. Future research should determine whether different aspects of trait mindfulness are all similarly related to EMS.

Conclusion

In summary, this is the first known study to examine the relationship between EMS and trait mindfulness. In a sample of women seeking residential substance use treatment, findings demonstrated that 12 of the 18 EMS were negatively associated with trait mindfulness. In addition, women endorsing high levels of multiple EMS reported the lowest levels of trait mindfulness. Future research is needed to better understand the relationship between EMS and trait mindfulness. In addition, treatment outcome research is needed to determine whether interventions specific to EMS or trait mindfulness result in improvements in both constructs, thus leading to better substance use outcomes.

Acknowledgments

This work was supported, in part, by grant K24AA019707 from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) awarded to the last author. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIAAA or the National Institutes of Health.

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Table 1

Means, standard deviations, and score range among study variables.

	Mean	Standard deviation	Range
MAAS	3.71	0.88	1.71–5.43
Abandonment	27.23	26.78	0–91
Approval-seeking	20.07	21.60	0–82
Defectiveness	19.32	23.17	0–84
Dependence	16.52	21.37	0–84
Emotional deprivation	9.04	12.13	0–46
Emotional inhibition	10.37	12.63	0–49
Enmeshment	13.35	19.15	0–66
Entitlement	13.26	16.86	0–66
Failure	10.49	15.41	0–50
Insufficient self-control	29.20	22.67	0–79
Mistrust/abuse	25.05	28.18	0–80
Negativity/pessimism	21.58	20.90	0–66
Punitiveness	27.79	21.72	0–82
Self-sacrifice	45.65	30.28	0–102
Social isolation	10.91	15.40	0–57
Subjugation	17.29	17.94	0–57
Unrelenting standards	30.19	25.52	0–96
Vulnerability	14.98	17.01	0–66

MAAS, mindful attention awareness scale.

Table 2

Bivariate correlations between trait mindfulness and early maladaptive schemas.

Early maladaptive schema	Trait mindfulness (<i>r</i>)
Disconnection and rejection	
Abandonment	−0.23
Mistrust/abuse	−0.25 [*]
Emotional deprivation	−0.21
Social isolation	−0.31 [*]
Defectiveness	−0.32 ^{**}
Impaired autonomy and performance	
Failure	−0.24 [*]
Dependence	−0.29 [*]
Vulnerability	−0.28 [*]
Enmeshment	−0.26
Impaired limits	
Insufficient self-control	−0.36 ^{***}
Entitlement	−0.17
Other directedness	
Approval-seeking	−0.30 [*]
Self-sacrifice	−0.27 [*]
Subjugation	−0.25 [*]
Overvigilance and inhibition	
Emotional inhibition	−0.21
Negativity/pessimism	−0.21
Punitiveness	−0.29 [*]
Unrelenting standards	−0.38 ^{**}

*
 $p < 0.05$.**
 $p < 0.01$.***
 $p < 0.001$.