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THE RELATIONSHIP BETWEEN EARLY MALADAPTIVE SCHEMAS, CHRONIC  
AND ACUTE DEPRESSION, AND HELP SEEKING BEHAVIORS

by  
Jason Walker

A Thesis

Submitted in partial fulfillment of the requirements of the  
Master of Arts Degree  
of  
The Graduate School  
at  
Rowan University  
20 May 2009

Approved by \_\_\_\_\_  
Dr. Jim A. Haugh

Date Approved May 28, 2009

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## ABSTRACT

Jason Walker

THE RELATIONSHIP BETWEEN EARLY MALADAPTIVE SCHEMAS, CHRONIC  
AND ACUTE DEPRESSION, AND HELP SEEKING BEHAVIORS

2008/09

Dr. Jim A. Haugh

Master of Arts in Mental Health Counseling and Applied Psychology

Depression is a disorder that affects many people's lives; approximately 24% of Americans are diagnosed with some form of depression in their lifetime. In order to effectively treat depression we must first understand the disorder and how the symptoms affect people. This study aims to investigate unipolar depression in two ways through the use of a questionnaire. One is to understand the etiology of depression, specifically the role of Early Maladaptive Schemas in the etiology of chronic and acute depression. Hierarchical regressions on 88 participants indicated that EMS and anxiety significantly predict acute and chronic depression. The other aim of this study is to understand when depressed clients seek treatment, because treatments are only effective if clients seek out help. A one-way analysis of variance (ANOVA) on 88 participants indicated that there were significant differences on reported EMS between three groups of help seeking; those who sought help, those who wanted help but did not seek it, and those who did not need or want help.

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## CHAPTER I

### Introduction and Issues to Be Addressed

Depression is a disorder that is both prevalent and significantly affects many people. In regard to its prevalence, Eisenberg, Gollust, Golbersein, and Hefner (2007) found that 14% of college undergraduates screen positive for depressive disorders. (Furthermore, Oliver and Simmons (1985) found that 24% of Americans will suffer from depression at some point in their lifetime. In regard to its impact, studies have indicated that depressive symptoms are related to a number of other significant life problems. For example, depression has been found to be related to relationship distress (Bodenmann, Plancherel, Beach, Widmer, Gabriel, Meuwly, et al., 2008), occupational performance, and distress among members of a family or others who are involved with an individual suffering from depression (De Matos, Tome, Borges, Manso, Ferreira, & Ferreira, 2008).

Since depression is prevalent and has a significant impact, it would benefit treatment to study the cause of depression. One factor that has been linked to depression is cognition. Depression is theorized to be caused by negative and dysfunctional thoughts. One form of these thoughts are schemas. Schemas are core beliefs formed through life experience. They are used to filter stimulus from the environment in order to make an interpretation about any given situation. When early life experiences are negative, a person forms schemas that are centered on the negative and neutral stimuli in the environment are then filtered through these schemas and interpreted negatively. As a result of this negative interpretation bias, people with negative schemas may be more prone to experiencing depressive symptoms. There is some evidence to support this

theoretical link (Harris & Curtin, 2002; Stopa, Thorne, Waters, & Preston, 2001); however, there are problems with the link between schemas and depression. The first problem is that there is little knowledge about the relation of schemas to acute and chronic presentations of depression. Given that 6% of people will experience chronic presentations at some point in their life and that as high as 62% of those people in traditional studies might be experiencing chronic, rather than acute depression, we need to know more about these distinctions (Klein, & Santiago, 2003). The first goal of the current study is to explore whether schemas are differentially predictive of chronic versus acute depression.

The second goal of the current study is to learn more about the relationship between schemas and help seeking behaviors for individuals who are experiencing depression. One of the things we know is that of those who seek treatment, approximately 84% recover (Vittengl, Clark, & Jarrett, 2009). However, 89% of depressed individuals will never seek treatment (Roness, Mykletun, & Dahl, 2005). These people avoid seeking help for many reasons. Often they do not possess the insight that they have a problem, or that they need help from anyone with their problems (Calhoun et al., 1974). Also, many people seek professional help as a last resort, after a failed attempt to improve their situation on their own or after the failed aid of those who are close to them (Vogel & Wei, 2005; Hinson & Swanson, 1993). Another contributing factor to the avoidance of seeking help may be the presence of early maladaptive schemas. Young's (2003) schema theory states that schemas lead to difficulties in relationships and may negatively affect the therapeutic relationship. The problems associated with early maladaptive schemas may also interfere with a person seeking help.



## Overview of Unipolar Depressive Illness

### *The Diagnosis and Prevalence of Unipolar Depressive Disorders*

Unipolar Depressive disorders are characterized by depressed mood which lasts for at least two weeks. While there are many times in a person's life when depressed mood is normal, it becomes dysfunctional and possibly dangerous when depressed mood begins to affect the quality of a person's life and when it persists over that long time period. Oliver and Simmons (1985) found that approximately 6% of Americans met criteria for diagnosis of some type of unipolar depression and that approximately 20% were diagnosed with unipolar depression at some point in their life.

According to the Diagnostic and Statistical Manual of the American Psychiatric Association, unipolar depressive disorders might present themselves in one of three diagnoses (2000). The first diagnosis that unipolar depression can present with is Major Depressive Disorder. Oliver and Simmons (1985) found that approximately 4% of Americans met criteria for Major Depressive Disorder and that approximately 15% were diagnosed with Major Depressive Disorder at some point in their life. Major Depressive Disorder is defined by the presence of a depressive episode. A depressive episode lasts for at least two weeks and is characterized by either a sad mood most of the day on most days or a significant reduction in the ability to experience pleasure. Other symptoms of a depressive episode include changes in eating habits, sleep disturbances, observable psychomotor changes, fatigue, feelings of worthlessness, an inability to concentrate, and/or thoughts of death. Major Depressive Disorder is often considered an acute unipolar depressive illness because the symptoms come on somewhat rapidly and consist

of a change from baseline mood states. In addition, the symptoms of MDD often diminish over time and complete recovery is not uncommon. In contrast to MDD, the other two types of unipolar depressive disorders are considered chronic depressive disorders because their symptoms seem to persist over time and often do not represent a clear change from baseline mood states. There are two diagnoses that can be considered chronic depression. The first is Dysthymic Disorder which is a chronic disorder that lasts for at least two years without remission. Oliver and Simmons (1985) found that approximately 2% of Americans met criteria for Dysthymic Disorder and that approximately 2% were diagnosed with Dysthymic Disorder at some point in their life. Dysthymic Disorder is defined by a depressed mood that lasts throughout most days, uninterrupted, for at least two years. Dysthymic Disorder is also defined by changes in eating habits, sleep disturbances, low self-esteem, fatigue, feelings of hopelessness, and an inability to concentrate. The important distinction between Dysthymic Disorder and Major Depressive Disorder is the long term, uninterrupted, period of depressed mood. Some people experience episodes of depression concurrent with dysthymia. This leads to a “double depression” where a person can be diagnosed with Dysthymic Disorder as well as Major Depressive Disorder.

The second type of chronic depressive disorder is Depressive Personality Disorder, which is characterized as a disorder that begins in early adulthood and is defined by depressive cognitions and behaviors in a variety of contexts. Depressive Personality Disorder is also defined by the usual mood being unhappy and gloomy, the self-concept being of inadequacy and worthlessness, criticalness towards the self, worry, critical and judgmental towards others, pessimism, or being prone to guilt or remorse.

The depressive symptoms in this disorder have been found to be a stable part of the person's personality. In this case a person may not realize that their affect is impaired by a personality disorder and may believe that the depressed mood that they feel is simply the way that they are.

Understanding the etiology is crucial to developing an effective treatment package when treating people diagnosed with different types of depression. However, despite recognition of the different presentations and variations, most studies examining the etiology of depression do not examine how etiological mechanisms might be differentially related to these unique presentations or how co-morbid symptoms might impact these relationships. One goal of the current study is to examine one etiological factor-early maladaptive schemas (EMS's)-to examine how they are related to both current and chronic depressive symptoms.

#### *The Etiology of Unipolar Depressive Disorders*

When working with a depressed client, how the diagnosis is understood and conceptualized affects how it is treated. There are four major theories regarding the causes of depression: biological theory, behavioral activation, interpersonal theory, and cognitive theory.

One theory on the etiology of depression is biological. The biological theory of depression can be broken into three possible theories; genetic, structural, and functional. A genetic model of depression suggests that the risk of experiencing a depressive disorder is genetically transmitted. To date, evidence suggests that having a first degree relative diagnosed with either a unipolar or bipolar mood disorder does place an individual at greater risk for experiencing a unipolar mood disorder (McGuffin, Rijdsdijk,

Andrew, Sham, Katz, & Cardno, 2003), thus supporting a possible genetic role in the etiology of depression. A structural model of depression suggests that depression is caused by some physical injury or medical disease. Research evidence does suggest a possible link between depression and medical health. For example, depression has been related to abnormal functioning of the thyroid gland. Finally, a functional model suggests that depression is caused by abnormal levels of neurotransmitters such as dopamine and serotonin, which are regulated by the central nervous system. These neurotransmitters are needed for normal brain function and are involved in the control of mood, eating, and sleeping. Thus, deregulation of these neurotransmitter systems might be causally related to the development of symptoms consistent with a depressive disorder diagnosis.

Another theory of the etiology of depression is behavioral. The theory of behavioral activation is centered on the idea that people who experience depressive symptoms often become withdrawn and fail to engage the environment. As a result, the individual fails to receive sufficient opportunity for positive reinforcement (Fuchs & Rehm, 1977), effectively making it more difficult to maintain or initiate new behaviors. As a result, the individual becomes increasingly passive and their mood becomes increasingly depressed (Lewinsohn, Sullivan, & Grosscup, 1980). This lack of reinforcement may occur in the environment because the person lacks the skills to obtain the reinforcement or because of a lack of availability of reinforcing scenarios.

The next theory of the etiology of depression is interpersonal. Interpersonal theory suggests that depressive symptoms arise because the individual is experiencing interpersonal difficulties within their environment. Interpersonal theory suggests that

there are four common types of interpersonal problems that might lead to depression: 1) loss of a significant other, 2) role disputes within a relationship, 3) role transitions such as the ending or beginning of a relationship, or 4) interpersonal skill deficits. Problems in any of these areas may result in an increase in depressive symptoms or make it difficult for a person to understand the social consequences of their behaviors and effectively navigate interpersonal relationships. This keeps the person disconnected from the environment, defeated in social situations, wary of interpersonal involvement, and devoid of a sense of agency to act upon the world. As a result, the individual's interpersonal needs go unmet and a depressed mood develops (Constantino, Manber, DeGeorge, McBride, Ravitz, Zuroff, et al., 2008).

The final theory of the etiology of depression is cognitive. The cognitive theory of depression is centered on the idea that depressed mood comes from distortions in thought. These distortions cause a person to view themselves, the world, and the future negatively (Beck, 1976). In the cognitive theory of depression, all symptoms of any depressive disorder, such as the mood, behaviors, and somatic symptoms, are all the effects of negative thoughts (Sacco & Beck, 1995). These negative thoughts are arranged in a hierarchy. At the top of the hierarchy are schemas. Schemas are cognitive structures that are used to screen stimuli that come to a person and evaluate the information that is screened. A depressed person has schemas that are rigid, global, and negative; causing the person to filter out any stimuli that does not fit the negative schema, and thus ignore any positive stimulus in the environment (Sacco & Beck, 1995). At the bottom of the hierarchy of thoughts are automatic thoughts. Automatic Thoughts are based on the schemas held by a person. When the person encounters a neutral situation, their schemas

give rise to negative thoughts. The person with depression believes these automatic thoughts to be true, and validate their negative beliefs about the world. Finally, between AT's and schemas are what are referred to as Intermediate Beliefs. These cognitions are the meaning making structures in that they allow the individual to make meaning of the information and experiences that they have within the environment. Years of research on the cognitive model support the relationship between cognitive factors and depressive illness (e.g., Beck, 1976).

### *The Treatment of Unipolar Depressive Disorders*

There are a number of treatments for depression. Each treatment is based on the conceptualization of the disorder. Each treatment has a corresponding etiology that has shaped the treatment and designates how the intervention progresses. The various treatments include biological or medical treatments, behavioral activation, interpersonal interventions, and cognitive interventions.

Biological or medical treatments involve the use of psychotropic medication to change the chemical makeup of the brain. In a depressed person, the brain removes neurotransmitters such as serotonin and dopamine too quickly. These neurotransmitters control mood, eating, sleeping, and pain. Some antidepressants, such as selective serotonin reuptake inhibitors (SSRIs) slow this removal in order to allow for accumulation of serotonin in the brain. The restoration of the neurotransmitters allows the brain to function normally again and relieves symptoms of depression.

Behavioral activation is a treatment strategy that increases the amount of positively reinforcing activities. Clients are first trained to monitor their daily activities and rate how pleasant or unpleasant the activities are (Fuchs & Rehm, 1977). Clients are

also trained to monitor their daily mood. This teaches the client to associate the reinforced activities with their mood. From this, clients are taught relaxation techniques to cope with unpleasant events that they will inevitably encounter. The therapist also works with clients to develop daily plans and time management skills that will help the client to cope with the unpleasant events. The plan is also used to schedule pleasurable activities that the client has reported enjoying. This leads the client to participate in activities that have a high chance of positive reinforcement for interaction with their environment (Lewinsohn et al., 1980).

Interpersonal interventions are used when the cause of depression is one of four interpersonal difficulties including; unresolved grief, role disputes within a relationship, role transitions such as the ending or beginning of a relationship, or interpersonal deficits (Mufson, Weissman, Moreau, & Garfinkel, 1999). Interventions in interpersonal therapy include identifying which of these four problem areas best describe the client's situation. If the client is experiencing unresolved grief the therapist works with the client to mourn the loss and develop new relationships. When there is a role dispute the therapist works with the client to identify the nature of the dispute, make a plan of action, and modify or reassess the pattern of the relationship. The therapist does not attempt to preserve unworkable relationships. Often when there are transitions with a depressed person, there is a loss rather than an opportunity. The therapist works with the client to give up the old role, mourn the loss, develop new skills, and new interpersonal relationships around the new role. When there are interpersonal deficits the therapist works to end the client's isolation. The focus here is on past relationships, the therapeutic relationship, and attempting to develop new relationships. Often this requires skill training on ways to

develop new relationships such as assertiveness training, or social interaction (Carr, 2008).

Cognitive therapy is based on identifying dysfunctional automatic thoughts and recognizing the connection that these thoughts have to emotions, behaviors, and physiological reactions. The intervention is based on the theory that negative thoughts lead to negative feelings, behaviors, and physiological reactions. The therapist works with the client to understand how thoughts produce an emotional reaction, and from that emotional reaction a behavioral choice is made (Beck, 1976). Then the therapist works with the client to decide how realistic their automatic thoughts are. When an unrealistic thought is identified, the therapist works with the client to show how the thought is unrealistic, and substitutes other possible interpretations and uses logic to make a more realistic evaluation for the thought (Sacco & Beck, 1995; Young, Weinberg, and Beck (2001).

A recently developed derivation of cognitive therapy introduced by Young (2003) specifically focuses on schemas. This Schema Therapy, as Young calls it, helps clients to stop using maladaptive coping styles and identify their core beliefs. There are two major goals of Schema Therapy, psychological awareness and the healing of schemas. First, to become psychologically aware, a person identifies schemas and the emotions, cognitions, physiological sensations, and coping styles that develop from that schema. The awareness also includes those things that the person does to perpetuate the schema. This may include self defeating patterns, coping styles, and cognitive distortions. The second part of Schema Therapy is the healing of a schema, and involves healing all of the psychological components of the schema that have been discovered. The goal is for more



adaptive behaviors, cognitions, and emotions. Therefore, multiple interventions are used to address all components of the schema. Many people often have multiple schemas, and schemas are often slow to change, therefore this type of therapy is often long term (Young, Klosko, & Weishaar, 2003).

### Help Seeking

The goal of this section is to understand why people seek help or fail to seek help for depression. A therapeutic intervention can only be effective if a client seeks help from the therapist for a problem that they are facing; thus it is important to understand what does or does not lead to help seeking behavior. Help seeking is defined as the action taken by those who have been assessed by the self or significant other as needing help, have the means to seek help, and have accepted the assessment (Millman, 2001). Unfortunately, while a wide range of therapeutic intervention exists; many people who experience mental health problems do not seek help from a trained professional (Calhoun, Peirce, Walters, & Dawes, 1974; Cramer, 1999; Tessler & Schwartz, 1972; Tinsley, St. Aubbin, & Brown, 1982). Henderson, Pollard, Jacobi, and Merkel (1992) studied people with symptoms of depression and found that only approximately one third of the participants sought help for their symptoms. This is problematic because the avoidance of professional help puts the client at risk for further impairment or physical harm, and the many benefits of therapy are lost (Butler & Neuman, 1995). In order to assess this problem, we must first understand how people make the decision to seek out help or to avoid help that may be needed.

Anderson (1995) developed a behavior model of seeking help that is divided into social and individual factors that either enhance or hinder a person from seeking needed medical or mental health services. The decision that people make to seek help is affected by both the social and individual factors. The social factors affect the individual factors and the decision regarding utilizing mental health services is made.

### *Social factors*

First, social factors for seeking help are defined by the availability of mental health resources in the community as well as the societal norms and perceptions of mental health services. One possible barrier a person may have in seeking help is if there are not adequate mental health services available in the community. People are not able to physically access the services when they are needed if there are no services in the community. While the availability of mental health services is a relatively straightforward matter, the societal norms and perceptions can be both complicated and detrimental to the help seeking decision. Many cultures have rules and social norms that conflict with the therapeutic process.

One way that the societal norms can influence the help seeking decision is through the culture of the client. Russian immigrants often will not seek help from mental health professionals because of the abuses that are associated with psychiatrists in the Soviet Union (Shor, 2007). In the Russian culture mental health problems have stigma associated with them and the families often have a sense of shame about the mental illness. Similar problems exist in Asian American cultures where mental illness is often associated with shame. This makes accessing psychological services difficult for people with symptoms within the culture. Reluctance to seek treatment can be overcome

by culturally competent initial communications, including services in a preferred language other than English and knowledge about the specific types of mental health problems that the Asian American population seeks professional help for; namely depression (Akutsu & Chu, 2006).

Another way social factors can influence help seeking is the societal perceptions of mental illness. The action of seeking help causes a threat to many people. The threat is that people will find out that they are not capable of solving their own problems. The anxiety that is felt in this situation may lead to the concealment of inabilities rather than the attempt to seek help. This type of behavior may be exhibited in an effort to avoid feelings of shame due to their inability to solve their problems on their own (Marchand & Skinner, 2007). Those who feel more threatened by this consequence are less likely to admit that they are in need of help. For example, Karabenick (2004) found if people do ask for help, it is often only for the purpose of ending the shame of others knowing about the problem rather than to fix the problem for any personal gain. The shame about one's abilities is formed from the social perceptions about mental illness and leads to the denial that there is a problem that cannot be resolved without the aid of others.

*Individual factors: Predisposing*

The other type of factor in the decision to seek mental health services are the individual factors. Anderson (1995) developed a framework that defines individual factors into three categories: predisposing factors, enabling factors, and illness level. Together these factors work to shape the decision that an individual makes about whether to seek help for the mental illness that they are experiencing.

One category of individual factors is the predisposing factors. Predisposing factors can predict whether a person is likely to seek help before the start of a specific illness. The relationship of these factors to help seeking has been studied in regard to the demographic information about clients, the social and family structure that the person was raised in, and the beliefs of the person. The demographics of those who seek help have been studied with regard to gender, those in a college setting, and those in mental health field (Anderson & Newman, 1973).

One demographic variable that has been thoroughly studied is gender. Often the elements of therapy do not fit well with the ideas of masculinity. In many cultures gender roles designate men to be strong, tough, independent, emotionless achievers. In therapy a client admits to needing help, discusses emotion reactions, and essentially goes against the masculine role that many men fight to uphold. For this reason the male gender role creates a barrier for many men to seek help for psychological problems that they may be experiencing (Mahalik, Good, & Englar-Carlson, 2003).

Another demographic category that is often studied is college students. People in college have similarities that those who are not in college often do not share. When in a college setting, where many studies are conducted, there are special circumstances surrounding confidentiality and the perceived roles of those involved in the therapeutic process. When students of psychology or professional counselors attempt to seek help they can enter into situations which make the therapeutic process more difficult, thus discouraging help seeking behaviors (Dearing et al., 2005). One of the concerns of psychology graduate students was confidentiality. However, these concerns did not

affect their help seeking behavior, in fact, those who had concerns about confidentiality were more likely to seek help (Dearing et al., 2005).

The last demographic category looked at were mental health professionals. This is another unique population that has different characteristics than the general population. Mental health professionals often have unique problems in their ability to seek help for their own mental health illnesses. In a study of helping professionals' help seeking behavior it was found that professionals sought help more often if they were licensed. They also sought help for depressive symptoms more than symptoms of other disorders (Siebert & Siebert, 2007). Mental health professionals were found to avoid seeking help when they identified their role as a prominent caregiver; meaning that they formed idealized identities for themselves that center on their formal education, their ethical codes, and their abilities as a helper and problem solver (Siebert & Siebert, 2007). Those who identified themselves as prominent caregivers often feel a conflict between the idealized identity that they have formed and their actual identity. While seeking help would work to solve this conflict, the nature of their caregiver identity works against changing their role from "caregiver" to "client" (Siebert & Siebert, 2007).

Another predisposing factor of the help seeking decision is the social structure of the family. One way that this has been studied is through attachment in adults. As children, the bond between child and caregiver helps to shape our personality and social development as we mature (Craig & Dunn, 2007). The secure and insecure attachment that a person develops affects their interpersonal relationships as an adult, including the therapeutic relationship (Lopez, Melendez, Sauer, Berger, & Wyssmann, 1998). In adults, attachment styles are classified as secure, dismissive, preoccupied, and fearful.

Secure and dismissive attachment styles are defined by a positive self image; however dismissive attachment style has a negative view of others leading one to believe that interpersonal relationships are unneeded (Simpson, Rholes, & Nelligan, 1992). Those with preoccupied and fearful attachment styles are defined by a negative self image. Those with a preoccupied attachment style view others positively and are dependant on others, whereas those with a fearful attachment style believe that they cannot trust others.

The style of attachment that a person demonstrates affects their interpersonal relationships with significant others, the therapeutic relationship, and the likelihood that they would seek out professional help. For example, those people who are securely attached have been found to seek help from their significant personal relationships in high anxiety situations (Simpson et al., 1992). Those who are insecurely attached with dismissive and fearful attachment styles are less willing to seek help from mental health professionals and view mental health counseling negatively (Lopez et al., 1998).

While the demographic information and social structure of the family can tell us a lot about the likelihood of a person seeking help, perhaps the most important aspect of the predisposing factors are the beliefs and attitudes that a person has towards counseling and other forms of health services. One of the reasons why many people fail to seek help from professional counselors is because they believe that the problem that they are experiencing is not large enough of a problem to seek out help. However, if a person does believe that they have a problem, or unsuccessfully attempts to solve the problem on their own, the symptoms can worsen and the recovery of the disorder could be slower. The concept of denial about a problem that one is experiencing stems from the lessons of autonomy in their development. People generally want to solve problems on their own

(Marchand & Skinner, 2007). The value of autonomy is taught in schools and we learn to be self-reliant as much as we are able (Butler, 1998). As we mature, we value the traits of autonomy, self-reliance, as well as independent mastery of our problems. This affects help seeking behavior because people work hard to solve their problems on their own, even when it has proven to be more than they can accomplish alone (Karabenick, 2004). People sometimes feel shame that they were not able to solve the problem on their own, and continue to attempt the solution privately as to not make others aware of their shame. These feelings of shame that are accompanied by failure of the independent mastery of a problem can be exacerbated by the cultural factors and expectations that are placed on them from an outside source. For example, Ryan and Pintrich (2007) found that if peers knew of a person seeking help it would increase the avoidance of help seeking behavior.

Another type of belief that affects the help seeking decision is knowledge that a person has about health services. Often people do not seek the help of professional counselors because they do not have a clear understanding of what therapeutic services entail, and what the therapeutic relationship is like. For example, Cash, Kehr, and Sazbach (1978) found that those who have received counseling before are more likely than those who have not, to: recognize a need for therapy, tolerate the stigma and stereotype of professional help, be open about their personal problems in therapy, and have confidence in the therapeutic services that they are participating in. One possible explanation for this is that those who have knowledge of the therapeutic process are more likely to participate in therapy. Ames and Lau found that those who are given information about the benefits of receiving help, and information about how receiving help improved the situation for others, are more likely to seek. Confidence in services

leads to an increase in participation in the services, thus informing potential clients of the benefits of therapy may increase help seeking behavior.

These predisposing factors affect help seeking behaviors before the time of the decision to seek help. In contrast, enabling factors occur during the time that the decision is made and form the environment in which the decision is made. They can either enable the decision to seek help or impede it.

*Individual factors: Enabling*

There are many factors that can enable or impede help seeking behavior. Different than predisposing factors, enabling factors often occur at the time that the decision is made to seek help or not. These factors come from the family and community that the person belongs to and consist of concrete factors such as socioeconomic status and other situational variables, as well as social factors such as social support and acceptability of mental health services.

When thinking of factors that may impede or enable help seeking, the concrete factors often spring to mind first. One of the most concrete factors of help seeking behaviors is accessibility to the services. The accessibility of services is often related to the socioeconomic status of those seeking services. One logical reason why people would fail to seek help for their mental health problems is because they do not have the financial means to pay for help. While many people can seek help from a mental health professional through their insurance policies, many people in the lower socioeconomic level do not have insurance and therefore do not have the money to pay for services. For this reason, the price of the mental health services is also a factor in the enabling of people to seek health services.



Another way that socioeconomic status affects access to services is the ability to travel to services. While there are programs that provide in home services, the majority of mental health services require the client to travel to the provider. This can be problematic for people without financial means to travel. Furthermore, those in the lower socioeconomic level are the most likely group, when compared to other socioeconomic levels, to have impaired mental health. When compared to the middle socioeconomic level and the upper socioeconomic level, the lower socioeconomic group is least likely to seek help for their mental health problems (Millman, 2001).

The other types of enabling factors are the social factors. These factors can be grouped into the social support that a person has and how acceptable the person thinks therapy is in their community.

One type of social factor is how a person's social support influences whether they believe professional help is needed. This influence is determined by the reliability of their supporters. When a person is in need of help there is a belief that they have failed some task. How one perceives others to view their failure is a factor in their decision to seek out help. When seeking help the threat to self-esteem is proportional to the failure acknowledged when seeking help (Tessler & Schwartz, 1972). The acknowledged failure is reduced when the source of help is less threatening, such as help from a medical doctor. If a person perceives their close friends and relatives as being reliable and able to help with their problems, then many people will seek help from those sources first and not seek help from a professional counselor if the problem is resolved, thus decreasing help seeking behaviors (Tinsley et al., 1982). For example, Cramer found that while mental health counseling may be a better alternative, individuals sought help from their

interpersonal relationships and sought help from professional counselors when their social support system was perceived to be ineffective. Similarly, a perceived lack of social support can increase help seeking behavior because distress increases and the person may seek help to relieve the extra distress that is added by the lack of social support in their mental health or behavioral problem (Vogel & Wei, 2005). However, Cramer (1999) also found that social support can act as a buffer, stopping the distress from being troublesome enough to cause the individual to seek help from a professional counselor. This leads the person to endure a moderate amount of distress that could otherwise be elevated with the help of a professional counselor.

The other social enabling factor is the acceptability of therapy within a person's community. The most common source of help that people initially look to is helpful activities that can be done in private, such as attempting to fix problems through changing personal behavior or self help techniques. The next place people look for aide is through informal sources, such as friends, then through formal sources, such as therapy, and if these did not work, then people attempt to lower their aspirations and alter their goals of change (Karabenick & Knapp, 1991). The reason for these decisions is a fear of negative judgment about the need for therapy. In general, people are more comfortable with the idea of therapy when they believe that it is a normal process and accepted by the general population. One study found that the core component to help seeking behaviors was the need that participants had to fit in (Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003). The need to be accepted by those in their environment fueled many of their decisions, in much of the same way that people are more likely to seek treatment if they know that their problem is common among the populous. This can

be seen in a study of graduate students; students were more likely to have a positive attitude toward therapy if they believed that their professors viewed therapy as an integral part of their learning experience, and lacked any negative stigma about weakness as a therapist (Dearing, Maddux, & Tangney, 2005).

These enabling factors affect the decision to seek help but ultimately there must be some illness or distressing situation for a person to seek help. Therefore, the last factor in the help seeking model is the illness level or amount of distress that a person feels.

*Individual factors: Illness level*

Where a person seeks help from also depends on the type of problem that they are facing. People are more likely to seek help from a close friend or relative when there is a personal problem and more likely to seek help from an academic advisor, instructor, or close friend when the problem is related to their career (Tinsley et al., 1982). The perceived severity of the problem that a person is experiencing has a direct effect on the help seeking behavior of the individual. For example, Mansfield, Addis and Courtenay (2005) found that many people minimize the problems that they are experiencing because they do not believe that the problem is serious enough to seek help for. If a psychological problem is not serious enough to cause significant impairment to the person's life they are more likely to live with the disturbance than seek help to change a perceived minor problem. This occurs even when the problems are symptoms of psychological disorders, which a person may not realize they have if they are minimizing the symptoms and living with the problems that it is causing. Similarly, if a person believes that the dysfunction that they are experiencing is something that they can cope with effectively, then they will

not think that they are experiencing enough psychological stress to seek help for their problem. Those who believe that they are coping poorly with the problems they are facing are more likely to seek help for these problems (Tracey, Sherry, Bauer, Robins, Todaro, & Briggs, 1984).

### *Depression and help seeking*

One goal of the current research is to examine factors that may impact help seeking for individuals who experience depressive symptoms. While a number of studies have examined help seeking broadly, only a few have examined the relationship between help seeking and depressive symptoms. There are often risks for people with depressive symptoms when they seek treatment. These risks include increasing painful thoughts through confronting depressive symptoms in therapy, as well as the social burden of the stigma that is related to experiencing depression and seeking help from a mental health professional.

One risk is that, while people who are suffering from depression and those who are not all agree that confronting painful depressive symptoms is likely in therapy, only those who are not suffering from depression view this experience positively (Halgin, Weaver, Edell, & Spencer, 1987). If an individual does not believe that therapy will be a positive experience they are less likely to participate in it.

Another risk is that many people believe that if they are to seek help for their depressive symptoms, they are risking having others think less of them for seeking a psychiatrist, psychologist, or other professional counselors (Barney, Griffiths, Jorm, & Christensen, 2006). This risk often depends on the social support that a person has. If a person believes that they have an adequate amount of social support available to them,

they are less likely to suffer from depressive symptoms and are more likely to seek treatment for any symptoms that ail them (Wing & Bebbington, 1985). A lack of social support can not only increase symptoms of depression but also increase the likelihood of relapse after treatment has been successful (Cronkite & Moos, 1995).

### Schemas and Depression

One way to understand depression is to understand the etiology of the disorders. One way that this study attempts to understand the etiology of depression is by understanding the schemas that accompany depression. Beck (1976) theorized that schemas are cognitive structures that are used to screen stimuli that come to a person and evaluate the information that is screened. Schemas are defined as stored information that has been learned from past experiences that are used when the person attempts to filter information available from a similar situation where the knowledge will be applicable (Ashcraft, 2006). Schemas can be functional in the environment, but they also may be dysfunctional. While schemas can be useful tools for filtering information about the environment to make quick decisions, they are only as accurate as the perception and lesson learned from the original situation. For example, a dysfunctional schema that may lead to symptoms of depression could be “I am a bad person,” where a functional schema that would not be associated with depression would be “I sometimes do good things, and sometimes do bad things.” The dysfunctional schema would influence the person’s perceptions towards a depressed mood, where the functional schema is flexible and more closely resembles reality.

The strength of a schema is based on the accessibility and availability of the interpretation that the schema leads to. The accessibility of the interpretation is based on the frequency with which the interpretation is made. For example, the more a person makes an interpretation, the more likely that interpretation comes to mind, and will thus be used to filter future stimuli (Segal, 1988). The availability of an interpretation is the ease in which a specific interpretation comes to mind. While everyone makes interpretations with the use of schemas, those with mental illnesses are more likely to make interpretations that are negative and maladaptive (Segal, 1988).

#### *Early maladaptive schemas*

In this study, the question of whether individuals who do or do not seek help for depression differ with regard to their schemas will be explored. In addition, the ability of these schemas to differentiate between chronic and acute depression will also be explored. Young defines early maladaptive schemas as a broad pattern regarding the self and the relationship with others that is built from memories, emotions, thoughts, and bodily sensations (Young et al., 2003). Early maladaptive schemas are dysfunctional, formed during childhood and last through a person's life. Schemas develop when a child's core needs are not met. These needs include attachment to others, autonomy, freedom to express needs, spontaneity, and realistic limits. When these needs are not met early in life they form early maladaptive schemas that affect a person's interpersonal relationships throughout life.

Young defines eighteen early maladaptive schemas and classifies them into five domains (Young et al., 2003). Each of the early maladaptive schemas is defined in Table 1. Each domain is categorized by the emotional needs that are common among that

domain's schemas. The first domain, disconnection and rejection, is defined by the expectation that a person's needs for security, safety, stability, empathy, and acceptance will not be met predictably. This domain holds what Young (2003) considers the most powerful and damaging schemas, the abandonment/instability, mistrust/abuse, emotional deprivation, and defensiveness/shame schemas. These schemas are formed by the most traumatic early life experiences, and therefore are the most dysfunctional. These schemas occur when a person is brought up in an abusive, unstable, cold, rejecting, or isolated environment (Young et al., 2003).

The second domain is impaired autonomy and performance and is defined by expectations that interfere with a person's perceived ability to function independently, or perform successfully. Schemas in this domain are formed when a person is raised in an environment where their parents were overprotective and promoted dependence on the parents rather than autonomy. While it is rare, the opposite can produce the same effect, where the parents do not care for the child at all. People with schemas in the impaired autonomy and performance domain are not able to form their own identities and live their own lives. This domain includes the dependence/incompetence, vulnerability to harm or illness, enmeshment/undeveloped self, and failure schemas. These people believe that they are unintelligent, untalented, and unsuccessful (Young et al., 2003).

The third domain is of impaired limits and is defined by a lack of internal limits and lack of respect for others. Schemas in this domain are formed when a person is raised in a family that is permissive and did not teach them to follow the rules that others are made to follow. As adults, people with schemas in this domain may appear selfish, spoiled, or irresponsible. This domain includes the entitlement/grandiosity and the

insufficient self-control/self-discipline schemas. People with these schemas do not control themselves or control their own frustration in order to reach their goals.

The fourth domain is other-directedness and is defined by an excessive focus on the desires of others. This is done at the expense of one's own needs in order to gain love, approval, maintain one's sense of connection, or avoid retaliation. These schemas are formed when a person is raised in situations where they were not allowed to pursue their personal preferences. Furthermore, in these families, acceptance and love is often conditional on the child's behavior. As adults, people with schemas in this domain are directed by the desires of others rather than by their personal will. This domain includes the subjugation, self-sacrifice, and the approval seeking/recognition seeking schemas. This domain is focused on a person giving up control to some aspect of their life.

The last domain is overvigilance and inhibition and is defined by suppressing spontaneous feelings and impulses while maintaining rigid, personal rules. People with schemas in this domain are often raised in a family that is strict, and values self control and self denial over ideas of pleasure and spontaneity (Young et al., 2003). This leads to an adult who has learned to focus on negative life events and fear that things could fall apart at any minute if they are not alert and careful at all times. The schemas included in this domain are the negative/pessimism, emotional inhibition, unrelenting standards/hypercriticalness, and punitiveness schemas.

There has been a good deal of research on Young's early maladaptive schemas. Early maladaptive schemas have been used to predict and compare to depressive symptoms. However there are some inconsistencies within this research. There are nine schemas that have been shown within the research to predict depressive symptoms.



These studies have been completed within a number of populations, including clinical and non-clinical populations.

Stopa et al., (2001) compared the YSQ long version to the YSQ short version in their ability to predict levels of depression in a clinical population. The study compared the predictions of the subscales of the short and long version of the YSQ of scores on the BDI. With the YSQ long scale, four schemas were found to significantly account for 43% of the variance on depression scores. These schemas were abandonment, defectiveness, subjugation, and self-sacrifice. The YSQ short scale showed two schemas accounting for 39% of the variance in BDI scores. These were the abandonment and self-sacrifice subscales

Glaser, Campbell, Calhoun, Bates, and Petrocelli (1995) used a clinical population to study whether the YSQ short form can predict scores on the BDI, the Depression subscale of the Symptoms Checklist-90-revised, and the Major Depression subscale of the Millon Clinical Multiaxial Inventory-II. First, the study found that together, all 15 early maladaptive schemas accounted for 54% of the variance in BDI scores. Also, there were three schema subscales that were predictive of scores on measures of depression. First, regression analysis of the individual subscales of the YSQ found abandonment/instability to be significantly predictive of scores on the depression subscale of the Symptoms Checklist-90-revised, the BDI, and the major depression subscale of the Millon Clinical Multiaxial Inventory-II. Second the social isolation/alienation subscale significantly predicted scores on the Depression subscale of the SCL-90-R.

In a clinical population, Welburn, Corisine, Dagg, Pontefract, and Jordan, (2002) studied the ability of the YSQ to predict scores on the depression subscale of the BSI. A regression analyses showed the YSQ accounted for 47% of the variance in the depression scores. Two schema subscales significantly predicted scores on the depression subscale: abandonment and insufficient self control.

Within a clinical population, some patterns emerge. Six early maladaptive schemas were found to predict depressive symptoms in the clinical population: abandonment, defectiveness, subjugation, self-sacrifice, social isolation/alienation, and insufficient self control all predicted depressive symptoms. These schemas contributed to approximately half of the variance in depression among the clinical samples. There were some differences when comparing the clinical samples to the non-clinical samples.

In a study of a non-clinical sample, Barnoff, Oei, Ho Cho, and Kwon (2006) examined the use of the YSQ short form to predict scores on the BDI. The YSQ short form showed two schemas accounting for 44% of the variance in the BDI. The insufficient self-control and failure schemas specifically accounted for this variance.

Calvete, Estevez, Lopez de Arroyabe, and Ruiz (2005) studied early maladaptive schemas in a non-clinical sample. Specifically the study examined the relationship between schemas and affective disorders, including depression. The results of the study found that defectiveness/shame, self-sacrifice, and failure were positively associated with symptoms of depression.

Harris and Curtin (2002) tested the relationship between early maladaptive schemas and reported depressive symptomology in a non-clinical sample. The regression analysis showed that four of the YSQ subscales, defectiveness/shame, insufficient self

control, incompetence/ inferiority, and vulnerability, accounted for 63% of the variance in BDI-II scores.

From this research some patterns emerge among the non-clinical samples. Early maladaptive schemas accounted for approximately half of the variance in depressive symptoms. There were some differences when comparing the specific schemas that contributed to the variance of the non-clinical sample and the clinical sample. The non-clinical sample schemas included insufficient self control, failure, defectiveness/ shame, incompetence/ inferiority, and the vulnerability to harm or illness schema. These changes within the sample may account for some of the inconsistencies, however there are other inconsistencies within the past research as well.

Generally, all the studies agree that schemas can predict variance in scores on depression inventories. The major conflict in the research is which schemas are responsible for predicting the change. Some of the variance can be accounted by the different measures being used. While the BDI is the most widely used measure for depression, the studies also used the depression subscale of the Symptoms Checklist-90-revised, depression subscale of the Millon Clinical Multiaxial Inventory-II, and the depression subscale of the BSI. A total of nine early maladaptive schemas have been found to significantly predict depression. Three schemas have been relatively consistent with clinical and non-clinical samples: defectiveness/shame, insufficient self-control/self-discipline, and abandonment. This difference may be due to the severity of the symptoms that participants have. Scores on the depression inventories are likely higher in clinical samples. Another way that the clinical and non-clinical samples differ is in the length of their problem. Those in a clinical setting tend to have more chronic problems than those

in a non-clinical setting. Therefore, this research attempts to add to the current research by studying the differences between chronic depressive symptoms and acute depressive symptoms.

### Rationale for Study

Depression affects many people each year, and while much research has been done to understand depression, studies have only begun to understand the etiology of depression. Early maladaptive schemas play a role in the development of mental health disorders, especially depression. While all of the research shows that early maladaptive schemas can predict depression, there are inconsistencies within the past research.

This study will extend past research in order to assess if early maladaptive schemas significantly predict changes in acute and chronic depression. Furthermore, anxiety will be controlled for in the current study in order to be more confident that what is being predicted are pure depressed states versus a mixture of depression and anxiety. Based on past research and the schema theory, there should be a link between early maladaptive schemas, chronic and acute depression, and help seeking behaviors for depression. It is hypothesized that a) scores on the YSQ-3 will significantly predict chronic depression as measured by the DPDI, b) scores on the YSQ-3 will significantly predict acute depression as measured by the BDI-II, and c) anxiety, as measured by the BAI, will account for a significant amount of the variance in acute depression (BDI-II) and chronic depression (DPDI). However, it is expected that the amount of variance accounted for in acute versus chronic symptoms will vary, with schemas accounting for greater variance in chronic symptoms versus acute symptoms.

The other aspect of this research is an attempt to understand help seeking behaviors for symptoms of depression. Research has shown that there are many factors that influence a person's decision to seek help. A person's attitude about treatment, how they view their problems, their attachment style, and social supports have all been found to affect their decision to seek help. While it has not been studied, Young (2003) theorized that early maladaptive schemas would affect a person's decision to seek help. Therefore, it is hypothesized that there will be differences between scores on the YSQ-3 between groups of individuals who vary on their current and past help seeking behavior.

## CHAPTER II

### Method

#### *Participants*

Participants for this study were obtained from introduction to psychology classes at a public university in the northeast. The sample consisted of 88 participants. The sample included 61 women (69.3 %) and 27 men (30.7 %), with a mean age of 19.55 years ( $SD = 1.45$ ). Sixty-two (70.5 %) of the participants were Caucasian, 11 (12.5 %) were African American, 6 (6.8 %) were Hispanic, and 8 (9.1 %) identified as another ethnicity. Forty-two (47.7 %) identified themselves as freshmen, 24 (27.3 %) as sophomores, 15 (17.0 %) as juniors, 5 (5.7 %) as seniors, and 2 (2.3 %) were classified as “other.” Participants were given course credit for completion of the study.

#### *Measures*

##### *Demographic questionnaire*

The demographic questionnaire consisted of four questions which asked the participant to indicate their age, sex, ethnic and racial background, and the year of college that they were in.

##### *Help seeking questionnaire*

The help seeking questionnaire consisted of eight questions about current and past use of therapy to assist the individual in coping with depressive symptoms. Participants were asked if they were currently attending therapy sessions for depression, if they have attended therapy sessions for depression in the past, if they believe they needed therapy for depression but had not sought it (e.g. Have you ever believed that you could benefit

from therapy but decided against seeking help?), or whether they neither thought they needed therapy for depression nor ever sought therapy for depression. Each question has yes and no as possible answers. If participants had participated in therapy, they are asked from what professional source the therapy came from and if they believed the therapy was helpful. Options for the source of therapy include psychiatrist, therapist, family doctor, psychologist, counselor, and social worker.

#### *Acute Depressive Symptoms*

The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) was used as a measure of acute depressive symptoms. It is a modified version of the original Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The BDI-II consists of 21 items that are designed to assess the amount of depressive symptoms that a person has experienced over the past two weeks. Each item is rated on a four point Likert scale. Each point of the Likert scale is individually defined and ranges from zero (a lack of the symptoms) to three (overwhelming symptoms). The items were created to parallel the symptoms of a Major Depressive Disorder as defined by the DSM-IV.

A total score is calculated for the BDI-II by adding the Likert scale points from each question. Scores can range from zero to sixty-three, with higher scores indicating higher levels of reported depressive symptoms. A score of 16 has proved to be an effective cut score for determining depressed mood (Sprinkle, Lurie, Insko, Atkinson, Jones, Logan, et al., 2002).

The BDI-II has been shown to be a reliable measure. In samples of undergraduate participants, internal consistency has been reported at an alpha of .92 (Beck et al., 1996).

In a study of test-retest reliability the correlation between the total scores reported on an average of 3.2 days apart were .96 (Sprinkle, et al., 2002).

The BDI-II does have some problems with construct validity. Convergent validity between the BDI-II and the SCID-I is shown with a high correlation, ( $r = .83$ ) showing that the BDI-II correlates with another measure of depression (Sprinkle, et al., 2002). However, with respect to divergent validity, the BDI-II correlates to the BAI moderately, .60 (Beck et al., 1996). This may be due to the high rates of co-morbidity between these two constructs.

#### *Chronic Depressive Symptoms*

*The Depressive Personality Disorder Inventory (DPDI;* Huprich, Sanford, & Smith, 2005) was used to assess for chronic symptoms of depression. The DPDI is a 41 item, 7 point Likert questionnaire that contains the possible responses from 1 (totally agree) to 7 (totally disagree), with 4 being a neutral attitude towards the item. Items include statements such as “I am inadequate” and “I blame myself when I do not succeed.” Scores are computed by adding the total scores of all items after reversing scores on 14 items. Scores range from 125 to 203, with lower scores indicating greater endorsement of chronic depressive symptoms. Huprich et al., (2005) suggested a cutoff score of 170 for the DPDI, scores below 170 would indicate Depressive Personality Disorder, after comparing it to the Diagnostic Interview for Depressive Personality Disorder.

The psychometric properties of the DPDI have been found to be adequate. In samples of undergraduate participants, internal consistency has been reported at an alpha of .91 (Huprich et al., 2002). Regarding convergent validity, Huprich found that there



were correlations between the DPDI and two other measures of Depressive Personality Disorder, SCID-SR and BSI. The correlations between these measures were  $r = .48$  and  $.51$ , respectively. However, the DPDI also showed high rates of overlap with other types of personality disorders including paranoid, dependent, borderline and avoidant. In this case, 50% or more of the criteria for Depressive Personality Disorder correlated with the criteria for another Axis II disorder (Huprich, 2004).

### *Depression Diagnosis*

The Checklists for Depressive Personality Disorder, Dysthymia, and Major Depressive Disorder (Huprich, Porcerelli, Binienda, & Karana, 2005) was used to identify the symptoms consistent with the respective diagnostic labels and to provide participants with a depression diagnosis. The checklist is based on the DSM-IV-TR criteria and is designed to identify symptoms of the three disorders that correspond with their related diagnosis (Huprich et al., 2005). The checklist is split into three sections: Depressive Personality Disorder, Dysthymia, and Major Depressive Disorder. Participants are diagnosed with the disorder if they endorse criteria for the respective disorder. Part one contains fifteen questions regarding DPD. Part two contains nine questions regarding Dysthymic Disorder. Part three contains twenty-two questions regarding Major Depressive Disorder.

The checklist is scored differently according to the three parts of the checklist that compose the scale. For part one, the first twelve questions are arranged in pairs and both of the paired questions must be answered “yes” for the question to meet criteria for the disorder, there are a total of 13 questions and the last question is unpaired. To meet criteria for Depressive Personality Disorder five of the seven groups of DSM criteria

must be met. For part two, two criteria must be met. First, question one must be answered “yes”. Then in questions two through eight, two of the seven must be answered “yes”. This checklist also has one paired answer; in this case only one question had to be answered “yes” for the criteria to be met. Finally, in part three each of the nine criteria were represented by one to four questions. A “yes” response to any of the 1 to 4 questions would qualify the subject as meeting criteria for that symptom on most of the criteria. However, in one series of questions on psychomotor agitation, two of the four questions have to be answered “yes” in order for that criterion to be considered met. The other exception to this scoring process is on the question about appetite. If the participant admits to dieting, then a criterion for this symptom is not met.

The psychometric properties for the checklist are adequate. Huprich, Sanford, & Smith, (2002), for example, found the internal consistency to be adequate. The internal consistency of the Depressive Personality Disorder section of the checklist was .86. The internal consistency of the Dysthymic Disorder section of this checklist was .91. The internal consistency of the Major Depressive Disorder section of the checklist was .88. The evidence regarding the validity of the checklist is less conclusive. For example, Huprich, et al.(2005) found that the measures of Depressive Personality Disorder, Dysthymia, and Major Depressive Disorder were highly intercorrelated. Specifically, the DPDI was positively and significantly correlated with the DSM-IV checklist of Dysthymic symptoms ( $r = .53$ ) and the DSM-IV checklist of Major Depressive Disorder symptoms ( $r = .62$ ). The DSM-IV checklist for Dysthymic symptoms were positively and significantly correlated with the DSM-IV checklist of Major Depressive Disorder symptoms ( $r=.62$ ).

### *Anxiety*

The Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) is a 21 item scale that assesses symptoms of anxiety experienced over the last two weeks. The items on the BAI are based on common DSM-IV criteria for anxiety disorders. Each item is rated on a four point Likert scale ranging from zero (not at all) to three (severely). Scores can range from zero to sixty-three, with higher scores higher levels of anxiety. A total score for the BAI is calculated by adding the responses to each item. Scores can range from zero to sixty-three, with higher scores indicating higher anxiety.

The psychometric properties of the BAI are good. The BAI has been shown to be a reliable measure. Internal consistency has been reported at .92 and test-retest reliability was .75 (Beck et al., 1988). With regard to validity, the BAI is correlated .56 with the MMPI-Anxiety scale, indicating good convergent validity (Osman, Hoffman, Barrios, Kopper, Breitenstein, & Hahn, 2002). With respect to divergent validity, the BAI correlates to the BDI-II moderately, .60 (Beck et al., 1996), indicating that it might not be a good divergent measure when compared to the BDI-II.

### *Schemas*

The Young Schema Questionnaire: Short Form (YSQ-S3; Young & Brown, 2003) is a self-report measure that was used to assess for early maladaptive schemas. While a long form of the questionnaire exists (205 items), the short form (90 items) is less susceptible to participant fatigue, and it has been shown to have similar psychometric properties. The YSQ-S3 measures for the presence of 18 early maladaptive schemas and contains 18 subscales for each schema.

Each item of the YSQ-S3 is rated on a six-point Likert scale from 1 (completely untrue of me) to 6 (describes me perfectly). The YSQ-S3 is scored by summing all of the items, a score which indicates the overall presence and severity of early maladaptive schemas. In addition, mean scores are calculated for each of the 18 early maladaptive schemas. Total scores on the YSQ-S3 can range from 0 to 540. Item mean scores are calculated for each of the 18 domains with higher scores indicating a more dysfunctional level of that schema domain (Oei & Baranoff, 2007). Total scores on each of the 18 subscales can range from 0 to 30.

Limited research exists on the psychometric properties of the YSQ-S3. However, in a study examining the psychometric properties of the long and short version of the young schema questionnaire, the YSQ-S3 has internal consistency reported at .92 (Oei & Baranoff, 2007).

With regard to the validity of the YSQ-S3, Oei and Baranoff (2007) found that there was a positive correlation between the YSQ-LF and the BDI ( $r = .59$ ), indicating good predictive ability. In addition, when comparing the YSQ short form to the YSQ long form, there are similar results, however the short form has been reported to produce slightly more conservative results than the long form. For example, Stopa, Thorne, Waters, and Preston (2001) compared the YSQ long version to the YSQ short version in their ability to predict levels of depression in a clinical population. Different scores were found on the dependency, self-sacrifice, and unrelenting standards subscales. There was also a significant gender difference between the short and long version.

#### *Design and Procedure*

Two separate yet related questions were being asked in this study, both of which used a different design to answer those questions; however, both studies were cross sectional in design and data was through the use of self report surveys. For the first question which addressed the ability of schemas to predict acute and chronic depressive symptoms, a correlational design was used. For the question addressing the differences between help seeking groups on schemas, a between groups design was used. The groups in this case were the help seeking status of the participants, and there were four levels. Thus, help seeking served as the independent variable. The dependent variable was the participant's scores on the YSQ-3.

#### *Procedure*

Upon arrival to the research room, informed consent is obtained from each participant before data collection. Questionnaires are administered in groups of 1-20 and the study took approximately 60 minutes to complete. The order of the packets remained consistent such that the demographic questionnaire was completed first, the help seeking questionnaire second, the YSQ-3 third, the BAI fourth, the BDI-II fifth, the DPDI sixth, and the checklist for DPD, Dysthymia, and MDD last. Upon completion of the packet of questionnaires, participants were debriefed. The questionnaires were given to participants in this order to avoid participants thinking about their current mood state before they respond to questions concerning beliefs about their need for therapy.

## CHAPTER III

### Results

#### *Preliminary Analysis*

A series of initial analyses were conducted to explore if sex, age, or ethnicity were related to early maladaptive schemas, chronic depression, or acute depression. First, twenty-two, independent sample t-tests were conducted to assess for differences in sex. Results indicated that there were significant differences between males and females on the subjugation subscale of the YSQ-3 [ $t(86) = -2.207, p = .030$ ] with females scoring significantly higher. However, there were no other statistically significant differences between the two sexes. Second, a correlational analysis was conducted to assess for a relationship between age, early maladaptive schemas, chronic depression, and acute depression. Results of this correlation indicated that there were no significant relationship between age and these constructs. Finally, a MANOVA was conducted to identify differences between ethnicity, early maladaptive schemas, chronic depression, and acute depression. Results of this correlation indicated that there were no significant differences between ethnic groups on these constructs. Because the sex, age, and ethnicity had minimal impact on the constructs of interest, these variables were excluded from all future analyses.

#### *Correlational Analyses*

The correlations between the affect scales and the YSQ-S3 are displayed in Table 2. As examination of this table indicates, the BDI-II and BAI were positively correlated ( $r = .68, p < .01$ ), the BDI-II and DPDI were negatively correlated ( $r = -.69, p < .01$ ), and

the DPDI and BAI were negatively correlated ( $r = -.52, p < .01$ ). While the correlations with the DPDI were negative, this shows a positive correlation between chronic depression and acute depression, as well as between chronic depression and acute anxiety because the DPDI is reverse scored (lower scores indicate greater amounts of chronic depression). The total YSQ-3 score was significantly related to the DPDI ( $r = -.76, p < .01$ ), the BDI-II ( $r = .64, p < .01$ ), and BAI ( $r = .57, p < .01$ ), indicating a significant relationship between early maladaptive schemas and these constructs.

The correlations between the specific early maladaptive schemas and the affect scales are displayed in Table 3. Of the eighteen schemas, only two schemas were not significantly correlated to these measures of affect; the entitlement/ grandiosity and unrelenting standards/ hypercriticalness schemas.

#### *Hierarchical Multiple Regression Analyses*

Two hierarchical regression analyses were conducted to test whether anxiety and early maladaptive schemas would significantly predict acute and chronic depression. The results are displayed in Table 4. The first hierarchical regression was performed with the BDI-II as the criterion variable and the BAI and eighteen early maladaptive schema subscales as the predictor variables. The BAI was entered on the first step in order to account for the variance in depression accounted for by anxiety. Early maladaptive schemas were entered on the second step of the equation. Results indicated that anxiety significantly predicted acute depression, accounting for 46% of the variance in the model,  $F(1, 86) = 71.84, p < .001$ . Schemas accounted for an additional 28% of unique variance,  $F(18, 68) = 3.84, p < .001$ . There were three early maladaptive schemas that contributed significant and unique variance to the model, namely mistrust/ abuse ( $t = 2.24, p < .05$ ),

entitlement/ grandiosity ( $t = -3.59, p < .05$ ), and insufficient self-control/ self-discipline ( $t = 2.31, p < .05$ ).

The second hierarchical regression was with the DPDI as the criterion variable and the BAI and eighteen early maladaptive schema subscales as the predictor variables. The BAI was entered on the first step in order to account for the variance in depression accounted for by anxiety. Early maladaptive schemas were entered on the second step of the equation. Results indicated that anxiety accounted for significant and unique variance in chronic depression, accounting for 27% of the variance in the model,  $F(1, 86) = 31.09, p < .001$ . Schemas accounted for an additional 47% of unique variance,  $F(18, 68) = 6.83, p < .001$ . There were three early maladaptive schemas that contributed significant and unique variance to the model, namely entitlement/ grandiosity ( $t = 2.36, p < .05$ ), dependence/ incompetence ( $t = -2.20, p < .05$ ), and emotional inhibition ( $t = -2.38, p < .05$ ).

#### *Univariate Analysis of Variance (ANOVA)*

The final question addressed in this study was whether or not there were differences between help seeking groups on schemas. To analyze this question, an ANOVA was conducted, with the help-seeking status as the independent variable and the YSQ-S3 scores serving as the dependent variable. The main effect of help seeking behavior was significant  $F(2, 84) = 21.05, p < .001$ . The results of the Tukey post hoc for help seeking group and early maladaptive schemas are displayed on Table 5. The post hoc analysis indicates that those who sought help significantly differ from those who did not seek help nor wanted help, also those who wanted help but did not seek it significantly differed from those who did not seek help nor wanted it. In contrast, those



who sought help were not significantly different than those who wanted help but did not seek it.

## CHAPTER IV

### Discussion

This study had two aims. The first was to replicate past research on the relationship between early maladaptive schemas and acute depression and to extend this research by studying the relationship between early maladaptive schemas, anxiety, and chronic depression. The second aim was to compare help seeking behaviors and depressive symptoms to early maladaptive schemas. These two aims will be discussed separately.

The purpose of the first aim of this study was to replicate and extend on past research of unipolar depression. To replicate the past research, the relationship between early maladaptive schemas and acute depression was studied in order to compare to past research. The result of this analysis found early maladaptive schemas to significantly predict acute depression as measured by the BDI-II. The schemas accounted for 28% of the variance in acute depression. This is consistent with past research findings. The results of this analysis also found that the mistrust/ abuse, entitlement/ grandiosity, and insufficient self control/ self discipline schemas to contribute significant and unique variance to the model. These results show some similarities to past research. The insufficient self control/ self discipline schema has been found to significantly contribute variance to depression in many past studies. However, the finding that mistrust/ abuse and entitlement/ grandiosity schemas contribute unique and significant variance to depression is inconsistent with past research findings. This may be due to variations in the sample, such as differences in the severity of symptoms or length of symptoms

between the samples that were studied. There were also differences in the version of the YSQ used, which may contribute to the differences. This study utilized the YSQ-3, which contains eighteen early maladaptive schemas, where past studies used the YSQ-2 which contained 15 early maladaptive schemas.

This study extended upon past research in two ways, by accounting for the variance associated with anxiety when measuring acute depression and by examining the relationship between early maladaptive schemas and chronic depression. The first extension of past research was accounting for the variance contributed by anxiety. Anxiety contributed to 46% of the variance in acute depression, suggesting that anxiety is a significant predictor of depression and must be accounted for when analyzing the relationship between early maladaptive schemas and acute depression. The differences in the relationship between specific schemas and acute depression might also be explained by the fact that previous researchers had not accounted for anxiety in their samples. Thus, the results they got may have been attributable to the fact that they were not studying “purer” forms of depressive illness.

The second extension of past research was examining the relationship between early maladaptive schemas and chronic depression. After accounting for the variance associated with anxiety, early maladaptive schemas were found to predict 47% of the variance in chronic depression. The results of this analysis also indicated that the entitlement/ grandiosity, dependence/ incompetence, and emotional inhibition schemas contributed significant and unique variance to the model. These results may explain some of the inconsistencies in past research which did not differentiate between acute and chronic symptoms and instead only studied acute symptoms. The dependence/

incompetence schema has been found to predict acute depression in one past study. The sample studied may have shown chronic symptoms that were not measured and labeled as acute symptoms, thus confounding the variable.

When comparing the variance that schemas account for in acute depression and chronic depression there are some interesting findings. Early maladaptive schemas accounted for approximately 30% of the variance in acute depression, but accounted for nearly 50% of the variance in chronic depression. Schemas may have accounted for nearly double the variance in chronic depression than acute depression because of the nature of schemas. These stable, chronic constructs lead to a stable state of affect, chronic depression. Acute depression is a short term condition that is not stable, leading to less variance being accounted for by the early maladaptive schemas.

The schemas that were predictive of acute depression and chronic depression are understood through the theory of early maladaptive schemas and the behaviors and cognitions that they exhibit. The mistrust/ abuse schema is the expectation that others will abuse, humiliate, or take advantage of the person. This type of thought is theorized to lead to depression, and therefore is expected in the results of this study. The entitlement/ grandiosity schema had a negative relationship to acute and chronic depression, meaning that a lack of entitlement/ grandiosity leads to depression. The entitlement / grandiosity schema is the belief that one is superior to other people and entitled to rights and privileges. This goes against cognitive theory of depression, where negative thoughts of the self would lead to depression. This explains the negative relationship between the entitlement/ grandiosity schema and chronic and acute depression. The insufficient self control/ self discipline schema is a lack of self control

and its relationship to depression may be explained through behavioral activation of depression. If a person lacks self control, they are likely to violate social norms and be punished by their surroundings, leading to depressive symptoms. The dependence/incompetence schema is the belief that one is helpless. This is directly related to cognitive theory of depression. The emotional inhibition schema is defined by a regulation of one's actions in order to avoid disapproval. This belief that one's actions lead to disapproval will reduce actions and increase negative cognitions, which are depressive symptoms.

The second goal of the current study was to examine whether or not there were differences between help seeking groups on schemas. The results indicated that there were significant changes in the amount of schemas when comparing those who sought help and those who did not. Those with more early maladaptive schemas were likely to seek help or want help, rather than not seek help and not want help. This may be representative of level of illness that early maladaptive schemas contribute to. The more schemas that a person has, the more likely they have significant problems in their life that they would believe that they need help for. There were some limitations to this part of the research that may have affected the results. The sample size of participants who had sought help was small; only 12 participants had sought help at some point. Future research with a larger sample size may find that there is a change in the relationship between help seeking and early maladaptive schemas.

While this research has accounted for some limitations of past research there are some limitations and considerations that need to be accounted for in the current study. The first limitation of this research is the sample size. Additional data needs to be

collected and analyzed in order to be confident in these findings, and the number of statistical tests conducted in this study was too large in relation to the sample size. Thus, the probability of type I error is too high in the current study and the findings must be interpreted cautiously.

A second limitation of the current study is that it was done using a college-age, non-clinical sample. As the review of the literature indicated, the relation between schemas and depression varies by whether the sample is clinical or non-clinical. Thus, the results of these findings need to be considered applicable to non-clinical populations only.

Finally, the current study was done using a cross-sectional design. This limits our ability to understand the temporal relationship between the variables under study. Future research using a longitudinal design to study the relationship of early maladaptive schemas, chronic depression, and acute depression should be conducted.

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APPENDIX  
Tables

Table 1.

*Early Maladaptive Schemas and Defining Characteristics*

Domain	Schema	Defining characteristics/beliefs of schema
<b>Disconnection &amp; Rejection</b>		
	Abandonment/instability	Perceived instability of those available for support
	Mistrust/abuse	Expectation that others will abuse, humiliate, or take advantage of the person
	Emotional deprivation	Expectation that emotional support will not be provided by others
	Defectiveness/shame	Belief that one is defective, bad, or unwanted
	Social isolation	Belief that one is different from others and isolated
<b>Impaired Autonomy &amp; Performance</b>		
	Dependence/incompetence	Belief that one is helpless and unable to handle everyday responsibilities without help
	Vulnerability to harm or illness	Belief that unpreventable catastrophes will happen at any time
	Enmeshment/undeveloped self	Excessive emotional closeness with others at the expense of individual development
	Failure	Belief that a person is fundamentally inadequate
<b>Impaired Limits</b>		
	Entitlement/grandiosity	Belief that one is superior to other people and entitled to rights and privileges
	Insufficient self-control/self-discipline	Lack of self control
<b>Other-Directedness</b>		
	Subjugation	Surrendering of control to others in order to avoid anger, abandonment, or retaliation
	Self-sacrifice	Focus on routinely meeting the needs of others at the expense of personal gratification

Approval seeking/recognition seeking    Emphasis on gaining approval, recognition, or attention from others

Overvigilance & Inhibition

Negativity/pessimism    Focus on the negative, such as pain and disappointment, while ignoring the positive

Emotional inhibition    Regulation of spontaneous actions in order to avoid disapproval, shame, or a loss of control

Unrelenting standards/hypercriticalness    Striving to meet very high personal standards of behavior in order to avoid criticism

Punitiveness    Belief that people should be harshly punished for making mistakes

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Table 2.

*Correlations among Depressive Personality Disorder Index, Beck Depression Inventory, Beck Anxiety Inventory, and Total Young Schema Questionnaire Score*

Variables	1	2	3	4
1. DPDI	-	-.69*	-.52*	-.76*
2. BDI-II		-	.68*	.64*
3. BAI			-	.57*
4. Total YSQ				-

\* $p < .01$

Table 3.

*Correlations between DPDI, BDI-II, BAI, and the Schema Subscales of the YSQ-3*

Early Maladaptive Schemas	DPDI	BDI	BAI
Abandonment/instability	-.54**	.51**	.48**
Mistrust/abuse	-.58**	.59**	.52**
Emotional deprivation	-.47**	.28**	.26*
Defectiveness/shame	-.53**	.38**	.32**
Social isolation	-.53**	.46**	.26*
Dependence/incompetence	-.60**	.42**	.40**
Vulnerability to harm or illness	-.66**	.57**	.51**
Enmeshment/undeveloped self	-.47**	.39**	.31**
Failure	-.55**	.50**	.30**
Entitlement/grandiosity	-.14	.01	.17
Insufficient self-control/self-discipline	-.40**	.52**	.43**
Subjugation	-.63**	.58**	.50**
Self-sacrifice	-.33**	.38**	.53**
Approval seeking/recognition seeking	-.41**	.30**	.22*
Negativity/pessimism	-.74**	.59**	.53**
Emotional inhibition	-.66**	.43**	.33**
Unrelenting standards/hypercriticalness	-.11	-.03	.10
Punitiveness	-.32**	.37**	.26*

\* $p < .05$ , \*\* $p < .01$

Table 4.

*Summary of Hierarchical Regression Analysis for Anxiety and Schemas as Predictors of Acute and Chronic Depression*

Criterion Variable	Predictor	R <sup>2</sup>	ΔR <sup>2</sup>	β
BDI-II	Step I (BAI)	.46**		.68**
	Step II	.73**	.28**	
	Mistrust/Abuse			.26*
	Entitlement/Grandiosity			-.34**
	Insufficient self control/Self discipline			.24*
DPDI	Step I (BAI)	.27**		-.52**
	Step II	.74**	.47**	
	Entitlement/Grandiosity			.22*
	Dependence/ Incompetence			-.22*
	Emotional Inhibition			-.22*

*Note: Only the EMS's that contributed significant and unique variance to the model are displayed in the chart; \*p<.05, \*\*p<.001*

Table 5.

*Summary of Post Hoc Analysis of Help Seeking Behavior on differences of YSQ Scores*

Depression Group		Mean Difference	<i>p</i> value
Not Depressed	Acute Depression	-49.40	.039*
	Chronic Depression	-61.14	.000*
Acute Depression	Chronic Depression	-11.74	.838

\**p* < .05