Study of Early Maladaptive Schemas in Depressed, Anxious and Obsessive Patients and Non-Clinical Group

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http://dx.doi.org/10.13005/bpj/1064

(Received: July 21, 2016; accepted: September 02, 2016)

ABSTRACT

The current research is conducted to evaluate early maladaptive schemas. It aimed to study the early maladaptive schemas of depressed, anxious or obsessive compulsive patients along with early maladaptive schemas of individuals in non-clinical group. The statistical population was selected randomly from the patients that were suffering from depression, anxiety and obsessive compulsive disorder who visited Shafa Psychiatric Hospital in Rasht in 2014 to 2015. In order to collect data, Young Schema and DASS-21 questionnaire plus Maudsley Obsessive Compulsive Inventory were used. Data were analyzed using multivariate analysis of variance. The results showed that there is a difference between early maladaptive schemas of patients with depression, anxiety and OCD in vulnerability to harm or illness, unrelenting standards/ hypercriticalness, undeveloped self / enmeshment, failures, dependency/ incompetence, entitlement /grandiosity and emotional inhibition and early maladaptive schemas of non-clinical group.

Keywords: Early maladaptive schema, Depression, Anxiety, Obsessive compulsive, Non-clinical groups.

INTRODUCTION

Depression is one of the most common and debilitating psychiatric disorders that, if left untreated, causes a lot of psychological and socio-economic damages for patients (translation by Khodayarifard & Abedini, 2010). Depressive mood as well as loss of interest and pleasure is the main signs of depression. Anxiety is one of the most prevalent symptoms that affect about 90 percent of individuals with depression (Kaplan &Sadock Translation Rezaei, 2010). Anxiety disorder is also considered as one of the most prevalent psychiatric disorders in the general population. In the United States approximately 30 million people suffer from anxiety disorder and women are twice as likely to experience depression as men (Kaplan & Sadock Translation Rezaei, 2010). Anxiety is a warning to keep the person alert that a danger is coming which prepares him/her to deal with the risk. Obsession is an incongruent thought which the person recognizes it as a foreign feeling to his own sense of mental existence. No matter how deep the obsession is, the person usually finds it nonsense and unreasonable. The individual with obsessive disorder generally tends to resist against that sentiment (Kaplan & Sadock Translation Rezaei, 2010). Beck and his colleagues, based on researches and multiple clinical experiences, concluded that depressed people have negative thoughts and impression about themselves, the world, their experiences and also their future. They also see others as dismissive and discouraging and themselves as someone with deficiencies and weaknesses on important aspects of life. This is because people have schemas in their childhood

which find its way into adulthood. In fact early maladaptive schemes are the background factors that underlie many emotional disorders. Activation of early maladaptive schemas cause some levels of emotions to release which directly or indirectly leads to various forms of psychological trauma. Basically the evolutionary root of early maladaptive schemas hides in childhood's unpleasant experiences. Schemas that are created early in one's life are usually the most powerful schemas that arise from nuclear families. When individual's maladaptive schemas activates in different situations in adulthood, the person is usually experiencing thrilling memory from his/her childhood life. Social isolation schema, which usually occurs in late childhood, may not reflect the dynamics of the nuclear family. Emotional inhibitation or emotional abandonment schemas arise due to defects in the original environment. There is no understanding or love in the environment of such kids. In dependence / incompetence schemas the kid is barely treated in a serious and strict way, rather they get spoiled. As a result, the child's emotional do not get satisfied with self-regulation or realistic restrictions (young, klosko & weishaarr, Trans. Hamidpour va Anduze, 2011).

In general, schemas are frameworks and patterns of information processing that show the person's way of conceptualization of a set of stimuli. Early maladaptive schemas are related to negative deeply rooted beliefs about the self, others and the world (Young, 1994).

One of the significant and fundamental concepts of the field of psychotherapy is that many schemas are formed early in life, continue in life and impose themselves into future experiences in life.

The schema can be positive or negative, compatible or incompatible and also formed in early childhood or later on in life (Yang and Vyshar, 2003, translation Hamidpour and Anduze, 2011). The purpose of current research is to investigate the early maladaptive schemas of depressed, anxious or obsessed individuals compare with a non-clinical group. The research hypothesis is that:

Vulnerability to harm or Illness schema to damage or disease in patients with depression, anxiety and obsession is different from those in non-clinical group.

Insufficient self-control/ self-discipline schema in patients with depression, anxiety and obsession is different from those in non-clinical group.

Unrelenting standards/ Hypereritcalness schema in patients with depression, anxiety and obsession is different from those in non-clinical group. Emotional Inhibition schema in patients with depression, anxiety and obsession is different from those in non-clinical group. Self-sacrifice schema in patients with depression, anxiety and obsession is different from those in non-clinical group.

Subjugation schema in patients with depression, anxiety and obsession is different from those in non-clinical group. Enmeshment/ undeveloped self schema in patients with depression, anxiety and obsession is different from those in non-clinical group Failure schema in patients with depression, anxiety and obsession is different from those in non-clinical group.

Dependence / incompetence schema in patients with depression, anxiety and obsession is different from those in non-clinical group. Entitlement / Grandiosity schema in patients with depression, anxiety and obsession is different from those in non-clinical group. Defectiveness / shame schema in patients with depression, anxiety and obsession is different from those in non-clinical group.

Social isolation/ Alienation schema in patients with depression, anxiety and obsession is different from those in non-clinical group. Mistrust / abuse schema in patients with depression, anxiety and obsession is different from those in non-clinical group.

Abandonment/ Instability schema in patients with depression, anxiety and obsession is different from those in non-clinical group. Emotional deprivation schema in patients with

depression, anxiety and obsession is different from those in non-clinical group.

MATERIALS AND METHODS

In the current research semi-experimental design, correlations and ex post facto research design has been used and the statistical population was randomly selected from all patients that were suffering from depression, anxiety and obsessive compulsive who visited Shafa Psychiatric Hospital in Rasht between 2014 and 2015. First, the patients were interviewed by the psychiatric doctor based on structured interviews, then, if the patient was being diagnosed with depression, anxiety or obsessive compulsive disorder he/she will be introduced to the researcher in order to be used in the research.

Then 120 patients were selected from the statistical population (30 patients with depression, 30 patients with anxiety, 30 patients with OCD and 30 individuals from companions of the patients who were willing to participate in the research were enrolled as a control group).

Tools

Young Schema questionnaire (short form)

Young Schema Questionnaire-Short Form (1998) contains 75 items. Each item is scored based on a scale of 6 points (Likert scale). In this questionnaire each every 5 questions measures one schema. Therefore the 15 early maladaptive schemas are as below:

1. Emotional deprivation schema,
2. Abandonment schema,
3. Mistrust / abuse schema,
4. Social isolation Scheme,
5. Defectiveness and shame schema,
6. Failure schema,
7. Dependence / incompetence schema,
8. Vulnerability to harm schema,
9. Enmeshment and undeveloped self schema,
10. Subjugation scheme,
11. Self-sacrifice schema,
12. Emotional Inhibition schema,
13. Unrelenting standard schema,
14. Entitlement / Grandiosity schema,
15. Insufficient self-control/ self-discipline schema.

It is noteworthy to

1. The scope of cut and exclusion (5 schemas); mention that the 15 above schemes are evaluated in five areas:
2. Autonomy and impaired performance, (4 schemas);
3. Impaired limits (2 schemas);
4. Other directedness, (2 schemas);
5. Over alertness and inhibition (2 schemas);

The reliabiity of YSQ-SF scale has been obtained 0.94 for the whole test and for the subclass 0.62 to 0.90 a by Cronbach's(Sadoughi, Aguilar, Rasoulzadeh, Esfahanian, 2008).

Depression, Anxiety, Stress Scale (DASS)

The scale of depression, anxiety and stress was developed by Lovibond, S.H. & Lovibond, P.F. in 1995. This scale has two forms. The short form contains 21 items and each components of depression, anxiety and stress is measured by 7 different items. Three factors of stress, anxiety and depression are measured by DASS-21 scale. The DASS-21 subscales have been validated for Iranian population by the Sahebi and colleagues (2005). This scale is for adults. Stress in this scale contains both physical and mental stress. According to the studies conducted by Lovibond and Lovibond in 1995, the validity and retest reliability for the subscales is 0.81 for stress, 0.79 for anxiety and 0.71 for depression. Additionally for the validity of the Scale, Anxiety Inventory and the Beck Depression Inventory obtained correlation coefficient of 0.81 and 0.74 respectively.

Therefore this scale has sufficient validity to use in research activities and diagnostics. Each subscales of DASS-21 consist of 7 questions and the final score of each subscale is calculated from the sum of the responses for a set of the related questions. The numbers assigned for each item starts from zero (completely wrong in my case) to 3 (completely true in my case). Since the DASS-21 is short form of the original scale (42 questions) therefore the final score of each subscale should be multiple to 2. (Lovibond & Lovibond, 1995).

Maudsley Obsessive Compulsive Inventory

The Maudsley Obsessive Compulsive Inventory was designed by Hodgson and Rachman in 1977 in order to assess the type and intensity of obsessive-compulsive behavior. This questionnaire consistes of 30 items with true/false response format. It produces a total score in addition to scores for its four subscales: Checking, washing, doubting and slowness. A simple method of scoring gives an overall obsession score overall and four subscores. In a study with 40 patients, Hodgson and Rachman (1977) showed that the total score of this questionnaire is sensitive to changes in therapy and its results. In general, obsessive compulsive inventory (MOCI) has proved to be a useful tool for clinicians and researchers in relation to treatment outcome. The reliability and validity of Maudsley's obssesive questionnare has been examined and proved after testing on various populations.

For example Sanavio obtained 0.70 for correlation between the score of all subjects in MOCI and Padua. The calculated reliability coefficient between test and test-retest was high (r = 0.89) (Rachman, Hodgson, 1977). In Iran sticky (1976) measured the instrument reliability by retest method and obtained 0.85 for it. Dadfar (1996) acquired 0.84 for reliability of the test and also convergent validity of the test with the Yale Brown obsessive compulsive scale is achieved 0.87 (Lindsey, quotes of Nikkhooi et al., 2000).

RESULTS AND DISCUSSION

Due to the design of the current study, the best way to analyze the data is using multivariate analysis of covariance (MANCOVA). The data obtained from the results has been analyzed, using descriptive statistics (mean, standard deviation) and inferential statistics MANCOVA.

In order to test the hypothesis Analysis of covariance (MANCOVA) has been used which is a statistical method that allows the examination of the effect of the independent variable on the dependent variable, while the effect of other variables is controlled or deleted.

` According to the table below, sig = 0.997 which is larger than alpha level 0.05 with the probability of 0.95. We could say that the assumption of homogeneity of variance-covariance has been met.

As we can see on above table, the significant amount for self-control, dependency and emotional inhabitation variables are 0.007, 0.021 and 0.000 respectively. This result indicates that equality of variance error has not been met for these variables but the significance amount of other variables is greater than 0.05. Therefore, the equality of variance error has been established for the latest variables.

According to the above table, the significant level of 0.000 is smaller than Bonferroni alpha level of 0.0007 and with the probability of 0.99 we can state that the vulnerability to harm or disease has a significant effect on the mentioned variables for the patients in compare with non-clinical group.

$F_{(3,106)} = 22.54$; $P < 0.01$ Partial $\eta^2 = 0.389$

As it can be seen on the above table, the significant level is 0.046 which is greater than Bonferroni alpha level 0.007 and with the probability of 0.95 we stated that Insufficient self-control/ self-discipline does not have a significant effect on the studied variable for the patients in compare to non-clinical group.

$F_{(3,106)} = 22.54$; $P < 0.01$ Partial $\eta^2 = 0.072$

According to the above table, the significant level of 0.000 is smaller than Bonferroni alpha level of 0.0007 and with the probability of 0.99 we can state that Unrelenting standards/ Hypereritcalness has a significant effect on the mentioned variables for the patients in compare with non-clinical group.

$F_{(3,106)} = 29.08$; $P < 0.01$ Partial $\eta^2 = 0.452$

As it can be seen on the above table, the significant level is 0.988 which is greater than Bonferroni alpha level 0.007 and with the probability of 0.95 we stated that Emotional Inhibition does not have a significant effect on the studied variable for the patients in compare to non-clinical group.

Table 1: Significant test of homogeneity of variance-covariance matrix

s MåBox	F	Df_1	Df_2	Sig
392.314	0.809	360	2.372	0.997

$F_{(3,106)} = 0.42$; $P < 0.01$ Partial $\eta^2 = 0.001$

As it can be seen on the above table, the significant level is 0.422 which is greater than Bonferroni alpha level 0.007 and with the probability of 0.95 we stated that Self-sacrifice does not have a significant effect on the studied variable for the patients in compare to non-clinical group.

Table 2: Test of equality of variances

variable	Df_1	Df_2	F	Sig
Vulnerability to harm schema	3	106	0.584	0.627
Insufficient self-control/ self-discipline schema	3	106	4.282	0.007
Unrelenting standard schema	3	106	1.068	0.366
Emotional Inhibition schema	3	106	0.091	0.965
Self-sacrifice schema	3	106	1.144	0.335
Subjugation scheme	3	106	0.339	0.797
Enmeshment and undeveloped self schema	3	106	1.51	0.216
Failure schema	3	106	2.25	0.086
Dependence / incompetence schema	3	106	3.37	0.021
Entitlement / Grandiosity schema	3	106	0.481	0.696
Defectiveness and shame schema	3	106	1.62	0.188
Social isolation Scheme	3	106	0.129	0.943
Mistrust / abuse schema	3	106	0.799	0.497
Abandonment schema	3	106	1.68	0.176
Emotional deprivation schema	3	106	8.74	0.000

Table 3: Univariate analysis of variance for the variable Vulnerability to harm or Illness

Variable	SS	df	MS	F	sig	η^2
Vulnerability to harm	1884.751	3	628.25	22.54	0.000	0.389
Error	2954.239	106	27.87			

Table 4: Univariate analysis of variance for the variable Insufficient self-control/ self-discipline

Variable	SS	df	MS	F	sig	η^2
Insufficient self-control /self-discipline	154	3	51.333	22.54	0.046	0.072
Error	1978.69	106	18.667			

Table 5: Univariate analysis of variance for the variable Unrelentingstandards/ Hypereritcalness

Variable	SS	df	MS	F	sig	η^2
Unrelenting standard	3002.699	3	1000.9	29.086	0.000	0.452
Error	3647.67	106	34.412			

Table 6: Univariate analysis of variance for the variable Emotional Inhibition

Variable	SS	df	MS	F	sig	η^2
Emotional Inhibition	1.949	3	0.65	0.42	0.988	0.001
Error	1633.505	106	15.41			

Table 7: Univariate analysis of variance for the variable Self-sacrifice

Variable	SS	df	MS	F	sig	η^2
Self-sacrifice	83.404	3	27.801	0.944	0.422	0.026
Error	3120.196	106	29.43			

Table 8: Univariate analysis of variance for the variable Subjugation

Variable	SS	df	MS	F	sig	η^2
Subjugation	17.779	3	5.933	0.239	0.869	0.007
Error	2631.192	106	24.822			

Table 9: Univariate analysis of variance for the variable Enmeshment/ undeveloped self

Variable	SS	df	MS	F	sig	η^2
Enmeshment and undeveloped self	2317.93	3	772.259	25.463	0.000	0.276
Error	3286.434	106	30.344			

Table 10: Univariate analysis of variance for the variable Failure

Variable	SS	df	MS	F	sig	η^2
Failure	1731.778	3	577.259	13.48	0.000	0.276
Error	4538.440	106	42.815			

Table 11: Univariate analysis of variance for the variable Dependence / incompetence

Variable	SS	df	MS	F	sig	η^2
Dependence / incompetence	1979.782	3	659.927	15.804	0.000	0.309
Error	4426.181	106	41.756			

Table 12: Univariate analysis of variance for the variable Entitlement / Grandiosity

Variable	SS	df	MS	F	sig	η^2
Entitlement / Grandiosity	1189.141	3	396.38	9.979	0.000	0.22
Error	4210.677	106	27.25			

Table 13: Univariate analysis of variance for the variable Defectiveness / shame

Variable	SS	df	MS	F	sig	η^2
Defectiveness and shame	148.385	3	49.463	1.815	0.149	0.049
Error	2888.488	106	27.250			

Table 14: Univariate analysis of variance for the variable Social isolation

Variable	SS	df	MS	F	sig	η^2
Social isolation	7.915	3	2.638	0.106	0.957	0.003
Error	2642.313	106	24.927			

Table 15: Univariate analysis of variance for the variable Mistrust / abuse

Variable	SS	df	MS	F	sig	η^2
Mistrust / abuse	76.727	3	25.567	1.171	0.324	0.032
Error	2315.537	106	17.55			

Table 16. Univariate analysis of variance for the variable Abandonment/ Instability

Variable	SS	df	MS	F	sig	η^2
Abandonment	33.175	3	11.058	1.63	0.597	0.018
Error	1860.288	106	17.55			

Table 17. Univariate analysis of variance for the variable Emotional deprivation

Variable	SS	df	MS	F	sig	η^2
Emotional deprivation	1057.82	3	352.4	18.14	0.000	0.339
Error	2060.405	106	19.438			

$F_{(3,106)} = 0.944$; $P < 0.01$ Partial $\eta^2 = 0.026$

As it can be seen on the above table, the significant level is 0.869 which is greater than Bonferroni alpha level 0.007 and with the probability of 0.95 we stated that Subjugation does not have a significant effect on the studied variable for the patients in compare to non-clinical group.

$F_{(3,106)} = 0.239$; $P < 0.01$ Partial $\eta^2 = 0.007$

According to the above table, the significant level of 0.005 is smaller than Bonferroni alpha level of 0.0007 and with the probability of 0.99 we can state that Enmeshment/ undeveloped self has a significant effect on the mentioned variables for the patients in compare with non-clinical group.

$F_{(3,106)} = 25.463$; $P < 0.01$ Partial $\eta^2 = 0.276$

According to the above table, the significant level of 0.005 is smaller than Bonferroni alpha level of 0.0007 and with the probability of 0.99 we can state that Failure has a significant effect on the mentioned variables for the patients in compare with non-clinical group.

$F_{(3,106)} = 13.48$; $P < 0.01$ Partial $\eta^2 = 0.276$

According to the above table, the significant level of 0.005 is smaller than Bonferroni alpha level of 0.0007 and with the probability of 0.99 we can state that Dependence / incompetence has a significant effect on the mentioned variables for the patients in compare with non-clinical group.
$F_{(3,106)} = 15.8$; $P < 0.01$ Partial $\eta^2 = 0.309$

According to the above table, the significant level of 0.005 is smaller than Bonferroni alpha level of 0.0007 and with the probability of 0.99 we can state that Entitlement / Grandiosity has a significant effect on the mentioned variables for the patients in compare with non-clinical group.

$F_{(3,106)} = 9.97$; $P < 0.01$ Partial $\eta^2 = 0.22$

As it can be seen on the above table, the significant level is 0.149 which is greater than Bonferroni alpha level 0.007 and with the probability of 0.95 we stated that Defectiveness /shame does not have a significant effect on the studied variable for the patients in compare to non-clinical group.

$F_{(3,106)} = 1.81$; $P < 0.01$ Partial $\eta^2 = 0.049$

As it can be seen on the above table, the significant level is 0.957 which is greater than Bonferroni alpha level 0.007 and with the probability of 0.95 we stated that Social isolation does not have a significant effect on the studied variable for the patients in compare to non-clinical group.

$F_{(3,106)} = 0.106$; $P < 0.01$ Partial $\eta^2 = 0.003$

As it can be seen on the above table, the significant level is 0.324 which is greater than Bonferroni alpha level 0.007 and with the probability of 0.95 we stated that Mistrust / abuse does not have a significant effect on the studied variable for the patients in compare to non-clinical group.

$F_{(3,106)} = 1.71$; $P < 0.01$ Partial $\eta^2 = 0.032$

As it can be seen on the above table, the significant level is 0.597 which is greater than Bonferroni alpha level 0.007 and with the probability of 0.95 we stated that Abandonment/ Instability does not have a significant effect on the studied variable for the patients in compare to non-clinical group.

$F_{(3,106)} = 1.63$; $P < 0.01$ Partial $\bullet^2 = 0.018$

According to the above table, the significant level of 0.0005 is smaller than Bonferroni alpha level of 0.0007 and with the probability of 0.99 we can state that Emotional deprivation has a significant effect on the mentioned variables for the patients in compare with non-clinical group.

$F_{(3,106)} = 18.14$; $P < 0.01$ Partial $\eta^2 = 0.339$

Based on the results from the tables 3, 5, 9, 10, 11, 12, 17 vulnerability to harm and disease, unrelenting standard /hypocriticalness, enmeshment / undeveloped self, failures, dependency / incompetence, entitlement / grandiosity, and emotional deprivation schemas in patients with depression, anxiety and obsessive compulsive is different than in non-clinical group.

These findings are consistence with Montazeri et al (2013), the Ahmadian (2008), Noei et al (2010) and Lee's (2007) findings.

For the sake of explaining these hypothesis we should state that individuals who have schemas related to self-regulation and dysfunction such as dependence / incompetence, vulnerability to harm or illness, undeveloped self/ enmeshment, failure schemas, do not have identity independence and are not able to manage to live without getting staunch help from others. They cannot set specific goal for themselves or to be proficient in specific skills. It also can be said that in depressed, anxious and obsessed individuals, early maladaptive schemas is significantly predictable in compare to normal individuals. People who have got this schemas has an unreasonable extreme fear that a disaster like heart attack, going crazy, airplane crash or earth quick is nearby and it will occur in any moment and the person will not be able to prevent it from happening.

Based on the results on Tables 4, 6, 7,8,13, 14, 15, 16 there is no difference on insufficient self-control /self-discipline, emotional inhibition, self-sacrifice, subjugation, defectiveness / shame, social exclusion, mistrust / abuse, abandonment/instability schemas in patients with depression, anxiety, and obsession with non-clinical group. These findings are inconsistent with the findings of Ghanbari, Naziri and Barzegar (2012), Ahmadi (2008) and Lee (2007).

Young believed that individuals with the mentioned schemas, restrict their spontaneous behaviors, emotions and interpersonal relationships. They usually do so to avoid being criticized or loss of control over their impulses. The most common areas of inhibition are: 1- inhabitation of anger 2- inhibition of positive impulses (e.g. humor, love, positive provocation and playfulness), 3- difficulty expressing vulnerability and 4- emphasis on rationality and ignoring emotions.

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