The importance of parental socialization and Early Maladaptive Schemas in the development and maintenance of psychological symptoms in young adults

Kiranjeet Kaur Uppal

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THE IMPORTANCE OF PARENTAL SOCIALIZATION AND EARLY MALADAPTIVE SCHEMAS IN THE DEVELOPMENT AND MAINTENANCE OF PSYCHOLOGICAL SYMPTOMS IN YOUNG ADULTS

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Masters of Arts
in
Psychology:
General Experimental

by
Kiranjeet Kaur Uppal
September 2006
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ABSTRACT

Cognitive theory of emotional disorders suggests that negative schemas leads to the development of a variety of emotional disorders. A.T. Beck (1967) called this maladaptive pattern of thinking, the cognitive triad, including distorted attitudes about oneself, the world, and the future. Chronic toxic parent/child interactions lead to the development of cognitive schemas which are presumed to lead to symptoms of depression and anxiety. The current study explored the relationship between recollections of parenting, Early Maladaptive Schemas (EMS) described by J.T. Young (1994), and symptoms of depression and anxiety in a sample of undergraduate students (N = 232). The EMS of Defectiveness/Shame, Dependent/Incompetence, and Vulnerability were associated with perceptions of parental psychological control and symptoms of depression. Further, the schema domains of Disconnection/Rejection, Impaired Autonomy/Performance, and Other Directedness were also associated with perceptions of parenting and symptoms of depression. Consistent with prior research (Harris & Curtain, 2002), the EMS of Defectiveness/Shame, Insufficient
Self-Control/Self-Discipline, Dependence/Incompetence, Failure to Achieve, and Vulnerability were found to mediate the relationship between parental socialization and depressive symptoms. Additionally, exploratory analyses revealed similar trends; however, the maternal/paternal socialization was delineated and current sample specific EMS predictors of depression and anxiety were distinguished. Partial mediation of EMS was found with maternal connection and psychological control, but not with paternal socialization. Findings lend support to the schema model and suggest that clinical work with adults suffering from depression and/or anxiety may need to identify and re-structure EMS that develop from “toxic parenting”. Findings are discussed in relation to the prevention and treatment of psychological distress.
ACKNOWLEDGMENTS

I wish to thank all friends and family for their endless support in my academic endeavors. A special thanks to Professor M.R. Lewin for his constructive advice and his advance lab in their assistance with data collection. I am also very grateful to the faculty and staff at Cal State San Bernardino for their encouragement and support, especially, Professor(s) Ricco and Chavez for coming aboard the thesis committee.
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CHAPTER ONE

LITERATURE REVIEW

Introduction

Modern clinical theorists have turned to cognitive psychology for a better explanation of psychosocial phenomena. They have theorized about the nature of information processing of emotional information in terms of attention, perception, and memory. A.T. Beck (1967) suggested that under stress, an individual who is prone to depression may engage in negative thinking or depressive cognitions. Beck (1967) pointed out specific cognitive manifestations that were characteristic of individuals with emotional disorders, specifically depression. These manifestations or distortions included low self evaluation, negative expectation, self-blame, self criticism, indecisiveness, distorted self-image, loss of motivation, and suicidal wishes. It is has been thought that individuals who possess such cognitive manifestations are vulnerable to depressive symptoms (Beck, 1967; Derry & Kuiper, 1981; Greenberg & Beck, 1989; Loeb, Beck, & Diggory, 1971; Moilanen, 1993).
According to Beck (1963) schemas are 'cognitive structures', relatively persistent, self-defeating, and automatic in nature. These specific cognitive structures serve as filters to guide and influence how individuals orient themselves and organize the immediate situations within the environment. The schema provides only a conceptual framework for cognition; the details are filled in by the current situation. Beck (1964) explained the cognitive distortions' interaction with the environment as follows: "instead of a schema being selected to fit the external details, the details are selectively extracted and molded to fit the schema... The result is inevitably distortion of reality" (p.565). An individual, for example, who has the notion that he is a failure, will tend to interpret other people’s reactions on the basis of this premise. When schemas of this nature are evoked, cognitive processes quickly become dominated by feelings of depression and the more appropriate schemas are displaced (Beck, 1967).

Cognitive theory of emotional disorders suggests that biased information processing of life events leads to the development of a variety of emotional disorders (e.g.,
anxiety, depression, somatization; Beck, 1967). Beck proposed that biased information is processed at a surface level (e.g., I failed my exam therefore I will flunk out of school) as well as a deeper core level (I am incompetent or I am a failure). The deeper, more generalized core beliefs are referred to as schemas while the more content specific thoughts are called automatic thoughts. Depression is viewed as a maladaptive pattern of thinking explained by Beck's cognitive triad, a model that includes distorted attitudes about oneself, the world, and the future. Further, it is thought that an individual prone to depression may be at an increased risk for entering these negative cognitive cycles under stressful situations, feeling as if they cannot escape these cognitive patterns (Beck, 1967).

**Cognitive Vulnerability**

Attention has been given to variables that predispose some individuals to depression and related disorders. This section will briefly discuss possible origins of vulnerability, specifically cognitive vulnerability as a diathesis for depression (Kenny, Moilanen, Lomax, & Brabeck, 1993; Parker, 1993). Vulnerability is discussed
within schema models, attachment theory, and the broader topic of parent-child interactions (Ingram, 2003). Vulnerability models may link depression and other related mental illnesses to early childhood experiences.

Schema Model. First, it is necessary to gain a cognitive perspective on the conflicting schema models, which have been discussed within the current literature. Theorists have demonstrated the existence and potent nature of such memory models. A clear and concise technical-definition that can be used in theory and practice is provided by Beck (1967):

A schema is a {cognitive} structure for screening, coding, and evaluating the stimuli that impinge on the organism. . . On the basis of the matrix of schemas, the individual is able to orient himself in relation to time and space and to categorize and interpret experience in a meaningful way. (p.283)

Schemas are developed in response to parent-child interactions early in childhood (Beck, 1967), suggesting that childhood experiences are at the core of cognitive vulnerability (Goodman & Gotlib, 1999; Ingram et al.,
1998). Although schemas can be positive in nature, Jeffrey Young (Young & Klosko, 1994; Young, 1999; Young, Weinberg, & Beck, 2001; Young, Klosko, & Weishaar, 2003) proposes that maladaptive schemas develop early in life as a result of the failure of primary caretakers to meet children's basic fundamental needs. For example, Young surmises that a child whose primary caretakers are cold, distant and generally uncaring may develop schemas related to connection and rejection in relationships. Therefore schemas are not irrational, but have been thought to reflect childhood experiences related to attachment and approval/disapproval experiences.

**Attachment Theory.** Bowlby's (1969; 1973; 1980) attachment theory proposes that certain factors (e.g. a loving, caring, nurturing environment) shape people's ability and capacity to form meaningful emotional bonds with others and in future relationships. Attachment begins in the early years of infancy, however, it has been understood that these primary emotional attachments are carried into adulthood (Bowlby, 1973, 1988; Ainsworth, 1989), thus, affecting adult relationships. Bowlby (1969)
cleverly described the attachment process as stretching from "cradle-to-grave".

Children hope to find secure attachments with their caretakers; such attachment patterns are determined through the quality of contact with primary caregivers (Bowlby, 1973; Ainsworth, Blehar, Waters, & Wall, 1978). Following in Bowlby's footsteps, many researchers have examined parental contributions to the parent-child bond (i.e., the attachment process) (Parker, Tupling, & Brown, 1979). Parker et al. (1979) defined a strong parent-child bond as "an unbroken attachment to one specific person in the family" (p.52). Bowlby (1969) typically referred to the mother providing the necessary care, love, and nurturance for the child to develop a healthy sense of self. Further, Bowlby reasoned that this motherly behavior served as a protective function, keeping the child close to the mother (or parent), and thus allowing the mother to be able to care for the child. Caregivers who are consistently affectionate, sensitive, protective, and supportive provide positive and secure attachments with their children, and thus the children will be able to form normal emotional bonds in future relations (De Wolff & van
Dysfunctional or insecure attachment patterns are formed when early bonding processes are disrupted, when the caretakers are routinely inattentive, undependable, neglectful, and distrustful. Individuals with insecure attachment styles tend to become shy and emotionally unresponsive (Ainsworth, 1979, 1989), and later, assume that other significant people in their lives will also be unresponsive. These individuals are at risk for depression (Bemporad & Romano, 1992; Cummings & Cicchetti, 1990).

Parker et al. (1979) developed a Parental Bonding Instrument to further explore parental contributions to the parent-child bond, and on children's psychological and social functioning. Based on previous research (Ainsworth et al., 1975; Rutter, 1972; Raskin et al., 1971; Bowlby, 1969; Roe & Siegelman, 1963; Schaefer, 1965), Parker and colleagues conclude that parental bonding is characterized by two main principals, the level of care provided for the child and overprotection (a level of psychological control over the child). Using a sample of 150 mothers and 148 fathers (ages 17 to 40 years), two raters assessed the content of the interviews and assigned a number score (1-
5) for each parent's level of care and overprotection. The two dimensions (i.e., caring and overprotection) correlated negatively, suggesting that overprotection is associated with a lack of care. As theorized, the responses suggested that mothers were somewhat more caring, and directly or indirectly more controlling, than fathers. However, the authors noted that the possible influence of gender was not to be contributed to the gender of the child. In that parents were not found to be more caring or overprotective towards daughters over sons. Instead, mothers in general were more caring and overprotective towards both sons and daughters compared to fathers. The final scales allow five types of parental bonding to be measured (i.e., average, high care-low overprotection, low care-low overprotection, high care-high overprotection, and low care-high overprotection) and consist of 25 items (12 'caring' and 13 'overprotection'). The author's conceptualize 'high care-low overprotection' as the optimal parent-child bond. The present study utilizes the principles used to design the Parental Bonding Instrument in developing hypotheses. Additionally,
results from the present study are compared with previous studies reporting use of the instrument.

According to attachment theory, internal working models, or cognitive representations of self in relation to others, develop due to early childhood relationships with primary caregivers. These working models are somewhat similar to schema models (Ingram, 2003) discussed above. Once developed, working models influence the future thoughts and beliefs individuals experience in their interpersonal relationships. As a result, individuals who have formed insecure attachments will tend to have distorted working models about interpersonal interactions, and, thus will be at heightened risk for developing maladaptive relationships (Bowlby, 1988), a predisposition for depressive symptoms.

Young's Schema Model

According to J.E. Young's (1999) schema therapy model, schema structures are at the center of the individual's self-concept. Young's (1999) schema model is a theoretical model, that was developed as an expansion of the cognitive model proposed by Beck (1967) which highlighted the importance of schemas in the development
of emotional disorders. Schemas are working structures in memory that become inactive and then suddenly energized or de-energized through environmental factors (e.g., an Abandonment (AB) schema is activated by a divorce).

Secondly, these schemas leave individuals vulnerable to misconceptions, distorted attitudes, invalid premises, unrealistic goals and expectations through biased interpretations of events in the environment. Although schemas can be positive in nature, Young (1999) and Beck (1967) emphasize the formation of Early Maladaptive Schemas (EMS), which form a cognitive diathesis for depression and other psychopathology. There is a growing body of empirical support for the relationship between EMS and psychological distress. As empirical support for the model is gathered, a more concise and accurate measure for EMS has also developed. However, only one study (Welburn et al., 2002) examines this relationship using the Schema Questionnaire-Short Form, the primary measure that is consistent with the current investigation.

Over the years, researchers have also discussed several defining characteristics of EMS. Early Maladaptive Schemas are described as rigid, unconditional beliefs
and/or feelings towards oneself and oneself in relation to the surrounding environment (Guidano & Liotti, 1983; Young, 1999; Young et al., 2003; Schmidt & Joiner, 2004). Therefore, if and when the schema is activated, individuals feel as though they cannot avoid the painful emotional outcome (Young, 1999). They can only cope by delaying, avoiding, or surrendering to the emotional consequences of outcomes such as rejection, punishment, etc. Schemas are developed early in life and often shape an individual’s conceptions of the environment. Being at the center of the individual’s identity, EMS are resistant to change (Ingram et al., 1998; Goodman & Gotlib, 1999; Young, 1999; Young et al., 2003). Individuals become comfortable and familiar with schemas, even given their maladaptive nature. In an effort to maintain consistency, the individual is forced to distort information to keep the schema intact, while he/she is faced with the threat of schematic change (Millon, 1981). Each time the EMS is reconfirmed, it is made more stable. Over time, the schema transforms from belief to something certain and is unquestioned as truth by the individual (Guidano & Liotti, 1983).
EMS are reoccurring and are proposed to be activated by current life stressors that lead to problematic psychological outcomes such as depression, panic, loneliness, destructive relationships, poor work performance, psychosomatic disorders, substance abuse, and eating problems (Young, 1999; Waller, Chanian, Meyer, & Osman, 2000; Harris & Curtin, 2002; Schmidt & Joiner, 2004). After an EMS develops, it can be activated by related events in the individual's environment (Young, 1999). For example, when a woman with a Failure (FA) schema (the belief that one is inadequate relative to one's peers, in areas of achievement, i.e., stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.) is asked out on a dinner date by a new employee, where the person may be judged, the schema erupts. Thoughts begin to arise such as “I’m unattractive and have a weak personality.” “No one will ever like me.” “I’ll make a fool of myself.” “I just can't handle this.” Schema activation, as a result of an activating event (e.g. the date request triggering a Failure (FA) schema), is usually accompanied by a high level of affective arousal (Young et al., 2003). In the example above, the
individual may experience anxiety and perhaps even sadness and/or shame. A final characterizing element of an EMS is the idea that the schema development is closely linked with the individual’s personality style leading to possible dysfunctional interpersonal and intrapersonal experiences (Millon, 1981; Young et al., 2003).

Traumatic events may lead to the development of EMS; however, it is believed that most schemas develop as a result of more insidious or chronic toxic parent/guardian interactions (Young et al., 2003). An EMS is a template of dysfunctional themes or patterns that develop during childhood and adolescence and are focused on oneself and one’s relationship to others. Schema include memories, emotions, cognitions, and bodily sensations.

Young lists 18 different themes, or EMS, that are grouped into five broad 'Schema Domains' based on the consequences of children’s unmet core emotional needs at key developmental periods, (Goodman & Gotlib, 1999; Ingram et al., 1998). In childhood, the EMS and coping efforts may be adaptive and functional for the individual. However, as the individual moves into adulthood, the EMS
and coping styles are no longer adaptive and yield distress.

Domain I: Disconnection and Rejection. Young proposes that in developing a healthy sense of self, children need to be in a secure and safe environment with stability, nurturance, empathy, sharing of feelings, acceptance, and respect from their parents, siblings, and peers. The first Domain concentrates on feelings of Disconnection and Rejection (DR) and appears to develop when children do not have the love and respect of parents and siblings, and the social acceptance of peers (Young, 1999). Social integration is vital for healthy development. Children must feel connected to other people in a stable, enduring, and trusting manner. He/she needs to feel loveable, acceptable, and desirable to others, and that they are worthy of this attention, love, and respect. When children do not have this kind of healthy secure environment, they are prone to developing EMS related to Disconnection and Rejection Domain (DR): Abandonment/Instability (AB), Mistrust/Abuse (MA), Emotional Deprivation (ED), Defectiveness/Shame (DS), and Social Isolation/Alienation (SI) (Young, 1999).
The Abandonment/Instability (AB) EMS (the perceived instability and unreliability of social support and connection) develops when children fear that social support may be removed due to the fact that parents are emotionally unstable, unpredictable, and/or unreliable. The Mistrust/Abuse (MA) EMS encompasses a belief that others will intentionally hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage of the individual. Expectations of Emotional Deprivation (ED) are developed when the individual’s need for emotional support is not adequately met by parents. Emotional deprivation can be experienced in three ways: without nurturance, empathy, and protection. Individuals who develop a Defectiveness/Shame (DS) EMS (feelings of defectiveness, unworthiness, inferiority or invalidity about oneself) view themselves as incompetent, unattractive or unlovable. The final EMS within the first domain is Social Isolation/Alienation (SI), where one is left feeling isolated from the rest of world, not belonging to any group or community, and somehow different from others. Children who do not receive love, affection, respect, acceptance, or attention from their primary caregivers are
thought to be more prone to developing EMS related to feelings of Disconnection and Rejection (DR) (Young, 1999).

The schemas clustered within the Disconnection Rejection Domain (DR) include feelings of disconnection, defectiveness, and alienation from others, especially parents. These schemas have been found to be highly associated with symptoms of depression (Harris & Curtin, 2002; Schmidt et al., 1995; Schmidt & Joiner, 2004; Wellburn et al., 2002). Feelings of disconnection and rejection can develop when children have been left alone from a very young age; primary caretakers maybe absent due to death, illness, career, divorce, etc. (Young et al., 2003). The schemas mentioned above can also develop if children are abused, cheated, or lied to by parents (Young, 1999). Finally, it is important for parents to encourage children to socialize with other children their own age. Feelings of rejection also develop when children are over criticized by parents or are made to feel unwanted by their peers. One way for these feelings to emerge is through labeling; for example, if the child is constantly told that they are stupid or inept when they
make mistakes, even developmentally appropriate mistakes, the child may be mislead and forced to develop a schema that fosters the idea that they are incompetent in relation to peers and others. Children, who are teased or treated differently by their peers and others, are also vulnerable to developing these maladaptive ideas.

Domain II: Impaired Autonomy and Performance. Young proposes that competent individuals need to develop a unique sense of self that is independent of others. These independent individuals acquire a sense of integrity and are better able to develop physical, mental, and psychological control on their own; in order to accomplish all of this, the individual needs to feel safe and secure within their environment. If children become overly dependent on parents and feel that they are unable to survive in the world outside of family without the continual support from others, they can develop cognitive distortions of the Impaired Autonomy and Performance Domain (IP) (Young, 1999). For healthy development, individuals need assurance that they are strong and competent individuals with the ability to make sound decisions and judgments for themselves. If children fail
to see themselves as autonomous and competent individuals in a safe environment they are prone to developing EMS related to the Impaired Autonomy and Performance Domain (IP): Dependence/Incompetence (DI), Vulnerability to Harm and Illness (VH), Enmeshment/Undeveloped Self (EM), and Failure (FA) (Young, 1999).

Feelings of Dependence/Incompetence (DI) (the belief that one is completely helpless without the support of others) develop when children are not given responsibilities or are not reinforced for individuating. Vulnerability to Harm or Illness (VH) is an exaggerated fear that an emotional, physical or external catastrophe is imminent and one has no control to prevent it. Thoughts associated with Enmeshment/Undeveloped Self (EM) develop when individuals are completely fused with others and feel that they cannot survive or be happy without the other person. Additionally, this EMS leads to problems with choosing a direction in life, and even to questioning one’s own existence. Finally, the beliefs that one is ignorant, untalented, and lower in status comprise the EMS of Failure (FA). If a child’s environment is enmeshed and overprotective, the child is likely to develop maladaptive
views related to Impaired Autonomy and Performance (IP) (Young, 1999).

The schemas in this group include feelings of failure, incompetence, and vulnerability and have been found to be associated with depression, anxiety, and panic disorders (Harris & Curtin, 2002; Riskind, Williams, Gressner, Chrosniak, & Cortiña, 2000; Schmidt et al., 1995; Schmidt & Joiner, 2004; Parkes, 1984; Sarson et al., 1978, Seligman, 1975). Children with overprotective or overbearing parents are given the message that they are incapable of making good decisions. These children become overly dependent and feel incompetent due to parents’ constant intervention, even in small and irrelevant matters. On the other hand, such beliefs may also develop if the child is not given enough direction in life (Young, 1999). The thoughts and feelings of failure arise when children aren’t given enough individual responsibility to accomplish tasks on their own and their confidence was always undermined (Young, 1999). Children feel unsafe in their environment when parents become overprotective and continually warn their children of exaggerated dangers and risks in their environment (Young et al., 2003).
Domain III: Impaired Limits. Young hypothesizes that for healthy development children need to be taught genuine concern for others, and made aware that relationships involve sharing, cooperation, and reciprocity. When children are unable to maintain enough self-discipline in order to control their impulses and respect others needs and rights, they develop thoughts associated with the Impaired Limits Domain (IL) (Young, 1999). Children reach realistic internal limits when primary caregivers provide an adequate amount of supervision, direction, and guidance. Children have to be taught that following the rules and norms of society are important for normal social interaction. Without realistic self-control and concern for others, children are prone to developing EMS within the Impaired Limits Domain (IL): Entitlement/Grandiosity (ET) and Insufficient Self-Control/Self-Discipline (IS) (Young, 1999).

The Entitlement/Grandiosity (ET) EMS (the belief that one is somehow better than others, with special and/or unrealistic rights and privileges) can lead to an exaggerated sense of superiority. These people may find themselves constantly trying to achieve dominance over
others, through power and control, and in competition with their peers. These individuals will do anything to get what they want, without empathy or consideration for others who may be involved. Insufficient Self-Control/Self-Discipline (IS) EMS leads to the avoidance of pain, conflict, confrontation, or responsibility due to insufficient self-control and low frustration tolerance when attempting to meet one's goals.

When children are not given adequate supervision, direction, and guidance they develop schemas within the Impaired Limits Domain (IL), which have been found to mediate the relationship between parental perceptions and emotional disorders (Harris & Curtin, 2002; Schmidt et al., 1995; Shah & Waller, 2000). A deficiency in internal limits is developed by parental extreme permissiveness, overindulgence, lack of guidance, and a sense of superiority in a child's life (Young, 1999). Schemas associated with this domain develop when the child's environment has been too laissez-faire. Feelings of grandiosity develop when children are unable to deal with defeat or frustration, and selfishness is tolerated. Further, thoughts of entitlement are formed when parents
praise children for inappropriate behavior, rather than appropriately confronting and disciplining them.

**Domain IV: Other-Directedness.** For healthy development one needs both a sense of other-directedness and a sense of inner-directedness, thus having the ability to express his/her own needs and emotions when appropriate (Young, 1999). The fourth domain, Other-Directedness (OD), is believed to develop when the child is forced to suppress his/her desires, feelings, and responses in order to feel connected with primary caregivers (Young, 1999). A sense of inner-directedness is developed when parents allow their children to express their own needs appropriately, and allow them to act upon their needs without restriction or punishment. When children are taught or reinforced to place a greater emphasis on the desires, feelings, and responses of others over their own, they are prone to developing EMS related to Other-Directedness (OD): Subjugation (SB), Self-Sacrifice (SS), and Approval-Seeking/Recognition-Seeking (Young, 1999).

Subjugation (SB) is the belief that surrendering of control to others is necessary in order to avoid anger, retaliation, or abandonment, with the assumption that
one's own desires, opinions, and feelings are not valid. This leads to resentment that is expressed in maladaptive ways (e.g., passive aggression), which often involves a very controlling parent. People with the Self-Sacrifice (SS) schema, view themselves as martyrs and voluntarily meet the needs of others over their own to help those they view as needy. As a child, the individual may have felt responsible for the well-being of their caregivers leaving some of the child’s needs unmet. While in reality, the parent should have been responsible for the child’s well-being and making sure that his/her needs were successfully met. This EMS is associated with a tendency to feel guilty for “selfish behavior” and thus the individuals are more confident in benevolent connections where they are the giving hand. These individuals may have problems tolerating grief, pain or difficulties in others. Finally, the Approval Seeking/Recognition-Seeking (AR) EMS (a focus on gaining approval, recognition, or attention from other people) develops when the individual’s sense of identity becomes dependent on other’s reactions over one’s own achievement and success.
The schemas within the Other-Directedness Domain (OD) are usually found in individuals who grew up with parents that fostered conditional acceptance of their children. These schemas include feelings of abandonment, withdrawal, and guilt, and may lead to feelings of deep hopelessness, passive aggressive behavior, and psychosomatic symptoms (Young et al., 2003; Hewitt & Flett, 1991, Beck, 1967). Children are forced to suppress awareness and expression of their feelings and emotional needs, to obtain conditional acceptance from their caregivers; resulting in unmet needs for the child. These individuals learn to follow the inclinations of others rather than their own wishes (Young, 1999). There is a greater interest in social acceptance and status within these families, and sometimes the emotional needs and desires of the families are valued over the child’s needs and desires. Children who are brought up with conditional acceptance, fear punishment and withdrawal of support from their parents, when they act upon their own inclinations and wishes (Young et al., 2003).

Domain V: Overvigilance and Inhibition. In developing a strong sense of self, children need a calm and
comfortable environment in which they can act freely and pursue creativity, happiness, and relaxation (Young, 1999). When children are taught to be overly cautious to the possibility of making mistakes and are expected to inhibit natural reactions, they may develop expectations associated with the Overvigilance and Inhibition Domain (OV) (Young, 1999). In addition to encouraging individualism, it is important for parents to understand and accept the individual’s unique goals, abilities, and characteristics. Children, who grow up in a pessimistic environment, rather than a comfortable one, are more likely to develop EMS related to the Overvigilance and Inhibition Domain (OV): Negativity/Pessimism, Emotional Inhibition (EI), Unrelenting Standards/Hypercriticalness (US), and Punitiveness (Young, 1999).

The Negativity/Pessimism EMS (a constant focus on the negative aspects of life while completely ignoring all positive aspects in life) creates a chronic worry that everything in life is going to fall apart. Thoughts related to Emotional Inhibition (EI) (the inhibition of anger and aggression, positive impulses, expressing vulnerability or communicating one’s needs and feelings)
occur with an excessive importance on rationality to gain approval of others and avoid feelings of shame. Unrelenting Standards/Hypercriticalness (US) EMS (the belief that one must meet unrealistically high or perfectionistic standards of behavior and performance in order to avoid criticism from others) often presents as a demanding and critical nature towards self and others. The final theme within this domain is Punitiveness (the individual becomes angry, intolerant, and impatient towards anyone who fails to meet their expectations). These individuals have a hard time understanding that perfection is not possible and thus do not value forgiveness. Further, they have trouble understanding people's true intentions.

Schemas associated with excessively high standards of performance may lead to a variety of emotional disorders, most strongly related to anxiety and depression (Frost, Heimberg, Holt, Mattia, and Neubauer, 1993, Hewitt & Flett, 1991; 1993; Joiner & Schmidt, 1995; Kanfer & Hagerman, 1981; Beck, 1967). Parents who are more concerned with achievement and perfection over happiness, and never seem to be satisfied with their child's
accomplishments are more likely to have children that are unhappy, lack self-expression, unnecessary stress, and poor health (Young, 1999). Parents tend to be harsh and strict, with rigid rules and excessively high unrealistic expectations (Young et al., 2003). In addition, these individuals are constantly worried about making mistakes that will have a negative impact on their life, making them exceptionally cautious and somewhat indecisive (Young, 1999).

Parental Socialization

Early interactions with caregivers have been found to predict later interactions and adjustment in children (Ingram, Miranda, & Segal, 1998; Koback & Sceery, 1988, Young, 1994). Although a number of aspects (e.g., belief structures, values, opportunity, etc.) have been critical for meeting the fundamental needs of a child, parental socialization is a basic component of child development. As previously discussed, in Attachment (p.5), for healthy psychological and social development children need to develop a strong, loving, caring, and protective bond/attachment with a parent. Research suggests that parents who are highly caring and affectionate but encourage
independence at the same time provide the best environment for the children (Parker et al., 1979). Early Maladaptive Schemas have been thought to mediate the relationship between perceptions of parenting and depressive symptoms (Young et al., 2003; Harris & Curtin, 2002; Shah & Waller, 2000).

**Connection.** Connection has long been established as one of the two basic dimensions of parent/child relations (Maccoby and Martin, 1983). Children need consistent, positive attachments with parents. As previously mentioned, parental connection is synonymous to the parental caring dimension of the Parental Bonding Instrument, described by Parker et al. (1979). This type of parental warmth involves a parent-child relationship characterized by encouragement, endearment, cooperation, physical affection, and helping behavior. Connected relationships lead to the development of a positive self concept and the increase of self esteem, fostering positive socialization in the child’s future (Barber, 1996).

Barber and Olsen (1997) found two unique relationships between family socialization and youth
functioning. Specifically, individuals who reported feeling strongly connected to their parents demonstrated better mental health and less involvement in antisocial behavior. This is particularly true for girls (Eccles et al., 1997; Connell & Wellborn, 1991; Goodnow, 1993)

**Behavioral Monitoring.** Monitoring is closely associated with behavioral regulation, and in much of the literature, has been found to be related positively to connection and self esteem (Barber, 1996; Steinberg, 1987; Hirschi, 1969). In this type of parent-child relationship the child’s behavior is heavily regulated by parents through fair rule setting and consistent limits. Parental monitoring seems closely related to the "optimal parent-child bond" (Parker et al., 1979), with high levels of caring and low levels of overprotection. These parents are well aware of the child’s affairs, where the child spends his/her time and money; who the child’s friends are; etc. (Patterson & Stouthamer-Loeber, 1984). This type of bonding can lead to positive or negative social outcomes depending on the degree of connection.

Children who report both perceptions of fair regulation and connection from family members have been
found to be the least involved in antisocial behavior (Barber & Olsen, 1997). In the event that the child is closely monitored by parents in the absence of warmth and connection increases the likelihood of 'conduct problems' (Forhand & Nousiainen, 1993; Patterson, Reid, & Dishion, 1992). Positive parental regulation is predictive of lower involvement in externalizing behaviors and the maintenance of interest in learning and achievement (Eccles et al., 1997; Barber, 1996; Barber, Olsen, & Shagle, 1994).

Psychological Autonomy. Psychological autonomy, the third dimension of parental socialization is characterized by a parent-child relationship where the self-expression, emotional development and thinking processes of the child are not intruded upon by the parent (Barber & Buehler, 1996). Overprotective parents do not allow for the development of this sort of psychological liberation (Parker et al., 1979). Children who feel forced to comply with the demands of parents perceive that if they don't comply, their parent's love (emotional support) will be taken away, (Barber, Olsen, Shagle, 1994). These children are said to be under psychological control and are not allowed to be autonomous. Parents should be able to
provide noncoercive, democratic discipline (Herman et al., 1997). Researchers have argued that support for psychological autonomy is vital for healthy development at any age (Barber, 1996; Connell & Wellborn, 1991; Deci & Ryan, 1985). More importantly, scholars have argued that support for autonomy is most important in early adolescence where the key developmental task of the adolescent is establishing independence (Eccles et al., 1993). If children aren't given the freedom to express feelings, the feelings often get turned inwards.

Psychological control (the opposite of psychological autonomy) predicts both internalized (Barber et al., 1994) and externalized (Barber, 1996; Conger, Conger, & Scaramella, 1997) problems in later adjustment, and has been associated with a lack of parental care (Parker et al., 1979). In fact, both Barber and Olsen (1997) and Eccles et al. (1997) found that support for psychological autonomy, from family, was strongly related to successful functioning in adolescents (e.g., school achievement; school alienation; lower levels of depressive affect; the least amount of behavioral problems). Further, it has been found that adolescents may reduce or even withdraw their
engagement and/or psychological interests from those contexts in which enough opportunities for autonomy are not provided (Eccles et al., 1993; Steinberg, 1990; Connell, 1990; Deci & Ryan, 1985). Successful socialization would allow the child to develop an autonomous sense of identity while preserving a positive connection to parents.

Assumptions of Young’s Schema Model

The current study aims to further investigate the relationship between EMS, depression and the role of parenting by investigating parental socialization (connection, behavioral monitoring, and psychological autonomy). Additionally, the negative relationship between parental care and overprotection is further assessed (Parker et al., 1979). Connection, behavioral monitoring, and psychological autonomy have been found to be pivotal in meeting children’s basic needs for healthy emotional and behavioral development (Barber, 1996). Specifically, these parenting characteristics, allow children to develop positive schemas (e.g., self-concept) about their world. When basic needs for connection, monitoring and autonomy are not met, children are more likely to have negative
social/emotional outcomes, possibly due to the development of Early Maladaptive Schemas. In a Diathesis Stress Model, it is presumed that disease (e.g., depression) is the result of a cognitive vulnerability (e.g., poor parenting, subsequent EMS) that is triggered by everyday life stress. The interaction of all of these factors leads to the development of psychopathology, (e.g., depression).

In summary, research has supported each link of the schema model. The link between early parental recollections (connection, monitoring and psychological autonomy) and adolescent emotional, behavioral and educational outcomes has been previously established (Herman et al., 1997; Eccles et al., 1997; Barber & Olsen, 1997). Next the relationship between early parental recollections of psychological control) the opposite of psychological autonomy) coupled with reduced levels of connection and depression was established (Herman et al., 1997; Eccles et al., 1997; Barber & Olsen, 1997). Finally, the partial mediating role of EMS on the relationship between parental recollections of overprotection and reduced caring (as measured by the Parental Bonding Instrument) on depressive symptoms was established (Harris
& Curtain, 2002; Shah & Waller, 2000). To date, no study has examined the relationship of parental connection, monitoring, and psychological autonomy with EMS or the possible mediating role EMS may play between the above parental recollections on depression and anxiety.

These studies provide support for Young's model of Early Maladaptive Schemas as they are consistent with the higher order (EMS Domains) and lower order (EMS) factors proposed by Young (1990). Additionally, Schmidt et al. (1995) found construct validity for the model proposed by Young as they found a positive relationship between EMS and psychological symptoms.

**Parenting and Psychological Symptoms.** The effects of parental socialization can exist in multiple contexts. In an attempt to assess the effects of parental socialization, Eccles, Early, Frasier, Belansky, and McCarthy (1997) investigated the relationship of perceptions of early parental socialization (e.g. connection, regulation, and psychological autonomy; Barber, 1996) and adolescent functioning across four social contexts (parent/child, sibling relationships, peer groups, and schools) in a sample of 1387 seventh graders
(mean age = 12.78), attending a public junior high school. Forty-nine percent of the targeted youth were females, and the sample included families from urban, suburban, and rural neighborhoods. Seventh graders and their primary caregivers (ninety-two percent of the primary caregivers were female) were given a self-report questionnaire and interviewed in their homes by a trained investigator assessing children's socialization, family demographics, and adolescent functioning. First, Eccles et al. (1997) assessed the independent relationship of connection, regulation, and autonomy to four factors (academic alienation, GPA, depressive affect, and problem behavior) of adolescent functioning, in all four contexts. Second, researchers addressed the importance of different contexts (e.g., parent/child vs. peer groups) as more or less important to the child at different stages of social development. They posited that, successful youth development may be context specific. Patterns of associations between the three central dimensions of socialization and the four indicators of adolescent functioning were compared in the four contexts. Regression analyses revealed that connection with parents, regulation
of behavior, and support for autonomy were strong predictors of successful youth functioning, regardless of family demographics. Secondly, each dimension made independent contributions to children’s healthy development. Regulation in the family context was strongly related to fewer behavioral problems. It was also found that adolescents with healthy interactions in one context also had healthy relationships in the other three contexts. For example, youth that faired well in the home had few if any problems with their peers and at school. In addition, positive experiences with parents and older siblings were negatively associated with depressive affect. Positive experiences with parents and peers were associated with minimized problem behavior; positive experiences with parents, siblings, peers, and school were all predictive of positive school-related functioning in adolescents.

Herman et al. (1997) examined Barber’s (1996) three dimensions of parental socialization (involvement/connection, regulation/monitoring, and psychological autonomy) and their effects on adolescent adjustment. Investigators looked at six adolescent outcomes; both
internal (e.g. physical and psychological symptoms) and external (e.g. education and deviance) distress are discussed in male and female adolescents. A total of 2,850 high school students completed self-report surveys assessing parental socialization and adolescent distress; surveys were administered over the course of two consecutive school years. Investigators hypothesized each of the three parental dimensions as unique predictors of six adolescent outcomes (grades, expectations, psychological symptoms, somatic symptoms, drug use, and delinquent acts). Herman et al. (1997) found that all three socialization dimensions independently were correlated with all six measures of adolescent functioning. Additionally, the interaction models of all three dimensions showed significance for various outcomes. Specifically, parental regulation was only found to be a strong predictor of high grades and high expectations. Psychological autonomy and parental regulation were both found to be uniquely related to health symptoms (psychological and somatic symptoms) and deviance (delinquent acts and drug abuse).
Barber and Olsen (1997) investigated perceptions of socialization within the family, school, neighborhood, and peers as it related to school grades, feelings of depression, and antisocial behavior in 900 fifth-and eighth-graders; two cohorts at relatively different stages of human development. Researchers looked at parental connection, regulation, and autonomy in four social contexts and four various models, predicting both independent and interactive effects on youth's psychological and social outcomes. A series of self-report questionnaires, assessing three dimensions of socialization, school grades, feelings of depression, antisocial behavior, and various demographics control variables including social economic status, race, and religion, was administered to the students in class. Multiple regression analyses found the three central dimensions of socialization (e.g., connection, monitoring, and psychological autonomy) to be relevant in all four social contexts, revealing family and peers, respectively, as the most influential in youth functioning (Youth Criterion Variables: Grades; Feelings of Depression; and Antisocial behavior) across both age groups. School
experiences varied between cohorts and children reported very little connection to other adults in the neighborhood. It can be concluded that children need some degree of parental monitoring and protection however; taken out of a loving, caring environment these positive parenting attributes can become negative.

Maladaptive Schemas and Psychological Symptoms. Welburn, Coristine, Dagg, Pontefract, and Jordon (2002) examined the relationship between the EMS as measured by the Schema Questionnaire-Short Form (SQ-SF; Young, 1998) and symptoms of anxiety, depression, and paranoia, using a sample of 196 patients in a psychological day treatment program. Referrals were made from a walk-in emergency service, a crisis unit, inpatient wards, and from general outpatient services. Thirty-three percent of the participants were Male and 67% were Female; age ranged from 18-63. The authors hypothesized that EMS that are conceptually congruent with psychological symptoms (e.g., EMS of Mistrust/Abuse (MA) and paranoia) should be strongly correlated with those symptoms on the Brief Symptoms Inventory (BSI; Derogatis, 1993). Multiple regression analyses revealed that, as hypothesized, EMS
were significant predictors of psychological symptoms. Overall, all 16 EMS accounted for 52% of the variance in anxiety. Specifically, five EMS (Abandonment (AB); Vulnerability to Harm (VH); Failure (FA); Self-Sacrifice (SS); and Emotional Inhibition (EI)) were unique and significant predictors of anxiety. For depression, all EMS accounted for 47% of the variance; however, The EMS of Abandonment (AB) and Insufficient Self-Control (IS) were the unique significant predictors. Sixty-two percent of the variance in paranoia was accounted for by all EMS. Specifically, Mistrust/Abuse (MA), Vulnerability to Harm (VH), Self-Sacrifice (SS), and Insufficient Self-Control (IS) were all significant predictors of paranoia. Results suggest that EMS in general are related to psychological symptoms, with partial support for the specificity of EMS and specific psychological symptoms. These results may be due to both the conceptual overlap of EMS and the co-morbid nature of psychological symptoms. Results provided support for Young’s schema model. The authors suggested that identifying and restructuring EMS with appropriate Cognitive Therapy could help alleviate related psychological symptoms. As suggested by Segal (1988),
given the rather automatic nature of schemas in a variety of situations, one is left vulnerable to psychological symptoms.

Schmidt, Joiner, Young, and Telch (1995) conducted a preliminary validation study of the Schema Questionnaire (SQ; Young 1990; 1991), using both a non-clinical as well as a clinical sample. In Study 1, a factor analysis using the principal-components analyses (PCA) of SPSS with orthogonal/varimax rotation procedure yielded 13 (i.e., Incompetence/Inferiority (II), Emotional Deprivation (ED), Defectiveness/Shame (DS), Insufficient Self-Control (IS), Mistrust/Abuse (MA), Self-Sacrifice (SS), Unrelenting Standards (US), Abandonment (AB), Enmeshment (EM), Vulnerability to Harm (VH), Dependence/Incompetence (DI), Emotional Inhibition (EI), and Fear of Losing Control) of the 16 EMS hypothesized by Young (1991); a sample of 1129 students enrolled in introductory psychology courses was used, with 423 male and 706 female participants. Further, hierarchical factor analysis revealed three higher order factors (e.g., Disconnection, Overconnection, and Exaggerated Standards) consistent with 3 of 5 of Young’s Schema Domains. Finally, Schmidt et al. (1995) found
adequate test-retest coefficients and alpha internal consistency coefficients \((r= .76)\) for test-retest and (average alpha = .90) for alpha.

In Study 2, a factor analysis of the Schema Questionnaire-Short Form, using the principle-components analyses of SPSS with a varimax rotation, revealed 15 of the 16 proposed EMS, in the clinical sample of 187 outpatients, mean age was 36.8, 52% were females, and a majority were white. Out of this clinical sample, 61% had received an Axis I diagnosis and 55% had received Axis II personality disorder diagnosis, at intake. The fifteen EMS (mentioned above) accounted for 53.7% of the total variance. Social Undesirability was the only scale that did not emerge. Only small differences were noted between the clinical and student samples by the authors.

In Study 3, the Schema Questionnaire-Short Form was tested for convergent and discriminate validity, in a sample of 163 undergraduates (96 males, 85 females; average age=19.2; average education level=13.1) enrolled in introductory courses, using measures of self-esteem, psychological distress, personality disorder traits, and dysfunctional attitudes related to depression. A negative
correlation between EMS and positive traits (i.e., self-esteem) was predicted. Further a positive association was predicted with EMS and distress, personality disorder traits, and dysfunctional attitudes. As predicted, a significant positive correlation was found between the Schema Questionnaire-Short Form total score and the overall distress as measured by the General Severity Index (GSI) of the Brief Symptoms Inventory and the Negative Affectivity scale of the Positive Affectivity/Negative Affectivity Scale (PANAS-NA; Watson & Clark, 1990; Watson, Clark, & Tellegen, 1988). A negative correlation was found between the SQ total score and the Positive Affectivity scale of the Positive Affectivity/Negative Affectivity Scale (PANAS-PA) was present. Significant positive correlations between the Schema Questionnaire-Short Form total score and the measures of depression (i.e., Beck Depression Inventory (BDI; Beck et al., 1979; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), Symptoms Checklist-90-Revised Depression (DEP) and Anxiety (ANX) subscales (SCL-90-R; Derogatis, 1983) were also found, with Pearson’s correlation coefficients ranging from .59 to .63 for depression and .47 for anxiety. As hypothesized, the
Schema Questionnaire-Short Form was also positively correlated with the Dysfunctional Attitudes Scale (DAS; Weissman, 1979) and negatively associated with self-esteem as measured by the Rosenberg Self-Esteem Questionnaire (SEQ; Rosenberg, 1965). Further, a correlational analysis between the total Schema Questionnaire-Short Form score and the sum of all thirteen criterion scores of the Personality Disorders Questionnaire indicated that the Schema Questionnaire-Short Form was strongly related to Axis II personality symptoms \((r=.71)\). It was found that the EMS proposed by Young (1991) in the Schema Questionnaire-Short Form accounted for a significant proportion of the variance (55%) in psychological distress. In addition, analyses suggested Dependency (DI) and Defectiveness (DS) EMS were associated more with depression, as Vulnerability (VH) and Inferiority/Incompetence (II) EMS were associated more with anxiety.

The authors mention a number of limitations to their study. In conclusion, they posited their findings for the clinical sample as tentative, mainly due to the relatively small clinical sample that was utilized.
Schmidt and Joiner (2004) evaluated the relationship between "global" maladaptive schemas as measured by the Schema Questionnaire (SQ; Schmidt, 1994) and negative life events as measured by the Schema Negative Life Events Survey (SNLES; Schmidt & Joiner, 2004), and psychological distress as measured by three unique scales: Beck Depression Inventory (BDI; Beck et al., 1979; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988), Symptoms Checklist-90-Revised (SCL-90-R; Derogatis, 1983); using a sample of 93 college students. All students were undergraduates enrolled in introductory psychology classes, with 52 males and 41 females, ages ranged from 17-29. EMS are a part of the individual's self concept, thus they are self-perpetuating, resistant to change, familiar and comfortable, giving rise to negative automatic thoughts and create psychological distress; however a distinction is made between the schema theories proposed by Young and Beck (Schmidt & Joiner, 2004). Young (1990) proposes that EMS are unconditional (hyper activated; e.g., "I am a failure") in nature, and that their stable and enduring nature is always present. Beck
(1967) had proposed that EMS had a conditional (e.g., "If I ace the exam, I will be considered intelligent") nature, suggesting that the EMS are only activated when specific environmental stressors or conditions are presented, taking on a more fluctuating course. The authors hypothesized that each EMS and negative life event would independently contribute to the prediction of psychological distress, based on the hyper activated maladaptive schema model. Additionally, the researchers hypothesized an interaction between EMS and life events in the prediction of psychological distress. Specifically, people with fewer EMS would experience similar distress when faced with greater negative life events. Where as, those with more EMS would experience similar distress even in the absence of negative life events. Separate regression analyses revealed significant main effects for Schema Questionnaire and Schema Negative Life Events Survey across all dependent variables (Positive and Negative Affect Schedule, Beck Depression Inventory, and Symptoms Checklist-90-Revised). Specifically, Schema Questionnaire and Schema Negative Life Events Survey each were predictors of all symptom oriented dependent
variables. Moreover, a significant SQ x SNLES interaction for each symptom oriented dependent variable was reported. As predicted, the distress scores of high SQ participants were less affected by the occurrence of negative life events compared to the distress scores for low SQ participants. This study provides support for Young’s hyper-arousal schema model, in which participants with more maladaptive schemas experienced symptoms of psychological distress independent of the number of negative life events they were experiencing. This finding is also consistent with Safran et al.’s. (1986) distinction between core and peripheral cognitive processes. Core cognitive structures (hyperarousal schemas model) have a higher likelihood of arousal across a wide range of situations. Further, these results can be used to explain the differential courses seen in Axis I and II pathology. Axis I conditions often show distinctive stress induced patterns of symptoms alternating with periods of remission. Axis II disorders are typically characterized as chronic and enduring conditions without remission.

Due to the limitations expressed by Schmidt et al. (1995) (e.g., small clinical sample), Lee, Taylor, and
Dunn (1999) examined similar hypotheses to Schmidt et al. (1995), only they used an Australian clinical sample of 433 patients from inpatient and outpatient clinics, including 182 males and 251 females. Lee et al. (1999) used the 205-item Schema Questionnaire (SQ; Young & Brown, 1990), designed to measure sixteen EMS, to assess whether or not the underlying structure of the Schema Questionnaire found in Schmidt et al.'s study was reliable and whether this reliability would differed amongst Axis I and Axis II patients. Sixty-two percent of Lee et al.'s (1999) sample included patients with a personality or Axis II disorder. Further, researchers examined the interaction of culture and personality by testing the applicability of Young and Beck's schema models across different cultural and sub cultural groups (e.g., Australian clinical population meeting DSM-IV criteria for personality disorder as opposed to an American student sample); questioning whether or not the differences in attitudes and practices would make a significant impact on the reliability and/or validity of the Schema Questionnaire. A Procrustes rotation method revealed only two major differences with the Axis II sample; the Insufficient
Self-Control (IS) EMS loaded to a greater extent on Impaired Autonomy Domain (IP), and the Abandonment (AB) EMS loaded equally on both Impaired Autonomy (IP) and the Disconnection (DR) Domains. However for the entire sample, the Abandonment (AB) EMS loaded solely on the Disconnection Domain (DR). The Axis I analyses revealed different correlations; only Insufficient Self-Control (IS) loaded on the Impaired Limits Domain (IL) whereas in the entire sample it also loaded on the Impaired Autonomy Domain (IP). Additionally, in the Axis I sample, the Vulnerability (VH) EMS loaded on both the Impaired Autonomy (IP) and Impaired Limits Domains (IL), however in the entire sample it loaded only on the Impaired Autonomy Domain (IP). Only a minor difference was observed between the Axis I and Axis II higher order factor structures. Finally, as expected, Axis II patients scored relatively higher on all scales, in comparison to Axis I patients. The greatest differences between Axis I and II patients was observed in the Disconnection (DR) and Impaired Limits (IL) scales. Further, analyses revealed that the Schema Questionnaire had good internal consistency. Principal-components analysis revealed that sixteen factors:
“Emotional Deprivation”, “Unrelenting Standards”, “Mistrust”, “Dependency”, “Failure”, “Abandonment”, “Enmeshment”, “Self Sacrifice”, “Insufficient Self Control”, “Social Isolation”, “Entitlement”, “Vulnerability”, “Subjugation”, “Emotional Constriction”, and “Fear of Loss of Control” accounted for 60% of the total variance found in EMS. In addition, the higher order factor structure is consistent across clinical and nonclinical samples from different countries and varying degrees of psychopathology.

A Mediation Model. A number of studies (Herman et al., 1997; Eccles et al., 1997; Barber & Olsen, 1997) have shown the importance of parental socialization for later adjustment in youth. Particularly, three central dimensions of child and adolescent socialization: connection with parents, regulation of behavior, and support for autonomy have been demonstrated to facilitate positive outcomes in youth (Barber, 1997; Steinberg, 1990; Maccoby & Martin, 1983; Rollins & Thomas, 1979). Further research is needed to explore the relationship between youth socialization and adjustment in adulthood. Only two studies (Harris & Curtain, 2002; Shah & Waller, 2000) have
explored the relationship between parental socialization and later adjustment, as mediated by the Early Maladaptive Schemas.

Shah and Waller (2000) examined the role of EMS in the parenting-depression relationship. The study investigated a group of 60 depressed outpatients, meeting the DSM-IV criteria for major depressive disorder, with a comparison group of 67 adult volunteers from a healthy community sample. Investigators hypothesized that recalled perceptions of parenting will have a moderate but significant effect on levels of depression, and that this relationship will be mediated by EMS. Participants were asked to complete three self-report questionnaires including the Parental Bonding Instrument (PBI; Parker, Tupling, and Brown, 1979), Young Schema Questionnaire (YSQ; Young, 1994), and Beck Depression Inventory (BDI, Beck & Steer, 1987). Shah and Waller (2000) reported that Beck Depression Inventory and Parental Bonding Instrument scores were significantly higher in the clinical group than the comparison group. Additionally, the clinical group reported less parental recollections of caring and more recollections of overprotection than the comparison
group. Investigators used a MANOVA to find differences between the two groups in core beliefs. The clinical group scored significantly higher than control group on all measures of EMS. Further, a discriminate function analysis revealed that four EMS (Defectiveness/Shame (DS), Self-Sacrifice (SS), Insufficient Self-Control (IS) and Vulnerability to Harm (VH) EMS) were most successful in correctly classifying group membership (clinical versus control). Finally, regression analyses in both the clinical and comparison groups revealed that a relationship between parental care/paternal overprotection and severity of depressive symptoms was mediated by EMS existed. EMS mediation was found with both groups, however a greater level of mediation was found in the clinical group. Specifically, Shah and Waller (2000) found five (Dependence/Incompetence (DI), Emotional Inhibition (EI), Failure to Achieve (FA), Unrelenting Standards (US), and Vulnerability to Harm (VH)) of the sixteen core beliefs to be most influential in mediating the parenting-depression relationship.

Harris and Curtain (2002) investigated a similar relationship between EMS, depressive symptoms, and
retrospective reports of parenting (PBI-O/PBI-C; overprotection and caring subscales; Parker, Tupling, and Brown, 1979). They hypothesized that EMS mediate the relationship between perceptions of parenting and current depressive symptoms. A total of 211 undergraduates completed a number of self-report measures including The Parental Bonding Instrument (PBI, Parker, Tupling, and Brown, 1979), The Beck Depression Inventory-II (BDI-II, Beck, Steer, & Brown, 1995), and Schema Questionnaire (SQ, Young & Lindermann, 1992). In a step-wise regression analysis, Harris and Curtain (2002) found that several EMS were associated with perceptions of parenting and depressive symptoms. Specifically, parental caring (e.g. caring, loving, and affection) was negatively associated with and predicted by Defectiveness/Shame (DS), Insufficient Self-Control (IS), Incompetence and Inferiority (II) and Vulnerability to Harm and Illness (VH) schemas. It was found that these four Schema Questionnaire subscales accounted for 63.3% of variance in Beck Depression Inventory-II scores. Additionally, these authors found that parental overprotection (e.g. controlling, aggressive, and overly critical) was
positively correlated with and predicted by Defectiveness/Shame (DS), Insufficient Self-control (IS), and Vulnerability to Harm and Illness (VH) schemas. An attempt was made to establish a relationship between perceptions of parenting (Parental Bonding Instrument scores), depressive symptoms (Beck Depression Inventory-II scores) and the EMS subscales Defectiveness/Shame (DS), Insufficient Self-Control(IS), Incompetence and Inferiority (II), and/or Vulnerability to Harm and Illness (VH) (Schema Questionnaire scores). It is important to note that the Incompetence/Inferiority (II) EMS that is examined in Harris and Curtain (2002) combined the EMS of Dependence/Incompetence (DI) and Failure (FA), as studied by Young (1994) and others. Regression analysis revealed that scores of caring and overprotection subscales from the Parental Bonding Instrument accounted for 14.4% of variance in Beck Depression Inventory-II scores. Next, the second regression revealed that scores of the caring and overprotection subscales from the Parental Bonding Instrument accounted for 10.4% of variability in Defectiveness/Shame (DS) scores. The third regression analysis revealed that the DS score accounted for 51.2% of
the variability in BDI-II scores; and lastly, when controlling for the DS schema, perceptions of parenting only accounted for 2.4% of the variability in depressive symptoms. Although the 2.4% additional variance was still significant, the 12.2% decrease in explanatory variance while controlling for Defectiveness/Shame (DS) is suggestive of partial mediation, but not full mediation.

In testing the utility of the Parental Bonding Instrument scales to predict depressive symptoms while controlling for the other EMS, similar analyses were conducted with the other potential schema mediators. Perceptions of parenting, as measured by the Parental Bonding Instrument-Caring and Overprotection subscales, accounted for 12.5% of the variance in the Insufficient Self-Control (IS) subscale. Next, the Insufficient Self-Control (IS) score accounted for 32.7% of the variance in depressive symptoms as predicted by Beck Depression Inventory-II scores, and lastly, when controlling for the Insufficient Self-Control (IS) schema, perceptions of parenting accounted for 3.6% of the variance in depressive symptoms. Again, the 3.6% of additional variance added by the Parental Bonding Instrument subscales was significant; the 10.8% decrease
in explanatory variance while controlling for Insufficient Self-Control (IS) is still suggestive of partial mediation, but not full mediation. Regression analyses revealed that the Parental Bonding Instrument-Caring and Overprotection scores accounted for 6.3% of the variance in Vulnerability to Harm and Illness (VH) scores, and the Vulnerability to Harm and Illness (VH) score accounted for 34.3% of the variance in symptoms of depression, as measured by the Beck Depression Inventory-II, and finally, when controlling for the Vulnerability to Harm and Illness (VH) schema, perceptions of parenting accounted for 6.1% of the variance in depressive symptoms. Although the 6.1% of the variance accounted for was significant, it is important to note the 8.3% change, from the variance (14.4%) accounted for by perceptions of parental caring on depressive symptoms without controlling for the Vulnerability to Harm and Illness (VH) EMS; leaving grounds for partial mediation, and another possible mediator. In understanding the mediation of the Incompetence/Inferiority (II) score between perceptions of parenting and depressive symptoms, a different approach was administered due to the nature of the univariate
relationship between the Incompetence/Inferiority (II) score and the Parental Bonding Instrument-Overprotection scale. Further, analyses only examined the Parental Bonding Instrument-Caring scores in testing for mediation with the Incompetence/Inferiority (II) EMS. The Parental Bonding Instrument-Caring scores accounted for 13.0% of the variance in Beck Depression Inventory-II scores. Next, the Parental Bonding Instrument-Caring scores accounted for 2.8% of variability in Incompetence/Inferiority (II) scores. In the third step, the Incompetence/Inferiority (II) score accounted for 42.3% of the variability in Beck Depression Inventory-II scores. In the final regression, when controlling for the Incompetence/Inferiority (II) EMS mediator, the perceptions of parental caring, as measured by the Parental Bonding Instrument-Caring subscale, accounted for 6.5% of the variance in Beck Depression Inventory-II scores. A significant reduction, from the amount of variance (13%) accounted for by the Parental Bonding Instrument-Caring on Beck Depression Inventory-II scores in the absence of controlling for the mediator, was noted. Incompetence/Inferiority (II) scores accounted for 42.3% of the variance in Beck Depression Inventory-II
scores. When controlling for the Vulnerability to Harm and Illness (VH) schema, perceptions of parenting (as measured by the Parental Bonding Instrument-Caring subscale) accounted for 6.5% of the variance in depressive symptoms. In all four cases, a significant reduction was observed from the amount of variance accounted for by perceptions of parental caring and/or overprotection on depressive symptoms when the schema subscale was not controlled, suggesting support for the schema subscales, Defectiveness/Shame (DS), Insufficient Self-Control (IS), Incompetence/Inferiority (II), and Vulnerability to Harm and Illness (VH) as partial mediators between perceptions of parenting and depressive symptoms.

**Hypotheses**

Consistent with prior research on parental caring and overprotection, a negative correlation is predicted between parental connection, parental monitoring and the EMS of Defectiveness/Shame (DS), Insufficient Self-control (IS), Dependence/Incompetent (DI), Failure (FA), and Vulnerability to Harm and Illness (VH). Conversely, a positive correlation is predicted between parental
psychological control and the EMS of Defectiveness/Shame (DS), Insufficient Self-Control (IS), Dependence/Incompetent (DI), Failure (FA), and Vulnerability to Harm and Illness (VH). Consistent with Young's theory, it is predicted that the Disconnection/Rejection Domain (DR) of EMS will correlate negatively with the parenting characteristics of Connection. Additionally, based upon Young's model, it is expected that: (1) there will be a positive relationship between the Impaired Autonomy and Performance Domain (IP) EMS and parental psychological control; (2) it is expected that there will be a positive relationship between parental psychological control and the Other Directedness Domain (OD) EMS.

Based upon prior research (Parker et al., 1979) it is predicted that the interaction of parental connection and parental monitoring will account for unique explanatory variance in EMS, beyond those accounted for by these factors individually. Specifically, we predict that under low levels of parental connection, parental monitoring will be a positive predictor of EMS. Further, it is predicted that low levels of parental connection and high
levels of psychological control will be more predictive of EMS, than either factor alone.

Finally, based upon prior research (Harris & Curtain, 2002; Shah & Waller, 2000), we predict a mediating relationship between EMS and perceived parenting and depressive symptoms. Specifically, we predict that the Defectiveness/Shame (DS), Insufficient Self-Control (IS), Dependence/Incompetent (DI), Failure (FA), and Vulnerability to Harm and Illness (VH) EMS will partially mediate the relationship between parental connection, monitoring, and psychological control (the lack of parental psychological autonomy) and depressive symptomology.
CHAPTER TWO

METHODOLOGY

Methods

Participants

Participants were undergraduate students from California State University, San Bernardino who were conscripted from within the Department of Psychology. All participants received extra class credit after completion of a series of self-report questionnaires. Gender composition was skewed. Thus, a random selection procedure in SPSS was utilized to create a combined gender balanced sample of 232 participants. These participants were selected from four different data sets. This procedure randomly matched the number of female participants utilized from each data subset to the number of male participants recruited for the same data subset. Participants consisted of 118 males and 114 females, ranging in age from 17 to 50, with a mean age of 22 years and a standard deviation of 6. Ethnic composition of the sample was 31.9% Caucasian (or White), 41.4% Latino (or Hispanic), 9.5% African American (or black), 7.8% Asian (or Asian American), and 9.5% other. All participants were
treated with accordance to the Ethical Principles of Psychologists and Code of Conduct (APA, 2002). Appropriate sample size was estimated based upon Kleinbaum, Kupper, and Muller’s (1988) guidelines of at least 15 participants for each predictor and criterion variable. Thus a sample size of 225 is the minimum suggested sample.

**Design**

In this study, a correlational-regression approach was adopted to test the proposed hypotheses. The predictor variable was the parenting socialization, the criterion variable was psychological adjustment in young adults, and the mediating variable was the development of early maladaptive schemas. Parental socialization was measured with three different subscales (Acceptance Subscale on the Child Report of Parent Behavior Inventory (Schaefer, 1965), Monitoring Scale (Brown et al., 1993); Psychological Control Scale-Youth Self Report (Barber, 1996)); psychological adjustment was measured by the Symptom Checklist-90-Revised (Derogatis, 1994). Early maladaptive schema was measured with the Schema Questionnaire-Short Form (Young, 1998). All variables were quantitative and continuous.
Procedure

Data was collected in groups of 20, mostly by the advanced lab clinical students. Participants were briefly informed on the general nature of the study. Participants were handed a packet of self-report questionnaires. Data was gathered from a larger study on early maladaptive schemas, encompassing parental experiences, emotional health and coping strategies. Further, participants were told that the packet will take approximately 1 1/4 hours to complete. Participation was anonymous and voluntary. An informed consent and debriefing statement were provided. The data was collected over the course of two academic years. Participants completed a demographic information sheet, in addition to eight self-report questionnaires. Once the participants completed the questionnaires, they were handed to the researcher; in turn, the participant received extra class credit for their participation. At the end of the study, the participants were debriefed about the nature of the study, and its implications to the field. The researchers contact information was provided, in case any participant wanted to discuss the study.
further in detail. Participants were also urged not to discuss details of the study with fellow classmates.

Measures

A packet of questionnaires was handed out to all participants. The packet also contained an informed consent (see Appendix G) and debriefing statement (see Appendix H).

1. Demographic Form. The demographic form (see Appendix C) measures age, gender, ethnicity, and income.

2. Schema Questionnaire-Short Form. Schema Questionnaire-Short Form (SQ-SF; Young, 1998) (see Appendix D). The SQ-SF is a 75 item self-report questionnaire designed to assess the characteristic EMS (core beliefs), that affect the way in which an individual perceives self, others, and the world. In this survey 15 of the 18 early maladaptive schema subscales proposed by Young (1994) are assessed across five domains. Five questions are allotted per EMS. This measure is a shorter form of the original 205-item questionnaire designed by Young and Brown (1994), to briefly assess maladaptive schemas. The
Punitiveness, Negativity/Pessimism, and Approval Seeking EMS were omitted in the SQ-SF (Schmidt et al., 1995). Lee, Taylor, and Dunn (1999) report that the SQ-SF has a similar factor structure as the SQ-Long form and is consistent with the EMS proposed in Young’s model. Perceptions are rated on a 6-point Likert-type scale, in terms of how the respondent felt throughout their lives (1=completely untrue of me; 2=mostly untrue of me; 3=slightly more true than untrue; 4=moderately true of me; 5=mostly true of me; 6=describes me perfectly). Item total scores (range 1-6) are calculated for each subscale with a range of 5 to 30. Higher scores are indicative of greater dysfunctional levels of EMS. Internal consistency coefficients were calculated and yielded Cronbach’s alpha coefficients ranging from .76 to .93, suggesting moderate to good internal consistency (Welburn et al., 2002).

3. Acceptance Subscale of the Child Report of Parent Behavior Inventory. Acceptance Subscale of the Child Report of Parent Behavior Inventory (CRPBI; Schaefer, 1965) (see Appendix E). The CRPBI is a 10 item self-
report inventory designed to measure the perceived
degree of parental connection. Personal experience of
acceptance from parent(s) or guardian(s) (e.g.,
father figure and mother figure) are reported for the
subscale. Items are endorsed using a Likert-type
rating from 1-3, with total possible score ranging
from 10-30. Higher scores are indicative of greater
levels of parental support, caring, attention, and
nurturance. The CRPBI is valid, and has adequate
internal consistency, with a mean alpha coefficient
of .81 (Barber & Olson, 1997).

4. Monitoring Scale. Monitoring Scale (Brown et al,
1993) (see Appendix E). The monitoring subscale is a
5 item self-report inventory designed to assess
parental regulation. Perceived degree of parental
regulation, or monitoring, is reported for father
figures and mother figures. Items are endorsed using
a Likert-type rating from 1-3, with total possible
score ranging from 5-15. Higher scores suggest
greater levels of parental knowledge of childhood
activities. The monitoring subscale is valid, and has
adequate reliability, with a mean alpha coefficient
of .83 (Patterson & Stouthamer, Loeber, 1984).

Psychological Control Scale—Youth Self Report (Barber, 1996) (see Appendix E). The psychological control subscale is an 8 item self-report inventory designed to measure psychological autonomy. Perceived degree of psychological autonomy or psychological control is reported for father figures and mother figures. Items are endorsed using a Likert-type rating from 1-3, with total possible score ranging from 8-24. Higher scores are indicative of greater levels of parental use of control tactics that impede upon the emotional and social development of a child (e.g.; enmeshment, manipulation, and overuse of criticism). The psychological control scale is valid, and has adequate reliability, with a mean alpha coefficient of .88 (Barber & Olson, 1997).

For each of the three parenting scales, the mother’s and father’s scores were averaged; as many participants indicated only one parent. There were no hypotheses made regarding maternal or paternal connection, monitoring nor psychological autonomy.
6. Symptom Checklist-90-Revised. Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1994) (see Appendix F). This measure is a 90-item self-report inventory consisting of questions assessing the degree of endorsement of a variety of psychological symptoms experienced over the past week. Each item is rated on a Likert-type scale of 0 to 4 (0=not at all, 1=a little bit, 2=moderately, 3=quite a bit, 4=extremely). Scores for nine primary symptom dimensions are produced: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. The dimensions possess adequate internal consistency with alpha coefficients ranging from .79 to .90, and test-retest reliability coefficients ranging from .78 to .90 (Derogatis, 1994). Also included are three global indices to further summarize overall levels of distress. These are the Global Severity Index (GSI), Positive Symptom Distress Index (PSDI), and Positive Symptom Total (PST).
CHAPTER THREE

ANALYSIS

Results

The means, standard deviations, and Cronbach's reliability (alpha) coefficients for the SQ, Barber's Parenting Subscales, and relevant SCL-90-R subscales (global score, depression, and anxiety) are presented in a table (see Appendix A). Cronbach's alpha coefficients for all 27 variables were strong; greater than 0.7. Results of the reliability analyses allowed for confident interpretations of the results that proceed with the above variables. The proposed hypotheses were tested using the following statistical procedures: bivariate correlations, multiple hierarchical regressions, and linear regression analyses of mediation in the manner described by Baron and Kenny (1986). These researchers prescribed specific steps in order to perform the analysis to test mediation. The researchers summarized as follows:
A variable functions as a mediator when it meets the following conditions: a) variations in levels of the independent variable significantly account for variations in the presumed mediator (i.e., Path a), (b) variations in the mediator significantly account for variations in the dependent variable (i.e., Path b), and (c) when Paths a and b are controlled, a previously significant relationship between the independent and dependent variables is no longer significant, with the strongest demonstration of mediation occurring when Path c is zero. (Baron & Kenny, 1986, p.1176)
Bivariate Correlation Analyses

Table 2 shows the correlations among the main variables Defectiveness/Shame (DS), Insufficient Self-Control/Self-Discipline (IS), Dependence/Incompetence (DI), Failure (FA), Vulnerability to Harm and Illness (VH) and parental connection, monitoring, psychological control.

Table 1. Pearson's Bivariate Correlation Coefficients Between Early Maladaptive Schemas and Parenting Dimensions

<table>
<thead>
<tr>
<th></th>
<th>DS</th>
<th>IS</th>
<th>DI</th>
<th>FA</th>
<th>VH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Connection</td>
<td>-.04</td>
<td>.01</td>
<td>.03</td>
<td>.04</td>
<td>-.06</td>
</tr>
<tr>
<td>Parental Monitoring</td>
<td>-.07</td>
<td>.05</td>
<td>-.01</td>
<td>.01</td>
<td>-.05</td>
</tr>
<tr>
<td>Psychological Control</td>
<td>.18*</td>
<td>.04</td>
<td>.20*</td>
<td>.08</td>
<td>.22*</td>
</tr>
</tbody>
</table>

Note. * p < .05 (2-tailed)

Hypotheses 1 and 2 proposed a negative relationship between parental connection and monitoring and the EMS of Defectiveness Shame (DS), Insufficient Self-Control/Self-Discipline (IS), Dependence/Incompetence (DI), Failure (FA), and Vulnerability to Harm and Illness (VH).
Hypotheses 1 and 2 were not supported, an association was not found between the EMS of Defectiveness/Shame (DS), Insufficient Self-Control/Self-Discipline (IS), Dependence/Incompetent (DI), Failure and Vulnerability to Harm and Illness (VH) and the parental socialization dimensions of connection or monitoring. Refer to Table 2, above, for Pearson's bivariate correlation coefficients of study results.

Hypothesis 3 proposed a positive relationship between parental psychological control and the EMS of Defectiveness/Shame (DS), Insufficient Self-Control/Self-Discipline (IS), Dependent/Incompetence (DI), Failure (FA), and Vulnerability to Harm and Illness (VH). Part (a) of the hypothesis proposed a positive relationship between parental psychological control and the EMS of Defectiveness/Shame (DS). This part of the hypothesis was supported. There was a significant positive correlation between parental psychological control and Defectiveness/Shame (DS) EMS ($r = .181$, $n = 230$, $p < .05$). In other words, higher levels of EMS were associated with greater efforts to suppress individuation and expression of self. Part (b) of the hypothesis proposed a positive
relationship between parental psychological control and the EMS of Insufficient Self-Control/Self-Discipline (IS). This part of the hypothesis was not supported. Part (c) of the hypothesis proposed a positive relationship between psychological control and the EMS of Dependent/Incompetence (DI). This part of the hypothesis was supported. There was a significant positive correlation between parental psychological control and the Dependence/Incompetence (DI) EMS ($r = .200, n = 229, p < .05$). Parental psychological control or suppression of psychological autonomy was associated with the development of the Dependent/Incompetence (DI) EMS. Part (d) of the hypothesis proposed a positive relationship between psychological control and the EMS of Failure (FA). This part of the hypothesis was not supported. Part (e) of the hypothesis proposed a positive relationship between parental psychological control and the Vulnerability to Harm and Illness (VH) EMS. This part of the hypothesis was supported. There was a significant positive correlation between parental psychological control and the Vulnerability to Harm and Illness (VH) EMS ($r = .224, n = 229, p < .05$). The lack of parental support for autonomy
was associated with the development of the Vulnerability to Harm and Illness (VH) EMS. Refer to Table 2 for Pearson’s correlation coefficients.

Hypothesis 4 proposed a negative relationship between parental connection and the Disconnection/Rejection Domain (DR) (a combined score of the EMS: Emotional Deprivation (ED), Abandonment (AB), Mistrust/Abuse (MA), Social Isolation (SI), Defectiveness/Shame (DS)). This hypothesis was supported. There was a significant negative correlation between parental connection and the Disconnection/Rejection Domain (DR) \( (r = -.199, n = 230, p < .05) \). In other words, parental connection was negatively associated with the development of early maladaptive schemas in the Disconnection and Rejection Domain (DDR) of Young’s (1994) schema model.

Hypothesis 5 proposed a positive relationship between parental psychological control and the Impaired Autonomy/Performance Domain (IP) (a combined score for the EMS: Failure (FA), Dependence/Incompetence (DI), Vulnerability to Harm and Illness (VH), and Enmeshment (EM)). This hypothesis was supported. There was a significant positive correlation between psychological
control and the Impaired Autonomy/Performance Domain (IP) ($r = .193$, $n = 230$, $p < .05$). The lack of parental support for psychological autonomy was associated with the development of early maladaptive schemas in the Impaired Autonomy/Performance Domain (IP) of Young's (1994) schema model.

Hypothesis 6 proposed a positive relationship between parental psychological control and the Other Directedness Domain (OD) (a combined score for the EMS: Subjugation (SB) and Self-Sacrifice (SS)). This hypothesis was supported. There was a significant correlation between psychological control and the Other Directedness Domain (OD) ($r = .245$, $n = 229$, $p < .05$). Parental psychological control was associated with the development of early maladaptive schemas in the Other Directedness Domain (OD) of Young's (1994) schema model.

Hierarchical Regression Analyses

In order to test the predicted interaction terms, multiple linear regression equations, ($Y' = B_0 + B_1X_1 = B_2X_2 +...BzXz$), were calculated. $Z$ is the number of independent variables; $Y'$ is the dependent variable; and the $X$s are the independent variables. In step 1, parental connection
was entered alone. In step 2, parental monitoring (hypothesis 7) or parental psychological control (hypothesis 8) was added to the regression equation. Finally, an interaction term was calculated in step 3, between the two predictor variables. In Hypothesis 7 and 8 the dependent variable is the total score for all EMS combined and the independent variables (predictors) are the specified parental socialization dimensions.

Hypothesis 7 proposed an interaction between parental monitoring and parental connection that was expected to add explanatory variance above each of the main effects (e.g., parental connection and parental monitoring). Specifically, it was predicted that low levels of parental connection with high levels of parental monitoring would add explanatory variance above parental monitoring and connection alone. An interaction was not found, (Adjusted R square = -.003; $F_{3,226} = .793, p > .05$) and the hypothesis was not supported. Additionally, the main effects were not significant, e.g., parental connection (Adjusted R square = .004; $F_{1,228} = 1.962, p > .05$) and parental monitoring (Adjusted R square = .001; $F_{2,227} = 1.020, p > .05$).
Hypothesis 8 predicted an interaction between parental connection and psychological control that was expected to add unique explanatory variance above each of the main effects. Specifically, low levels of parental connection with high levels of psychological control were expected to predict greater levels of EMS. An interaction was not found, (Adjusted R square = .071; \( F_{3,226} = 6.862, p > .05 \)) and thus hypothesis 8 was not supported. However, a main effect for parental psychological control was found Adjusted R square = .072; \( F_{2,227} = 9.933, p < .05 \). Psychological control was a significant predictor of total EMS, accounting for 7.2% explanatory variance. No main effect for parental connection was found Adjusted R square = .004; \( F_{1,228} = 1.962, p > .05 \). Psychological control was the only significant predictor of total EMS.

**Mediation**

To further test the assumptions of the schema model, the relationship between parenting and depression was tested for mediation. The hypothesized mediators included five early maladaptive schemas (EMS) (Defectiveness/Shame (DS), Insufficient Self-Control/ Self-Discipline (IS), Failure (FA), and Vulnerability to Harm and Illness (VH))
according to the guidelines specified by Baron and Kenny (1986). That is, (Step 1) negative parenting is associated with depression; (Step 2) negative parenting is associated with EMS; (Step 3) EMS is associated with depression; and (Step 4) the relationship between parental socialization (i.e., parental connection, monitoring, and psychological control, respectively) and symptoms of depression is mediated by the five EMS. Hypothesis 9, 10, and 11 proposed that the relationship between parental socialization and depressive symptoms was mediated by EMS. The possible mediations were examined with linear and hierarchical regression analyses using the method suggested by Baron and Kenny (1986), as described earlier. In order to analyze the last condition of the mediated relationship, the following equation,

\[ \sqrt{b^2 + a^2 b^2 + a^2 S^2} \] (Baron and Kenny, 1986), was calculated.

Hypothesis 9 predicted mediation between parental connection, the EMS (Defectiveness/Shame (DS), Insufficient Self-Control/ Self-Discipline (IS), Defectiveness/Shame (DS), Failure (FA), and Vulnerability to Harm and Illness (VH)), and these EMS and depression.
In Step 1, parental connection did not predict depression, (Adjusted R square = .006; $F_{1, 228} = 2.292, p > .05$) and thus hypothesis 9 was not supported. According to Baron and Kenny (1986), no mediation can exist if any of the first three steps are not supported. The first condition was not met, thus the predictor variable was not tested further.

Hypothesis 10 predicted mediation between parental monitoring, the EMS (Defectiveness/Shame (DS), Insufficient Self-Control/ Self-Discipline (IS), Defectiveness/Shame (DS), Failure (FA), and Vulnerability to Harm and Illness (VH)), and these EMS and depression. The hypothesis was not supported. The predictor variable was eliminated in Step 1 because parental monitoring was not a significant predictor of depression, (Adjusted R square = -.004; $F_{1, 228} = .096, p > .05$). According to Baron and Kenny (1986) psychological monitoring did not satisfy the necessary assumptions for mediation.

Hypothesis 11 predicted mediation between parental psychological control, the EMS (Defectiveness/Shame (DS), Insufficient Self-Control/Self-Discipline (IS), Defectiveness/ Shame (DS), Failure (FA), and Vulnerability
to Harm and Illness (VH)), these EMS and depressive symptoms. In Step 1, parental psychological control was a significant predictor of depression, (Adjusted R square = .022; F_{1,228} = 6.09, p < .05). In this linear regression, parental psychological control accounted for 2.6% of the variance in depression. In Step 2, parental psychological control was a significant predictor of EMS, (Adjusted R square = .025; F_{1,228} = 6.952, p < .05), accounting for 3% of the variance in EMS. In Step 3, the potential mediator (e.g., Defectiveness/Shame (DS) EMS, Insufficient Self-Control/Self-Discipline (IS) EMS, Dependence/Incompetence (DI) EMS, Failure (FA) EMS, and Vulnerability to Harm and Illness (VH) EMS) was a significant predictor of depression, (F_{5,223} = 26.60, p < .05), accounting for a total of 37.4% of the variance in depression. In particular, the Vulnerability to Harm (VH) EMS and Insufficient Self-Control/Self-Discipline (IS) EMS were found to be the only significant predictors of depression. All three conditions were met and thus mediation was tested. First, the five EMS (Defectiveness/Shame (DS), Insufficient Self-Control/ Self-Discipline (IS), Defectiveness/Shame (DS), Failure (FA), and Vulnerability
to Harm and the Illness (VH)) were entered into a hierarchical regression, followed by the independent variable (psychological control). Results of the hierarchical regression revealed that the EMS (Defectiveness/Shame (DS), Insufficient Self-Control/Self-Discipline (IS), Defectiveness/Shame (DS), Failure FA), and Vulnerability to Harm and the Illness (VH)) was a significant predictor of depression, (Adjusted R square = .360; F(5,223) = 26.60, p < .05), accounting for 37.4% of the variance in depression. Once accounting for the five EMS, parental psychological control was not a significant predictor of depression, (Adjusted R square = .359; F(1,222) = .65, p > .05), accounting for only .2% of the variance in depression. According to the Baron and Kenny (1986) method, complete mediation of the relationship between parental psychological control and depression was found. Specifically, parental psychological control only accounted for .2% of variance in depression when controlling for the five EMS (Defectiveness/Shame (DS), Insufficient Self-Control/Self-Discipline (IS), Failure (FA), and Vulnerability to Harm and Illness (VH)), in
comparison to the 2.6% of the variance that was accounted when the psychological autonomy was considered alone.

Post-hoc Analyses

The study’s a priori hypotheses were based upon prior research (Harris & Curtain, 2002) which utilized composite scores (an average of paternal and maternal scores) for the three parenting dimensions and a subset of the early maladaptive schemas (EMS). Due to the limited amount of research available on EMS, an attempt was made to replicate and confirm previous findings. Further, in the current study’s a priori hypotheses the effects of the three parenting dimensions for maternal versus paternal effects were not examined, as we utilized a composite parenting score for parental connection, monitoring and psychological control, as did Harris and Curtain (2002). Additionally, Harris and Curtain (2002) first tested all 15 EMS as potential predictors of depression before choosing the significant predictors in testing for a mediation model.

Post-hoc analyses were conducted to further explore Young’s Early Maladaptive Schema model, specifically to
delineate maternal/paternal socialization and current sample specific EMS predictors of depression and anxiety. These analyses allowed for analysis of gender differences in terms of parental socialization in the prediction of depression and anxiety. A subset of potential mediators was selected based on significant predictors in our sample. In order to select these potential mediators a linear regression was performed, in which a relationship was established between EMS and the dependent variable (either symptoms of depression or anxiety). All 15 EMS (Emotional Deprivation (ED), Abandonment (AB), Mistrust/Abuse (MA), Social Isolation (SI), Defectiveness/Shame (DS), Failure (FA), Dependent/Incompetence (DI), Vulnerability to Harm and Illness (VH), Enmeshment (EM), Entitlement (ET), Insufficient Self-Control/Self-Discipline (IS), Subjugation (SB), Self-Sacrifice (SS), Emotional Inhibition (SI), Unrelenting Standards (US)) were forced into a regression model, predicting either symptoms of depression (first set of post-hoc mediation analyses) or symptoms of anxiety (second set of post-hoc mediation analyses).
Similar analyses were conducted with the six individual parenting dimensions. Additionally, the maternal and paternal parenting dimensions that were unique predictors of depression needed to be selected, in order to test for mediation. Harris and Curtain (2002) only assessed individual’s perceptions of their primary caretaker’s abilities to meet their early developmental needs. However, Harris and Curtain (2002) reported that about 76% of the participant pool provided recollections of maternal care. All six parenting dimensions (paternal connection, paternal monitoring, paternal psychological control, maternal connection, maternal monitoring, and maternal psychological control) were forced into a regression model, similar to the approach utilized by Shah and Waller (2000). A relationship was established between parenting and symptoms of depression or anxiety. Once significant predictors and potential mediators in the present data set were recognized as significant unique predictors of depression and anxiety in the regression equation, the following correlational and mediation analyses were performed.
Bivariate Correlations

Prior to mediation analyses, bivariate correlations were computed between all 15 EMS and six possible perceptions of parenting as assessed by Barber's three subscales. Results indicated that as perceptions of maternal connection decreased, Emotional Deprivation (ED), Social Isolation (SI), Abandonment (AB), Vulnerability to Harm and Illness (VH), and Emotional Inhibition (EI) scores increased. Likewise a negative relationship between paternal connection and the EMS of Emotional Deprivation (ED) was found. Additionally, perceptions of both maternal and paternal monitoring scores correlated negatively with EMS scores for Emotional Deprivation (ED). Finally, perceptions of maternal psychological control correlated significantly and positively with scores on the Emotional Deprivation (ED), Abandonment (AB), Mistrust/Abuse (MA), Defectiveness/Shame (DS), Failure (FA), Dependent/Incompetent (DI), Vulnerability to Harm and Illness (VH), Enmeshment (EM), Subjugation (SB), Self-sacrifice (SS), Emotional inhibition (EI), Entitlement (ET) EMS SQ-SF subscales. However, recollections of paternal psychological control correlated significantly
and positively with only six of the eleven EMS that were associated with maternal psychological control (Emotional Deprivation (ED), Abandonment (AB), Mistrust/Abuse (MA), Vulnerability to Harm and Illness (VH), Subjugation (SB), Emotional Inhibition (EI)) EMS. Please refer to Appendix B for a presentation of the Pearson’s correlation coefficients.

Mediators in Symptoms of Depression

In exploratory analyses, regression analyses were used to test whether EMS, as measured by the SQ-SF mediate the relationship between perceptions of parenting, as measured by Barber’s subscales, and symptoms of depression, as measured by the SCL-90-R depression subscale. First, a forced entry regression analysis was conducted to find the significant predictors of depression, as described above. All 15 of the EMS subscale scores were entered as independent variables predicting SCL-90-R scores for depression. All 15 EMS together accounted for 40.5% of the variance in depression scores, Adjusted R square = .363; F\textsubscript{15,213} = 9.653, p < .05. Only two EMS, Vulnerability to Harm and Illness (VH) (Beta = .315, p = .001) and Insufficient Self-Control/Self-Discipline
(IS) (Beta = .174, p = .017) accounted for unique explanatory variance in depression. To examine the independent effects of maternal and paternal socialization, a similar procedure was conducted, except this time all six of the parenting scores from the Barber parenting scales, were entered as the independent variable predicting SCL-90-R scores for depression. All six parenting dimensions accounted for 12.7% of the variance, Adjusted R square = .102; $F_{6,205} = 4.987$, $p < .05$. Of these six, only maternal connection and maternal psychological control were found to be the unique predictors of depression (Beta = .212, $p = .013$; Beta = .237, $p = .007$, respectively). Subsequent to the identification of the significant post-hoc predictors, tests of mediation following the four step approach described by Baron and Kenny (1986) was utilized to test whether Vulnerability to Harm and Illness (VH) EMS and Insufficient Self-Control/Self-Discipline (IS) EMS mediated the relationship between perceptions of maternal connection and psychological control and symptoms of depression. In Step 1, a significant relationship was found between the two significant parenting factors (e.g., maternal connection
and maternal psychological control) and symptoms of depression, Adjusted R square = .084; $F_{2,227} = 11.533$, $p < .05$, with the two maternal factors accounting for 9.2% of the variance in total depression scores. In Step 2, a significant relationship between maternal connection and psychological control and the EMS of Vulnerability to Harm and Illness (VH) and Insufficient Self-Control/Self-Discipline (IS) was established, Adjusted R square = .028; $F_{2,226} = 4.242$, $p < .05$, accounting for 3.6% of the variance in the EMS scores. In Step 3, a significant relationship was found between the EMS (Vulnerability to Harm and Illness (VH) and Insufficient Self-Control/Self-Discipline (IS)) and symptoms of depression, Adjusted R square = .342; $F_{1,227} = 119.244$, $p < .05$, accounting for 34.4% of variance in depression scores assessed by the SCL-90-R. In Step 4, mediation of the relationship between maternal connection and maternal psychological control and the dependent variable (symptoms of depression) by the EMS of Vulnerability to Harm and Illness (VH) and Insufficient Self-Control/Self-Discipline (IS) was tested. For mediation to be tested a two step, hierarchical regression analysis is needed. In the first step, the potential
mediator(s) (two EMS of Vulnerability to Harm and Illness (VH) and Insufficient Self-Control/Self-Discipline (IS)) were entered into the regression, followed by the independent variables, maternal connection and maternal psychological control. Results of the hierarchical regression revealed that the two EMS Vulnerability to Harm and Illness (VH) and Insufficient Self-Control (IS) were significant predictors of depression, Adjusted R square = .342; \( F_{1,227} = 119.244, p < .05 \), accounting for 34.4% of the variance in depression scores. Although maternal connection and maternal psychological control were still significant predictors of depression, Adjusted R square = .381; \( F_{3,225} = 47.860, p < .05 \), results were suggestive of partial mediation as maternal connection and maternal psychological control only accounted for 4.5% of variance in depression scores when controlling for the two EMS, versus the 9.2% when considered alone.

**Mediators in Symptoms of Anxiety**

In exploratory analyses, a similar procedure to that in the previous section (mediators in symptoms of depression) was used to test whether the EMS, as measured by the SQ-SF, mediate the relationship between perceptions
of parenting, as measured by Barber's subscales, and symptoms of anxiety, as measured by the SCL-90-R anxiety subscale. First, a forced entry regression analysis was conducted to find the significant predictors of anxiety, as described above. All fifteen of the EMS subscale cores were entered as independent variables predicting SCL-90-R scores for anxiety. Only two, Vulnerability to Harm and Illness (VH) EMS (Beta = .450, p < .05) and Defectiveness/Shame (DS) EMS (Beta = .184, p = .039) were found to be significant predictors of anxiety, accounting for 41.4% of the variance in anxiety scores, Adjusted R square = .373; F_{15,213} = 10.037, p < .05. Next, a similar procedure was conducted, except this time; all six of the parenting scores from the Barber parenting scales were entered, as the independent variable predicting SCL-90-R scores for anxiety. Maternal psychological control was found to be the single unique predictor of anxiety (Beta = .273, p = .002), accounting for 9.4% of the variance, Adjusted R square = .068; F_{6,220} = 3.553, p < .05. Finally, the four step approach described by Baron and Kenny (1986) (see p.60-61 for reference) was utilized to test mediation with Vulnerability to Harm and Illness (VH) EMS and
Defectiveness/Shame (DS) between perceptions of maternal psychological control and symptoms of anxiety. In Step 1, a significant relationship was found between maternal psychological control and symptoms of anxiety, Adjusted R square = .069; $F_{1,228} = 17.973$, $p < .05$, with maternal psychological control accounting for 7.3% of the variance in total anxiety scores. In Step 2, a significant relationship between maternal psychological control and the EMS of Vulnerability to Harm and Illness (VH) and Defectiveness/Shame (DS) was established, Adjusted R square = .075; $F_{1,228} = 19.501$, $p < .05$, accounting for 7.9% of the variance in the EMS scores. In Step 3, a significant relationship was found between the EMS (Vulnerability to Harm and Illness (VH) and Defectiveness/Shame (DS)) and symptoms of anxiety, Adjusted R square = .373; $F_{2,226} = 68.816$, $p < .05$, accounting for 37.8% of variance in anxiety scores assessed the SCL-90-R. In Step 4, mediation was tested between maternal psychological control and symptoms of anxiety, with the EMS of Vulnerability to Harm and Illness (VH) and Defectiveness/Shame (DS). For mediation to be tested a two step, hierarchical regression analysis is
needed. In the first step, the two EMS of Vulnerability to Harm and Illness (VH) and Defectiveness/Shame (DS) were entered into the regression, followed by the independent variable, maternal psychological control. Results of the hierarchical regression revealed that the two EMS Vulnerability to Harm and Illness (VH) and Defectiveness/Shame (DS) were significant predictors of anxiety, Adjusted R square = .373; F2,226 = 68.816, p < .05, accounting for 37.8% of the variance in anxiety scores. Although maternal psychological control was still a significant predictor of anxiety, Adjusted R square = .384; F1,225 = 4.862, p < .05, results suggest that the EMS of Vulnerability to Harm and Illness (VH) and Defectiveness/Shame (DS) are partial mediators of the relationship between maternal psychological control and symptoms of anxiety. Specifically, maternal psychological control only accounted for 1.3% of variance in anxiety scores when controlling for the two EMS, versus the 7.3% when considered alone.
CHAPTER FOUR
CONCLUSIONS AND RECOMMENDATIONS

Discussion

Findings from this study offer partial support for Young’s Early Maladaptive Schema Model outlined in the introduction. More specifically, support for the link between parenting and emotional symptoms (depression and anxiety) as mediated by EMS was found. Given the importance and development of EMS in psychological and social adjustment, it would be beneficial to detect and identify EMS early in a child's life. As hypothesized, a positive relationship was found between parental psychological control and the EMS of Defectiveness/Shame (DS), Dependent/Incompetence (DI), and Vulnerability to Harm and Illness (VH). Further, a positive relationship was found between parental psychological control and the schema domains of Impaired Autonomy and Performance (IP) and Other Directedness (OD), also as hypothesized. In addition, while testing the interaction between low levels of parental connection under high levels of psychological control, only a main effect for parental psychological control.
control in predicting greater levels of EMS was found. These results suggest that children whose parents inhibit their efforts at individuation, separation and autonomy may be more likely to develop distorted views about their world, others, and self (e.g., Beck's cognitive triad) and thus were left more vulnerable to developing emotional symptoms, particularly depression, when there was a parental lack of support for psychological autonomy.

Finally, as hypothesized, the EMS of Vulnerability to Harm and Illness (VH), and Insufficient Self-Control/Self-Discipline (IS) mediated the relationship between parental psychological control and depressive symptoms.

Overall, results from the a priori hypotheses provided partial support for Young’s (1994) model, revealing a fairly consistent link between negative parenting or toxic parenting styles and the development of EMS and symptoms of depression. Findings provided strongest support for EMS predicting symptoms of depression in young adults, EMS accounted for 37.4% of the variance in depression scores, whereas the parenting dimension of psychological control only accounted for 2.6% of the variance in depression scores. Additionally, there
was solid evidence for EMS mediating the relationship between parental socialization (particularly maternal parenting dimensions) and depression. Toxic parenting tactics are associated with poor social adjustment in children; however, the development of EMS better explains later adjustment in individuals. Early detection of EMS would be far less pervasive, creating fewer biases and distorted perceptions in the individual's life. It is fairly evident that parents who employ psychological control tactics in parenting interactions are suppressing individuation or autonomy. These "controlling" parents appear to be constantly and consistently sending an implicit message through their interactions. That is, the child is left feeling as if they are somehow incompetent, defective, and eminently vulnerable. These feelings result in a sense of dependency and the need for others in order to get by in the world. Throughout childhood, the child becomes accustomed to relying on others' decisions and thus fails to develop self-confidence and strong critical thinking skills on their own. The child is often forced to believe that their choice would be a bad one and may lead to negative consequences. This type of toxic parenting
fails to meet children's basic needs. Developing a secure sense of autonomy and identity is a vital task for healthy adolescent adjustment. As suggested by the model, for an individual to develop a strong, independent, and autonomous sense of self, children need to feel that they are in a safe and secure environment. Children also need to be encouraged to individuate so that they develop a sense of mastery in their life (that they have control over their life). When there is a clear lack of parental support for autonomy (or lack of assurance) from overprotective parents, individuals may feel overly dependent on others, and that they are not competent enough to make sound decisions and judgments on their own. Excessive parental intervention can be toxic to the child's confidence and can later lead to maladaptive social adjustment (Schmidt et al., 1995; Schmidt & Joiner, 2004), as suggested in the present study. Further, an exaggerated sense of discomfort-avoidance is developed in order to avoid pain, conflict, confrontation, and responsibility, especially in abusive homes. Usually, the abusive parent will shift the responsibility of the violence to the abused child (Rocklin & Lavett, 1987).
making him/her feel some how responsible for receiving the abuse. Physical abuse can also be seen as a form of psychological control. In the present study such demographic information was not collected or utilized. In the future, it may be worth collecting information pertaining to pathology as well as details of the family composition and maladaptive patterns observed in the home.

The hypotheses in the present study were based upon prior research. Partial support was found for Harris & Curtain’s (2002) study results. They had found four EMS mediators (one was separated into two EMS in the present study); where as the present study was able to establish mediation with only three of the 15 EMS. Although complete mediation was not found with all 15 of the EMS, both studies managed to find mediation with some of the EMS. The similarities and differences, a like, bring up more questions than they manage to answer.

However, as previously discussed in the introduction, the present study utilized different parenting scales (e.g., Acceptance Subscale of the Child Report of Parent Behavior Inventory, Monitoring Scale, Psychological Control Scale), than the Parental Bonding Instrument used
by Harris & Curtain (2002). Based on the survey questions, we have reason to believe that the Psychological Control Subscales utilized in the present study is measuring similar constructs as the Parental Bonding Overprotection subscale utilized in the previous study. Perhaps, we were falsely convinced that Barber's Connection Subscale would effectively measure the same constructs measured by the Parental Bonding Instrument-Caring subscale.

Additionally, it is possible that the voluntary college sample utilized in the present study had lower scores on the Symptoms Checklist List-90-Revised. Depression was measured by the BDI-II in Harris and Curtain (2002), a scale that assesses depressive symptoms preceding a 2-week period and has an increased emphasizes on cognitive symptoms of depression (Harris & Curtain, 2002), perhaps diluting the relationship between depressive symptoms and EMS. The present study utilized the Symptoms Checklist-90-R, which may have been less biased to cognitive symptoms alone, and thus may have provided a more conservative relationship between symptoms of depression and EMS. The decision to use Barber's scales was based upon the strong empirical support found by
Barber (1996); Eccles, et al., (1997), Barber & Olsen, 1997, etc. for their ability to predict adolescent adjustment. Thus, it is of no surprise that the Barber scales were able to help in defining the relationship between parental psychological control and later psychological adjustment mediated by EMS; the development of psychological autonomy is a key task during adolescence for healthy social adjustments. Perhaps, we over generalized findings, assuming that Barber’s scales would accurately predict social adjustment in healthier young adults, as well as it did for adolescents.

Further, it is uncertain whether or not both the SQ-SF and Barber’s parenting scales are independent of mood. It’s always possible that cognitive symptoms of depression may have negatively influenced reports of parenting and schemas. The cross sectional nature of the present design also makes causal findings inconclusive and more vulnerable to cognitive, mood, and age biases. At best, we can assume that the survey response reflects a moment, or is a result of numerous experiences (all a like or different), with hopefully at least some consistency over time. It was still important to test for mediation across
various parental socialization scales and depression scales, to test for the possibility that the EMS mediators in Harris and Curtain (2002) and Shah & Waller (2000) were not specific to the Parental Bonding Instrument used to gather recollections of parental interactions. In the development of research and empirical support for the model it is necessary to test for different parenting dimensions that result in healthy or unhealthy human development (e.g., factors other than Parker et al's. (1979) parental care and overprotection), and could potentially increase vulnerability to emotional symptoms. Although they are well supported empirical measures predicting adolescent outcomes, Barber's scales may not be valid for use with a college (young adult) sample. A college sample is typically healthier, more successful, and has come from a positive upbringing, in comparison to the average community sample. Further, it could be reasoned that individuals who attend a four year university, come from more educated families who may be aware of and more likely to employ positive parenting tactics. Additionally, individuals pursuing higher education usually come from supportive families with
sufficient regulation (e.g., following rules, setting goals and limits, etc.). Thus, Barber's Monitoring Subscale may have been too narrow for assessing the degree of healthy regulation in the participant's home. Future studies may consider the use of a different (broader) parenting measure and a longitudinal design. In a longitudinal design children are followed over a longer period of time and the parenting interactions are observed by the researcher, eliminating the need to rely so heavily on recollections (self-report). A longitudinal design may impose more complications and variables to the study, in that, children in abusive or highly dysfunctional homes will need to seek immediate interventions. In order to be granted IRBHS approval for experimentation, it would be the researcher's responsibility to have such resources at hand. Additionally, the research team would be obligated to make immediate and accurate reports to Child Protective Services. A longitudinal design may impose further limitations. Particularly, when manipulating variables for creating comparison groups. Obviously, such control groups would violate the code of conduct and research ethics (making it impossible to place children in a cold and
rejecting home for research investigation). The Parental Bonding Instrument, previously used by Harris & Curtain (2002) and Shah and Waller (2000), may be better at predicting social adjustment in young adults.

Post-hoc analyses examined unique significant predictors in the present data set. Partial mediation was found between parental socialization (maternal psychological control and maternal connection) and symptoms of depression, with the EMS of Vulnerability to Harm and Illness (VH) and Insufficient Self-control/Self-discipline (IS). As suggested by prior research, it was necessary to examine the individual contributions to the parent-child bond from each parent (Harris & Curtain, 2002; Shah & Waller, 2000). It may have been reasonable to expect similar findings with maternal socialization as was found by Harris & Curtain (2002) in their overall parenting scores, because Harris and Curtain (2002) had slightly skewed data, in that a majority (76%) of their participants reported recollections of maternal overprotection and care. Given the current divorce rate in American society today, the rising number of single parents, and Family Court's judicial rulings in giving
mother's child custody, it is likely that a large number of the present participant pool experienced greater amounts of maternal socialization. This piece of information was overlooked in designing the present study, thus a priori hypotheses were not made for individual parenting dimensions. Further, Shah and Waller (2000) examined both a clinical and a random community sample and found support for the idea that core beliefs mediate the relationship between parental care and maternal overprotection in both of their samples. In the non-clinical group, Shah and Waller (2000) found that Vulnerability to Harm (VH) partially mediated the relationship between parental care and depressive scores. In the clinical group (60 patients meeting DSM-IV diagnostic criteria for major depressive disorder), the EMS of Dependence/Incompetence (DI), Emotional Inhibition (EI), Failure to Achieve (FA), Unrelenting Standards (US) and Vulnerability to Harm and Illness (VH) were mediators in the relationship between maternal bonding and paternal overprotection and depressed symptoms.

In comparison to the previous literature, the present study was able to provide partial support for mediation
models of EMS between perceptions of parenting and symptoms of depression. In the present data, Vulnerability to Harm and Illness (VH) and Insufficient Self-Control/Self-Discipline (IS) EMS were found to mediate the relationship between perceptions of parenting and symptoms of depression. However, in the present data, we found different unique parenting dimensions to be significant, than what was found in Shah and Waller’s (2000) clinical and community samples. This may be due to the fact that the present study utilized a healthier college sample, or that the measures utilized in prior studies (BDI-I, II) may be projecting some sort of cognitive or mood biases. Previously, the BDI-II has been thought to place increased emphasizes on cognitive symptoms of depression, possibly diluting the relationship between depressive symptoms and EMS. Finally, if the scales utilized in both present and prior research are mood congruent, it is possible that the negative thoughts associated with depression may have negatively influenced reports of parenting and schemas.

In the present study, post-hoc analyses provided support for Young’s Early Maladaptive Schema model, however, once again, as in previous research, it was
revealed that although parenting alone accounts for 9.2% of the variance in depression scores, EMS accounts for greater variance (34.4%) in depression scores. Shah and Waller (2000) found that all six parenting dimensions accounted for 20% of the variance in depression scores for their non-clinical group, in their study, whereas EMS accounted for a larger proportion of explanatory variance in depression (60%). Although the clinical group is not directly comparable to the non-clinical control group, parenting factors alone accounted for 45.6% of the variance in depression scores and EMS accounted for a whopping 86% of the variance in depression for Shah & Waller's (2000) sample. The clinical group was not directly comparable to the clinical group for a number of reasons, including the method of data collection and the level of functionality of patients in the clinical group. Harris and Curtain (2002) found that scores on the Parental Bonding Instrument accounted for 14% of the variance in depression scores, whereas EMS was able to account for more variance in each of the four mediations (e.g., Defectiveness/Shame (DS)=51%, Insufficient Self-Control/Self-Discipline (IS)=33%, Vulnerability to Harm
(VH)=34%, Inferiority/Incompetence (II)=42%). In the present study a slightly different pattern is observed, where parenting is a predictor, but a rather weak predictor of depression, and conversely EMS is a much stronger predictor of depressive symptoms. The pattern observed in the present study is similar to that found by Shah and Waller (2000), perhaps due to their similar use of individual accounts for maternal and paternal contributions. However, the effects in the present study were not at strong as those published by Shah and Waller (2000); this could be for several reasons. The samples that Shah and Waller (2000) examined may have been very different from that used in the present study. First, Shah and Waller utilized a community sample, verses the university sample utilized in the present study. In their comparison group, Shah and Waller (2000) used a clinical sample of patients who had been diagnosed with major depression. This type of sample may have created a more exaggerated effect for the models ability to predict emotional symptoms. Additionally, given that the participants in the present study are all attending an American University, they are probably higher functioning
than Shah and Waller’s clinical samples and community samples. It is not to say that individuals who have developed maladaptive schemas are unable to cope with life, achieve, and/or succeed; however, it may be reasonable to postulate that students attending a 4-year university are functioning higher than the average community sample and/or have certain subgroup of schemas. This subgroup may be defined by more adaptive coping in response to schemas and thus less impaired. These more educated individuals may have learned coping mechanisms to help balance their distorted views and behaviors.

In the present data set, perceptions of paternal socialization are not very influential, in that the use of negative parenting tactics, alone, are not very effective at predicting emotional symptoms in young adults. Clearly, paternal contributions need closer examination. Future research needs to further investigate differences in maternal and paternal socialization influences. As noted in Shah and Waller (2000),” different forms of parental behavior may result in vulnerabilities to depression via different cognitive routes” (p.24). Given that the intimate and nurturing mother-child bond is the strongest,
it is of no surprise that maternal psychological control was found to be the most disruptive in our sample of relatively healthy participants. In particular, due to identification, maternal psychological control should be the most devastating for daughters. To test this hypothesis, future research needs to examine the relationship between female perceptions of parenting and symptoms of depression, and the relationship between male perceptions of parenting and symptoms of depression. Previous studies have not looked at gender-gender effects; this may be a future direction for research.

In order to develop a healthy sense of self, children must feel safe, accepted, and secure about themselves and their surrounding environment. Feelings of defectiveness and shame develop when the individual does not feel accepted and is forced to believe that they are incompetent. They are unable to make even small decisions for themselves. Related schemas within the Disconnection and Rejection Domain (DR) will develop if an individual feels manipulated (e.g., abused, cheated, or lied to) by parents. Again, parental support for psychological autonomy allows children to feel strong and competent.
about themselves and their ability to make good choices in life. Individuals who are psychologically controlled by their parents, where there is too much parental intervention on the child’s life (overprotection) and decisions, and/or parents force choices onto their children (control), are left vulnerable to developing maladaptive schemas within the Impaired Autonomy and Performance Domain (IP), including, the Vulnerability to Harm and Illness (VH) EMS, which was also consistent with the present findings. Individuals who develop this Vulnerability to Harm and Illness (VH) EMS feel that they have little control over their life and self, leading to a constant worry that their world is going to fall apart, and that there is nothing that can be done about it. Schemas with in the Impaired Autonomy and Performance Domain (IP) have been associated with anxiety and panic disorders (Riskind, Williams, Gressner, Chrosniak, & Cortin, 2000).

Next, based on the idea that anxiety and depressive disorders share some cognitive features (Derry & Kuiper, 1981; Greenberg & Beck, 1989; Smith, Ingram, & Brehm, 1983, Harris & Curtain, 2002) and the high rates of
comorbidity among generalized anxiety disorder and depressive disorders (Brawman-Mintzer et al., 1993; Sanderson, Beck, & Beck, 1990), post-hoc analyses examined and found the EMS of Vulnerability to Harm and Illness (VH) and Defectiveness/Shame (DS) to partially mediate the relationship between maternal psychological control and symptoms of anxiety. This finding also lends support to previous findings (Parker et al., 1979); maternal parenting is the strongest influence on the parent-child bond. Shah & Waller (2000) however, found paternal overprotection and only maternal caring to be a significant influence on the development of EMS. Once again, post-hoc analyses validated Young’s EMS model, however, parenting alone accounted for 7% of the variance in anxiety scores, and EMS accounted for 38% of variance in anxiety scores. A consistent pattern, not only supporting the mediation model, but also suggesting that EMS are more predictive of symptoms than parenting, and specifically, EMS are predictive of symptoms of anxiety as well as depression.

It should not be of surprise that the present study found the EMS of Vulnerability to Harm and Illness (VH) as
a mediator between parental socialization and both symptoms of depression and anxiety. The Vulnerability to Harm and Illness (VH) EMS involves constant worry and concern about one’s environment and well-being.

Another interesting point of discussion may require a closer analysis at the present participant pool. A common topic of debate, when looking at therapy models, includes cultural implications and constraints. Generally, it’s assumed that data and findings can be generalized across different people. However, it would be quite naïve for a researcher to ignore the fact that different cultures promote very different family environments, parenting behaviors, self-concept, and living styles (collectivistic versus individualistic cultures). As we already know, for an individual who identifies with his/her culture strongly, would have been socialized very differently from an individual who identifies with an entirely different culture. Thus, the concept of self may very well be defined by an individual’s cultural beliefs. In our a priori correlation analyses, Pearson’s coefficients pointed to a positive relationship between parental psychological control and the Other Directedness Domain.
(OD) ($r = .245, p < .05$). Now, it may be true that in the United States (or other similar individualistic cultures) that an individual who constantly puts others’ needs above him or herself is putting their own well being in jeopardy. However, if you ask someone who has been socialized in an entirely different culture, they may disagree with this notion; in their culture it may be widely accepted to put the family’s needs before your own. First generation and/or immigrant children would be very vulnerable to developing EMS and later psychological symptoms, in relation to their acceptance of a new culture’s value system and beliefs, and their parents’ tendency to revert back to their familiar and accustomed beliefs and interactions. An individual who is well acculturated might score relatively high on the Other Directedness Domain (OD) of Young’s Schema Questionnaire, and even Barber’s parenting scales, but may still show to be relatively healthy on the SCL-90-R. Given that a majority (41%) of our participant pool identified at least to some extent with the Latino/Hispanics population, a better understanding of this culture may help in accurately interpreting the results. Further, it may serve
well in the future to look at Young’s EMS in a variety of different cultures. Barber’s scales have now been utilized in nine different countries world wide (Barber et al., 2005). Due to our relatively healthy and diverse college sample, cultural differences may explain why the present study only found partial support for the Young’s mediation model and why we were unable to completely replicate previous findings.

In conclusion, the present study provided partial support for Young’s (1999) Schema Model. This notion suggests that a key component of therapy, for both depression and anxiety, needs to give more attention to maintaining factors such as core beliefs, cognitive distortions and maladaptive assumptions. There is now ample support from a number of studies (Harris & Curtain, 2002; Shah & Waller, 2000; present) suggesting that EMS relate to symptoms of depression and anxiety, and slowly but surely disrupt healthy psychological behaviors. Cautious interpretation is necessary for these implications due to three major limitations. First, the present study, consistent with prior research, relied upon recollections and self-report measures for data. Self-
Report measures are subject to memory biases and mood dependent effects and possibly artificially inflating the relationship between recollections of parenting, EMS, and mood. This is usually due to the common problem of shared method variance, experienced by self-report questionnaires. Second, the present study also runs the risk of type I error making results across samples and studies less reliable. This Type I error issue is due to the number of independent variables (SQ and parenting subscales). Future research may consider using a more conservative analysis (e.g., Sobel Test and/or structural equation model). The final limitation to this study lies in the demographics of the present sample; a voluntary university sample was utilized. There is an increased chance that this sample does not effectively reflect the demographics of the general population; also making it difficult to generalize findings to and from previous studies with clinical samples and presumably higher levels of depression and anxiety. For a relatively new area of research, the present study provides at least modest support for Young’s Early Maladaptive Schema Construct. Additionally, previous beliefs of 'overprotective' mothers
were supported (Parker et al., 1979), with maternal psychological control being the strongest parenting influence on the relationship between EMS and psychological symptoms. These implications pose great challenges for the field of psychology and the study of mental health. Studies (present; Harris & Curtain, 2002; and Shah & Waller, 2000) imply that these core beliefs, as well as more surface level negative thoughts and assumptions, can be detrimental. They are fairly spontaneous, are automatically triggered by cues in the environment, and may have been engrained in the individual from a very young age with continuous reinforcement. Studies, like the present, leave clinical practitioners searching for an intervention powerful enough to combat such negative information processing, after years of use and acceptance by the individual. Individuals who have become more vulnerable to depression and anxiety due to their distorted cognitive processes will need more than behavioral therapy; perhaps, they will benefit from cognitive-behavioral therapies. Naturally, a professional EMS youth assessment would help identify and combat EMS at earlier stages of development. Further, parenting
interventions need to emphasize positive parental socialization (e.g., connection, monitoring, and psychological autonomy). Implications from the present study and previous literature suggest the utility of schema-focused cognitive-behavioral therapy in treating depression and anxiety symptoms, especially in individuals with characterological issues. Such practices may include creating positive balanced schemas, in addition to diminishing traces of distorted views and the individual's automatic reliance on EMS.
APPENDIX A

DESCRIPTIVE STATISTICS
## Descriptive Statistics

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APPENDIX B

CORRELATION COEFFICIENTS MATRIX
## Correlation Matrix

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Note. * P < .05
APPENDIX C

DEMOGRAPHICS FORM
DEMOGRAPHICS

Please answer each question to the best of your knowledge.

1. Age: __________

2. Gender: M ___ F ___

3. Ethnicity: Asian or Asian American ____ African American (or black) ____
   Caucasian (or white) ____ Native American (or American Indian) ____
   Latino (or Hispanic) ____ (please indicate specific Hispanic origin below)
   __________________________ (e.g., Mexican, Puerto Rican, Columbian etc)
   Other ____ (please specify) __________

4. Primary Language(s) spoken by parents or primary caretakers ________________

4. Monthly Income: __________  4a. Number living on the income _____
APPENDIX D

YOUNG SCHEMA QUESTIONNAIRE
INSTRUCTIONS:
Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it describes you. When there you are not sure, base your answer on what you emotionally feel, not on what you think to be true. Choose the highest rating from 1 to 6 that describes you and write the number in the space before the statement.

RATING SCALE:
1 = Completely untrue of me
2 = Mostly untrue of me
3 = Slightly more true than untrue
4 = Moderately true of me
5 = Mostly true of me
6 = Describes me perfectly

1. ______ Most of the time, I haven't had someone to nurture me, share him/herself with me, or care deeply about everything that happens to me.
2. ______ In general, people have not been there to give me warmth, holding, and affection.
3. ______ For much of my life, I haven't felt that I am special to someone.
4. ______ For the most part, I have not had someone who really listens to me, understands me, or is tuned into my true needs and feelings.
5. ______ I have rarely had a strong person to give me sound advice or direction when I'm not sure what to do.
6. ______ I find myself clinging to people I'm close to, because I'm afraid they'll leave me.
7. ______ I need other people so much that I worry about losing them.
8. ______ I worry that people I feel close to will leave me or abandon me.
9. ______ When I feel someone I care for pulling away from me, I get desperate.
10. _____ Sometimes I am so worried about people leaving me that I drive them away.
11. _____ I feel that people will take advantage of me.
12. _____ I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me.
13. _____ It is only a matter of time before someone betrays me.
14. _____ I am quite suspicious of other people's motives.
15. _____ I'm usually on the lookout for people's ulterior motives.
16. _____ I don't fit in.
17. _____ I'm fundamentally different from other people.
18. _____ I don't belong; I'm a loner.
19. _____ I feel alienated from other people.
20. _____ I always feel on the outside of groups.
21. _____ No man/woman I desire could love me one he/she saw my defects.
RATING SCALE:
1 = Completely untrue of me 4 = Moderately true of me
2 = Mostly untrue of me 5 = Mostly true of me
3 = Slightly more true than untrue 6 = Describes me perfectly

22. _____ No one I desire would want to stay close to me if he/she knew the real me.
23. _____ I'm unworthy of the love, attention, and respect of others.
24. _____ I feel that I'm not lovable.
25. _____ I am too unacceptable in very basic ways to reveal myself to other people.
26. _____ Almost nothing I do at work (or school) is as good as other people can do.
27. _____ I'm incompetent when it comes to achievement.
28. _____ Most other people are more capable than I am in areas of work and achievement.
29. _____ I'm not as talented as most people are at their work.
30. _____ I'm not as intelligent as most people when it comes to work (or school).
31. _____ I do not feel capable of getting by on my own in everyday life.
32. _____ I think of myself as a dependent person, when it comes to everyday functioning.
33. _____ I lack common sense.
34. _____ My judgment cannot be relied upon in everyday situations.
35. _____ I don't feel confident about my ability to solve everyday problems that come up.
36. _____ I can't seem to escape the feeling that something bad is about to happen.
37. _____ I feel that a disaster (natural, criminal, financial, or medical) could strike at any moment.
38. _____ I worry about being attacked.
39. _____ I worry that I'll lose all my money and become destitute.
40. _____ I worry that I'm developing a serious illness, even though nothing serious has been diagnosed by a physician.
41. _____ I have not been able to separate myself from my parent(s), the way other people my age seem to.
42. _____ My parent(s) and I tend to be overinvolved in each other's lives and problems.
43. _____ It is very difficult for my parent(s) and me to keep intimate details from each other, without feeling betrayed or guilty.
44. _____ I often feel as if my parent(s) are living through me--I don't have a life of my own.
45. _____ I often feel that I do not have a separate identity from my parent(s) or partner.
46. _____ I think that if I do what I want, I'm only asking for trouble.
RATING SCALE:
1 = Completely untrue of me          4 = Moderately true of me
2 = Mostly untrue of me               5 = Mostly true of me
3 = Slightly more true than untrue    6 = Describes me perfectly

47. _____ I feel that I have no choice but to give in to other people's wishes, or else they will retaliate or reject me in some way.
48. _____ In relationships, I let the other person have the upper hand.
49. _____ I've always let others make choices for me, so I really don't know what I want for myself.
50. _____ I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account.
51. _____ I'm the one who usually ends up taking care of the people I'm close to.
52. _____ I am a good person because I think of others more than of myself.
53. _____ I'm so busy doing for the people that I care about, that I have little time for myself.
54. _____ I've always been the one who listens to everyone else's problems.
55. _____ Other people see me as doing too much for others and not enough for myself.
56. _____ I am too self-conscious to show positive feelings to others (e.g., affection, showing I care).
57. _____ I find it embarrassing to express my feelings to others.
58. _____ I find it hard to be warm and spontaneous.
59. _____ I control myself so much that people think I am unemotional.
60. _____ People see me as uptight emotionally.
61. _____ I must be the best at most of what I do; I can't accept second best.
62. _____ I try to do my best; I can't settle for "good enough."
63. _____ I must meet all my responsibilities.
64. _____ I feel there is constant pressure for me to achieve and get things done.
65. _____ I can't let myself off the hook easily or make excuses for my mistakes.
66. _____ I have a lot of trouble accepting "no" for an answer when I want something from other people.
67. _____ I'm special and shouldn't have to accept many of the restrictions placed on other people.
68. _____ I hate to be constrained or kept from doing what I want.
**RATING SCALE:**
1 = Completely untrue of me        4 = Moderately true of me
2 = Mostly untrue of me            5 = Mostly true of me
3 = Slightly more true than untrue  6 = Describes me perfectly

69. _____ I feel that I shouldn't have to follow the normal rules and conventions other people do.

70. _____ I feel that what I have to offer is of greater value than the contributions of others.

71. _____ I can't seem to discipline myself to complete routine or boring tasks.

72. _____ If I can't reach a goal, I become easily frustrated and give up.

73. _____ I have a very difficult time sacrificing immediate gratification to achieve a long-range goal.

74. _____ I can't force myself to do things I don't enjoy, even when I know it's for my own good.

75. _____ I have rarely been able to stick to my resolutions.
APPENDIX E

BARBER’S PARENTING SCALES
Directions: Please circle the number of the response that best reflects your personal experience with the parent(s) or guardian(s) who was the most influential during your childhood. Make sure to answer for both your father and mother figure. There are no right or wrong answers. We would just like your honest response.

Part A: For each statement, indicate the extent to which each statement applies to you using the scale provided.

1 – Was not like him/her
2 – Was somewhat like him/her
3 – Was a lot like him/her

“My father/mother figure was a person who ...”

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<th>Father figure</th>
<th>Mother figure</th>
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<td>1. made me feel better after talking over my worries.</td>
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<td>1 2 3</td>
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<tr>
<td>2. smiled at me often.</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>3. able to make me feel better when I was upset.</td>
<td>1 2 3</td>
<td>1 2 3</td>
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<tr>
<td>4. enjoyed doing things with me.</td>
<td>1 2 3</td>
<td>1 2 3</td>
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<tr>
<td>5. cheered me up when I was sad.</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>6. gave me a lot of care and attention.</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>7. made me feel like the most important person in his/her life.</td>
<td>1 2 3</td>
<td>1 2 3</td>
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<tr>
<td>8. believed in showing his/her love for me.</td>
<td>1 2 3</td>
<td>1 2 3</td>
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<tr>
<td>9. often praised me.</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>10. was easy to talk to.</td>
<td>1 2 3</td>
<td>1 2 3</td>
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**Part B:** For each statement, indicate the extent to which each statement applies to you using the scale provided.

1 – Did not know  
2 – Knew a little  
3 – Knew a lot

“How much did your father/mother figure REALLY know...”

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<tr>
<td>11. who your friends were?</td>
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<td>1 2 3</td>
</tr>
<tr>
<td>12. where you went at night?</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>13. how you spent your money?</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>14. what you did with your free time?</td>
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<td>1 2 3</td>
</tr>
<tr>
<td>15. where you were most afternoons after school</td>
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<td>1 2 3</td>
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133
Part C: For each statement, indicate the extent to which each statement applies to you using the scale provided.

1 – Was not like him/her
2 – Was somewhat like him/her
3 – Was a lot like him/her

“My father/mother figure was a person who …”

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<th>Statement</th>
<th>Father figure</th>
<th>Mother figure</th>
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<td>16. was always trying to change how I felt or thought about things.</td>
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<td>1 2 3</td>
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<tr>
<td>17. changed the subject whenever I had something to say.</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>18. often interrupted me.</td>
<td>1 2 3</td>
<td>1 2 3</td>
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<tr>
<td>19. blamed me for other family members’ problems.</td>
<td>1 2 3</td>
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<td>20. brought up past mistakes when he/she criticized me.</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>21. was less friendly with me if I did not see things his/her way.</td>
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<td>1 2 3</td>
</tr>
<tr>
<td>22. would avoid looking at me when I had disappointed him/her.</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>23. if I had hurt his/her feelings, stopped talking to me until I pleased him/her again.</td>
<td>1 2 3</td>
<td>1 2 3</td>
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APPENDIX F

SYMPTOMS CHECKLIST-90-REVISED
**Instructions:** Below is a list of problems people sometimes have. Please read each one carefully, and circle the number that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Circle only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example before beginning, and if you have any questions please ask them now.

0 = Not at all  
1 = A little bit  
2 = Moderately  
3 = Quite a bit  
4 = Extremely

1. 0 1 2 3 4 Headaches
2. 0 1 2 3 4 Nervousness or shakiness inside
3. 0 1 2 3 4 Repeated or unpleasant thoughts that won’t leave your mind
4. 0 1 2 3 4 Faintness or dizziness
5. 0 1 2 3 4 Loss of sexual interest or pleasure
6. 0 1 2 3 4 Feeling critical of others
7. 0 1 2 3 4 The idea that someone else can control your thoughts
8. 0 1 2 3 4 Feeling others are to blame for most of your troubles
9. 0 1 2 3 4 Trouble remembering things
10. 0 1 2 3 4 Worried about sloppiness or carelessness
11. 0 1 2 3 4 Feeling easily annoyed or irritated
12. 0 1 2 3 4 Pains in heart or chest
13. 0 1 2 3 4 Feeling afraid in open spaces or on the streets
14. 0 1 2 3 4 Feeling low in energy or slowed down
15. 0 1 2 3 4 Thoughts of ending your life
16. 0 1 2 3 4 Hearing voices that other people do not hear
17. 0 1 2 3 4 Trembling
18. 0 1 2 3 4 Feeling that most people cannot be trusted
19. 0 1 2 3 4 Poor appetite
20. 0 1 2 3 4 Crying easily
21. 0 1 2 3 4 Feeling shy or uneasy with the opposite sex
22. 0 1 2 3 4 Feelings of being trapped or caught
23. 0 1 2 3 4 Suddenly scared for no reason
24. 0 1 2 3 4 Temper outbursts that you could not control
25. 0 1 2 3 4 Feeling afraid to go out of your house alone
26. 0 1 2 3 4 Blaming yourself for things
27. 0 1 2 3 4 Pains in lower back
28. 0 1 2 3 4 Feeling blocked in getting things done
29. 0 1 2 3 4 Feeling lonely
30. 0 1 2 3 4 Feeling blue
31. 0 1 2 3 4 Worrying too much about things
32. 0 1 2 3 4 Feeling no interest in things
33. 0 1 2 3 4 Feeling fearful
34. 0 1 2 3 4 Your feelings being easily hurt
35. 0 1 2 3 4 Other people being aware of your private thoughts
36. 0 1 2 3 4 Feeling others do not understand you or unsympathetic
37. 0 1 2 3 4 Feeling that people are unfriendly or dislike you
38. 0 1 2 3 4 Having to do things very slowly to insure correctness
0 = Not at all  1 = A little bit  2 = Moderately  3 = Quite a bit  4 = Extremely

39. 0 1 2 3 4 Heart pounding or racing
40. 0 1 2 3 4 Nausea or upset stomach
41. 0 1 2 3 4 Feeling inferior to others
42. 0 1 2 3 4 Soreness of your muscles
43. 0 1 2 3 4 Feeling that you are watched or talked about by others
44. 0 1 2 3 4 Trouble falling asleep
45. 0 1 2 3 4 Having to check or double-check what you do
46. 0 1 2 3 4 Difficulty making decisions
47. 0 1 2 3 4 Feeling afraid to travel on buses, subways, or trains
48. 0 1 2 3 4 Trouble getting your breath
49. 0 1 2 3 4 Hot or cold spells
50. 0 1 2 3 4 Having to avoid certain things, places, or activities because they frighten you
51. 0 1 2 3 4 Your mind going blank
52. 0 1 2 3 4 Numbness or tingling in parts of your body
53. 0 1 2 3 4 A lump in your throat
54. 0 1 2 3 4 Feeling hopeless about the future
55. 0 1 2 3 4 Trouble concentrating
56. 0 1 2 3 4 Feeling weak in parts of your body
57. 0 1 2 3 4 Feeling tense or keyed up
58. 0 1 2 3 4 Heavy feelings in your arms or legs
59. 0 1 2 3 4 Thoughts of death or dying
60. 0 1 2 3 4 Overeating
61. 0 1 2 3 4 Feeling uneasy when people are watching or talking about you
62. 0 1 2 3 4 Having thoughts that are not your own
63. 0 1 2 3 4 Having urges to beat, injure, or harm someone
64. 0 1 2 3 4 Awakening in the early morning
65. 0 1 2 3 4 Having to repeat the same actions such as touching, counting, or washing
66. 0 1 2 3 4 Sleep that is restless or disturbed
67. 0 1 2 3 4 Having urges to break or smash things
68. 0 1 2 3 4 Having ideas or beliefs that others do not share
69. 0 1 2 3 4 Feeling very self-conscious with others
70. 0 1 2 3 4 Feeling uneasy in crowds, such as shopping or at a movie
71. 0 1 2 3 4 Feeling everything is an effort
72. 0 1 2 3 4 Spells of terror or panic
73. 0 1 2 3 4 Feeling uncomfortable about eating or drinking in public
74. 0 1 2 3 4 Getting into frequent arguments
75. 0 1 2 3 4 Feeling nervous when you are left alone
76. 0 1 2 3 4 Others not giving you proper credit for your achievements
77. 0 1 2 3 4 Feeling lonely even when you are with other people
78. 0 1 2 3 4 Feeling so restless you couldn’t sit still
79. 0 1 2 3 4 Feeling of worthlessness
80. 0 1 2 3 4 The feeling that something bad is going to happen to you
81. 0 1 2 3 4 Shouting or throwing things
82. 0 1 2 3 4 Feeling afraid you will faint in public
0 = Not at all   1 = A little bit   2 = Moderately   3 = Quite a bit   4 = Extremely

83.  0 1 2 3 4 Feeling that people will take advantage of you if you let them
84.  0 1 2 3 4 Having thoughts about sex that bother you a lot
85.  0 1 2 3 4 The idea that you should be punished for your sins
86.  0 1 2 3 4 Thoughts and images of a frightening nature
87.  0 1 2 3 4 That idea that something serious is wrong with your body
88.  0 1 2 3 4 Never feeling close to another person
89.  0 1 2 3 4 Feelings of guilt
90.  0 1 2 3 4 The idea that something is wrong with your mind
APPENDIX G

INFORMED CONSENT FORM
Early Maladaptive Schema Study

Informed Consent Statement

You are invited to participate in a study designed to assess different factors that may be related to the way in which you have learned to view relationships, yourself, and the world around you. We are also examining how these views relate to early parental experiences, emotional health and coping strategies. This study is being conducted by PSYC 432 Advanced Lab: Clinical students, under the supervision of Dr. Michael R. Lewin, Associate Professor of Psychology. This study has been approved by the Department of Psychology Institutional Review Board Sub-Committee of the California State University, San Bernardino, and a copy of the official Psychology IRB stamp of approval should appear somewhere on this consent form. The university requires that you give your consent before participating in this study.

In this study you will be asked to complete a packet of questionnaires designed to measure your views of self and the world around you, your relationship with your parents, your coping style, and questions related to your emotional well being. The packet will take approximately 1 ½ hour to complete. You will earn four extra credit units for your participation. Your participation is anonymous, so please do not give any identifying information on the questionnaire packet. Presentation of the results of the study will be reported in group format only.

This study involves no risks beyond those routinely encountered in daily life, nor any direct benefits to you as a participant other than extra credit for one of your psychology courses. Your participation in the research is completely voluntary and you are free to withdraw at any time during this study without penalty and not to answer any questions that make you uncomfortable. At the conclusion of the study, you may receive a report of the results by contacting Dr. Michael R. Lewin. Any questions about this study or your participation in this research should be directed to Dr. Lewin at (909) 537-7303.

I acknowledge that I have been informed of, and understand the true nature and purpose of this study, and I freely consent to participate. I acknowledge that I am at least 18 years of age.
Please indicate your desire to participate by placing an "X" on the line below

Participant's X

Date

Researcher's Signature

Date

CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
PSYCHOLOGY INSTITUTIONAL REVIEW BOARD SUB-COMMITTEE
APPROVED 12/20/05, VOID AFTER 12/20/06

ERB#: 61661102 CHAIR
APPENDIX H

DEBRIEFING STATEMENT
The main objective of this study is to assess how our experience with our parents effects the way we view ourselves, relationships and the world around us. Additionally, we are examining how these views effect our means of coping with stress and emotion. This information may be useful for the training of parents and the prevention/intervention efforts of counselors.

You were instructed not to give your name as the study is anonymous. Therefore, there is no way to connect your responses with you. This study was conducted in accordance with ethical and professional codes set by the CSUSB Department of Psychology Human Subjects Review Board and the American Psychological Association. The focus of this research is on all participants as a group and not on individual responses. Therefore, the data will be analyzed by group and not on an individual level. Please contact Dr. Lewin if you are interested in the results of the study or if you have any questions about your participation. It is unlikely that participating in this study will result in significant distress, however, if you have experienced some distress and would like to discuss your response, please contact either Dr. Lewin at (909) 880-7303 or the CSUSB Counseling Center at (909) 880-5040 or the Community Counseling Center at (909) 880-5569. If you are interested in the results of this study, you may contact Dr. Lewin at the conclusion of the Winter quarter, 2004.

Please do not reveal details about this study to anyone who may be a potential participant, as we will be collecting data throughout the year. Thank you for your participation.
REFERENCES


Barber, B.K. (1997). Introduction: Adolescent socialization in context - Connection, regulation,


Rocklin, R. & Lavett, D. (1987). Those who broke the cycle: Therapy with nonabusive adults who were


