

**Effects of Parenting Experiences &
Early Maladaptive Schemas on Adjustment to Atopic Dermatitis**

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**Submitted for the degree of
Doctorate in Counselling Psychology
September 2014**

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Preface

This preface will introduce various components of the doctoral thesis portfolio. The portfolio focuses on four different areas associated with the practice of counselling psychology. Firstly, there is an exploratory piece of research focusing upon the experience of adjusting to atopic dermatitis. Secondly, a case study presents the application of cognitive behavior couples theory to working with a couple presented with medical problems. Thirdly, there is a process report critically evaluating the use of schema therapy model with a client suffering from a chronic medical condition. Finally, a critical reflective essay provides an account into my personal, clinical, and theoretical learning that has taken place as a trainee counselling psychologist. A brief overview of each of these sections will now be presented whilst describing briefly the area that they cover and their respective aims and objectives. The preface will conclude by presenting a brief summary of the interconnectedness of the aforementioned sections. This will take place via illustrating a theme that has considerable value and implications for my personal and professional development as a counselling psychologist and a researcher.

Section A: Empirical Research

This section consists of an original piece of research that aims to explore in-depth the factors that contribute to adjustment to a chronic, disfiguring and painful psychosomatic skin condition like atopic dermatitis (eczema). The study uses certain self-report measures that assess current difficulties in adjustment to atopic dermatitis and ways by which past experiences contributed to current phenomenology and course of condition. Data was gathered by people with an early

onset of the condition, people with a late onset and people with no medical condition and was analyzed using a cross-sectional, quantitative methodology. The analysis is discussed in the light of existing theoretical knowledge as well as the extant empirical literature. Implications for the clinical practice of counselling psychology, limitations of the present study and future directions are identified and discussed.

Section B: Case Study

This section focuses on demonstrating my clinical skills of undertaking six sessions of couples therapy with a mother [who suffered from myasthenia gravis (a neuromuscular disease)] and her daughter (who suffered from acne) whose relationship was presented with significant communication difficulties that had led to significant emotional disturbances. The specific purpose here is to illustrate via a case study, the learning and the application of core cognitive behavioral ideas into the assessment and formulation of working with this couple. The brief cognitive behavioral couples' model is employed in order to inform treatment planning and interventions carried out with this particular couple. This piece of work also reflects my own process in terms of my development as a cognitive behavioral couples' practitioner.

Section C: Process Report

The aim of this section is to critically evaluate the application of schema therapy based skills and interventions with a 35-year old woman presented with Crohn's disease, acute urticaria and clinical depression. This client was referred in the past for cognitive behaviour therapy. However, two years after therapy had

ended she experienced a relapse and was re-referred. The focus of this report is to highlight the importance of using deeper-level, schematic work –instead of symptom-oriented ones- when confronting people with chronic medical, emotional and relational difficulties

Section D: Reflective Essay

This section includes a reflective practice essay as an attempt to explore the development of my own personal philosophy and orientation to Counseling Psychology adopted in my clinical practice throughout the course of my professional training. The aim of this essay is to take the reader through an experiential journey of my clinical training and development, whilst drawing upon my earlier influences that defined my decision to get cognitive behavioral therapy training, and develop my own personal philosophy and style as a therapist.

Thematic Connection for the Portfolio

Reflecting upon the work within each of these sections, there appear to be two common themes: a) the concept of *self* in shaping the experience and course of chronic medical conditions (i.e. Chron's disease, acne, atopic dermatitis) and b) the role of early (parenting) experiences in shaping such concepts.

Indeed, although limited in numbers, a number of studies exists demonstrating a link between early parenting experiences and chronic medical conditions (such as gastrointestinal disorders, fibromyalgia, and pain syndromes) mediated by the development of self-concepts (Maunder and Hunter, 2001).In keeping with this, the thematic connection that ties the various sections of the

present thesis together is the possibility that adjustment to and course of current medical conditions might permeate much deeper than the condition per se, into one's own sense of self and early experiences that constituted the cornerstone of his/her personality development.

Specifically, the doctoral research highlights the ways by which early parenting experiences can profoundly shape a person's self-constructs (self-schemas) and how these constructs can further predict the experience and adjustment to an ulterior chronic, disfiguring skin condition like atopic dermatitis. Similarly, the couples' case study further echoes the role of parent-child interactions on an adolescent girl's personality structures and condition (i.e. acne) management. The process report details some of the challenges and difficulties that I experienced as a therapist while working on a symptomatic level, using traditional cognitive behavioural work, with a patient suffering from Crohn's disease and clinical depression, and how therapeutic work was optimized when therapy shifted on an emotional, schematic level and addressed early parent-child interactions. Last but not least, the theoretical essay provides a valuable insight into the development of a stronger personal and professional self that has made me better able to consider the unique needs of each of my clients, be flexible on the therapeutic orientations that I use and consequently maintain therapeutic integrity.

So far, the most prevailing therapeutic interventions aimed at the management of medical (or psychosomatic) conditions, have been primarily guided by symptom-oriented disciplines like clinical, medical or health psychology (Gatchel and Turk, 2002). Thus, not only the emotional dimensions related to these conditions are left unaddressed, but it can also be seen that the distress arising from

these emotional dimensions may well be a significant factor in affecting the course of the condition itself. This portfolio underscores the importance of looking behind medical problems into the experience of one's own sense of self (with or without the medical problem) and emotions when treating medical difficulties. Understanding a person's personal experience and facilitating him/her in achieving personal growth and adjusting to life adversities (like the presentation of medical problems) is what distinguishes Counselling Psychology from other models that try to diagnose and treat psychological imbalances (Strawbridge, Woolfe & Dryden, 2009). Thus, it is recommended that the humanistic (non-pathologizing) perspective embedded in the discipline of Counseling Psychology be incorporated in routine care for patients with dermatological symptoms (and specifically atopic dermatitis) in hope that integral adjustment will be facilitated.

ACKNOWLEDGMENTS

To Dr Alexandra Mizara, my supervisor, mentor and above all, good friend, thank you for all the care, and the so helpful feedback. Thank you for all your support that kept me motivated to move and fulfill my goals. You have been a valuable source of inspiration to me on both a professional and a personal level.

To Dr John Dovelos, my true good friend and mentor, thank you for being there for me these last three years broadening my perspectives and keeping me in touch with my true authentic self.

To Mrs Mary Dovelou who believed in me and encouraged me in her own special way to move on.

To my loving sister and her loving family who provided me with a valuable source of emotional support and encouragement when it was mostly needed and constituted a familial frame of reference for me

To George, thank you for being there for me, keeping me smiling, sharing your love and affection with me and becoming the mirror that I feel proud of looking myself at.

To my good friends Phoebe, Eleftheria, Konstantinos and Angelos for their strong belief in me and for making this journey easier with all their smiles, laughter and joyful personalities. Thank you for all the miles that we run together and for all the beautiful and meaningful experiences that we shared.

To my cousin John, thank you for your valuable advice and technical support

Finally to my beloved mother who always believed in me, gave me the foundations for believing in myself and achieving my goals. Thank you for giving me so much so effortlessly!

Last but not least, to my beloved father who taught me how it is like to give without asking anything in return. Thank you for being who you are!

ABBREVIATIONS

AB = Abandonment	HDS = Honesty Significant Difference
AD = Atopic Dermatitis	ISC = Insufficient Self Control
ACSDQ = Adjustment to Chronic Skin Disease Questionnaire	M = Mothers
AP = Appraisal theory	MA = Mistrust/Abuse
BE = Belittling	OP = Overprotective
BPS = British Psychological Society	PF= Perfectionist
CBT = Cognitive Behaviour Therapy	PS = Pessimism/Pessimistic
CD = Conditional	PU = Punitiveness/ Punitive
CNS = Central Nervous System	QoL = Quality of Life
CoP = Counseling Psychology	RS = Recognition Seeking
CT = Controlling	SB = Subjugation
DI = Dependence	SI = Social Isolation
DS = Defectiveness	SRMoI = Self Regulatory Model of Illness
DSM = Diathesis Stress Model	SS = Self-Sacrifice
ED = Emotional Deprivation/Emotionally Depriving	ST = Schema Therapy
EI = Emotional Inhibition/Emotionally Inhibiting	VH = Vulnerability to Harm
EM = Enmeshment	US = Unrelenting Standards
EMS = Early Maladaptive Schemas	YPI-R = Young Parenting Inventory-Revised
ET = Entitlement	YSQ-S3 = Young Schema Questionnaire Short Form
F = Fathers	
FA = Failure	

ABSTRACT

Atopic dermatitis (eczema) is a psychosomatic chronic skin condition. Onset of the condition usually occurs in early life. Some people however, do develop it much later. Even though studies have demonstrated high levels of psychological disturbance and maladjustment among most people with AD, some others still do not, suggesting that a certain level of variability exists in the way people adjust to their skin condition. The goal of the present study was to identify the factors that determine adjustment to AD and account for this variability. Existing studies on this topic have considered factors such as: age of onset of the condition, demographic characteristics, disease severity and visibility, cognitive representations of illness and condition appraisals. Most of these studies however are limited in the explanations that they offer. Drawing upon the schema theory model of personality development and psychopathology, the present study proposes that adjustment to AD is mediated by personality-level structures (self-schemas) that have their origins in early experiences. Design: A cross-sectional design was employed with three groups: a) patients with an early onset of atopic dermatitis (n = 130), b) patients with a late onset (n = 76) and c) people with no chronic medical condition (n = 74). Method: All groups completed the Young Parenting Inventory-Revised, and the Young Schema Questionnaire-Short Form 3. The two atopic dermatitis groups also completed the Adjustment to Chronic Skin Disease Questionnaire. Results suggest that: a) people with an early and a late onset of atopic dermatitis were presented with a certain schematic profile that differentiated them from participants in the control groups; b) a certain pattern of early parenting experiences was linked to the development of this schematic profile and c) this

schematic profile predicted high levels of dysfunctional coping and difficulties in adjustment. Findings have a clear relevance to the practice of Counselling Psychology. Limitations of the study and clinical implications are discussed.

CHAPTER 1

INTRODUCTION

1.1 Introduction

Atopic dermatitis (AD) – also termed atopic eczema or neurodermatitis- is a common inflammatory skin condition. AD accounts for 30% of all skin conditions examined by General Practitioners and 10% -20% of the skin conditions seen by dermatologists in secondary care (Fennessy, Coupland, Popay and Naysmith, 2000). Studies conducted in the UK over the last 40 years reveal that the prevalence has arisen four-fold in children. An estimate of the financial cost of treating AD in 1996 showed to be approximately £465 million (Ellis, Drake, Prendergast, et al., 2002).

Even though such evidence suggests that treatment of AD is expensive and consumes a large amount of National Health resources, there seems to be little awareness or understanding as to how life-limiting suffering with AD can be to the sufferer. Thus, the psychological impact on the sufferer is often underestimated and/or minimized (Choi and Koo, 2003). Recent research has demonstrated that the degree of psychiatric morbidity and the psychological impact of living with AD is comparable to the one faced by people with other chronic medical illnesses such as cancer, arthritis, hypertension, heart-disease and diabetes (Rapp, Feldman, Exum, et al., 1999).

The purpose of the present study was to explore developmental and core factors that might contribute to adjustment to AD. The overall aim was to look across the developmental span of people with AD in order to understand whether there are important differences among people whose skin condition started early in their

childhood to those that developed it later on in their adulthoods, in terms of their parenting experiences, schematic perceptions and overall adjustment to it.

1.2. Understanding Atopic Dermatitis (AD)

AD is a chronic inflammatory skin condition characterized by red rashes, moist red weeping skin during acute periods (see picture 1: A, B) and dry scaly skin during chronic periods (see picture 1: C, D). It is very often associated with allergic conditions, asthma and hay fever (Papadopoulos and Walker, 2003a). In fact, the word *atopic* refers to a hereditary predisposition to react to certain allergies (Panconesi and Hautmann, 1996).

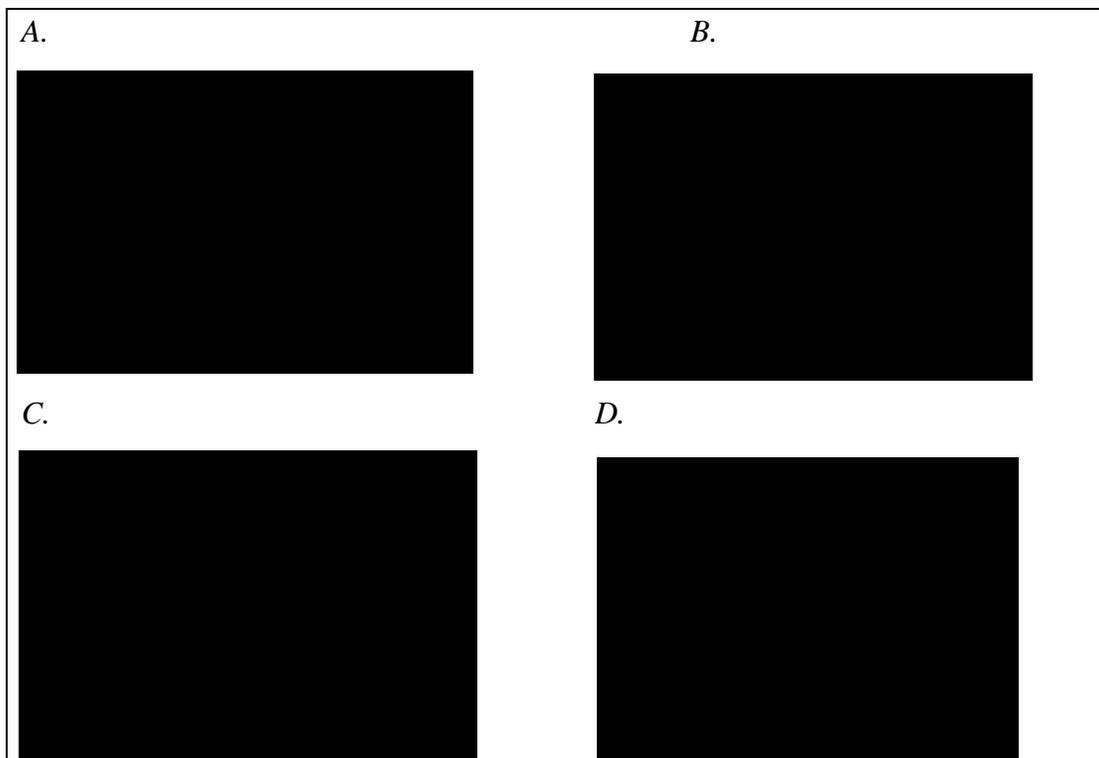
The main symptom of AD is dry, itchy skin. Scratching in response to itch may cause inflammation, delay healing and facilitate infection. It can also increase itchiness and eventually cause lichenification (thickening) of the skin (Lerda and Angelini, 2004).

1.2.a. Distribution

Eczematous lesions can affect any part of the body. Typically they appear on the face, knees, elbows and the trunk (Figure 1). AD symptoms range from mild patches to severe, widespread and extremely painful rashes that can be persistent for years leading to physical disability. Patches are merely characterized by crusting, scaling, cracking, severe dryness and swelling (Hoare, Li Wan Po and Williams 2000).

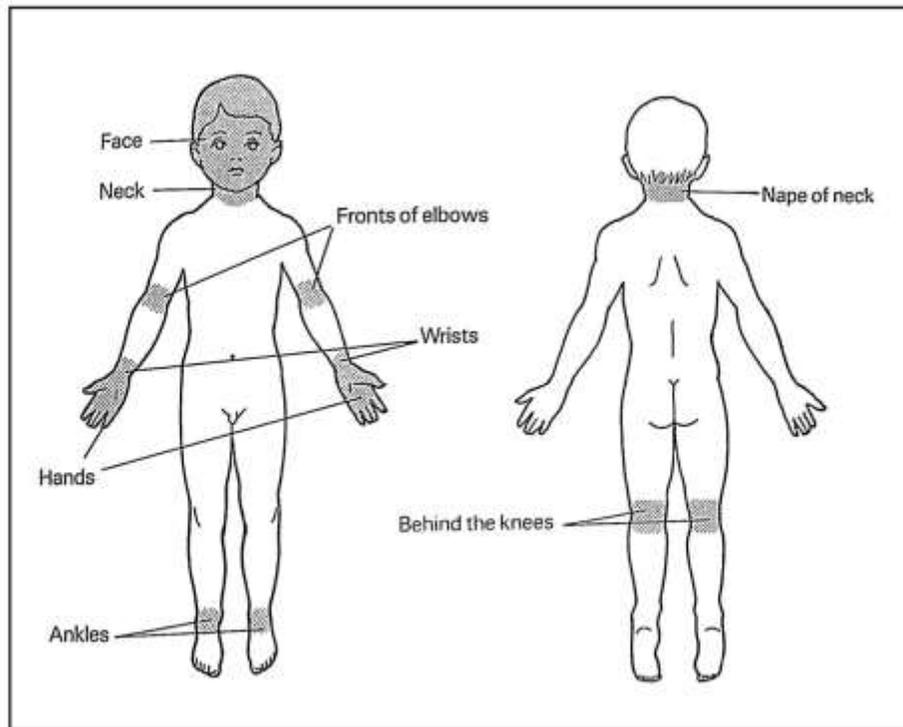
1.2.b. Prevalence

AD is a disease with onset in infancy however, an upward tendency has been observed the past three decades (Williams, 1992). Estimates have shown that almost 70% of the affected people develop the condition in infancy or early childhood (early onset) while the remaining 30% develop the condition in young adulthood or adulthood (late onset) (Pauli-Pott, Darui, and Backmann, 1999). Studies on gender differences have been contradictory as some report that females are at greater risk of developing AD compared to males while others demonstrate no significant differences between the two genders (Fennessy et al, 2000).



Source: Dermnet(2011)

Picture 1. Common Acute and Chronic Periods of AD



Source: Mizara (2007)

Figure 1: Commonly Affected Sites of the Skin in Atopic Dermatitis.

1.2.c. Management

There is no cure for AD as yet and clinical symptoms can only be managed mainly through the use of emollients, potent or topical corticosteroids and ultraviolet light therapy. However, such management can be extremely time-consuming, can involve significant side effects and is not always successful (Papadopoulos and Walker, 2003b). Unsuccessful management of the condition leads to reduced adherence to treatment and observations have shown that 35-45% of the cases fail to adhere to treatment (Serup, Lindblad, Maroti et al, 2006).

1.2.d. Etiology

A number of factors appear important for AD development. These include defects in the skin barrier, and abnormalities in the normal inflammatory and allergy responses. A tendency to atopic conditions often runs in families and is genetically determined. An abnormality in the gene which is responsible for the production of *filagrin* (a protein that forms a protective layer for the skin) has been closely linked to the development of AD (Hoare et al, 2000).

Research so far has not managed to find a standard pathogenic model involved in the etiology of the condition. However, recent studies point to directions such as: a) immune imbalances (Papadopoulos and Walker, 2003a; Koblenzer, 1992); b) other genes encoding structures of the epidermis (Schultz-Larsen, Holm, and Henningsen, 1986); and c) environmental and lifestyle factors (e.g. house dust mites, pet dander, air pollution, pollen etc) (Williams, 1995). One of the most commonly agreed factors implicated in the etiology of AD [among early and late authors (e.g. Knapp, 1969; Buske-Kirschbaum, Gierrens, and Hellhammer, 2001)] however, has been *psychological stress*.

1.3. Psychological Distress and AD: A Bidirectional Link

The skin and the central nervous system (CNS) are embryonically related (the epidermis and the neural plate are produced by the ectoderm), thus they share certain hormones, receptors and neurotransmitters (Picardi and Abeni, 2001). It is not surprising that emotional states -that designate a collection of responses triggered from certain parts of the brain (Damasio, 1998)- can have physical

repercussions that lead to certain dermatological conditions, including AD (Bruske-Kirschbaum, et al, 2001).

Psychological stress and AD appear to be bidirectionally linked as stress might lead to an exacerbation of the condition while worsening of the condition might contribute to increased stress levels. In fact, there is a common conception that stress aggravates AD in almost 50-90% of the cases (Picardi and Abeni, 2001). It was this observation that led to the conceptualization of epidermal symptoms of AD as the manifestation of internal emotional conflicts (e.g. shame, excitement, rage/anger, etc) and underlying psychological processes and classify AD as a merely *psychosomatic condition* (Lerda and Angelini, 2004). Therefore, psychological stress is now commonly considered to play an etiological role in the onset, progression and management of the condition itself (Koblenzer, 1988b; Gil, Keefe, Sampson et al, 1987; Gil, Francis, Sampson et al, 1988; Papadopoulos, Bor and Legg, 1999a).

This relationship has also been empirically demonstrated (e.g. Papadopoulos, Bor, Legg & Hawk, 1998; Greismar, 1978; Raap, Werfel, Jaeger, and Schmid-Ott, 2003; Kimyai-Asadi and Usman, 2001 etc). A classic, seminal study was conducted by Lester, Wittkower, Kalz and Azuna (1962) who examined this relationship by considering the effects of tranquilizers and antidepressants on people suffering from skin conditions (including AD) using a double-blind methodology. Results showed that the progression of AD was affected by drugs only in situations where participants experienced *significant* psychological distress that pre-existed the condition. Participants with *minor* psychological distress that

pre-existed the condition showed little improvement on their skin after receiving psychotropic medication.

Several criticisms can be made with regards to these findings. First, it could be argued that both physical and psychological symptoms were increased by certain levels of stress and that medication –which provided a buffer to stress- relieved both types of symptoms concurrently. Second, it was not clear whether psychological problems constituted the cause or the result of the condition. Nevertheless, Lester et al. (1962) clearly demonstrated that psychological factors can be linked to the precipitation of AD.

Even though evidence suggest that psychological stress is implicated in the etiology and/or progression of AD, a question that arises is *why all people that experience psychological distress are not equally vulnerable to AD*. One explanation comes from the Diathesis (or predisposition) Stress Model (DSM). According to this model, people inherit a weak organ (e.g. the skin) that determines the effect of psychological/biological upsets in such a way so as autonomic activity will be directed toward that weak organ (Walker and Papadopoulos, 2005).

Even though genetic predisposition constitutes a necessary factor for AD onset, it is not sufficient in itself enough to cause the disease. According to the DSM a more central environmental cause, like *stress*, is needed for the manifestation of the condition (Papadopoulos, et al. 1998). The question that arises then is *what are the factors that mediate stress levels among this population*. One of the central aims of the present study is to identify these factors and understand what might affect people's vulnerability to AD.

CHAPTER 2

PSYCHOLOGICAL ADJUSTMENT TO

ATOPIC DERMATITIS

2.1. Psychological Adjustment to AD

Psychological adjustment has been defined as the presence or absence of diagnosed psychological disturbances, symptoms or negative moods mediated by the occurrence of the condition (Stanton, Revenson & Tennen, 2007). The functional, psychological and social impact of AD is actually equivalent to many other chronic medical conditions (i.e. diabetes, heart-disease, cancer, AIDS etc) (Su, Kemp, Varigos and Nolan, 1997; Laughter, Istvan, Tofte et al., 2000)

AD is a physical condition that has actual practical difficulties around its management such as time consuming application of topical regimes, attendance of frequent hospital and treatment appointments as well as sleeping disturbances due to itching, absences from work, financial costs, etc. All these practical challenges can eventually lead to the sufferer feeling exhausted, dishearted, angry and helpless (Jowett and Ryan, 1985; Picardi, Abeni, Melci, et al, 2000).

Along the practical aspects, there are also many psychosocial ones. AD can be highly disfiguring and, as it affects the skin, readily visible to others. Living with AD means that one has to come to terms with constant changes in their appearance and be open to public scrutiny (Fox, Rumsey and Morris, 2007; Kent, 2005). Feelings of stigmatization, whether actual or perceived, may adversely impact on the overall quality of life of the person. Patients for example, often report an inability to engage in social activities due to fear of rejection and eventually become isolated (Anthis, 2005).

Additionally, chronic, inflammatory skin conditions, like AD, have been found to affect the intimate and sexual life of people in almost 72% of the cases (Gupta,

Gupta, Haberman, 1987). In their study, Sukan and Maner (2007) demonstrated that affected people scored significantly lower than unaffected ones on: a) sexual drive, b) sexual arousal, c) reaching orgasm and d) getting satisfaction from orgasm. These impairments were related to both feelings of embarrassment/shame and physical pain.

To a large extent, beliefs related to how others will evaluate our appearance determine our self-concept, (i.e. the *looking glass self*). These evaluations are influenced both by the social and cultural demands that are placed on the individual (Cash, 2001). Butters and Cash (1987) have argued that subjective evaluations of successfully meeting these demands can adversely impact on the person's self-esteem, body image perception (body satisfaction) and overall self-concept that is often associated with serious emotional distress and psychological disturbances.

Indeed, research and literature exist documenting the presence of increased psychological morbidity among this population. Hughes and colleagues (1983) for example, demonstrated that 30% out of 196 outpatients with chronic skin conditions (including AD) and a 60% out of 40 inpatients, reported impaired mental health. In fact, a 20% out of the total sample was presented with psychological problems that were severe enough to be classified as an adjustment disorder. In addition, in Jowett and Ryan's (1985) study a striking 90% of dermatological patients (including AD) reported feelings of shame, embarrassment and stigmatization due to their appearance while 61% experienced some form of anxiety disorders (e.g. social anxiety) and approximately 35% were diagnosed with clinical depression.

Furthermore, a proportion of affected people presents with even more enduring psychiatric symptoms (Wessley and Lewis, 1989; Walker and Papadopoulos, 2005). Specifically, Walker and Papadopoulos (2005) have argued that almost 30% of dermatology patients (including patients with AD) are presented with: major depressive disorder, obsessive compulsive disorder, social and health anxiety, post-traumatic stress disorder, body dysmorphic disorder, delusional disorder and eating disorders. They also argued that Axis II disorders such as borderline, narcissistic, histrionic and obsessive-compulsive personality disorders also tend to be very common among skin condition sufferers.

However, an important point to make is that – to the knowledge of the present author- no study so far has managed to identify whether the psychological morbidity presented among this population pre-exists the development of the condition and defines its manifestation/progression, or whether it constitutes a result of its debilitating effects.

2.2. Early Onset of AD

As it has been documented, the greatest proportion (approximately 70%) of people with AD develop the condition at very early stages of life (Pauli-Pott et al. 1999). Overall, there are strong indications suggesting that such an early onset of AD has the potential to impose distress on *the child*, on *parents* and most importantly on the *parent-child relationship* impeding the psychodevelopmental experience of the afflicted (Warschburger, Buchholz and Petermann, 2004; Thompson, 2005).

2.2. a. The Developmental Experience of The Affected Child

According to research, the predominant condition-related challenges experienced by a child with AD are: itching, scratching, sleep loss, mood changes, physical impairments, bathing/dressing/diet/playing restrictions, hospitalization etc (Lewis-Jones, 2006; Papadopoulos, Bor and Legg, 1999a; Howlett, 1999). These problems negatively interfere with the emotional well being of the affected child. Pauli-Pott et al (1999) for example, have explained that due to the pruritic aspect of the condition or the annoyance related to it, children with AD are very frequently presented with behavioural restlessness, persistent crying and sleep disturbances. Tiredness from sleep disturbances, may further lead to physical and mental exhaustion that eventually result in loss of concentration and time off school for older children. As a consequence, the child might observe differences in performance compared to other children of its age and attribute them to personal inadequacy or incompetence. The child may thus become socially withdrawn, exhibit behavioural problems or even develop anxiety disorders (e.g. school/social phobia) (Lewis-Jones, 2006).

Moreover, due to the physical impairments of the condition, many of the first steps towards independence might be difficult to be achieved. For example, the painful nature of the condition may render children almost incapable of getting in charge of daily self-care activities (e.g. dressing, washing, putting on emollients etc) (Warschburger, et al., 2004). In addition, some very early studies (such as Shirley, 1948; Stone, 1953) have described that depending on the severity of the condition, treatment regimes may sometimes require the child to be tied flat in bed almost completely motionless until creams and emollients have been completely

absorbed. Unfortunately, more recent authors (such as Diamond, 1996) describe that little has changed in terms of condition management for a child with AD ever since. All of these condition-related constraints might take place at a critical stage when the child should normally be experiencing psycho-developmental triumphs (such as sitting, creeping, standing, walking, exploring etc) and generally start to see his/herself as a separate entity from his/her caregiver (Bernstein et al, 1997).

Negative social comments constitute another early challenge for children with AD. As Magin, Adams, Heading, et al., (2008) have demonstrated, teasing, taunting and bullying is a considerably common experience among children/adolescents with skin conditions and particularly AD. Howlett (1999) argued that these insensitive comments might eventually be internalized by the child leading to the perception of self as ugly, repulsive and different impacting on self-confidence and self-reliance and negatively reinforcing parental overprotection and reliance.

In addition, many studies (e.g. Robinson, Clarke and Cooper, 1996; Ben-Tovim and Walker, 1995) have demonstrated that the psychological problems accompanying the onset of a skin condition in adolescence (approximation of age range 10-18 years of age) can also be very severe as the condition challenges central developmental tasks like the consolidation of self-image. Adolescence constitutes another critical period for psychosocial development. During adolescence self-esteem, social confidence and identity are in an unstable formative stage while appearance becomes a central aspect of a person's sense of self. Thus coping with an impaired appearance- during a period of peer comparison and identity formation-can result in serious difficulties like stress, feelings of inferiority and social isolation (Fox, Rumsey and Morris, 2007).

2.2.b. The Experience of Parents of Affected Children & the Parent-Child Relationship

Thompson (2005) has argued that the onset of AD can be very distressing for caregivers as well, as they tend to respond (at least initially) negatively toward the affected child (e.g hold babies less close, pay less attention to other needs of the child, avoid physical contact etc). He added that this may lead the child to experience a general sense of anxiety and rejection (i.e. the desire of parents for a normal child). This tendency is compounded by other condition-related dimensions.

Indeed, in their study investigating the impact of a child's AD on parents, Lawson, Lewis-Jones, Finley et al., (1998) observed that:

- 74% of parents viewed the special care of their child as a huge burden
- 71% reported extreme guilt, exhaustion, helplessness, anger and frustration in accepting their child's condition
- 64% suffered from sleeping problems

Accordingly, the most commonly reported reactions of parents according to Papadopoulos, Bor and Legg (1999a) include parental mourning, denial, anger and sadness experienced as a result of:

	Child	Parents
Physical Health	<p>Itching & scratching</p> <p>Sleep disruptions/poor sleep quality</p> <p>Pain during baths</p> <p>Painful/irritated skin</p> <p>Diet restrictions</p>	<p>Exhaustion</p> <p>Sleep deprivation</p>
Physical Functioning	<p>Hold child's hands because of scratching</p> <p>Restricted/altered bath routine</p> <p>Restricted outdoor play</p> <p>Restricted swimming</p> <p>Symptoms interrupt play</p>	<p>Affects decision to work</p> <p>Affects work performance</p> <p>Avoid family photos</p> <p>Child sleeping in parent's bed</p> <p>Family stays home more</p> <p>More housework</p> <p>Reluctant to leave child with others</p> <p>Time-consuming treatments</p> <p>Trouble getting baby sitters and child care</p> <p>Vacation restrictions</p>
Social Functioning	<p>Adults avoid interaction with child</p> <p>Other children avoid interaction with child</p>	<p>Adverse strangers reactions</p> <p>Affects relationships with relatives and friends</p>
Emotional Health	<p>Behavior and discipline problems</p> <p>Cries more</p> <p>Dislikes application of topical medication</p> <p>Frustration</p> <p>Hates taking oral medication</p> <p>Hyperactivity</p> <p>Irritability and fussiness</p> <p>Restlessness</p>	<p>Affected confidence in medical care</p> <p>Affected decision to have other children</p> <p>Disappointment</p> <p>Embarrassment about child's appearance</p> <p>Frustration</p> <p>Helplessness</p> <p>Sadness and depression</p> <p>Guilt and self-blame</p>
	Scratches to get attention	Strain on relationship with spouse

	Wants to be hold more	Worry about: <ul style="list-style-type: none"> - Child making friends - Child's self esteem - Cost of care - Environment/food allergies - Future for child - Side effects of treatment
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Source: Chamlin, Frieden, Williams, & Chren (2004)

Figure 2: *Effects of AD on Children and Their Parents*

- a) The birth of an “anomalous” child.
- b) Overprotection/overindulgence
- c) Focusing attention on the practical needs of the affected child, disregarding the needs of the other children
- d) Emotional neglect/rejection of the affected child
- e) Financial and time burdens of caretaking and medical treatment

Titman, (2005) also described that the way a parent will respond to the demands of an affected child and interrelate with it, depends partially on their perceived ability to cope with the current situation. For example, if a situation is perceived as difficult to cope with by the parent, they might be less likely to empathize with the child and maintain an emotional bond with it. In this situation, the parent is more likely to react in a rejecting and critical or an overprotective way toward the needs of the child. On the other hand, if the situation is not perceived by the parent as over-exceeding his/her ability to cope with the condition this might lead the parent

to react in a less ambivalent manner towards the child. Thus, according to Titman (2005), parental (subjective) appraisals of coping can define the interactional quality between an affected child and his parent.

Moreover, physical contact is another important determinant of the quality of the parent-child relationship that unfortunately, has received very little investigation. Koblenzer, (1990) and Ross, (2004) commonly described that if the parent has to apply treatment regimes on the skin of the child or if the child requires a lot of physical contact in order to sooth the pain and reduce discomfort, this can result in an interactional quality that might be affected by uncomfortable and unpleasant feelings. Howlett (1999) has argued that parental caresses might be perceived by the child as painful, intrusive and punitive. As a result this may become the predominant form of physical contact, representing a significant part of the child's parental experience and replacing the more spontaneous loving hugs and caresses. In support of this argument, Langlois and Sawin's (1997) demonstrated that even at two days old, infants with AD are held less close and are given less physical contact by their caregivers as compared to unaffected infants. Howlett (1999) concluded that child and parents may eventually get trapped into dysfunctional patterns of attitudes and behaviours that place more stress on both parties and might lead to a deterioration of AD partly due to its psychosomatic nature.

However, contrary to those findings that demonstrated a disrupted interaction between caregivers and affected children, Solomon and Gagnon (1987) demonstrated that mothers of affected children soothed and stroked their babies as much as mothers of non-affected ones. Additionally, there were no differences in the degree of distress or difficulty in soothing between mothers of unaffected and

affected children. Nevertheless, results in that study also demonstrated that affected mothers did have fewer instances of positive interactions with their children.

Findings from Solomon et al's (1987) study are open to debate. Firstly, researchers did not control for the subjective amount of pain experienced by children every time the mother soothed/stroked them. Secondly, it cannot be determined whether these fewer instances of positive interactions were a function of an inordinate interactional bond that was *already* formed due to previous painful experiences of soothing/stoking -or even due to other reasons (un)related to the condition. In other words, it could be that the presence of the condition in that study had impacted on the quantity -rather than the quality- of interactions. Of course in such a framework, these two concepts are actually interrelated and equally important. Nevertheless, what all of these studies do suggest is that regardless of the type of impact, interactional patterns between the child and his parents can be affected by the presence of AD (Figure 2 summarizes the effects of AD on both children and parents).

2.3. Conclusions

As it has been documented, the psychological sequel of living with AD circles around the concept of *adjustment*. The presence of the condition seems to be enough in itself to tax the coping resources of the patient and potentially lead to significant psychological distress (or even impede the sufferer's psycho-developmental experience) that might further mediate the mere progression of the condition. However, according to literature and research in clinical health and skin conditions (Thompson and Kent, 2001; Kent and Thompson, 2002; Kalick, Goldwin and Noe, 1981), there seems to be a significant level of individual

variation in adjustment: Some people present with minimal psychological distress and can make a positive adjustment to their skin condition across different areas such as: social integration, emotional adjustment and self-esteem; others may appear to be severely disturbed. Others might be severely disturbed, while others may report an intermediate level of disturbance. An interesting question that research over the years has tried to answer is *how people with AD, or other chronic skin conditions, are not equally susceptible to the same levels of psychological morbidity and what determines this process*. One of the central purposes of the present study was to identify the key-factors that account for this variability in adjustment

CHAPTER 3**VARIABILITY IN
ADJUSTMENT TO AD**

3.1. Factors That Determine Variations in Adjustment to AD

Several studies have tried to identify the variables that mediate adjustment to skin conditions and account for individual variations. Contrary to what one would expect, the least useful variables in explaining variability in adjustment have been demographic characteristics (e.g. gender, marital status, employment status etc) and disease severity or visibility of affected areas (Thompson and Kent, 2001; Kent and Thompson, 2002; Thompson, Kent and Smith, 2002; Griffiths and Richards, 2001).

Some authors have tried to consider the role of age of onset on adjustment to AD. Studies that investigated this link however have been consistently inconclusive. Tucker (1987) for example, demonstrated that an early onset of a dermatological condition confers adjustment simply with the passage of time. He argued that the greater the passage of time (i.e. the earlier the onset) the lower the levels of psychopathology and the greater the level of adjustment as the person gets used to their condition. On the other hand, Williams and Griffiths (1991) demonstrated that psychological maladjustment can arise several years after the onset of a disfiguring skin condition while Porter and Beuf (1988) found a strong negative correlation between age of onset and psychological disturbance such that the younger the age of onset, the greater the psychological disturbance experienced by the sufferer.

Some other authors have attempted to identify a link between AD and certain personality characteristics in order to explain adjustment to AD. Again however, findings have been significantly inconsistent. Some authors (e.g. Lerda and Angelini, 2004; Buske-Kirschbaum et al. 2004; Poot, Janne, et al., 2000) for

example, have argued that people with AD are presented with certain personality traits like: a) neuroticism, b) hostility, c) anxiety, d) aggressiveness, e) feelings of inferiority, f) depression, g) tension, h) restlessness, i) emotional lability, j) insecurity k) rigidity, l) dependency and m) alexythimia. On the other hand, others (e.g. Gil and Simpson, 1989) have argued that there are no significant differences on the personality profiles of people with AD, people with other skin conditions and healthy people.

A central criticism of the proposition of a certain personality profile among AD patients has been that these traits might not reflect an atopy-relevant personality profile but rather a profile of the chronically-ill person (Buske-Kirschbaum et al., 2004). Scheich, Florin, Rudolph and Wilhelm (1993) however, demonstrated that indeed AD patients tend to get more easily upset, have less functional coping strategies and are more suspicious/paranoid when compared with other chronic medical conditions (i.e. chronic obstructive brochitis) disconfirming the chronically-ill personality hypothesis.

Buske-Kirschbaum et al's (2004) study who investigated and compared personality traits between people presented with AD and psoriasis (another chronic inflammatory psychocutaneous condition), did reveale a personality effect for both groups but there were no significant differences between the two. The traits that were revealed were: trait anxiety, stress vulnerability and low self-concept. The authors concluded that there might be a personality profile linked to inflammatory skin diseases. However, another study by Bahmer, Kuhl and Bahmer (2007) revealed significant personality differences between psoriasis and AD patients. Specifically, people with psoriasis reported lower levels of subjective stress,

general dissatisfaction and negative affect; they also expressed a lower explicit interest in power. On the other hand, people with AD scored above average in need for power and below average in need for affiliation and achievement. These results suggest that the possibility of a personality profile linked to inflammatory diseases should be further investigated.

Inconsistency in the so far findings on the role age of onset and personality traits on variability in adjustment to AD could be attributed to several reasons. Firstly, and as Gupta, Gupta, Schork, and Ellis, (1994) have argued, none of these studies has managed to identify whether psychological morbidity (adjustment problems), or personality traits among this population, pre-existed the development of the condition or whether they constituted the result of the debilitating effects of having AD. Secondly, given the complexity of the condition and its debilitating effects, it is highly unlikely that there can be a direct, categorical link between a single variable and variability in adjustment. Specifically, it cannot be that *all* people with an early onset will be psychologically maladjusted and that *all* people with a late onset will be resistant to psychological disturbances. Likewise, it seems unlikely that *all* people with AD have the same personality traits. The present study views the process of adjustment as more complex and dynamic and argues that there might be many more factors implicated in it.

In accordance with this argument, more updated conceptualizations of adjustment have attempted to identify different factors that could explain variability in adjustment to AD. These conceptualizations have shifted their focus more on *coping processes* rather than years of coping with the condition (i.e. age of onset) or personality traits. According to Salewski and Lissner (2002), the conceptualization

of coping processes constitutes a proximal aspect of adjustment that can also explain any individual variability.

3.2. Coping

Coping has been defined by Lazarus and Folkman (1984) as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (pp. 141). These efforts are aimed at either the *protection* or the *presentation* of the self and have two main functions: a) to regulate emotions and b) to modify the problem (Lazarus and Folkman, 1984).

Generally, coping has been categorized into two types: a) *approach* and b) *avoidance*. The former type refers to a tendency to approach and confront difficulties and is associated with better psychological adjustment (Krohne, 1993). Examples of approach coping among dermatology patients include: positive reappraisal or seeking help and social support, information seeking, consistency in treatment regimes etc (Hill and Kennedy, 2002). Scharloo, Kaptein, Weinman, et al., (2000) demonstrated that skin condition patients that engaged in more active coping, more expression of emotions and more use of social support were prescribed less treatment regimes and were presented with lower levels of anxiety and depression.

Avoidance coping on the other hand, has been related to psychological maladjustment and high levels of anxiety and depression (Wells, 2002). According to Mizara (2007), dermatology patients tend to engage more in avoidance coping (i.e. avoiding social situations, concealing affected parts etc.) and tend to exhibit

higher levels of psychological distress. Avoidance of social encounters for example, might perpetuate or even exacerbate psychological distress as it does not allow for disconfirmation of existing fears or irrational beliefs about rejection (Thompson and Kent, 2001). In addition, avoidance might potentially lead to impaired social skills. Once social skills become poor, others may respond reciprocally further confirming fears related to social rejection (Rumsey, Bull, and Gahagan, 1986).

3.3. Factors That Determine Coping

3.3.a. Appraisal Theory (AP)

Many theories on adjustment to chronic illness converge on the point that coping is determined by the way people *appraise their disease* (Schwarzer, 1999). According to Lazarus and Folkman's (1984) appraisal theory, cognitive appraisals are highly subjective and depend on the person's perceived goals, values and coping abilities rather than objective characteristics. Cognitive appraisals are categorized in two types:

- a) *Primary Appraisals* where one evaluates a situation's potential for harm / benefit to self-worth
- b) *Secondary Appraisals* where one evaluates a situation's controllability and the relevant available coping resources (Walker, Jackson and Littlejohn, 2004)

These subjective evaluations, determine the extent to which a situation will be appraised as threatening and consequently the emotional or behavioural

responses (coping) that will be elicited in response to these threats (Stanton et al., 2007).

With regards to skin conditions, McGrath (1982) has identified three main threats conceptualized as mediating the way dermatology patients cope with and adjust to their condition :

- a) *Physical Threat*: itching / scratching or pain that can lead to a perceived loss of control attributed to personal failure that further leads to helplessness and resignation
- b) *Interpersonal Threat*: negative social reactions that lead to social withdrawal and feelings of isolation/loneliness attributed to a personal deficiency
- c) *Psychological Threat*: reduced self-esteem and body image, perceived lack of control and helplessness

However, empirical evidence (e.g. Levanthal, Meyer and Nerenz, 1980) has demonstrated that in an effort to cope with their condition, people with chronic skin diseases actively construct subjective models of their disease. This observation shifted the focus of attention away from cognitive appraisals to the way *cognitive representations of illness* can affect coping.

3.3.b. Self Regulatory Model of Illness (SRMoI)

Leventhal, Diefenbach, & Leventhal (1992) proposed a model named as the *self-regulatory model of illness (SRMoI)* that conceptualizes coping as a dynamic problem-solving process that depends on contextual factors and specifically on cognitive representations of illness. These representations are comprised of general

pre-existing knowledge and beliefs related to their self-esteem, health and illness, and perception of others and provide the framework through which illness can be interpreted (Walker and Papadopoulos 2005). According to Levantal et al (1980), illness cognitions have been categorized into five domains:

- a) Beliefs about causes of the disease
- b) Beliefs about consequences of the condition,
- c) Beliefs related to its cure and controllability
- d) Beliefs about expected duration of the condition and
- e) Beliefs about illness identity (i.e. disease symptoms).

Leventhal and colleagues (1992) believed that the meanings associated with being ill affect mood and self-worth and determine the patient's coping style. This process has been empirically demonstrated. Specifically, Scharloo, et al. (2000) revealed that dermatology patients made greater use of outpatient services (approach coping) if they perceived their condition to have serious consequences, to be controllable and themselves to have a heightened illness identity.

However, according to the present study, both the SRM and AP models provide only a limited answer to a proximal question: *What is it that defines: a) a person's beliefs related to one's self-worth, health / illness, and perception of others (SRMoI) or b) one's own goals, values and perceived coping abilities (AP) in the first place that eventually determines the way this person will cope with AD and adjust to it?* For example, would all people with high/low self-worth establish the same meanings associated with being ill and develop the same condition-related

cognitive representations? Similarly, why is it that in the face of the very same event (in terms of perceived threat and controllability), different people are likely to respond with different emotions or behaviours?

These points suggest that there might be deeper level, underlying beliefs mediating individual differences in both cognitive appraisals and representations of illness and consequently in coping with/adjusting to AD. In fact, Ball, Mitchell, Malhi et al, (2003) have described that these processes/factors might be related to concepts like *identity* and *self-concept* –or the related aspect of *personality*. Walker et al, (2004) have argued accordingly that such personality aspects can indeed influence one's ability to evaluate situations and choose coping strategies accordingly.

CHAPTER 4

PERSONALITY DEVELOPMENT

&

PSYCHOPATHOLOGY

4.1. Personality

Despite the plethora of definitions, most authors generally converge to point out that **personality** is the dynamic interplay between emotional and cognitive sets of characteristics possessed by a person that uniquely influence his/her motivations and behaviours in any given situation (Ryckman, 2000). This set of characteristics – that can also be thought of as psychological constructs or self-schemas - involve each person's distinctive genetic background and learning history as well as the ways in which these factors influence his/her responses to different situations. Thus, they are deeply embedded in a person's self-identity (Bernstein, Clarke-Stewart, et al., 1997; Mizara, 2007). Therefore, many investigators consider the study of personality as mainly the scientific analysis of *individual diversity* that explains the reasons *why* and *how* people react uniquely to various situational demands (Ryckman, 2000).

Even though there are different schools of personality development, most – if not all – converge to point out that the development of personality is defined by early experiences with significant others and defines the experience of future situations. An array of empirical evidence (e.g. Murray, Waller and Legg, 2000; Parker, 1983; Brewin, Andrews and Gotlib, 1993; Belsky, Spritz and Crnic, 1996) exists supporting this principle. One of the most recent, influential and empirically validated model explaining this relationship that has also attracted the attention of both clinicians and researchers has been schema-focused therapy (Young, Klosko and Weishaar, 2003).

4.2. Schema Therapy (ST) Model of Personality Development & Psychopathology

4.2.a. Model's Theory

ST that has been developed by Young (1990) and constitutes a second generation cognitive behavioural therapy (CBT) model that also blends elements from attachment, Gestalt, object relations, constructivist and psychoanalytic approaches into a unifying treatment model (Young, et al., 2003). Compared to standard CBT, ST focuses on three aspects: a) problematic emotions, b) childhood issues, and c) the therapeutic relationship (Arntz and Jacob, 2013).

The difference of ST to CBT is that ST offers both a complex and a more structured approach and it can be used as a transdiagnostic approach (Arntz and Jacob, 2013). At the heart of this model, are the so called *early maladaptive schemas* (EMS) that are considered to be pervasive patterns that underlie all personality pathology and influence cognitions, emotions and memories, interactions and behaviour (Young et al., 2003). The model's blending of different school of thoughts, as well as its emphasis on early attachments and EMSs have led ST to be considered as one of the most adequate approaches for treating people with chronic difficulties that have their roots in childhood difficulties and life-long interpersonal problems (James, 2001)

Overall, the model posits that there are five core emotional needs necessary for the emotional and psychosocial development of the person. These are the following (Young, 1990):

- a) Secure attachments to others
- b) Autonomy, competence and sense of identity
- c) Freedom to express emotions and needs
- d) Spontaneity and play
- e) Realistic limits and self control

According to ST, the psychologically healthy person has managed to adaptively meet these needs through positive early parenting experiences. Negative early parenting experiences relative to these needs on the other hand (frustration of needs), result in the development of distorted constructs (EMSs) about one's self or relationships with others.

According to Young et al., (2003), EMSs are defined as: *“a broad pervasive theme/pattern, comprised of memories, emotions cognitions and bodily sensations regarding one's self and relationship with others, developed during childhood or adolescence, elaborated throughout one's life-time and dysfunctional to a significant degree”* (pp.7). The model proposes eighteen different EMS that are grouped into five general categories (see Figure 3).

Domain	Associated Core Emotional Need	Associated Early Maladaptive Schemas	Associated Parenting Experiences
Disconnection & Rejection	Secure attachments to others	<ul style="list-style-type: none"> • Emotional Deprivation • Abandonment • Mistrust/Abuse • Defectiveness • Social Isolation 	<ul style="list-style-type: none"> • Unstable, • Abusive, • Cold, • Rejecting • Socially isolated
Impaired Autonomy	Autonomy, competence & sense of identity	<ul style="list-style-type: none"> • Dependence • Vulnerability to harm • Enmeshment • Failure 	<ul style="list-style-type: none"> • Enmeshment • Overprotection.
Impaired Limits	Realistic limits and self control	<ul style="list-style-type: none"> • Entitlement • Insufficient selfcontrol/Self discipline 	<ul style="list-style-type: none"> • Heightened permissiveness, • Overindulgence • Lack of direction
Other-Directedness	Freedom to express emotions and needs	<ul style="list-style-type: none"> • Subjugation • Self-sacrifice • Approval Seeking 	<ul style="list-style-type: none"> • Conditional acceptance
Overvigilance and Inhibition	Spontaneity and play	<ul style="list-style-type: none"> • Emotional Inhibition • Unrelenting Standards • Pessimism/negativity • Punitiveness 	<ul style="list-style-type: none"> • Punishment • Demandingness • Grimness

Source: Pinto-Gouveia, Castilho, Galhardo & Cuhna (2006).

Figure 3: Schema Domains & Associated Core Emotional Needs, EMS & Parenting Experiences

An important notion is that even though EMSs are developed in early years, they continue to be elaborated and superimposed in adult life, even when they are no longer applicable. As Young et al (2003) have proposed, EMSs fight for survival due to the human drive for consistency. EMSs constitute what people regard as a priori truths, and although they may cause suffering, they feel comfortable and familiar to the person. Thus, EMSs color the processing of later experiences and impact on how people think, feel, behave and relate to others throughout their lives. The model suggests that EMSs operate within the individual through three primary processes: schema maintenance, schema avoidance and schema compensation (see Figure 4) (Young, 1999).

According to Young (1990), EMSs are activated in situations where the *self* is threatened or related (even in an indirect way) to the person's *unmet* original core emotional need. The

stress that accompanies schema activation can be pervasive, charged and difficult to manage and thus governs the monitoring and appraisal of information and influences how the person will feel, relate to others, and cope.

Research has provided empirical evidence of the association between Young's EMSs and different psychopathologies such as: personality disorders (Nordhal, Holthe and Haugum, 2005), bipolar disorder (Ball, Mitchell et al, 2003); anxiety disorders (Hinrichsen Waller and Emanuelli, 2004; Atalay, Atalay, Karahan, and

Caliskan, 2008), mood disorders (Harris and Curtin, 2002), disruptive behaviour, eating disorders (Sheffield, Waller, Emanuelli, et al., 2009) substance abuse (Muris, 2006) etc. For example, Hinrichsen et al (2004) found that social anxiety was strongly associated with the abandonment and emotional inhibition EMS while agoraphobia was associated with the EMS of vulnerability to harm.

In addition, although limited in numbers, the model provides empirical evidence demonstrating the links between negative early parenting experiences, development of EMSs and psychopathology. Specifically, Harris and Curtin (2002) investigated the concurrent relationship between retrospective reports of parenting, EMSs and endorsement of depressive symptoms in an undergraduate population. Using the Parental Bonding Instrument, the Beck Depression Inventory and the Young Schema Questionnaire, they demonstrated that parental overprotection and low caring was specifically associated with EMSs of defectiveness, insufficient-self-control, vulnerability and failure EMSs which were further associated with the presence of depression.

Recently, Sheffield et al, (2005) used the Young Parenting Inventory (YPI - a measure designed specifically for assessing early parenting experiences) and the Young Schema Questionnaire (that assesses EMSs) to test Young's hypothesis with regards to the link between parenting experiences and the presence of EMSs. Results identified nine types of parenting experiences:

- a) Emotionally depriving parenting (deprivation of emotional nurturing)
- b) Overprotective parenting

- c) Belittling parenting (behaviour in the parent that belittles the child, leading the child to feel defective)
- d) Perfectionist parenting (high parents' expectations of themselves and of their child)
- e) Pessimistic/fearful parenting (anxious fearful traits)
- f) Controlling parenting (controls / inhibits the child's independence)
- g) Emotionally inhibited parenting (parental inability to share the feelings of the child)
- h) Punitive parenting (punitive parenting of the child's mistakes)
- i) Conditional narcissistic parenting (conditional positive regard)

Results also indicated that these parenting experiences were strongly correlated with EMSs. However, these correlations were not in the linear pattern that was predicted by the authors. For example, high scores on a particular parenting experience (e.g. emotionally depriving parenting) did not necessarily correlated only with its corresponding EMSs (e.g. emotional deprivation) but was rather associated with a variety of other EMSs (Sheffield et al., 2005).

These results suggest that even though a negative parenting experience is highly likely to contribute to the development of one or more of the eighteen EMSs, this link is not categorical and it is still not possible to identify which parenting experience leads to each EMS. Young (1990; 1999) would argue that this is due to the fact that EMSs are not actually the product of objective parenting but are rather

based on *subjective perceptions* of parenting. An otherwise punitive parent for example, might be perceived by the child as emotionally inaccessible and may thus lead to the development of emotional deprivation schema as well as the punitive schema. Despite these difficulties though, the schema model offers a good level of explanation with regards to the mechanisms involved in the development of maladaptive schemas and psychopathology.

4.2.b. Model's Assessment & Critique

Overall, ST has brought a number of clear benefits to professionals that work within a counselling psychology context. Briefly, the development of ST has facilitated the establishment of more comprehensive conceptualizations that help inform the therapist better about the development and perpetuation of people's problems and facilitate the identification of obstacles to effective change. Furthermore, the introduction and emphasis on underlying structures has assisted the development of approaches for treating people suffering with chronic problems and life-long interpersonal difficulties.

However, it is important to note that ST also presents with certain limitations. Firstly, there is light empirical evidence with regards to its efficacy (Morrison, 2000). Indeed, despite the wealth of literature in the area of ST (e.g. Nordhal, et al., 2005; Ball, et al, 2003; Hinrichsen et al. 2004; Atalay et al., 2008; Harris and Curtin, 2002; Sheffield, et al., 2009; Muris, 2006 etc.) there has been lack of empirical work of good quality testifying to its comparative efficacy and some notable exceptions to this demonstrate contradictory findings. Jacobson et al's (1996) for example, conducted a component analysis of CBT for chronic

depression, comparing a cognitive therapy treatment that contained ST techniques (that addressed depressogenic schemata) with two different approaches: a) behavioural treatment and b) treatment using behavioural therapy and work on automatic thoughts. Results revealed no evidence that the treatment addressing schemas was better than either of the other two conditions. This tendency was also true at 6 months follow-up. On the other hand, Giesen-Bloo, Dyck, Spinhoven, et al. (2006) revealed that compared to transference-focused therapy, ST had a lower drop-out rate and a higher improvement rate in the psychopathologic dysfunction of borderline outpatients.

Appart from the lack of empirical evidence supporting its effectiveness, an additional limitation of the model lays in its presenting tendency to shift the blame and responsibility regarding current problems away from the client and backwards in time towards early experiences with parents/caregivers. James (1999; 2001) has argued that overemphasizing the role of negative early parenting experiences runs the risk of generating to the person feelings of victimization or anger towards significant figures (particularly parents). He also added that in understanding personality development and psychopathology, one needs to consider all the possible variables (such as cultural norm, societal demands etc) that may have contributed to the development of a person's overall belief system. With regards to the former critique, Young et al (2003) explain that the target of therapy is not necessarily centered around blaming figures of the past but rather around identifying, and validating emotions that originated in the past. According to the model, this process facilitates the expression of suppressed emotions that will eventually lead to schema-healing. Regarding the later critique, Young et al (2003)

argue that even though the development of less pervasive, conditional schemas might indeed be dependent on experiences/factors that are not necessarily related to early parenting, the development of core, pervasive schemas is extrinsictly dependent on the early parent-child interaction.

The presentation of contradictory positions and/or research findings relative to the limitations of the model points to the need of more research that will allow the replication and subsequently the solidification of conclusions. Nevertheless, despite lacking clarity and empirical support, ST seems to be becoming increasingly popular -both in terms of theory and practice- as most theories of personality development and psychopathology converge to the point that personality constructs like self-schemas have the greatest potential in mediating the link between the way people appraise situations and respond (cope with/adjust).

In investigating the factors that mediate variations in adjustment to AD therefore, the main goals of the present study were to: a) investigate whether certain maladaptive schemas (personality constructs) exist among people with AD b) what type of parenting (or early experiences) has contributed to their development and c) how schemas affect the way people with AD adjust to their condition.

SCHEMA PROCESSES	DESCRIPTION
Schema Maintenance	Serves to perpetuate the EMS through highlighting information consistent to the schema and minimizing information that contradicts it.
Schema Avoidance	<p>Serves to avoid activation of the schema. Cognitive, affective and behavioural avoidance is used in order to ward off the emotional pain related to the activation of the schema.</p> <p>For example, avoiding intimate relationships may serve to avoid activation of the abandonment schema.</p>
Schema Compensation	<p>Serves the person to act in ways that contradict the schema.</p> <p>For example, overworking and putting unrealistically high expectations in one's self may serve to compensate for feelings of inadequacy</p>

Source: Ball, et al, (2003)

Figure 4: The Three Primary Schema Processes

CHAPTER 5

RATIONALE

5.1. Thesis: A New Explanatory Model of Adjustment to AD

5.1.a. Overview

A bidirectional link exists between AD and psychological stress: psychological stress might lead to an exacerbation of the condition while worsening of the condition might lead to increased stress levels (Buske-Kirschbaum, et al, 2001). Great variations exist among sufferers' distress levels suggesting that adjustment constitutes a multifactorial and complex process. The central purpose of the present study is to investigate factors (such as early parenting experiences and self-schemas) that are central to personality development in order to assess whether such concepts mediate adjustment to AD.

So far, recent models on adjustment to skin conditions agree that adjustment encompasses the concept of coping mainly through three proximal condition-related threats: a) a physical threat (symptoms); b) an interpersonal threat (negative social reactions) and c) a psychological threat (reduced self-esteem / self-worth). Variations observed in adjustment are actually the result of differences in coping with these threats (McGrath, 1982). However, there is considerable disagreement among authors as to the factors that determine variations in coping. For example, some argue that coping is a matter of *cognitive appraisals* (e.g. Lazarus and Folkman, 1984) while others attribute coping to *cognitive representations of illness* (e.g. Levantal et al., 1980); Some (e.g. Gil and Simpson, 1989) have attempted to identify differences in *personality characteristics* in order to explain individual variations and some (e.g. Williams and Griffiths, 1991) have tried to investigate the role of *age of onset on coping / adjustment*. Nevertheless, none of the suggested

models have managed to adequately explain individual differences in coping with and adjusting to AD.

Two main reasons might account for this: a) the focus might have mistakenly remained on surface levels of processing (such as cognitive appraisals and representations of illness) while the contribution of deeper level, central processes – like personality traits and self-schemas- that constitute *core psychological themes*, has been left unexplored; b) most of these studies have attempted to find a linear relationship between factors (e.g. age of onset and adjustment / personality types and AD) when in fact this relationship might actually be a complex, multifactorial one operating as a unified system.

The present study sets out to identify the contribution of deeper-level risk factors [such as early (parenting) experiences and schematic-level beliefs] to adjustment to AD. It is assumed that such an investigation is crucial as it would promote further our understanding of adjustment to living with AD but also lend its knowledge to the implementation of effective counselling interventions.

5.1.b. Case Conceptualization

In proposing a theoretical multidimensional model of adjustment to AD one needs to consider the way various factors interact to contribute to outcome.

As it has been documented, the onset of AD in childhood - at an age when the child is still dependent on his parents - might impact not only on the emotional and physical functioning of the child, but also on the quality of his early parenting experiences (e.g. Meijer, 1976; Pauli-Pott et al, 1999). According to personality

development models (and specifically ST), such experiences might result in the frustration of early core emotional needs and thereby the development of maladaptive schematic patterns that further color the overall coping styles of the child and consequently the way he/she will adjust to his/her condition. However, the coping styles the child would use constitute the processes that perpetuate the schemas.

For example, a child with AD that experiences his parents as emotionally distant and rejecting (due to a possible over-emphasis on the child's practical needs related to his skin condition rather than his emotional needs), might develop the schema of *abandonment* and/or *emotional deprivation* (Appendix A). He might then either *avoid* disclosure of intimate thoughts and feelings in an effort to prevent further rejection, *overcompensate* by pushing others away, or *surrender* to his schemas by becoming emotionally clingy and needy of others' attention (Young, 1999; Young and Klosko, 1994). The result of these coping styles might lead to a poor supportive network and a diminished sense of self (e.g unworthy of love and nurturing). Such feelings might be (mistakenly) attributed to the skin condition whose unpredictable and chronic nature might further lead to a dysfunctional loop that perpetuates emotional disturbance and condition deterioration.

On a surface, cognitive level, thinking biases like *personalizing* peoples' comments or stares, *mind reading* that others are thinking negatively or *jumping to conclusions* that they will be rejected / abandoned will operate. Cognitive appraisals of situations [as suggested by Lazarus and Folkman, (1984)] and illness representations [as suggested by Levant et al., (1980)] operate at this level. Such biases might further affect coping responses and hinder adjustment through specific

behaviours such as: not adhering to treatment regimes and/or dietary restrictions or even adopting self-defeating behaviours like smoking or alcohol consumption.

The present study argues that more surface levels of cognitive and behavioural functioning – that so far have been argued to define adjustment – are actually mediated by deeper-level personality processes (like schemas) that have their origins in early parenting experiences.

Even though it has been documented that an early onset of AD can have significant contributions to maladjustment as it might interfere with psychosocial development in a domino-like process starting from affecting parenting styles and further leading into the development of maladaptive schemas, the case becomes complicated when considering that a small proportion of patients that have developed the condition at a much later stage - when parental styles could not have been affected by coping with a child with AD and certain (maladaptive) schemas have already been formed – they also present with adjustment problems. According to the ST model an explanation that can be put forward for this group of people is that even though the presence of AD was not implicated in the development of their schemas, it might still have acted to reinforce *already existing maladaptive schemas* (originated in early life due to experiences unrelated to the condition) or have served to disconfirm existing positive ones.

Some authors however, have provided a different explanation; Whitlock (1980) for example viewed AD as the cause of an inner impulsive-driven conflict originated during the course of a distressing mother-child interaction that manifests itself through pathological eruptions of the skin. He explained that the onset of AD

in adulthood (i.e. late onset) is actually the manifestation of these conflicts that might be re-experienced throughout interactions with significant others.

Recent evidence supporting Whitlock's (1980) suggestion comes from Berisoglu, Akdeniz, Agragrum et al's (2009) study which examined the role of early traumatic experiences, disassociation and thought suppression on psychosomatic skin diseases. Authors employed three groups: a) patients with psychosomatic skin diseases (e.g. psoriasis, pruritus etc), b) patients with no psychosomatic skin condition (e.g. mycosis, insect bites) and c) patients with no condition. Using a battery of self-report questionnaires (i.e. Childhood Trauma Questionnaire, Dissociative Experiences Scale, White Bear Suppression Inventory, Social Readjustment Rating Scale and Beck Anxiety Inventory) results revealed a strong relationship between early emotional neglect, dissociation and thought suppression for the psychosomatic skin conditions. Results, also demonstrated that emotional neglect among the psychosomatic skin condition group was higher than the control groups. Berisoglou et al (2009) concluded that when psychological trauma is experienced in early life, psychological results can be overwhelming and might further lead to dissociation and conversion of emotional symptoms into somatic complaints referred to the skin.

Finally, neurobiological evidence (e.g. Plotsky and Meaney, 1993; Kaufman, Plotsky, Nemeroff and Charney, 2000; Mitrescu, Peters, and Gould, 2004) also exist further confirming this link by demonstrating that early emotional trauma (i.e. deprivation of maternal care for prolonged periods of time) can affect the physiology of the individual by leading to increased concentration of immunoreactive CRH in the median eminence and of CRH mRNA expression in

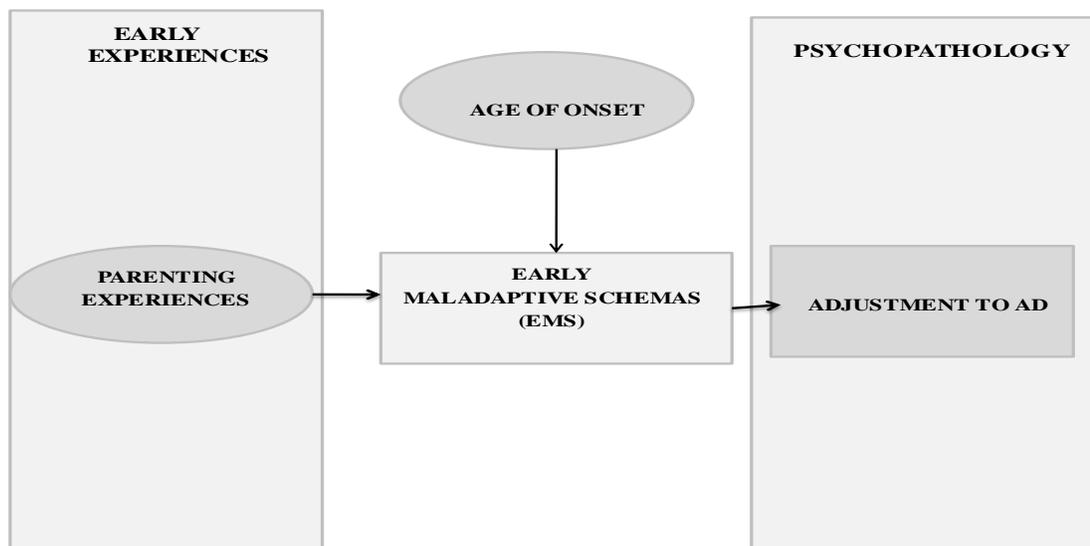
the paraventricular nucleus. This biological process has been found to be responsible for the development of vulnerability to physiological diseases.

5.2. Conclusions

Concluding, even though some authors viewed AD as a factor that mediates parenting styles and early experiences, some others argue that parenting styles actually pre-exist the development of the condition, contribute to its manifestation and shape the overall phenomenology of the person including the experience of the condition. In such a framework, it is argued that people with an early and a late onset of AD should share similar parenting experiences that mediate disease progression and overall adjustment through the development of disruptive emotional processes (i.e. schemas). This possibility would indicate that adjustment to AD might not be a function of years of coping with the condition, or even other condition-related dimension, but rather a function of the complex interaction between early experiences and development of personality-level structures.

A diagrammatic summary of the present study's conceptualization of adjustment to AD is depicted in Figure 5.

Understanding whether people who have early and late onset of AD share the same patterns of early experiences and maladaptive schemas and whether these schemas do affect people's adjustment to the condition constitutes the primary purpose of the present study. This investigation is of importance as it would allow us to: a) gain a general understanding of the processes leading to adjustment to AD and b) develop further tailor-made psychological intervention programs aimed at facilitating better adjustment to this debilitating skin condition.



Source: This diagram was developed by the author specifically for the purposes of the present paper

Figure 5: Diagrammatic Conceptualization of Adjustment to AD

5.3. Clinical Significance for Counselling Psychology (CoP)

Counseling psychology constitutes a branch of psychological practice which is significantly influenced both by human science research and by all the main psychotherapeutic approaches. Even though, CoP aligns itself with a science-practitioner paradigm that focuses on the importance of an empirically-based theory and practice, it also attributes high value to the use of the *self* and the understanding of interplay of both subjective and inter-subjective factors within its practice (Rizq and Target, 2009). In other words, CoP uses research as a means of gaining an understanding on the experience of the *self* and providing updated treatments that are reliable and relevant to its practice (Hermans and Lyddon, 2006).

Given the possibility that the development of AD can be inextricably connected to one's intrinsic part of schematic sense of *self*, it is surprising how little of schema-based formulation has been translated into therapeutic approaches for people with AD, or other chronic inflammatory skin conditions.

So far, studies on the effectiveness of psychological interventions on chronic skin conditions, have used a variety of different approaches ranging from biofeedback (e.g. Hughes, England and Goldsmith, 1981), to hypnosis (e.g. Waxman, 1973), relaxation (e.g. Bar and Kuypers, 1973), meditation (e.g. Gaston, Crombez and Dupuis, 1989), cognitive behavior therapy (e.g. Fortune, Richards, Kirby et al., 2004), person-centered therapy, group therapy (e.g. Papadopoulos, Walker and Anthis, 2004) etc. However, most of these studies focus on the condition per se and symptom management rather than the person (the *self*) behind the condition.

The present study underscores the fact that the effects of dermatological disorders, and specifically AD, permeate much deeper than the skin. When treating patients¹ with cutaneous illnesses, therapists must take into account not only the impact that these can have on a person's sense of self but also how one's sense of self can be implicated in the progression of the condition, and seek to develop therapies which adequately address these complex processes.

As Mizara (2007) has argued, each person has a unique personality structure which involves a varying degree of probabilities in responding. Developing

¹Even though the term *client* would be much more appropriate given the counselling context of the present study, the term *patient* is preferred due to its encapsulation of the medical properties of the condition under investigation

formulations that are based on an early experiences and a schematic level might open numerous possibilities of tailor-made interventions. Firstly, given that the vast majority develops the condition in childhood, investigating early experiences and parental responses might first contribute to the development of tailor-made family intervention programs aimed at condition management and even prevention in situations where the individual is still a child. Studies exist (e.g. Daud, Garralda and David, 1993) demonstrating that improving parent-child relationships can also result in improvements in both skin condition and behavioural difficulties. Also, according to Dennis, Rostil, Reed and Gill (2006) a child patient is more likely to cope with AD by withdrawing into itself and present with low-self-esteem, low mood and anxiety. This constitutes a particular challenge to professionals as internalizing difficulties are less visible than overt behavior and thus distress might go unrecognized. Looking into early parenting experiences and self-schemas therapists will be better able to understand the origins of these emotional difficulties and manage them appropriately.

Second, in situations where the patient is an adult, although therapy cannot change the past, there is general agreement that the therapist-client relationship can constitute an emotionally *corrective experience* for the client. As Gravell (2010) has argued, the therapist can provide a caring environment which can help to promote the natural tendency of the client toward emotional growth and maturity by supplying to the client what he/she emotionally needed as a child but never

received from his/her parents. This description of the therapist's role is what Young et al's (2003) has described as *limited re-parenting*².

By developing an awareness into the negative early experiences among people with AD and the core psychological themes (i.e self-schemas) developed by these experiences, counselling psychologists can be facilitated in a) understanding the core emotional needs that were frustrated during each client's early years, b) how these unmet needs influence the current life of the person along with the course and progression of the condition, c) how to overcome possible barriers in establishing a therapeutic relationship that could work as a antidote to client's emotional difficulties and finally d) how to develop interventions aimed at encouraging the client to produce a structural change in his/her personality, to unconditionally and compassionately accept his/her *self* with or without the condition and subsequently to fully adjust to AD. Given the psychosomatic nature of AD, such a holistic confrontation of the client could also lead in symptom relief, decrease in the frequency of exacerbations and improvement of the sufferer's health behavior.

Finally, even though the aims of the present study would require a qualitative analysis, a quantitative design was also considered to be appropriate at this preliminary stage of exploration. As it has been argued, quantitative analysis allows for the exploration of the emotional and motivational features of people's experiences and the identification of more narrative themes which constitutes the scope of the present study. As a method, quantitative analysis includes tools for stimulating the process of meaning construction and development and facilitates

²Limited Reparenting: supplying (within appropriate therapeutic limits) to the client what he/she emotionally needed as a child but never got from his/her parents

comparisons of different meaning units within and between different people and the utilization of more general and nomothetic forms of data analysis and summaries (Hermans and Lyddon, 2006). In accordance with these descriptions, the selection of the specific questionnaires [such as the Young Schema Questionnaire-Short Form 3 (YSQ-S3) and the Young Parenting Inventory-Revised (YPI-R)] used in the present study was based on the fact that they both require participants to go back in their past and explore how past experiences contributed to the development of core psychological themes that stimulate the process of meaning construction in their present life. Overall, in accordance with the basic tenets of CoP, such an approach combines humanistic, phenomenological and a science-practitioner aspects into a unifying whole that places emphasis on enhancing psychological functioning and well-being rather than on pathologizing or curing sickness.

Concluding, there is an increasing need for evidence-based practice in the field of CoP. Overall, this study attests to this need as it focuses on how early experiences and schemas can be implicated in the development of psychological distress with the aim of informing the practice of CoP with people presented with AD.

5. 4. Purpose

The present study supports the view that adjustment constitutes a complex, multifactorial process. Thus, the overall purpose of the present study is to explore the contribution of some central factors that have been assumed to mediate this process and understand the interplay between them in order to gain a better

understanding of how each person adjusts to AD and what defines variability in adjustment.

5.5. Aim

The present study has three main aims: a) to examine whether differences exist between people with an early and a late onset of AD in terms of early parenting experiences, maladaptive schemas and adjustment; b) to identify whether maladaptive schema development is a function of the condition per se, parenting experiences or both; and c) to identify whether adjustment to AD is mediated by personality level structures such as self-schemas

5.6. Hypotheses

H1: There will be significant differences on EMS between: a) sufferers with an early and a late onset of AD or b) the two clinical groups and the control group as it will be evidenced by scores on the YSQ-SF.

H2: There will be differences on perceived parenting experiences between: a) the early and the late onsets groups or b) between the two clinical groups and the control group as it will be evidenced by scores on the YPI-R.

H3: EMSs in each group will be predicted by parenting experiences as theorized by the ST model.

H4: Each aspect of adjustment to AD (each scale of the ACSDQ) will be predicted by EMS **H5:** There will be no significant differences on adjustment to AD between the early and the late onsets as it will be evidenced by scores on the ACSCQ.

This hypothesis aims to verify the present study's suggestion that adjustment to AD is not a linear categorical process between age of onset and coping but rather constitutes a more complex, multi-factorial process.

CHAPTER 6

STUDY

6.1. METHOD

6.1.a. Research Methodology

The selection of the methodology that was used in the present study was based on certain criteria. A cross-sectional design was preferred over a longitudinal one due to time and financial limitations. A quantitative design was deemed as the most suitable and its selection criteria were considered as follows: a) previous researches in this field have also used similar designs (e.g. Papadopoulos et al, 1999); b) quantitative designs are most appropriate for testing a theory in a systematic way and for producing results that can be generalized and applied to this specific population (Mizara, 2007). Additionally, a central goal of the present study was to make comparisons of different meaning units within and between different groups of people. Certain questionnaires exist (i.e. The Young Schema Questionnaire, The Young Parenting Inventory and the Adjustment to Chronic Skin Conditions Scale) that constitute standardized, validated measures with good psychometric properties, have been extensively used in both clinical and research settings and facilitate such comparisons. Thus, a survey design, and particularly the use of specific questionnaires, was considered as the most suitable for the present study.

With regards to the statistical analysis, parametric tests were employed based on the criteria that: a) analysis of variance is a strong statistical procedure even if there are violations of its core assumptions (Mizara, 2007); b) previous studies that used the psychometric instruments of the present study have also employed parametric tests (e.g. Sheffield et al, 2009; Stopa and Waters, 2005; Picardi, Pasquini, Cattaruzza et al., 2003); and c) according to the *central limit theorem*, the sample

means of sample sizes of $n \geq 30$ are considered to be normally distributed even for populations of unknown shape (Downing and Clark, 2009).

One of the central aims of the present study was to investigate differences between three groups (early onset of AD, late onset of AD and control groups) on outcome measures like: schemas, parenting experiences and adjustment difficulties. Each outcome measure consisted of many different levels: a) 18 YSQ scales, b) 9 scales of parenting experiences and c) 5 adjustment to chronic skin condition scales]. MANOVA was deemed as the most suitable for this investigation as it allows for comparisons between groups, informs about whether the mean differences between groups on the combination of the outcome measures' levels are likely to have occurred by chance and provides the univariate results for each level of the outcome measure separately. Overall, MANOVA is considered as the most appropriate test for comparing differences on outcome measures with many different levels (Pallant, 2010).

Finally, a last aim of the present study was to investigate whether (and particularly which) early parenting experiences can predict the development of schemas and whether (and particularly which) schemas can predict adjustment difficulties in the patient's current life. To investigate this, two separate multiple regression analyses were employed. Multiple regression can inform on how well a set of variables can predict a particular outcome and the relative contribution of each variable to the outcome as a whole. *Stepwise* regression was preferred over *standard* [that only demonstrates how much of the variance in a dependent variable can the independent variables explain as a group] and *hierarchical* [that requires the researcher to specify the order of the independent variables] as it allows the

program to automatically select which variables it will enter and in which order they will go into the equation - according to a set of statistical criteria- and is thus considered as the most valid type of regression analysis (Pallant, 2010).

6.1.b. Participants

A power analysis was conducted with an alpha level of 0.05 and the power at 0.95 and effect size at 0.5 in order to determine the appropriate sample size that would account for significant effects. The total sample size was estimated to be 280 participants.

The study involved three groups: two clinical (people with early and late onset of AD) and one control (no skin or any other physical disease).

Clinical Group 1: Early onset

Participants were adults with an onset of AD from birth until the age of 19. According to theorists (Young, 1990 and Erikson, 1982) these are considered to be the most critical ages of personality development. Thus, for the purposes of the present study this age range was termed as an *early onset* of AD.

Inclusion Criteria:

- Age \geq 18 years of age
- Good spoken and written English
- An official diagnosis of atopic eczema by a dermatologist
- An onset of the condition between 1 to 19 years of age

Clinical Group 2: Late Onset

Participant in that group were adults with an onset of AD from 19 years of age and above. According to Young (1990) this age range is not considered to be as critical in personality formation as earlier ages. For the purposes of the present study this age range was termed as a *late onset* of AD

Inclusion Criteria:

- Age \geq 18 years
- Good spoken and written English
- An official diagnosis of AD by a dermatologist
- An onset of the condition at age 19 and onwards

Control Group 3: No Medical Condition

This group consisted of adult participants that did not have any chronic medical condition. This group was used as a comparison group.

Inclusion Criteria:

- Age \geq 18 years
- Good spoken and written English
- No chronic disease

Exclusion Criteria for all groups:

- Participants that received psychological therapy prior to their participation in the present study

- Participants from the clinical conditions that had another chronic or disfiguring condition in addition to AD
- Participants from the control group that had a chronic medical condition
- Participants that used psychotropic medication

These three exclusion criteria were established on the basis that all of these factors might confound the results

An opportunistic sample and snow balling was used for this study as ways of recruiting participants for all groups. This process involved asking different people to forward to others an information sheet with the details of the study. All groups were recruited from the community. An advertisement of the present study was also posted on certain dermatological or AD organizations and on certain facebook AD groups (appendix F).

Overall, 20 participants were excluded from the statistical analysis of the present study: 7 had left some of the questionnaires unanswered, 1 had answered “No” to the consent form, 4 had received psychological support and was under psychiatric medication and 8 had another chronic health condition (5 from the experimental and 3 from the control groups).

In addition, 45 participants from the experimental groups were presented with: hay-fever, asthma and allergies in addition to AD. However, since these conditions are closely associated with AD (Papadopoulos and Walker, 2003b) these participants were included in the analysis.

6.1.c. Design

A cross-sectional design was employed with three groups: *early onset*, *late onset* and *control*.

The **dependent variables** were:

- a) Adjustment as measured by the Adjustment to Chronic Skin Disease Questionnaire (ACSDQ)
- b) EMS as measured by the Young Schema Questionnaire-Short Form 3
- c) Early parenting experiences as measured by the Young Parenting Inventory- Revised

Depending on the hypothesis to be tested the **independent variable** was either the:

- a) health status of participants with two levels: AD vs No condition
- b) age of onset of AD participants with three levels: Late vs Early vs No condition.

Self-report standardized questionnaires were administered in order to investigate the hypotheses of the present study. All of the questionnaires had good reliability and validity and were therefore considered suitable for such an investigation.

6.1.d. Instruments

The *Young Schema Questionnaire-Short Form 3 (YSQ-S3)* (Young, 1990) is a self-report, 90-item instrument that assesses levels of schema severity in each of the

18 EMS (appendix A). The 90 items are grouped into 18 sub-scales (EMS), each consisting of 5 items.

Respondents are asked to rate each of the 90 items in terms of how they have felt throughout their lives on a 6-point Likert scale (1= “*completely untrue of me*” to 6= “*describes me perfectly*”). The overall score for each sub-scale is estimated from the mean of the five items in each scale. Higher scores indicate higher schema endorsement and maladaptiveness.

The factor structure of the YSQ-S3 has been confirmed and expanded by factor analysis (Schmidt, Joiner, Young, and Telch, 1995). Internal consistency has also been found for scores from the entire 18 EMSs. Schmidt et al (1995) demonstrated an average alpha coefficient of .86 for scores from the YSQ-S3 suggesting a very good internal consistency. Welburn, Cristine, Dagg, et al., (2002) have also confirmed the construct validity of this instrument.

The YSQ-S3 has been extensively used in the assessment of personality disorders and Axis I and II diagnoses both in clinical and research settings (Glaser, Campbell, Calhoun, et al., 2002) (appendix B).

The *Young Parenting Inventory* (YPI) (Young, 2011) was designed on the basis of clinical experience and its utility is the identification of the potential origins of the 18 EMSs. It is a 72-item, self-report instrument that consists of statements describing parenting experiences (e.g. “*lied to me, deceived me or betrayed me*”). Each statement is rated on two different six-point Likert scales (1 = “*completely untrue*” to 6 = “*describes him/her perfectly*”), one for the mother and one for the

father. High scores on the YPI indicate that perceived parental response is more closely related to schema severity.

Sheffield et al (2005) have attempted to validate the YPI. Factor analyses however, demonstrated that a revised version of the questionnaire, the YPI-R, could represent more coherent and meaningful parental perceptions. The YPI-R consists of nine scales of parenting: *emotionally depriving, overprotective, belittling, controlling, emotionally inhibited, punitive, perfectionist, pessimistic / fearful and conditional / narcissistic* (appendix C). All of these scales have good test-retest reliability, very good internal consistency and adequate construct validity. The YPI-R has been extensively used for clinical and research purposes (Sheffield, et al., 2009).

The *Adjustment to Chronic Skin Disease Questionnaire* (ACSD) (Stangier et al, 2003) measures coping in skin disease patients. It is a 51-item self-report questionnaire that consists of 5 scales comprising the 5 main coping strategies used in skin conditions: a) *social anxiety / avoidance* (avoidance of certain situations), b) *itching-scratching* (deficient self-control), c) *helplessness* (perceived ability to influence the course of the disease), d) *anxious-depressive mood* (symptomatology as a result of missing adaptation), and e) *quality of life* (objective consequences that influence life) (appendix D).

Each item is scored on a 5-point Likert scale (from 1 = “*not at all*” to 5 = “*very much*”). Participants are asked to rate how much each statement applied to them *in the last week*. ACSD is a fully standardized measurement with very good internal

consistencies, test-retest reliabilities, and sufficient correlations and construct validity (Stangier, Ehlers and Gieler, 2003).

The *Demographic Information Questionnaire* (appendix E) was specifically designed for the purposes of the present study. The questions were mostly related to demographics and were established in accordance with the inclusion and exclusion criteria.

6.1.e. Procedure

The researcher requested approval and clearance by certain dermatological/AD organizations (i.e. Talkeczema, DermNet NZ, and The National Eczema Association) in order to post an advertisement of the present study on their official web sites asking for participation (appendix F).

The same advertisement was also posted on certain AD-related facebook groups such as: TalkHealth, Eczema, and Support for Eczema Sufferers and on a facebook account that was specifically created for the purposes of the present study.

Lastly, the researcher contacted the Administrator at London Metropolitan University and requested to circulate an advertisement (appendix G) of the present study to university's students.

All potential participants were asked if they were willing to participate in a research study on adjustment to chronic skin conditions, conducted by the researcher as part of a doctoral thesis in Counselling Psychology. An internet link was presented at the end of the advertisement where all participants could visit should they wished to participate. In addition, an e mail address that was

specifically created for the purposes of this study was provided to all participants should they wished to receive a PDF version of the questionnaires.

As soon as participants visited the link, an information sheet was presented to them (appendix H). Participants were asked to complete the questionnaires in their own time but were instructed to make sure not to take more than two breaks for each questionnaire. They were also explained that there were no right or wrong answers.

Navigation from one page to another required a clicking on the appropriate button (i.e. Next/Previous) at the end of each page. Thus, once participants had read the information page they could navigate to the next page which presented the consent form. Certain measures were taken so as to ensure that participants would not be able to proceed to the next page unless they had consent for their participation first.

The demographic questionnaire followed next. Participants could respond by clicking on the corresponding answer. Once the demographic questionnaire was completed, a filter question was presented asking participants to indicate whether they suffered from a skin condition or not. This filter question directed participants to the appropriate questionnaires (i.e. control participants did not have to complete the ACSD)

Special measures were taken in order to ensure that important information on each page (e.g. Likert-scales, instructions etc) would be visible on any computer screen without having to scroll down/up. This measure aimed at ensuring that participants could remember all the information that was necessary for the

completion of questionnaires at all times. In addition, at the top of each page appeared the name of the questionnaire, the number of questions included and instructions about its completion. Once participants had completed the last questionnaire they were directed to the debriefing page. Data collection lasted over a 12-month period.

Overall, given the fact that all of the present study's instruments were web-designed, certain measures were taken [as suggested by Dillman (2000)], in order to present them in a respondent-friendly manner, reduce measurement error and increase response rates:

- a) Make sure that the introductory screen that is motivational, emphasizes the simplicity of responding to the questions, and offers instructions on how to proceed to the next page
- b) Start with a question that can be easily comprehended and answered by all respondents
- c) Present each question in a conventional format that is similar to that one used in paper questionnaires
- d) Provide specific directions on computer actions (e.g. click on the next button etc) for responding to the questions
- e) Design the questionnaire in a way that prevents respondents from proceeding to subsequent questions unless they have responded to all previous ones
- f) Include graphical symbols that convey a sense of where the respondent is in the completion progress

- g) Use question structures to prevent known measurement problems (e.g. open-ended questions)

6.1.f. Ethical Considerations

British Psychological Society's (2009) guidelines formed the basis upon which the ethical issues of the present study were evaluated. The present study was conducted over the internet thus it also made sure to meet the BPS' standards for maintaining ethical practice in on-line psychological research (for more information see British Psychological Society, 2007).

Ethical approval for this study was granted by the Research Ethics Committee of the Psychology Department at London Metropolitan University (appendix J). Anonymity of participants was ensured at all times and appropriate psychological support was available to them in case they felt distressed by the study.

An information sheet (appendix H) provided detailed information on the purposes of the study, confidentiality, information related to what will happen to the data collected, contact details of the researcher etc. All participants were given explanations about the possibility of publication of the present study and were invited to contact the researcher should they needed more information or a copy of the study's report.

The consent form (appendix I) explained to participants the voluntary nature of the study, assured them about confidentiality issues and requested them to indicate whether they agreed or not to participate in the study by clicking on the corresponding option ("yes" or "no"). In case participants indicated "No" they were

directed to a page that thanked them for their time and presented a debriefing of the study. In case participants indicated “yes” they were preceded to the demographic questionnaire.

The debriefing (appendix K) included more details about the expectations and the purposes of the study. Participants were encouraged to contact the researcher should they had any questions or concerns and were also provided a list of organizations, web-sites and self-help, on-line resources for psychological support.

6.1.g. Data Analysis

Data of the present study was analyzed using the SPSS 20.00 for Windows. Parametric tests were used based on the following criteria:

- a) Analysis of Variance is a strong statistical procedure even if there are violations of its core assumptions (Mizara, 2007),
- b) Previous studies that employed the psychometric instruments of the present study have also used parametric tests (e.g. Sheffield et al, 2009; Stopa and Waters, 2005; Picardi, Pasquini, Cattaruzza et al., 2003) and
- c) According to the *central limit theorem*, sample data drawn from populations not normally distributed or from populations of unknown shape can also be analyzed by using the normal distribution, as the sample means are considered to be normally distributed for sample sizes of $n \geq 30$ (Downing and Clark, 2009).

Finally, the internal consistency of the scales in each questionnaire was calculated for all three conditions using Cronbach’s alpha. Multivariate analysis of

variance, between subjects' designs, correlations and regression analyses were used in order to test the hypotheses of the present study.

6.2. Results

6.2.a Internal Consistency of Scales

Internal consistency assesses reliability or in other words, whether all items in a given scale measure the same thing. Chronbach's alpha was used in order to determine the reliability of each questionnaire. Table 6.1 presents the Chronbach's alpha values.

According to Nunnally (1978) a score of .75 is taken as an indication of high reliability while .50-.75 is accepted as moderate reliability and any value below .50 as low reliability. According to the above tables the scales of the present study were presented with sufficient reliability.

Table 6.1 *Internal consistency of scales*

	Mean	Variance	Standard Deviation	Chronbach's Alpha
YPI	362.67	7184.16	84.76	.962
YSQ	221.31	4305.52	65.62	.969
ACSD	140.71	2285.68	47.81	.970

6.2.b. Demographic Characteristics

The sample of the present study consisted of 280 participants: early onset $n = 130$, late onset $n = 76$ and no condition $n = 74$. Table 6.2. displays the demographic characteristics of all participants

6.2.c . Differences in YSQ-S3 Scores Among Groups

A MANOVA between subjects design was conducted in order to examine the effects of group condition (early vs late vs control) on the 18 YSQ scales. Table 6.3 illustrates the mean scores and standard deviations of the three groups on each of the 18 scales along with the 95% confidence intervals and the MANOVA. An alpha level of .05 was set for the statistic tests.

Overall, results revealed that there were *strong significant effects* [$F(522) = 2.74$, $p = .000 < .05$] of the group condition on EMSs. The test of between-subjects effects revealed a significant effect of group condition specifically on:

1. *Emotional Deprivation (ED)* [$F(2, 277) = 4.63$, $p = .011$]
2. *Mistrust/Abuse(MA)* [$F(2,277) = 4.36$, $p = .014$]
3. *Social Isolation(SI)* [$F(2, 277) = 9.22$, $p = .000$]
4. *Defectiveness (DS)* [$F(2, 277) = 5.19$, $p = .006$]
5. *Failure (FA)* [$F(2, 277) = 9.65$, $p = .000$],
6. *Vulnerability to Harm (VH)* [$F(2,277) = 3.19$, $p = .042$]
7. *Subjugation (SB)* [$F(2,277) = 3.34$, $p = .037$]
8. *Self Sacrifice (SS)* [$F(2,277) = 8.00$, $p = .000$]

Table 6.2. *Demographic characteristics of participants*

	Early	Late	No Condition
<u>Age (years)</u>			
Mean	33.83	37.75	31.72
SD	13.12	13.71	7.74
<u>Gender (%)</u>			
Male	19.2	17.1	37.8
Female	80.8	82.9	55.4
<u>Marital Status (%)</u>			
Single	33.1	23.1	33.8
In a Relationship	22.3	21.1	35.1
Married/Cohabiting	43.1	48.7	25.7
Divorced	.80	3.9	2.7
Widowed	.80	2.6	2.7
<u>Ethnic Background (%)</u>			
Hispanic	1.6	1.3	0
White British	4.9	16.9	13.5
White Irish	1.6	0	0
White Other	61.0	66.1	60.8
Asian-Indian	10.6	5.1	5.4
Asian-Pakistani	1.6	0	0
Asian Other	8.1	5.1	6.8
Mixed	8.1	0	10.8
Chinese	0	0	0
Black-Caribbean	2.4	5.1	2.7

9. *Emotional Inhibition (EI)* [F(2,277) = 12.5, p = .000]
10. *Unrelenting Standards (US)* [F(2,277) = 17.81, p = 000]
11. *Entitlement(ET)* [F(2, 277) = 3.22, p = .041],
12. *Insufficient Self Control (ISC)* [FF(2, 277) = 6.66, p = .001]
13. *Pessimism (PS)* [F(2,277) = 5.46, p = .005]
14. *Punitiveness (PU)* [F(2,277) = 5.99, p = .003].

Post Hoc Tuckey's HDS pairwise comparison revealed a significant difference:

- Between the *early onset* and the *control* groups on:
 1. ED ($p = .028$),
 2. MA ($p = .015$),
 3. SI ($p = .000$),
 4. DS ($p = .010$),
 5. FA ($p = .000$),
 6. VH ($p = .032$),
 7. SB ($p = .031$),
 8. SS ($p = .000$),
 9. EI ($p = 000$),
 10. US ($p = .000$),
 11. ISC ($p = .002$),
 12. PS ($p = .003$) and
 13. PU ($p = .002$).

Specifically, the mean scores of the early onset group were significantly higher compared to the control group on those EMS (Table 6.4)

- Between the *early and the late onset* on :
 1. ED ($p = .040$),
 2. SI ($p = .049$),
 3. FA ($p = .008$) and
 4. ISC ($p = .051$)

Specifically, the mean scores of the early onset group were significantly higher than the mean scores of the late onset group on those four EMS (Table 6.5)

Table 6.3. *Mean YSQ scores, standard deviations, 95% confidence intervals and MANOVA among the conditions*

	Condition	Mean	SD	Confidence Intervals 95%		F	P	
				Lower Bound	Upper Bound			
YSQ Scales	ED	Control	1.88	.99	1.6	2.14	4.63	.011
		Early	2.30	1.22	2.11	2.49		
		Late	1.91	1.00	1.66	2.16		
	MA	Control	2.37	.96	2.09	2.65	4.36	.014
		Early	2.87	1.40	2.66	3.08		
		Late	2.53	1.16	2.25	2.80		
	SI	Control	2.39	.93	2.11	2.66	9.21	.000
		Early	3.13	1.33	2.92	3.34		
		Late	2.71	1.27	2.44	2.99		
DS	Control	1.96	.91	1.71	2.21			
	Early	2.43	1.22	2.24	2.62			
	Late	2.07	.99	1.83	2.32			

						5.19	.006
FA	Control	1.83	.26	1.61	2.06		
	Early	2.41	1.17	2.24	2.58		
	Late	1.99	1.04	1.77	2.21	9.66	.000
VH	Control	2.05	.81	1.82	2.27		
	Early	2.40	1.07	2.24	2.57		
	Late	2.26	.93	2.04	2.48	3.19	.042
SB	Control	2.14	.81	1.91	2.36		
	Early	2.50	1.07	2.33	2.67		
	Late	2.31	.98	2.09	2.53	3.34	.037
SS	Control	2.73	1.00	2.48	2.98		
	Early	3.35	1.11	3.16	3.53		
	Late	3.24	1.09	3.00	3.48	7.99	.000
EI	Control	2.32	.92	2.03	2.62		
	Early	3.27	1.60	3.04	3.49		
	Late	2.99	1.01	2.70	3.29	12.50	.000
US	Control	2.74	1.12	2.48	2.99		

	Early	3.63	1.05	3.44	3.82		
	Late	3.61	1.15	3.36	3.86		
						17.81	.000
ET	Control	2.55	.96	2.33	2.77		
	Early	2.82	1.05	2.66	2.99		
	Late	2.51	.83	2.29	2.73		
						3.22	.041
ISC	Control	2.43	.96	2.19	2.66		
	Early	2.94	1.09	2.77	3.12		
	Late	2.59	.96	2.36	2.82		
						6.66	.001
PS	Control	2.25	.88	1.98	2.52		
	Early	2.82	1.26	2.62	3.03		
	Late	2.58	1.31	2.32	2.85		
						5.46	.005
PU	Control	2.25	.77	2.02	2.48		
	Early	2.76	1.11	2.58	2.93		
	Late	2.62	1.05	2.40	2.85		
						5.99	.003

Table 6.4. *Mean YSQ scores and standard deviations of the early onset and the control groups*

EMS	Condition	Mean	Standard Deviation
ED	Early	2.30	1.22
	Control	1.88	.99
MA	Early	2.87	1.40
	Control	2.36	.96
SI	Early	3.13	2.71
	Control	2.38	.94
DS	Early	2.43	1.22
	Control	1.96	.92
FA	Early	2.41	1.17
	Control	1.83	.26
VH	Early	2.40	1.07
	Control	2.04	.80
SB	Early	2.50	1.07
	Control	2.14	.81
SS	Early	3.34	1.11
	Control	2.73	1.00
EI	Early	3.27	1.60
	Control	2.32	.92
US	Early	3.63	1.05

ISC	Control	2.73	1.12
	Early	2.94	1.09
PS	Control	2.42	.96
	Early	2.82	1.26
PU	Control	2.25	.88
	Early	2.76	1.11
	Control	2.24	.77

Table 6.5. *Mean YSQ scores and standard deviations of the early and the late onset groups*

EMS	Condition	Mean	Standard Deviation
ED	Early	2.30	1.22
	Late	1.91	1.00
SI	Early	3.13	1.33
	Late	2.70	1.27
FA	Early	2.41	1.17
	Late	1.99	1.04
ISC	Early	2.94	1.09
	Late	2.59	.96

- Between the *two experimental groups* (AD group) and the *control group* on:

1. MA ($p = .026$),
2. SI ($p = .000$)
3. DS ($p = .025$)
4. FA ($p = .002$)
5. VH ($p = .021$)
6. SB ($p = .029$)
7. SS ($p = .000$)
8. EI ($p = .000$)
9. US ($p = .000$)
10. ISC ($p = .006$)
11. PS ($p = .003$) and
12. PU ($p = .001$)

Specifically the mean scores of the AD group were significantly higher than the mean scores of the control group on those EMS (Table 6.6)

- Between the *late onset* and the *control* groups on:

1. SS ($p = .012$),
2. EI ($p = .005$), and
3. US ($p = .000$).

Specifically the late onset group scored higher on those EMS compared to the control group (Table 6.7)

Table 6.6. *Mean YSQ scores and standard deviations between the AD and the control groups*

EMS	Condition	Mean	Standard Deviation
MA	AD	2.74	1.32
	Control	2.37	.96
SI	AD	2.98	1.32
	Control	2.39	.94
DS	AD	2.30	1.15
	Control	1.96	.92
FA	AD	2.25	1.14
	Control	1.83	.26
VH	AD	2.35	1.02
	Control	2.05	.81
SB	AD	2.43	1.04
	Control	2.14	.81
SS	AD	3.31	1.10
	Control	2.73	1.00
EI	AD	3.17	1.41
	Control	2.32	.92
US	AD	3.62	1.09
	Control	2.73	1.12
ISC	AD	2.81	1.06

PS	Control	2.42	.96
	AD	2.73	1.28
PU	Control	2.25	.88
	AD	2.71	1.09
	Control	2.25	.77

Table 6.7. *Mean YSQ scores and standard deviations of the late onset and the control groups*

EMS	Condition	Mean	Standard Deviation
SS	Late	3.24	1.09
	Control	2.73	1.00
EI	Late	3.00	1.01
	Control	2.32	.92
US	Late	3.61	1.15
	Control	2.73	1.12

According to these findings, Hypothesis 1b that predicted differences on the YSQ-S3 scales between the groups was supported.

6.2.d. Differences in the YPI-R Scales Among Groups

A MANOVA between subjects design was conducted in order to examine the effects of group condition (early vs late vs control) on the 9 YPI-R scales (i.e. emotionally depriving (ED), overprotective (OP), belittling (BE), perfectionist (PF), pessimistic (PS), controlling (CL), emotionally inhibited (EI), punitive (PU) and conditional/narcissistic (CN) parenting.

Table 6.8 illustrates the mean scores and standard deviations of the three groups on each of the 9 scales along with the 95% confidence intervals and the MANOVA. An alpha level of .05 was set for the statistic tests.

Overall, results revealed that there was *a strong significant effect* ($F(518) = 1.934, p = .001 < .05$) of the group condition on perceived parenting experiences. Specifically, the test of between-subjects effects revealed a significant effect of group condition specifically on:

Mothers

- *ED* ($F(2, 275) = 5.251, p = .006$)
- *OP* ($F(2,275) = 3.34, p = .001$)
- *BE* ($F(2,275) = 4.82, p = .009$)
- *EI* ($F(2,275) = 3.36, p = .036$)
- *PU* ($F(2, 275) = 4.03, p = .019$)
- *PF* ($F(2,275) = 3.70, p = .026$) and on

Fathers

- *ED* ($F(2,275) = 6.81, p = .001$)

- *OP* ($F(2,275) = 4.73, p = .010$)
- *BE* ($F(2,275) = 3.22, p = .041$)

Post Hoc Tuckey's honestly significant difference (HDS) pairwise comparison revealed *significant differences* between the experimental and the control conditions but not between the two experimental conditions. A significant difference was found between:

- The *late onset* and the *control* groups on:
 1. *ED* mothers ($p = .004$) and fathers ($p = .005$)
 2. *OP* mothers ($p = .031$) and fathers ($p = .041$)
 3. *BE* mothers ($p = .006$)
 4. *EI* mothers ($p = .033$)
 5. *PU* mothers ($p = .019$)

Specifically, the late onset group scored significantly higher on all of these parenting experiences except *OP* where the control group presented a higher means score (Table 6.9).

- The *early onset* and the *control* groups on:
 1. *ED* fathers ($p = .003$),
 2. *OP* fathers ($p = .010$),
 3. *BE* fathers ($p = .038$) and
 4. *PF* mothers ($p = .050$)

Table 6.8. *Mean YPI-R scores, standard deviations, 95% confidence intervals and MANOVA among the three groups*

		Confidence Intervals 95%									
	Condition	Mean	Standard Deviation	Lower Bound	Upper Bound	<i>F</i>	<i>p</i>				
YPI Scales											
ED Mother	Control	1.88	1.00	1.58	2.19	5.25	.006				
	Early	2.30	1.39	2.07	2.52						
	Late	2.58	1.44	2.28	2.87						
ED Father	Control	2.25	1.06	1.91	2.60						
	Early	2.98	1.64	2.73	3.24						
	Late	3.03	1.56	2.70	3.37						
OP Mother	Control	2.89	1.14	2.60	3.18			6.81	.001		
	Early	2.70	1.39	2.48	2.91						
	Late	2.37	1.12	2.08	2.65						
OP Father	Control	2.75	1.11	2.48	3.03	3.34	.037				
	Early	2.24	1.28	2.03	2.45						
	Late	2.28	1.11	2.01	2.55						
BE Mother	Control	1.46	.83	1.15	1.77					4.73	.010
	Early	1.82	1.39	1.59	2.06						
		2.13	1.59	1.84	2.44						

Table 6.9. *Mean YPI-R scores and standard deviations of the late onset and the control groups*

Parenting Styles	Condition	Mean	Standard Deviation
ED Mother	Late Onset	2.57	1.44
	Control	1.88	1.00
ED Father	Late Onset	3.03	1.57
	Control	2.25	1.06
OP Mother	Late Onset	2.36	1.12
	Control	2.89	1.13
OP Father	Late Onset	2.27	1.11
	Control	2.75	1.11
BE Mother	Late Onset	2.14	1.59
	Control	1.46	.83
EI Mother	Late Onset	2.95	1.48
	Control	2.41	.93
PU Mother	Late Onset	2.92	1.43
	Control	2.34	1.25

Table 6.10. *Mean YPI-R scores and standard deviations of the early onset and the control conditions*

Parenting Styles	Condition	Mean	Standard Deviation
ED Father	Early Onset	2.98	1.64
	Control	2.25	1.06
OP Father	Early Onset	2.24	1.28
	Control	2.75	1.11
BE Father	Early Onset	2.02	1.50
	Control	1.53	1.00
PF Mother	Early Onset	3.92	1.20
	Control	3.50	1.11

- The *two experimental conditions* together (AD group) and the *control group* on:
 1. ED mothers ($p = .004$) and fathers ($p = .000$)
 2. OP fathers ($p = .002$)
 3. BE mothers ($p = .009$) and fathers ($p = .012$)
 4. EI mothers ($p = .015$) and fathers ($p = .026$)
 5. PU mothers ($p = .007$)

The AD group scored significantly higher on these parenting experiences compared to the control group except in the overprotective parenting where the control group scored higher (Table 6.11).

Table 6.11. *Mean YPI-R scores and standard deviations of the combined AD and the control groups*

Parenting Styles	Condition	Mean	Standard Deviation
ED Mother	AD	2.40	1.41
	Control	1.88	1.01
ED Father	AD	3.00	1.61
	Control	2.25	1.06
OP Father	AD	2.25	1.22
	Control	2.75	1.11
BE Mother	AD	1.94	1.47
	Control	1.46	.83
BE Father	AD	2.00	1.48
	Control	1.53	1.00
EI Mother	AD	2.84	1.42
	Control	2.41	.93
EI Father	AD	3.52	1.52
	Control	3.08	1.08
PU Mother	AD	2.82	1.32
	Control	2.34	1.25

- There were **no differences** on parenting experiences **between the two experimental conditions**.

Overall these findings support hypothesis 2b which predicted significant differences in parenting experiences between the two clinical and the control groups but reject hypothesis 2a which predicted significant differences between the two clinical groups.

6.2.e. Differences in ACSD Across Groups

A multivariate analysis of variance (MANOVA) between subjects design was conducted in order to examine the effects of group condition (early vs late onset) on the 5 ACSDQ scales. The control condition was not included in this analysis as participants in that group were not measured in terms of adjustment to a skin condition. Table 6.12 illustrates the mean scores and standard deviations of the two groups on each of the 5 scales along with the 95% confidence intervals and the MANOVA. Post hoc analysis was not estimated as there were only two levels (early vs late onset) in the independent variable. An alpha level of .05 was set for the statistic tests.

Overall, multivariate test revealed *no significant differences* between the late and early groups on adjustment [$F(1, 203) = 430, p > .05$]. Hypothesis 5 that predicted no significant differences between the two groups in terms of adjustment was supported. The mean scores on social anxiety, itch-scratch, helplessness, anxious-depressive mood and quality of life were almost equal between the two groups. In addition, the highest mean scores that indicated poorer adjustment to AD were

presented in the *itch-scratch*, *helplessness* and *anxious-depressive mood* scales for both groups.

Table 6.12. *Mean ACSD scores, standard deviations, 95% confidence intervals and MANOVA among early and late onset groups*

ACSD Scales	Condition	Mean	SD	Confidence Intervals 95%		F	p
				Lower Bound	Upper Bound		
Social	Early	2.72	1.10	2.52	2.92		
	Late	2.59	1.23	2.33	2.85		
						.645	.423
Itch-Scratch	Early	3.14	.99	2.96	3.33		
	Late	2.95	1.13	2.71	3.18		
						1.74	.189
Helplessness	Early	3.06	1.12	2.85	3.26		
	Late	2.94	1.31	2.67	3.21		
						.424	.516
Anxious-Depressive Mood	Early	2.84	1.00	2.65	3.02		
	Late	2.75	1.18	2.51	3.00		
						.303	.583
Quality of Life	Early	2.36	1.03	2.17	2.54		
	Late	2.28	1.08	2.04	2.51		
						.262	.609

6.3 Relationship Between Variables

6.3.a Relationship Between EMS & Adjustment

6.3.a.i Bivariate Correlations

The relationship between EMS and adjustment was examined using Pearson product-moment correlation coefficient. Table 6.13 presents correlations (r) between EMS and ACSD scales for the experimental groups.

Overall, for most of the YSQ scales there were significant positive and very strong correlations with psychological adjustment (ACSD scales) among the two experimental groups. Hypothesis 4 that predicted a positive correlation between EMS and ACSD scales was supported. A regressions analysis was required to investigate this relationship further.

6.3.a.ii. Regression Analysis

Five multiple regression analyses stepwise method were conducted in order to determine the relationship between the combinations of EMS (predictor variable) and ACSD scales (dependent variable). The exit criterion was $p > .10$. Assumptions of multiple linear regression were examined (Tables 6.14 & 6.15).

a) Social Anxiety/Avoidance

The regression equation of the 4th model revealed that *four EMS* predicted social anxiety: **DS, PS, VH, RS**. The 4th model was statistically significant [$F(4, 205) = 15.44, p = .000$] meaning that R for regression was different from zero ($R = .485$).

The regression model was:

$$Y = .480 X1 + (-.279) X2 + .341 X3 + (-.149) X4 + 1.95.$$

Table 6.13. *Pearson product-moment correlations between YSQ & ACSD scales*
(*n = 206*)

EMS	Social	Itch-Scratch	Helplessness	Anxious-Depressive	QoL
ED	.255**	.140*	.202**	.194**	.228**
AB	.306**	.170*	.273**	.277**	.224**
MA	.233**		.213**	.248**	.208**
SI	.236**		.191**	.332**	.233**
DS	.407**	.234**	.371**	.353**	.309**
FA	.339**	.302**	.343**	.363**	.340**
DI	.320**	.248**	.310**	.392**	.312**
VH	.300**	.163*	.265**	.312**	.307**
EM	.261**		.290**	.251**	.187**
SB	.248**	.169*	.255**	.262**	.222**
SS	.203**	.159*	.236**	.259**	.229**
EI	.207**	.157*	.240**	.273**	.226**
US					
ET	.152*		.140*	.197**	
IS	.198**		.191**	.289**	.198**
RS				.182**	
PS	.141*		.149*		
PU	.153*	.137	.177*		

** *p* < .01 level (2-tailed), * *p* < .05 level (2-tailed)

Table 6.14. *Model summary & ANOVA of regression analysis for ACSD scales*

	R	R Square	Adjusted R Square	ANOVA F	Sig.
Social Anxiety Model 4	.485 ^d	.235	.220	15.439	.000 ^e
Itch-Scratch Model 1	.302 ^a	.091	.087	20.516	.000 ^b
Helplessness Model 4	.443 ^d	.196	.180	12.287	.000 ^e
Anxious-Depressive Model 5	.497 ^e	.247	.229	.94285	.021
Quality of Life Model 4	.435 ^d	.190	.174	11.759	.000 ^e

a) *Itch-Scratch*

The regression equation revealed that **FA** contributed significantly to the prediction of itching-scratching

The model was statistical significant [F(1, 205) = 20.52, p = .000] meaning that R was different from zero (R = .302). As a result the regression model was:

$$Y = .278 X1 + 2.45$$

b) *Helplessness*

The regression equation revealed that **DS, EM, RS, FA** contributed significantly to the prediction of helplessness. The 4th model was statistically significant [F (4, 205) = 12.29, p = .000], (R = .443). The regression model was:

$$Y = .280 X1 + .192 X2 + (-.187) X3 + .193 X4 + 2.08$$

c) *Anxious/Depressive Mood*

The regression equation revealed that **DI, SI, PS, SS, VH** contributed significantly to the prediction of anxious-depressive mood. The 5th model was statistically significant [F (5,205) = 13.15, p = .000] (R = .497). The regression model was:

$$Y = .274 X1 + .198 X2 + (-.325) X3 + .173 X4 + .248 X5 + 1.39$$

d) *Quality of Life*

The regression equation revealed that **FA, VH, PS, ED** contributed significantly to the prediction of quality of life. The 4th model was statistically significant [F (4, 205) = 11.75, p = .000], (R = .435). The regression model was:

$$Y = .234X1 + .268 X2 + (-.266) X3 + .141 X4 + 1.36$$

Table 6.15. *Statistics of regression model with ACSD scales as dependent variable and EMSs as predictor variables (n = 206)*

		Unstandardized Coefficients	Standardized Coefficients	t	Sig.	
		B	Std. Error	Beta		
Social Anxiety	(Constant)	1.953	.212	9.207	.000	
	DS	.480	.084	.480	5.708	.000
	PS	-.279	.090	.311	3.108	.002
	VH	.341	.109	.304	3.125	.002
Itch-Scratch	(Constant)	2.446	.155	5.75	.000	
	FA	.278	.061	.302	4.530	.000
Helplessness	(Constant)	2.082	.238	8.747	.000	
	EM	.192	.092	.150	2.093	.038
	RS	-.187	.076	-.178	2.467	.014
	FA	.193	.087	.185	2.211	.028
Anxious- Depressive	(Constant)	1.387	.233	5.964	.000	
	SI	.198	.067	.244	2.970	.003
	SS	.173	.067	.178	2.574	.011
	VH	.248	.106	.237	2.343	.020
Quality of Life	(Constant)	1.359	.190	7.158	.000	
	VH	.368	.101	.359	3.625	.000
	PS	-.266	.081	-.325	3.293	.001
	ED	.141	.064	.156	2.193	.029

6.3.b. Relationship Between YPI-R and EMS

6.3.b.i. Bivariate Correlations

The relationship between YPI-R and EMSs scales was examined using Pearson product-moment correlation coefficient. Overall, for the entire 18 EMSs there were some significant positive or negative and very strong correlations with parenting experiences (table 6.16).

For many of the YPI scales there were significant and very strong correlations with each EMS. Hypothesis 3 that predicted a relationship between YPI-R and EMS scales was supported. Regression analysis was needed in order to investigate the scales of YPI-R that predicted each EMS further.

6.3.b.ii. Regression Analysis

Eighteen multiple regression analyses stepwise method were conducted in order to examine how the scales in parenting experiences (predicted variable) predicted EMS (dependent variable). The exit criterion was $p > .10$. Assumptions of multiple linear regression were examined (Tables 6.17 & 6.18).

Table 6.16. *Pearson product-moment correlations between YPI-R and EMSs (n = 280)*

PARENTING STYLES																
EMS	EDM	EDF	OPM	OPF	BEM	BEF	CTM	CTF	EIM	EIF	PUM	PUF	PFM	PF F	PSM	PSF
ED					.15*	.13*	.19**		.12*		.133*				.16**	.23**
MA					.20**	.21**				.15*	.14*		.13*		.15*	.15*
SI	.14*		.15*		.24**	.23**	.12*	.13*	.18**	.14*	.16*				.21**	.23**
DS					.19**	.25**	.12*	.13*	.13*						.20**	.16**
FA					.15*	.28**		.12*			.17*				.12*	.14*
DI		.13*			.20**	.26**		.15**				.14*				.17**
VH					.18**	.24**		.14*								.16**
EM	.12*		.23**	.17**			.16**	.14*						.17**	.13*	
SB					.17**	.14*	.21**	.14*	.16**		.14*		.17**			
SS													.13*			
US									.13*	.133*			.24**			.12*
ET		.13*	.14*			.13*				.14*			.16**		.16**	.15**
ISC			.18*			.19**	.14*	.16*							.22**	.19**
RS			.19**						.13*							
PS						.13*							.12*			

** $p < .01$ level (2-tailed), * $p < .05$ level (2-tailed)

Table 6.17. *Model summary & ANOVA of regression analysis for EMSs*

				ANOVA	
	R	R Square	Adjusted R Square	F	p
ED					
Model					
3	.300 ^c	.090	.080	9.04	.000
AB					
Model					
1	.201 ^a	.041	.037	11.654	.001
MA					
Model					
2	.255 ^b	.065	.058	9.544	.000
SI					
Model					
2	.313 ^b	.098	.091	14.930	.000
DS					
Model					
2	.294 ^b	.087	.080	13.022	.000
FA					
Model					
1	.298 ^a	.089	.086	26.976	.000
DI					
Model					
1	.265 ^a	.070	.067	20.785	.000
VH					
Model					
1	.233 ^a	.054	.051	15.888	.000
EM					
Model					
4	.319 ^d	.102	.088	7.719	.000
SB					
Model					
2	.255 ^b	.065	.058	9.578	.000

SS Model						
1	.128 ^a	.016	.013		4.614	.033
EI Model						
1	.184 ^a	.034	.030		9.636	.002
US Model						
2	.288 ^b	.083	.077		12.476	.000
ET Model						
4	.293 ^d	.086	.073		6.414	.000
ISC Model						
2	.260 ^b	.068	.061		9.995	.000
RS Model						
2	.240 ^b	.058	.051		8.405	.000
PS Model						
2	.182 ^b	.033	.026		4.687	.010
PU Model						
1	.125 ^a	.016	.012		4.359	.038

a) *Emotional Deprivation*

The regression equation of the third model revealed that **three parenting experiences** (PE) predicted ED: **PS father, CT mother, CD father**. The third model was statistically significant [$F(3, 277) = 9.04, p = .000$] meaning that R for regression was different from zero ($R = .300$). The regression equation was:

$$Y = .239x_1 + .141x_2 + (-.120) + 1.54$$

b) *Abandonment*

The regression equation of the model revealed that **one PE** predicted AB: **PS father**. The model was statistically significant [$F(1, 277) = 11.65, p = .001$] meaning that R for regression was different from zero ($R = .201$). The regression equation was:

$$Y = .195x_1 + 1.92$$

c) *Mistrust/Abuse*

The regression equation of the second model revealed that **two PE** predicted MA: **BE mother PF father**. The second model was statistically significant [$F(2, 277) = 9.54, p = .000$] meaning that R for regression was different from zero ($R = .255$). The regression equation was:

$$Y = .198x_1 + .141x_2 + 1.75$$

d) *Social Isolation*

The regression equation of the second model revealed that **two PE** predicted SI: **BE mother PS father**. The second model was statistically significant [F(2, 277) = 14.93, p = .000] meaning that R for regression was different from zero (R = .313).

The regression equation was:

$$Y = .198x_1 + .206x_2 + 1.96$$

e) *Defectiveness*

The regression equation of the second model revealed that **two PE** predicted DS: **BE father PS mother**. The second model was statistically significant [F(2, 277) = 13.022, p = .000] meaning that R for regression was different from zero (R = .294).

The regression equation was:

$$Y = .176x_1 + .128x_2 + 1.55$$

f) *Failure*

The regression equation of the model revealed that **one PE** predicted FA: **BE father**. The model was statistically significant [F(1, 277) = 26.976, p = .000] meaning that R for regression was different from zero (R = .298). The regression equation was:

$$Y = .217x_1 + 1.74$$

g) *Dependence*

The regression equation of the model revealed that **one PE** predicted DI: **BE father**. The model was statistically significant [F(1, 277) = 20.785, p = .000] meaning that R for regression was different from zero (R = .265).

The regression equation was:

$$Y = .182x_1 + 1.65$$

h) *Vulnerability to Harm*

The regression equation of the model revealed that **one PE** predicted VH: **BE father**. The model was statistically significant [F(1, 277) = 15.888, p = .000] meaning that R for regression was different from zero (R = .233). The regression equation was:

$$Y = .166x_1 + 1.96$$

i) *Enmeshment*

The regression equation of the fourth model revealed that **four PE** predicted EM: **OP mother, PF mother, ED mother, and EI mother**. The fourth model was statistically significant [F(4, 277) = 7.72, p = .000] meaning that R for regression was different from zero (R = .319). The regression equation was:

$$Y = .153x_1 + .093x_2 + (-.160)x_3 + .110x_4 + 1.33$$

j) *Subjugation*

The regression equation of the second model revealed that **two PE** predicted SB: **CT and PF mothers**. The second model was statistically significant [F(2, 277) = 9.578, p = .000] meaning that R for regression was different from zero (R = .255).

The regression equation was:

$$Y = .159x_1 + .17x_2 + 1.59$$

k) *Self Sacrifice*

The regression equation of the model revealed that **one PE** predicted SS: **PF mother**. The model was statistically significant [F(1, 277) = 4.61, p = .033] meaning that R for regression was different from zero (R = .128). The regression equation was:

$$Y = .118x_1 + 2.72$$

l) *Emotional Inhibition*

The regression equation of the model revealed that **one PE** predicted EI: **CT mother**. The model was statistically significant [F(1, 277) = 9.636, p = .002] meaning that R for regression was different from zero (R = .184). The regression equation was:

$$Y = .159x_1 + 2.57$$

m) *Unrelenting Standards*

The regression equation of the second model revealed that **two PE** predicted US: **PF mother ED father**. The second model was statistically significant [F(2, 277) =

12.476, $p = .000$] meaning that \underline{R} for regression was different from zero ($R = .288$).

The regression equation was:

$$Y = .261x_1 + .117x_2 + 2.09$$

n) *Entitlement*

The regression equation of the fourth model revealed that **four PE** predicted ET: **PF mother, ED father, PS mother, and PU mother**. The fourth model was statistically significant [$F(4, 277) = 6.41$, $p = .000$] meaning that \underline{R} for regression was different from zero ($R = .293$). The regression equation was:

$$Y = .177x_1 + .105x_2 + .161x_3 + (-.124)x_4 + 1.62$$

o) *Insufficient Self Control*

The regression equation of the second model revealed that **two PE** predicted ISC: **PS mother BE father**. The second model was statistically significant [$F(2, 277) = 9.995$, $p = .000$] meaning that \underline{R} for regression was different from zero ($R = .260$). The regression equation was:

$$Y = .164x_1 + .101x_2 + 2.09$$

p) *Recognition Seeking*

The regression equation of the second model revealed that **two PE** predicted RS: **OP mother EI father**. The second model was statistically significant [$F(2, 277) = 8.405$, $p = .000$] meaning that \underline{R} for regression was different from zero ($R = .240$). The regression equation was:

$$Y = .182x_1 + (-.122)x_2 + 2.66$$

q) *Negativity/Pessimism*

The regression equation of the second model revealed that **two PE** predicted PS: **PF mother BE father**. The second model was statistically significant [$F(2, 277) = 4.687, p = .010$] meaning that R for regression was different from zero ($R = .182$). The regression equation was:

$$Y = .120x_1 + .122x_2 + 1.30$$

r) *Punitiveness*

The regression equation of the model revealed that **one PE** predicted PU: **BE father**. The model was statistically significant [$F(1, 277) = 4.359, p = .038$] meaning that R for regression was different from zero ($R = .125$). The regression equation was:

$$Y = .093x_1 + 2.42$$

Table 6.18. *Statistics of regression model with EMSs scales as dependent variables and YPI-R scales as predictor variables (n= 280)*

		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
ED	(Constant)	1.542	.184		8.361	.000
	PS_father	.239	.061	.251	3.944	.000
	CT mother	.141	.056	.154	2.530	.012
	CD father	-.120	.054	-.141	-2.227	.027
AB	(Constant)	1.921	.155		12.371	.000
	PS father	.195	.057	.201	3.414	.001
MA	(Constant)	1.751	.258		6.773	.000
	BE father	.198	.053	.219	3.754	.000
	PF mother	.141	.061	.135	2.318	.021
SI	(Constant)	1.962	.180		10.888	.000
	BE mother	.198	.055	.212	3.625	.000
	PS father	.206	.062	.193	3.308	.001
DS	(Constant)	1.547	.161		9.590	.000
	BE father	.176	.049	.220	3.613	.000
	PS mother	.128	.057	.137	2.252	.025
FA	(Constant)	1.741	.098		17.851	.000
	BE father	.217	.042	.298	5.194	.000
DI	(Constant)	1.651	.093		17.749	.000
	BE father	.182	.040	.265	4.559	.000
VH	(Constant)	1.959	.097		20.217	.000

	BE father	.166	.042	.233	3.986	.000
EM	(Constant)	1.332	.222		5.992	.000
	OP mother	.153	.041	.214	3.695	.000
	PF mother	.093	.044	.123	2.122	.035
	ED mother	-.160	.053	-.236	-3.033	.003
	EI mother	.110	.053	.162	2.087	.038
SB	(Constant)	1.595	.204		7.838	.000
	CT mother	.159	.048	.197	3.347	.001
	PF mother	.117	.049	.141	2.401	.017
SS	(Constant)	2.719	.215		12.665	.000
	PF mother	.118	.055	.128	2.148	.033
EI	(Constant)	2.569	.124		20.788	.000
	CT mother	.159	.051	.184	3.104	.002
US	(Constant)	2.090	.269		7.764	.000
	PF mother	.261	.057	.269	4.606	.000
	ED father	.117	.045	.153	2.616	.009
ET	(Constant)	1.623	.246		6.607	.000
	PF mother	.177	.049	.217	3.579	.000
	ED father	.105	.040	.163	2.641	.009
	PS mother	.161	.055	.195	2.942	.004
	PU mother	-.124	.051	-.167	-2.418	.016
ISC	(Constant)	2.091	.155		13.516	.000
	PS mother	.164	.054	.185	3.012	.003
	BE father	.101	.047	.133	2.161	.032

RS	(Constant)	2.656	.194		13.713	.000
	OP mother	.182	.052	.207	3.520	.001
	EI mother	-.122	.050	-.145	-2.469	.014
PS	(Constant)	1.930	.254		7.583	.000
	BE ather	.120	.052	.138	2.320	.021
	PF mother	.122	.060	.122	2.048	.041
PU	(Constant)	2.420	.104		23.258	.000
	BE father	.093	.045	.125	2.088	.038

CHAPTER 7

DISCUSSION

7.1. Overview

The aims of the present study were to:

- a) Examine whether differences exist between people with an early and a late onset of AD in terms of early parenting experiences, maladaptive schemas and adjustment
- b) Identify whether maladaptive schema development is a function of the condition per se, parenting experiences or both
- c) Identify whether early experiences impact on adjustment to AD through the development of EMSs.

Generally, it was expected that:

- a) There will not be differences in EMSs between the two clinical groups
- b) There will be no differences in early parenting experiences between the two clinical groups
- c) Parenting experiences will be strong predictors of EMSs
- d) Schemas will be strong predictors of adjustment to AD.
- e) Age of onset will not affect adjustment to AD

7.2. Interpretation of Findings

7.2.a. Early Maladaptive Schemas Between Groups

Overall, results revealed reliable differences between the combined AD (both early and late onset groups) and the normal comparison groups. Specifically, the combined AD group can be differentiated best by twelve EMSs: *mistrust/abuse*,

social isolation, defectiveness, failure, vulnerability to harm, subjugation, self-sacrifice, emotional inhibition, unrelenting standards, insufficient self-control, pessimism and punitiveness. Lastly, the two AD groups (early and late onset) presented no actual differences in their schematic profiles with the exception of emotional deprivation that was exclusively presented in the early onset group.

The finding that both AD groups presented a certain schematic profile that differed from the profile presented in the control group suggests that there were certain common experiences among people with AD –regardless of age of onset– that contributed to the development of this profile. Plausibly, one such experience could be the mere presence of the condition. It could be argued that the mere manifestation of AD, at any age, may lead one to perceive his/herself as different and isolated, flawed, disapproved of and unlovable, unsuccessful, fearful of mistakes, unable to cope and subjugated and others as hurtful, cheatful and manipulative [growing up (early onset) with AD can only add to this experience the feeling that one’s emotional needs will not be adequately satisfied -or at least not as much as his/her practical/condition-related ones]. This argument has received support by Horing (2004) who argued that the mere traumatic experience of having a skin that is rather injured by and vulnerable to external stimuli and internal stressors, and therefore incapable of providing protection against one’s own environment, can significantly interfere with the psychosocial experience of the person and consequently cause disruptions on personality-level structures, at any age.

However, according to Young and Behary (1998)–as well as other personality theorists– personality structures are merely determined by early experiences and

temperament, remain stable over time -to a large degree- and define the way environmental influences (such as the manifestation of AD) will be appraised and coped with. In such a framework, the presence of a skin condition at an early age might be enough in explaining the schematic pattern presented in the early onset group but it might not be enough in explaining the schematic profile presented in the late onset group as well as the similarity of schemas between the two groups.

Specifically, studies and literature (e.g. Warschburger et al., 2004; Thompson, 2005; Lewis-Jones, 2006; Papadopoulos et al., 1999a; Howlett, 1999) argue that contrary to a late onset, the onset of AD at an early age becomes part of the person's developmental experience. Since the two groups are supposed to have different developmental experiences (at least in terms of coping with AD) then they should have also presented with different schematic structures. However, results in the present study demonstrated that this was not the case. In fact the two groups presented with similar schematic patterns and almost equally high schema severity (mean scores). According to the ST model, the presence of severe schematic patterns is the result of negative early –rather than later- experiences.

Apparently then, the two groups shared similar early experiences that were not necessarily related to AD. The present study proposes that attention to these early experiences needs to be shifted on early *parenting* experiences and core unmet emotional needs and away from the skin condition itself.

7.2.b. Early Parenting Experiences Between Groups

Findings revealed significantly strong differences in perceived parenting experiences between the combined AD and the control groups. Specifically, AD patients were differentiated best from controls by four parenting styles: *emotionally depriving* mothers and fathers, *belittling* mothers and fathers, *emotionally inhibiting* mothers and fathers and *punitive* mothers. According to the meaning attached to these parenting styles, AD patients commonly perceived their parents as more detached, cold, rejecting, demanding, punitive, withholding and undermining than the no condition status group. This finding is partially backed up by an array of previous empirical findings (e.g. Pauli-Pott et al, 1999; Papadopoulos et al., 1999a; Faight, Bierl, Barton and Kemp, 2007; Chamlin, et al, 2004; Bahmer, et al, 2007; Whitlock, 1980; Pauli-Pott et al, 1999 etc) demonstrating that parents of affected children are more likely to present certain characteristics such as: physical exhaustion, emotional strain, guilt, depression/hopelessness, resentment, rejection or overprotective attitude and emotional neglect toward their affected child; and report an overall more disturbed family functioning as well as a poorer overall quality of life, compared to parents of unaffected children or parents of children with other medical conditions (i.e. insulin-dependent diabetes).

However, contrary to most of those studies that attributed the development of these parenting patterns to the debilitating effects of AD onset, the present study revealed that there were no significant differences in perceived parenting experiences between the early and the late onset groups of people with AD. It seems that the presence of the condition does not affect perceived parenting

experiences. This finding is really intriguing as it indicates not only that people with AD shared some common early parenting experiences, but also that these experiences were not necessarily affected by the onset of the condition but might have rather pre-existed its development. It is very likely that these patterns constituted the result of parental dispositional characteristics -rather than external environmental influences (like the onset of AD)- and were thus most probably present or manifested ever since the very early, critical, caregiver-child interactions. According to this finding, it could be further argued that the specific pattern of perceived parental characteristics reported by participants in the present study, might actually have played an etiological role in the manifestation of AD.

Unfortunately, already existing research findings that could confirm this argument relative to the manifestation of AD are extremely scarce and most come from very early psychosomatic studies (e.g. Kepecs, Rabin, and Robin, 1951; Miller and Baruch, 1948; Meijer, 1976 etc) that have relied exclusively on clinical observations and thus have been questioned by most recent authors. Nevertheless, a number of recent studies exists verifying the link between early parenting experiences and the overall health or physiological well-being of the person. For example, a study conducted by Felitti, Anda, Nordenberg et al. (1998) demonstrated that families characterized by conflict, manifested in recurrent episodes, anger/aggression and/or hostility, and cold unsupportive, punitive and neglectful parenting styles, can have damaging outcomes not only on the mental, but also on the physical health of children. Specifically, authors in that study distributed a questionnaire about adverse childhood experiences to 13,494 people who had first completed a standardized medical evaluation at a large Health

Maintenance Organization (HMO). The questionnaire measured seven categories of adverse early experiences: 1) psychological, 2) physical or 3) sexual abuse, 4) violence against mother, and 5) living with a parent (or another family member) that abused substances, 6) was mentally ill or suicidal and 5) was ever imprisoned. Authors compared these early experiences to measures of adult risk behavior, health status and disease. Results revealed a graded relationship between the number of categories of adverse experiences and the adult health risk behaviours and diseases. People who had experienced four or more categories of adverse experiences presented four to twelve-fold increased risk for substance abuse, poor self-rated health, and severe health-related problems such as: ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease, compared to those who reported no early adverse experiences.

Although, one could argue that the link between health-related problems and early adverse experiences presented in that study could have been mediated by risk behaviours, much explanation relevant to the direct role of early adverse experiences in health revolves around a single process that Cannon (1932) originally termed as the *fight-or-flight* response. According to this process, the body uses the autonomic nervous system [the hypothalamic-pituitary-adrenal (HPA) axis, and the cardiovascular, metabolic, and immune systems] to restore equilibrium after challenge. When this system is used frequently to help respond to a lot of stress, the body is likely to be damaged. Repetti, Taylor and Seeman (2002) argued that living in a stressful family environment, children's developing physiological and neuroendocrine systems must repeatedly adapt to the threatening and stressful circumstances created by these family environments. This might lead to

disturbances in physiologic and neuroendocrine system regulation and specifically in the sympathetic-adrenomedullary (SAM) reactivity, hypothalamic–pituitary–adrenocortical (HPA) reactivity, and serotonergic functioning.

According to McEwen & Stellar (1993), such consistent biological dysregulations may contribute to a buildup of allostatic load (that is, the premature physiological aging of the organism) that enhances vulnerability to chronic diseases (e.g. hypertension, cardiovascular disease, diabetes, and some cancers) or even to early mortality in adulthood. This argument has received further support by many neurobiological studies (e.g. Plotsky and Meaney, 1993; Kaufman, et al., 2004; Mitrescu, et al., 2004; Berisoglou et al, 2009 etc). Walker and Papadopoulos (2005) further added that the place in one's body (e.g. heart, pancreas, skin) or the point in one's lifetime (e.g. early or late onset) that this allostatic load will be manifested causing health-related problems, depends on the organism's genetic vulnerabilities and the breadth of this vulnerabilities. Therefore, manifestations of health-related problems vary from person to person and can occur at any point in one's life (from infancy to late adulthood). In such a framework, it could be argued that the physiological upsets produced in a child living with emotionally depriving, belittling, emotionally inhibiting and punitive parents along with a genetically-based predisposition to a vulnerable skin, is what determines eczematous manifestation either at an early or a later stage of development. Unfortunately, the cross-sectional design of the present study cannot support such etiological conclusions and thus further research is needed before any conclusions can be drawn.

Concluding, according to the ST model of personality development (Young et al., 2003), the remarkable similarity in early parenting experiences among the two AD groups, could also explain the similarities found in the schematic profiles between people with an early and a late onset of AD. The following section addresses the link between EMSs and parenting experiences as theorized by the ST model and offers an understanding as to the processes through which early parenting experiences affect emotional and cognitive development.

7.2.c. Relationship Between Parenting Experiences & EMSs

Present findings revealed a strong and positive association between parenting experiences and EMSs. In fact, both maternal and paternal YPI-R scales were significantly correlated with YSQ-S3 sub-scales. Consistent with Sheffield et al's (2005) findings, these correlations were not in a linear pattern meaning that high scores on a particular YPI-R scale (e.g. emotionally depriving parenting) did not necessarily correlated with the corresponding EMS (e.g. emotional deprivation). On the contrary, it appeared that each parenting experience predicted a number of different EMSs (Figures 6 & 7). This finding is also consistent with earlier ones (e.g. Harris and Curtin, 2002; Sheffield et al, 2005; Parker, Tupling, & Brown, 1979; Murray, et al, 2000) and with Young's (1990b; 1999; 1994a; 1994b) theory that each parenting experience is susceptible to the subjective perception of the person and may thus lead to the development of different EMSs.

Even though a significant amount of early and recent studies exists (such as Ainsworth, Blehar, Waters and Wall, 1978; Brewin, et al, 1993) demonstrating that early parenting experiences can impact on emotional and cognitive (i.e. schematic)

development of the child, very recent neurobiological evidence further support this position and provide very strong evidence for this process. Specifically, studies (such as Weniger, Lange, Sachsse and Irle, 2009; Poeggel, Helmeke, Abraham et al. 2003; Cohen, Grieve, Hoth et al. 2006) have demonstrated that early distressing life experiences – even minor ones – can actually define brain development and neural architecture. Specifically, significant volume reductions and abnormalities in blood flow in the *hippocampus* and the *amygdala nuclei* have been observed among people reporting early trauma or even moderate levels of early-life stress³ (Cohen et al., 2006). These two brain systems constitute core mechanisms of emotional and cognitive registration, storage and retrieval; have been associated with the cognitive deficits presented in many psychological disorders [e.g. mood disorders (Bremner, Narayan, Anderson et al., 2000; Sheline, Gado, and Price, 1998); anxiety disorders, borderline personality disorder (Weniger et al., 2009) etc] and are considered to be implicated in adult psychopathology.

³The link between distressing early experiences and brain development has been demonstrated through the use of concrete, current technologies like EEG, scanners, imaging and mapping (picture 2) (Benoit, Coolbear & Crawford, 2003).

SCHEMA DOMAINS & CORRESPONDING EMSs	PARENTING EXPERIENCES
<p data-bbox="282 275 695 302"><u>Domain I: Disconnection&Rejection</u></p> <p data-bbox="282 363 695 390">Emotional Deprivation, Abandonment,</p> <p data-bbox="282 451 792 478">Mistrust/ Abuse, Social Isolation, Defectiveness</p>	<p data-bbox="915 275 1003 302"><u>Father:</u></p> <p data-bbox="915 363 1286 390">Pessimistic, Conditional, Belittling</p> <p data-bbox="915 451 1068 478">&Perfectionist</p> <p data-bbox="915 539 1305 567"><u>Mother:</u> Pessimistic, Controlling, &</p> <p data-bbox="915 627 1016 655">Belittling</p>
<p data-bbox="282 716 831 743"><u>Domain II: Impaired Autonomy & Performance</u></p> <p data-bbox="282 804 750 831">Dependence, Failure, Vulnerability to Harm</p> <p data-bbox="282 892 428 919">Enmeshment</p>	<p data-bbox="915 716 1003 743"><u>Father:</u></p> <p data-bbox="915 804 1016 831">Belittling</p> <p data-bbox="915 892 1331 919"><u>Mother:</u> Overprotective, Perfectionist,</p> <p data-bbox="915 980 1328 1008">Emotionally Depriving & Emotionally</p> <p data-bbox="915 1068 1019 1096">Inhibiting</p>
<p data-bbox="282 1157 613 1184"><u>Domain III: Impaired Limits</u></p> <p data-bbox="282 1245 678 1272">Entitlement, Insufficient Self Control</p>	<p data-bbox="915 1157 1003 1184"><u>Father:</u></p> <p data-bbox="915 1245 1302 1272">Emotionally Depriving, & Belittling</p> <p data-bbox="915 1333 1292 1360"><u>Mother:</u> Perfectionist, Pessimist &</p> <p data-bbox="915 1421 1003 1449">Punitive</p>
<p data-bbox="282 1509 643 1537"><u>Domain IV: Other Directedness</u></p> <p data-bbox="282 1598 841 1625">Subjugation, Self-Sacrifice and Recognition Seeking</p>	<p data-bbox="915 1509 1003 1537"><u>Father:</u></p> <p data-bbox="915 1598 1156 1625">Emotionally Inhibiting</p> <p data-bbox="915 1686 1321 1713"><u>Mother:</u> Controlling, Perfectionist, &</p> <p data-bbox="915 1774 1081 1801">Overprotective</p>

<p><u>Domain V: Overvigilance& Inhibition</u></p> <p>Pessimism, Emotional Inhibition, Unrelenting Standards and Punitiveness</p>	<p><u>Father:</u></p> <p>Belittling and Emotionally Depriving</p> <p><u>Mother:</u></p> <p>Perfectionist & Controlling</p>
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Source: This figure was developed by the author specifically for the purposes of the present paper

Figure 6: Parenting Experiences That Predicted EMSs Categorized by Schema Domains

Studies on the biology of the brain and information processing (LeDoux, 1996; Gaensbauer, 2002; Green, 2003) explain that the link between these two brain systems and psychopathology leads to the formation of schemas. Information stored in amygdala (emotions and bodily sensations) and the hippocampus (memories and cognitions) get synthesized/unified through the development of schematic structures. By Young et al's (2003) definition, schemas constitute a unified set of stored emotions, bodily sensations (amygdala) memories, and cognitions (hippocampus) that revolve around an early distressing theme (e.g. abandonment, rejection, neglect etc).

Stimuli reminiscent of that theme lead to schema activation that further leads the person to experience current situations as pervasive, emotionally charged and difficult to manage as the original early experience (Young et al, 2003). According to Young (1990), the more the

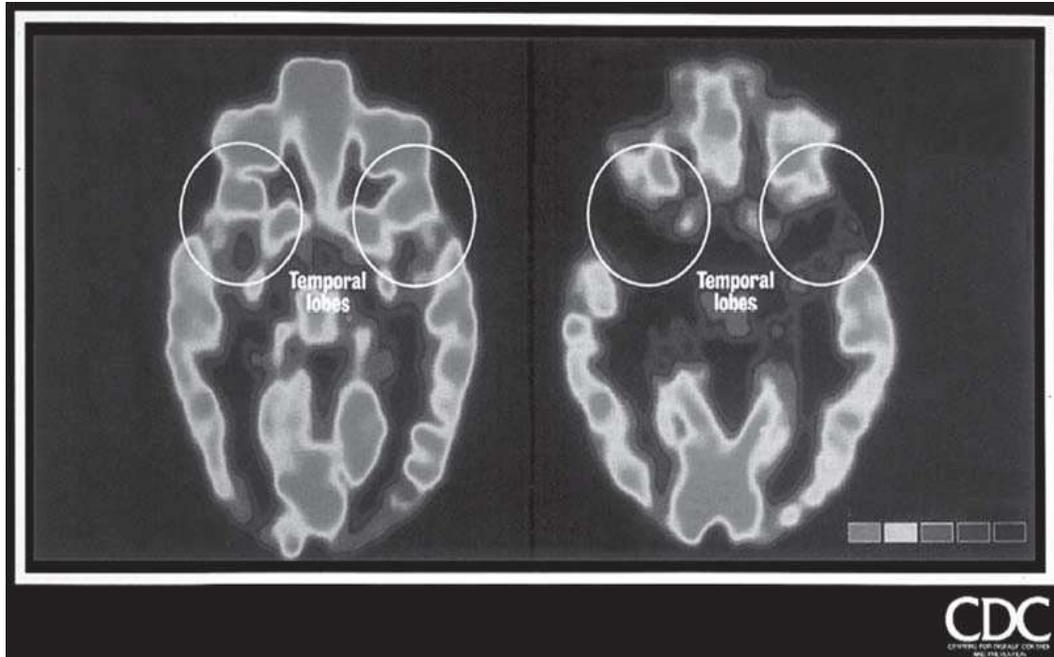
EARLY MALADAPTIVE SCHEMAS	PARENTING EXPERIENCES
Emotional Deprivation	Pessimistic & Conditional Father
	Controlling Mother
Abandonment	Pessimistic Father
Mistrust/Abuse	Belittling Mother
	Perfectionist Father
Social Isolation	Belittling Mother
	Pessimistic Father
Defectiveness	Belittling Father
	Pessimistic Mother
Failure	Belittling Father
Dependence	Belittling Father
Vulnerability to Harm	Belittling Father
Enmeshment	Overprotective, Perfectionist, Emotionally Depriving, & Emotionally Inhibiting Mother
Subjugation	Controlling & Perfectionist Mother
Self-Sacrifice	Perfectionist Mother
Emotional Inhibition	Controlling Mother
Unrelenting Standards	Perfectionist Mother

	Emotionally Depriving Father
Entitlement	Perfectionist, Pessimistic, & Punitive Mother
	Emotionally Depriving Father
Insufficient Self-Control	Pessimistic Mother
	Belittling Father
Recognition-Seeking	Overprotective Mother
	Emotionally Inhibiting Father
Negativity/Pessimism	Perfectionist Mother
	Belittling Father
Punitiveness	Belittling Father

Source: This figure was developed by the author specifically for the purposes of the present paper

Figure 7: Parenting Experiences That Predicted EMSs

stimuli that reenact the original experiences in one's environment and the more frequent the activation of schemas, the greater the level of emotional disturbance and psychopathology. Accordingly, it could be argued that emotionally depriving, emotionally inhibiting, belittling, and punitive parental characteristics may constitute a challenging experience to the affected child that defines neural architecture, schematic development and consequently cognitive, emotional and behavioural processing that further shape the way the child will experience and cope with life adversities (such as condition-related difficulties).



Source: Benoit, et al. (2009)

Picture 2. *Effects of Early Distressing Situations on Brain Structures*

Left PET Scan: This PET scan of the brain of a child who lives in an emotionally balanced and nurturing environment shows regions of high and low activity (presented in circles). At birth only primitive structures such as the brainstem (center) are fully functional; in regions like the temporal lobes (top), early childhood experiences wire the circuits.

Right PET Scan: This PET scan of the brain of an orphan, who was institutionalized shortly after birth, shows the effect of extreme deprivation in infancy. The temporal lobes (top), which regulate emotions and receive input from the senses, are nearly quiescent. Such children suffer emotional and cognitive problems.

Concluding, the present finding demonstrated that early experiences of parenting have a general effect on maladaptive schemas, as well as some specific etiological linkage. Its value therefore, lays in its ability to explain the possible origins of maladaptive schemas among people with AD. A detailed analysis of the way schemas can impact on overall adjustment to AD follows.

7.2.d. Differences in Adjustment to AD Between Groups

Overall, people with AD presented with high levels of maladjustment and specifically (according to the meanings attached to each of the ACSD scales): a) social anxiety, avoidance and negative self-perceptions (social anxiety scale); b) negative reactions to itching and loss of self-control over scratching (itching-scratching scale); c) perceived loss of control / helplessness over the course of the condition -manifested through hypochondriacal preoccupation with the skin- (helplessness scale); d) high levels of anxiety and depression (anxious-depressive mood scale); and e) social impairment and limitations in life-related domains (quality of life scale) (Stangier et al., 2003). These high levels of physical, psychological and interpersonal morbidity among this population are in keeping with previous studies (e.g. Gupta et al., 1987; Sukan and Maner, 2007; Hughes et al., 1983).

Interestingly, contrary to what has been demonstrated so far by some studies (e.g. Tucker 1987; Williams and Griffiths, 1991; Porter and Beuf, 1988) present findings also revealed that people with AD presented the same level of maladjustment regardless of age of onset of the condition. Further analysis revealed that these levels of maladjustment were strongly and positively associated with EMSs. This latter finding goes in line with an array of previous studies and literature demonstrating a strong association between EMSs and a variety of psychosocial and somatic difficulties [such as: psychosomatic problems (Saariaho, Saariaho, Karila and Jukamaa, 2010), personality disorders (Nordhal et al, 2005), anxiety disorders (Hinrichsen et al., 2004; Atalay et al., 2008;), mood disorders (Harris and Curtin, 2002; Mizara et al., 2012) etc] and further suggests that adjustment to AD is

primarily related to personality-level structures rather than years of coping with the condition.

7.2.e. Relationship Between EMSs & Adjustment

Results revealed that ten out of the eighteen EMSs showed very good patterns of association with each of the five adjustment scales for the combined AD group (Figure 6). Regression analysis revealed that overall adjustment to AD was predicted by: *defectiveness, vulnerability to harm, recognition seeking, failure, pessimism, social isolation, dependence, self-sacrifice, emotional deprivation and enmeshment*. The absence of significant correlations between the remaining EMSs (i.e. abandonment, mistrust/abuse, entitlement, insufficient self-control, subjugation, emotional inhibition, unrelenting standards and punitiveness) and the adjustment scales suggested that these particular EMSs were not (directly) related to adjustment to AD.

7.2.e.i. EMSs & Social Anxiety/Avoidance :

This sub-scale addresses the impacts of a skin condition on a social and self-concept level. Its items refer to emotional (i.e. anxiety), cognitive (i.e. expectation of negative social evaluation) and behavioural (i.e. avoidance) responses in threatening situations that involve the exposure of cutaneous symptoms as well as negative self-perception and perceived stigmatization. Higher scores reveal higher levels of social anxiety, avoidance and negative self-perception (Stangier et al., 2003). This category was predicted in the present study specifically by *defectiveness, recognition seeking, vulnerability to harm and pessimism*.

The finding that shame, need for approval, inability to cope and pessimism were associated with social anxiety has been readily supported. Young (1990; 1999) and Young et al (2003) have argued that the EMS of defectiveness can make a person feel inadequate and flawed in important respects. Both Fox, et al., (2007) and Ginsburg and Link(1989;1993) have argued that the mere presence of AD might reinforce such self-beliefs and amplify feelings of shame. As a result of these negative feelings, the person may become hypersensitive to criticism and rejection, highly self-conscious and also get involved with comparisons that make him/her feel insecure around others (Young et al, 2003). Attitudes and behaviours aimed at avoiding rejection and gaining approval from others (such as: avoidance of interaction, covering affected parts etc) might eventually become a potent method of managing these feelings of inferiority. According to the ST model, over the years, this way of coping might take the form of a separate cognitive construct (i.e. Recognition Seeking) that falls under the category of what Young et al (2003) termed as *conditional schemas*⁴.

The conditional schema of recognition seeking however, enhances social anxiety and fear of negative evaluation as it is unrealistic to be achieved/maintained. This social fear can be specific to situations that involve exposure of affected lesions (e.g

⁴*Conditional Schemas* (Figure 9) can be developed as a function of unconditional ones and hold out the possibility of hope. The person can have a choice in changing the outcome by seeking approval, subjugating, etc. In doing so, he has the option to avert the negative outcome, even temporarily. Conditional schemas are less pervasive and severe than unconditional ones. On the contrary, *unconditional schemas* are more severe, pervasive and involve no hope. No matter what the person does, he/she cannot stop feeling defective/worthless/unlovable etc. (Young, 1990; 1999; Young and Klosko, 1994; Young et al, 2003)

swimming, sexual intercourse etc), or generalized. Some people for example, might misinterpret general –unrelated to the condition- situations as hostile or disapproving. Thus, it is not uncommon for people with these schemas to avoid social situations altogether, as a way of reducing anxiety in the short term. However, avoidance only perpetuates social anxiety as it does not leave any space for disconfirmation of the latent beliefs, while the vicious cycle goes on.

Clark and Beck (2011) further explained that this vicious cycle might further lead to the perception of one's self as subject to both internal (stress and anxiety) and external dangers (social rejection) over which he/she feels has no control. These feelings of vulnerability might be particularly true for people with AD. AD is a condition whose course both affects and is affected by such internal and external threats. A perceived inability to control for these threats therefore, may trigger feelings of vulnerability to the patient that (according to present study's results) further lead to: heightened avoidance of threatening (social) situations; hypochondriacal self-monitoring behaviours; rumination over the threatening emotional and social consequences and constant comparisons with other people (e.g. their skin) or inhibition of spontaneity.

Clark and Beck (2011) described that for the socially anxious person this felt sense of vulnerability is maintained/magnified by certain dysfunctional, cognitive biases (e.g. minimization of positive aspects or personal resources, magnification of negative aspects, catastrophizing etc) that resemble a *pessimistic* way of thinking. Eventually, these negative expectations might end up interacting with the functional impairment inherent in the condition to exacerbate overall symptoms of SA (Erwin, Heimberg, Justern and Mindlin, 2002).

7.2.e.ii. EMSs & Itching/Scratching:

This subscale measures the perceived ability to cope with itching, helpless feelings relative to scratching and perceived impairment as a function of the itch-scratch vicious cycle. Higher scores show higher negative reactions to itching as well as loss of self-control over scratching (Stangier et al., 2003).

The present finding revealed that itching-scratching was exclusively and most strongly predicted by the schema of *Failure*. This finding was of particular surprise as it was originally expected that insufficient self-control would consist a much stronger predictor of this subscale. So far, intervention models on breaking the itch-scratch cycle of AD focus on increasing frustration tolerance/discomfort avoidance (core characteristics of insufficient self-control) by incorporating more steps in between the cycle (i.e. itching and scratching) (White, 2001). However, as the present finding suggests, the vicious cycle of itching-scratching might not be the result of discomfort avoidance/low frustration tolerance per se but rather the outcome of a deeper-level perceived inability to resist scratching that is associated with feelings of failure.

ADJUSTMENT SCALES	EMS THAT PREDICTED ADJUSTMENT	PARENTING EXPERIENCES THAT PREDICTED EMSs

<i>SocialAnxiety</i>	Defectiveness	Belittling Father
		Pessimistic Mother
	Negativity/Pessimism	Belittling Father
		Perfectionist Mother
	Vulnerability to Harm	Belittling Father
	Recognition Seeking	Emotionally Inhibited Father
		Overprotective Mother
<i>Itch-Scratch</i>	Failure	Belittling Father
<i>Helplessness</i>	Defectiveness	Belittling Father
		Pessimistic Mother
	Enmeshment	Overprotective Mother
		Emotionally Depriving Mother
		Emotionally Inhibiting Mother
		Perfectionist Mother
	Recognition Seeking	Overprotective Mother
	Emotionally Inhibiting Father	
	Failure	Belittling Father
<i>Anxious/</i>	Social Isolation	Belittling Mother
<i>Depressive Mood</i>		Pessimistic Father

<i>Quality of Life</i>	Negativity/Pessimism	Perfectionist Mother Belittling Father	
	Self-Sacrifice	Perfectionist Mother	
	Vulnerability to Harm	Belittling Father	
	Failure	Belittling Father	
	Vulnerability to Harm	Belittling Father	
		Perfectionist Mother	
	Negativity/Pessimism	Belittling Father Pessimistic Father	
	Emotional Deprivation	Controlling Mother Conditional Father	
	<i>Source: This figure was developed by the author specifically for the purposes of the present paper</i>		
	Figure 8: EMSs That Predicted Adjustment to AD and Parenting Experiences that		

Predicted EMSs

Unfortunately –to the knowledge of the present author- there is no study investigating the schematic mediators of itching-scratching that could support the

present finding. Eimer and Freeman (1998) though have demonstrated that the specific schema of defectiveness is strongly associated with chronic pain. Itching has been found to have several common features with pain as both emphasize an unpleasant sensory experience (Verhoeven, et al., 2006). However, an important distinction between the two is that chronic pain does not involve a sense of “ought to be controlling the condition”. People with chronic pain might perceive themselves as defective simply because there is something “wrong” with them that *they are not expected to and cannot control* whatsoever. On the other hand, people with AD *are expected* by their immediate (e.g. family) and surrounding environment (e.g. social network, medical professionals etc), as well as by their own selves, to adhere to a core restriction: *to not scratch*. Inability to control emotions and itching-scratching might be attributed by the sufferer (or his environment) to a personal failure that throughout the years might take the form of a self-defeating cognitive construct. This process might then operate in a vicious destructive loop. In such a framework, the EMS of failure might be foundational and influence the development and maintenance of itching-scratching.

7.2.e.iii. EMSs & Helplessness:

This subscale refers to perceived loss of control over the course of the condition and specifically: recurrence of red rashes, anticipation of spreading of lesions and hypochondriacal preoccupation with the disease. Higher scores reflect higher levels of helplessness (Stangier et al., 2003).-Helplessness was predicted by *defectiveness, recognition seeking, failure and enmeshment*.

The finding that helplessness was predicted by feelings of being flawed and inadequate can be explained by Abramson, Seligman and Teasdale's (1978) suggestions relative to the existence of two different types of helplessness: a) *universal helplessness* and b) *personal helplessness*.-The former type refers to the belief/expectation that the course of an event is independent of one's own responses or the responses of other people.-The later type refers to the belief that one does not possess the appropriate abilities to change the course of the condition. The person in the given situation believes that there are responses that could contingently change the course of a condition but that *he/she does not possess them*.

With regards to AD, unlike other medical conditions that are more stable and/or gradual in nature (e.g. diabetes etc), AD interchanges between periods of remissions and sudden-and/or intense exacerbations (Walker and Papadopoulos, 2005).This might lead people to develop the expectation that the course of AD can be controlled under certain –while unknown to the person- circumstances and attribute instances of uncontrollability to their own self. Apparently, this perceived sense of inability and helplessness might further lead to negative expectations relative to independent functioning and to a perceived need for constant support (enmeshment) and approval (recognition seeking).

Unconditional Schemas	Conditional Schemas
Abandonment/Instability	Subjugation
Mistrust/Abuse	Self-Sacrifice
Emotional Deprivation	Approval-Seeking/Recognition-Seeking
Defectiveness	Emotional Inhibition
Social Isolation	Unrelenting Standards/Hypercriticalness
Dependence/Incompetence	
Vulnerability to Harm or Illness	
Enmeshment/Undeveloped Self	
Failure	
Negativity/Pessimism	
Punitiveness	
Entitlement/Grandiosity	
Insufficient Self-Control/Self-Discipline	

Source: Young et al (2003), p. 22

Figure 9: *Unconditional vs Conditional Schemas*

7.2.e.iv. EMSs & Anxious/Depressive Mood:

This subscale measures emotional and physical symptoms of anxiety and depression in coping with the emotional distress of the condition. Higher scores indicate high anxious/depressive symptoms (Stangier et al., 2003). The EMSs that were found to predict anxious/depressive mood among people with AD were: *dependence, social isolation, pessimism, self-sacrifice and vulnerability to harm*. This finding suggests that perceptions of self as incompetent, different, vulnerable and in need of others determine the level of anxiety and depression among people with AD.

The role of these specific EMSs on depression and anxiety has also been demonstrated by previous studies. Schmidt, et al., (1995) for example, demonstrated that dependency and defectiveness were significantly associated with depression, while Hoffart, Sexton, Hedley et al. (2005) found that defectiveness, social isolation, dependence, vulnerability to harm and failure –among other schemas- explained up to 53% of the variance in depression severity in a sample of depressed population. Additionally, Beck et al (1985) and Clark and Beck (2011) have argued that defectiveness, pessimism and vulnerability to harm constitute the three core maladaptive beliefs in anxiety disorders.

7.2.e.v. EMSs & Quality of Life:

This subscale refers to social impairment and limitations in life-related domains like: professional, familial, nutritional and financial. Higher scores indicate more restrictions in overall quality of life (Stangier et al (2003). This subscale was

predicted in the present study by *failure, vulnerability to harm, pessimism and emotional deprivation*.

Generally, it has been found that everyday skin-related hassles like: itching-scratching, sleeping problems, absences from work/school, financial costs, types of treatment, hospital appointments etc (Picardi, et al, 2000), as well as anxiety, depression and low self-esteem lead to the reduction of pleasurable activities (e.g. gym, swimming, holidays etc), psychosocial difficulties (e.g. social withdrawal, loss of social support etc) and overall life dissatisfaction (Jowett and Ryan, 1985).

Even though no study so far has investigated the role of EMSs on QoL, some evidence exists demonstrating that reduction in pleasurable activities and overall QoL can actually be mediated by cognitive structures (core beliefs/schemas). Specifically, Judge, Locke, and Durham (1997) argued that people who hold negative evaluations about themselves (e.g. failure) will cope with everyday life adversities (e.g. job responsibilities) quite differently than those who believe that they are more competent. Similarly, people who consider others to be fundamentally untrustworthy or emotionally unresponsive (emotional deprivation) or the world to be a dangerous place (vulnerability to harm, pessimism) will view and cope with their life matters (e.g. job, family, financial matters etc) in a much less positive way than those with the opposite premises.

Summarizing, people with AD were commonly presented with psychosocial and physical morbidity. This morbidity was not determined by age of onset but was rather associated with certain EMSs. Altogether, these findings suggest that adjustment is not determined by years of coping with the condition but rather by deeper-level personality structures. By directing perceptions and coping behaviors,

personality structures (self-schemas) create meanings that shape the whole experience of AD and consequently adjustment to it.

7.3. Implications for Counselling Psychology (CoP)

The fact that some people with AD are presented with a variety of psychosocial difficulties in adjusting to their condition is increasingly recognized. At the same time, there seems to be a bidirectional link between psychological distress and course of the condition (Papadopoulos et al., 1999). Thus, it is obvious that psychological work has an important role to play in helping people adjust to this condition on both an emotional and a physical level.

So far, studies on the effectiveness of psychological interventions on chronic skin conditions, have used a variety of different approaches (e.g. Hughes, et al., 1981; Waxman, 1973; Bar and Kuypers, 1973; Gaston, Crombez and Dupuis, 1989 etc). However, CBT has been characterized as the most effective in dealing with disease severity and psychosocial sequelae and has been used as an adjunct to standard pharmacological treatment (e.g. Fortune, et al., 2002; Ehlers et al., 1995). Specifically, traditional CBT protocols employ directive cognitive and behavioural techniques aimed at improving social and problem solving skills, coping with itching-scratching, balancing body image perception and managing overall condition-related distress. Nevertheless, according to both Main et al., (2000) and Mizara et al., (2012), improvements on the psychosocial impacts of AD through the use of standardized CBT protocols have only been observed on anxiety levels rather than depression, suggesting that CBT has not been specifically tailored to the individual needs of this population.

The present study demonstrated that the presented difficulties among this population are actually permeated much deeper than skills deficits and symptom mismanagement. Specifically, current psychological disturbance and adjustment problems in this group of people was found to be mediated by chronic emotional difficulties that have their roots in childhood experiences and life-long interpersonal problems and define the current (condition-related) phenomenology of the person. As such, even though AD is a medical condition, effective therapy with AD does not necessarily require a purely clinical or symptom-oriented work but rather an emphasis on dynamics like *personality-level structures, patterns of relatedness* and the overall *emotional reality* of the person.

This conceptualization not only denotes the reason why CoP could be considered as the most effective discipline in dealing with the individual needs of the AD patient [CoP constitutes an ever-changing discipline that meets the individual needs of clients in a holistic way emphasizing the *self* instead of the symptom and remaining abreast with developments (Gladding, 2001)], but also highlights the need for specialization in counselling people with chronic skin problems and specifically AD. Unlike other disciplines that maintain a more biomedical or even pathologizing approach (like clinical psychology), CoP's emphasis on the *reflective-practitioner* approach and the *therapeutic relationship*⁵ lends itself very well to the specific needs of this population.

⁵ According to Ball et al., (2003), the establishment of a strong therapeutic relationship operates as an *antidote* towards the person's early toxic experiences and constitutes the core element of schema healing

Drawing upon the obtained schematic profiles therefore, counselling psychologists can help people with chronic skin problems gain an insight to the core emotional needs that were frustrated during their early years of life, and the ways these unmet needs influence the current life of the person (along with the course/progression of the condition). Acquiring an understanding into the origins and perpetuation of current difficulties is important as it can help one to get an overall sense of direction. However, as Hartman and Zimberoff (2004) have argued, merely remembering or gaining an insight into the effects of an intimidating or demoralizing situation does not necessarily change the effects of such an experience and thus does not contribute to a wholistic resolution of difficulties. Effective therapy with life-long, personality-level problems should also involve the re-experience of these past events and the venting of suppressed emotions. Hartman and Zimberoff (2004) further argued that this can only be achieved through the establishment of a strong therapeutic bond. For it is only the undoubtable reality of the *therapeutic relationship* and the corrective emotional experience that this bond constitutes to the person, that can undo the effects of previous experiences and lead to what Young et al (2003) defined as schema healing⁶. Such structural changes can then lead to cognitive and/or behavioural changes and facilitate the person to resolve difficulties in current life (and sub-consequently adjust to AD). Present findings on maladaptive schemas and patterns of early experiences of relatedness among people with AD confirm the importance and nature of *relating* to this population and the need to work therapeutically on this level. Specifically, shame,

⁶Schema Healing: It involves diminishing the set of memories, emotions, bodily sensations and cognitions associated with the schema. It also involves behavior change. As schemas heal they become increasingly more difficult to be activated and when it becomes activated the experience is less overwhelming (Arntz and Jacob, 2013)

inexpressiveness of emotions and social avoidance constituted characteristic ways of relating with others. Drawing upon these patterns of relatedness therefore, therapists can be informed better about the nature of the (counselling) relationship that needs to be established with this specific group of people in order to promote therapeutic outcome.

Finally, obtained results might contribute to the development of tailor-made therapeutic interventions that have a proactive nature in facilitating adjustment to AD and aim at the early family level. Specifically, drawing upon the obtained reports of parenting experiences and self-schemas, therapists working with affected families can be facilitated in addressing not only the emotional and practical needs of the affected child, but also the individual needs of parents as well as the needs of the family system as a whole and enhance effective communication between its members. Studies exist (e.g. Daud, et al, 1993) demonstrating that interventions on a family-level, and specifically on the parent-child relationship, lead to improvements in both skin condition and behavioural difficulties. Some schema-focused interventions aimed at enhancing the parent-child communication and family's adjustment to AD, are presented in Figure 10

Concluding, the link between theory and practice has always been an important one in CoP (Strawbridge, Woolfe & Dryden, 2009). This work provides support on how important it is that the nature of CoP remains that of scientist-practitioner. Present findings also demonstrate how important is look at the person behind the condition and put (medical) labels aside, to reflect on the psychological processes of the person presented with AD and to lay the ideology of such values in the core of clinical practice. This work also tried to provide the basis for establishing

personalized, schema-driven treatment protocols that could efficiently meet the needs of AD patients by conceptualizing them in accurate and relevant ways. One more implication of the present study to CoP therefore, is the revelation of the need to assimilate new routes within the practice of the discipline towards achieving an improved wholistic management of people with AD, but also within the training of counselling psychologists.

7.4 Limitations of the Present Study

7.4.a. Limitations

Even though the present study attempted to avoid methodological shortcomings, certain limitations need to be taken into account when considering the results.

The first limitation was related to the sample size of the present study's groups. Specifically, the early onset group outnumbered the late onset and the control groups in terms of participants number. Unfortunately, certain factors such as: a) limited availability of people with a late onset (the vast majority of affected people have an early onset); b) slow response rates; and c) time frame, precluded having equal sample sizes among the three groups. However, the fact that the early onset group had a larger sample size than the late onset and the control groups did not appear to affect the statistical significance of the present results since each of the three groups had enough participants to make results meaningful.

Obtained Parenting Styles	Suggestions for Working with Parents	Obtained Associated Schemas	Suggestions for Working with Children
Emotionally Depriving	<p><u>Train parents to:</u> focus on the emotional needs of the child and avoid focusing exclusively on the condition-related ones; avoid over-emphasizing overall performance on condition management; model a more concern-free attitude [e.g. spend more time (with their child) on activities for fun]; avoid using overly strict rules over family and condition-related matters; avoid emphasizing their own (condition-related) concerns over that of the child's.</p>	<p>Enmeshment Unrelenting Standards Entitlement</p>	<p><u>Train the child to:</u> directly ask for getting emotional needs met without using indirect strategies (e.g. clinginess, persistent crying, withdrawal, withholding of negative feelings); be spontaneous but respectful of family or condition-related restrictions; express affect adequately; spend more time on activities for fun.</p>
Belittling	<p><u>Train parents to:</u> manage their anger; establish more realistic expectations of both themselves and of their child (relative to condition or life matters); use positive and negative reinforcement in order to control desired/undesired behavior and set limits that protect</p>	<p>Mistrust Defectiveness Social Isolation Failure Dependence Vulnerability to Harm Insufficient Self Control Pessimism</p>	<p><u>Train the child to:</u> abandon strategies aimed at avoiding disappointment/rejection (e.g. lying, keeping secrets, seeming perfect, etc); strengthen his sense of self-worth and ability to protect his own self (e.g. condition</p>

Emotionally Inhibiting	<p>rather than punish the child; offer positive feedback more often; offer negative feedback without criticizing the child; demonstrate unconditional love; avoid causing to the child feelings of guilt (e.g. blaming or punishing the child) relative to condition flare-ups or not adhering to treatment regimes</p> <p><u>Train parents to:</u> become more emotionally expressive and accepting of the child's spontaneous emotions; engage more in fun activities with their child;</p>	Punitiveness	<p>management, problem solving and social skills training); develop good organizational skills, set realistic goals and prefer these over procrastination or withdrawal; generate alternatives of worried outcomes; recognize one's own emotions and develop affect regulation skills (e.g. anger management, frustration tolerance);show empathy and understanding of other people's mistakes.</p>
	<p><u>Train the child to:</u> become more autonomous (e.g. self management, problem solving, social and assertiveness skills training); develop a sense of self as more authentic without having to suppress personal</p>	Enmeshment Recognition Seeking	

Punitive	<u>Train parents to:</u> manage their anger and low frustration tolerance; demonstrate forgiveness and understanding of mistakes that are not too serious or immoral; empathize with the child's feelings	Entitlement	emotions and natural inclinations for the sake of gaining approval. <u>Train the child to:</u> manage aggressive feelings; respect rules and others peoples' feelings; feel empathy and concern for others; be more assertive of their own needs; maintain a realistic understanding of personal strengths and weaknesses
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Source: This figure was developed by the author specifically for the purposes of the present paper

Figure 10: *Suggestions of Family-Level Interventions for Enhancing Parent-Child*

Communication and Psychosocial Adjustment to AD

In addition, the three groups differed in certain demographic characteristics like: age, gender, marital status, educational and ethnic background etc. It could be argued that adjusting these variables might have revealed different results as it is possible that they constitute important mediators of schemas, early parenting experiences and adjustment problems. Nevertheless, previous researches have demonstrated that demographic characteristics add little to our understanding of variability in adjustment to AD (Fortune et al., 2002).

The cross-sectional design of the present study constitutes one more important limitation that precluded drawing conclusions relative to causality and direction of relationships. The identification of certain variables that were linked to adjustment problems (i.e. schemas) or schema development (i.e. early parenting experiences) for example, only permits descriptions of the associated factors of the outcome rather than cause-and-effect relationships. Despite this difficulty though, results offer a good level of analysis, specificity and clarification as to the possible links between variables and the contribution of these links to overall psychopathology (maladjustment).

Another limitation that needs to be considered is the use of a quantitative -rather than a qualitative- approach that prevented the identification of any other possible issues or core themes related to the way AD patients experience their self with (or without) the condition and cope with it. However, according to Hermans and Lyddon (2006), a quantitative analysis also includes tools for stimulating the process of meaning construction and development. The selection of the specific questionnaires used in the present study was based on the fact that they both require participants to go back in their past and explore how early experiences contributed

to the development of core psychological themes that stimulate the process of meaning construction in their present life. Thus, even though a qualitative analysis might have permitted greater clarification with regards to the phenomenology and response of the person, it is argued that at this preliminary stage of investigation, the use of a quantitative design also permitted a significant level of exploration relative to the emotional and motivational features of people's experiences and the identification of narrative themes.

Lastly, one more important limitation of the present study is its retrospective nature wherein peoples' reports of parental childrearing styles were associated with measures of adult personality characteristics. According to Furnham and Cheng (2000) such retrospective studies may be subject to a number of potential biases. The first bias is memory bias that might contribute to false reports of parenting experiences. However, the present study was not interested in the objectivity but rather in the *subjectivity* of early memories. According to Young (1990; 1999), subjective memories –even if biased- are the ones that define the current phenomenology of the person. Thus, subjectively biased memories of early parenting experiences were considered as more important in the present study, than objective descriptions.

The second bias is related to the impact of the child's personality on parental styles and the overall parent-child relationship instead of the reverse (Furnham and Cheng, 2000). Unfortunately, it was not easy to control for this type of bias in the present study. However, it is argued that since the interaction between children's personality and parenting styles is circular and mutual in nature (Thoma, 1980), and since the emotional disturbance caused by this mutual interaction has been

considered as an important co-factor in the chronification of the condition (Roos, 2004), then the identification of parenting styles and interventions aimed at this level will unavoidably bring structural changes in the personality of the child and consequently the course of AD, regardless of whether the child's personality preceded parenting styles or vice versa.

The third bias of retrospective studies is related to participants' concern of social desirability that might induce them to be less self-critical and minimize reports on any personality characteristics or early parenting experiences (Furnham and Cheng, 2000). This last bias was minimized in the present study by ensuring total anonymity to participants thereby reducing their need to be socially desirable.

Finally, a possibility exists that there was a certain level of selection bias that might have confounded results. Specifically, participants in the present study were recruited through certain eczema groups or associations. This indicates that most of the people who participated in the present study were either members of these organizations or visited their web sites on a regular basis, and thus they were most probably highly motivated in keeping themselves updated about their condition and receiving social support. Having recruited less motivated and socially supported participants might have brought different results in terms of early experiences, self-schemas and perhaps levels of maladjustment. Nevertheless, this often presents an issue with research of this nature as it is difficult to persuade less motivated people to participate in such a study in the first place.

7.4.b. Conceptual Limitations of the Present Study

Even though the present study's findings may contribute to an understanding into the origins and perpetuation of adjustment problems among people with AD and consequently into therapeutic advancements, it is important to pinpoint on the fact that they also run the risk of being misinterpreted as either accusatory or victimizing and lead to the development of stigmatizing biases relative to: a) the role of parental child-rearing attitudes on the psychological and physiological well-being of the child and b) one's own responsibility in overcoming adjustment difficulties

Specifically, the finding that people with AD tend to share certain early parenting experiences that contributed to the development of schemas which further impacted on adjustment difficulties, might be misinterpreted as an indication that parents are the ones to be blamed for the development of physiological and psychological difficulties in affected children or that people with AD cannot exert any control over these difficulties as they cannot control experiences of the past.

However it is important to clarify that the present study conceptualizes parenting experiences and schemas as an adding –rather than a causal- factor in the presentation of adjustment difficulties among people with AD. It is argued that the development of schemas and adjustment difficulties among people with AD constitutes a multi-factorial process that revolves around many different factors (such as cultural and societal values, life experiences/adversities, resilience factors etc.) and are not solely defined by parenting experiences. This can be further supported by the fact that even though regression models demonstrated a strong

relationship between parenting experiences and schemas, parenting experiences explained only a limited percentage of the variance in the development of EMSs (the highest being 9.8% of the variance in SI and 10.2% in EM). The rationale behind focusing on early parenting experiences –out of the many factors that may define schema development and adjustment problems- lays on the following arguments: a) according to personality development theories, parenting experiences play a proximal (yet not a defining) role; and b) any knowledge derived from exploring this factor can be readily utilized by professionals in the field of counseling psychology for the development of therapeutic as well as preventive interventions.

7.4.c. Researcher's Personal & Methodological Reflexivity

Certain measures were taken in order to control for possible biases from the researcher's own presence in the research process. These were: a) employing standardized self-report questionnaires, b) ensuring anonymity of participation and b) providing information sheets that explained the rationale and purpose of the present study.

Nevertheless, the researcher's impact on the overall research process goes far beyond these measures. Interpretation of findings for example, as well as construction of meanings is absolutely linked to the researcher's own expertise on the topic under investigation and his/her subjective beliefs, expectations and feelings (Seale 2004). Being able to reflect on these aspects constitutes one of the core features of the scientist-practitioner paradigm, within the discipline of CoP, and needs to become part of the overall analysis in order to enhance researchers' integrity and consequently good therapeutic practice (Brewer 1994). In the present

study a) supervision b) discussions with other professionals (e.g. statisticians, other Counseling Psychologists, dermatologists etc) and c) been kept up to date with latest studies, were used as methods of self-reflection and perspective-broadening in order to ensure integrity of ideas offered.

During the process of this study I tried to be as mindful as possible of the many issues that may have arisen for my participants and my role as a researcher. I am a thirty-five-year-old Caucasian European woman who was born and raised in Greece and who has lived five years of her life in London, from the ages of 27 to 32. I have worked within the field of both Adult and Child Mental Health in various capacities for approximately the last eleven years. I am currently working as a CBT lecturer in a Greek College and as a mental health practitioner for a Greek organization for people with psoriasis where CBT is predominantly offered as the standard evidenced-based treatment. Throughout my counselling psychology training I had the opportunity to obtain a certain level of theoretical and practical experience on different therapeutic disciplines. Working as a trainee counselling psychologist at a Primary Care setting for example, I had the opportunity to get supervision from a clinical and counselling psychologist with a CBT orientation who emphasized therapeutic content. My supervisor at the Secondary Care setting (where I was also working as a trainee counselling psychologist) had a counselling psychology background and a schema-focused orientation and placed particular emphasis on therapeutic processes. My personal therapy has ranged from a combination of CBT and schema-therapy, to a combination of person-centered and Gestalt therapy. Lately, I have been undergoing clinical hypnotherapy on both a personal therapy and a training level. Therefore, my theoretical orientation has been informed by my

counselling psychology training, my experience of working in the NHS, my personal therapy as well as my personal values and experiences in life. This has led me to favor humanistic and systemic ideas in both clinical practice and research.

My professional interest in researching personality structures and adjustment processes among people with AD comes from several years of working within a psycho-dermatology department in a Secondary Care setting. I have observed whilst working there that people with AD were presented with particular difficulties in managing their condition as well as increased levels of psychopathology. As it has been argued, the mere presence of the condition is enough in itself to cause a significant level of psychological disturbances and dysfunctionality in a patient's overall life. Due to the psychosomatic nature of the condition, these disturbances hinder condition management and overall adjustment as the person gets trapped into a vicious cycle (Thompson 2005). However, I also observed that psychopathology and maladjustment among this population was presented irrespective of condition severity, visibility and years of coping (i.e. age of onset). This observation led me to assume that the presentation of psychological difficulties among people with AD might not be necessarily related to the presence of the condition per se but might actually be linked to deeper-level personality aspects that pre-exist its development. The investigation of this possibility became a strong interest for me.

At a deeper motivational level though, what has driven me to investigate the link between physical symptoms (i.e. AD) and psychological processes has been my personal experiences, overall attitude in life as well as my theoretical orientation. As a person, I always had the need to develop networks of inter-linked

pieces of information in my mind that facilitated meaning construction. Even as a child, for example, I would spend many hours just trying to understand the way a radio produced sound. I would disassemble every little piece of a radio and assemble it back again in order to develop a structured understanding of the contribution of each piece in the operation of the whole radio-system. This tendency led me to conceptualize the contribution of many different factors in the development of a specific outcome. It also defined my training as a CBT therapist.

CBT has been extensively described as a structured, symptom-oriented therapy. This training allowed me to gain hands-on experience into the overt expression (symptoms) of different psychological problems and go one step deeper into the covert processes (like cognitions) that perpetuate these problems. Throughout my practice as a CBT therapist at the psycho-dermatology department, I experienced the significant role of cognitive and behavioural factors in the development and treatment of psychological and physiological (i.e. dermatological) morbidity (decreased condition exacerbations). Nevertheless, there were many occasions that I witnessed an emotional problem getting transformed into a different one while addressed exclusively on a cognitive-behavioural level, or persisting regardless of the amount or strength of the cognitive-behavioural interventions that were employed. Specifically, many times I witnessed a client coming out of his/her depression but be presented with panic attacks after a while; or relapse into depression after some period; or even be presented with therapy-resistant characteristics that hindered the overall progression of therapy. This led me to realize that there might be more factors (i.e. deeper-level emotional processes) implicated in the development of psychopathology and maladjustment among

people with AD -that actually mediate the more surface ones (i.e. cognitive-behavioural)- and develop an interest in investigating this possibility. My decision to utilize principles of ST into the conceptualization of adjustment problems among AD patients was based on the fact that ST belongs in the second wave of CBT approaches. Thus, ST involves a certain level of structure that matches with my subjective way of conceptualization and meaning construction. Contrary to CBT though, ST is heavily based on deeper-level emotional processes and aims at the expression of these processes.

Prior to undertaking this study, I was concerned and expected that people with AD would not be willing to participate. This expectation was based on: a) the level of frustration and resentment that I had witnessed among AD patients -whilst working in the psycho-dermatology setting- towards (medical) professionals; and b) a pilot investigation that I conducted on affected peoples' attitudes toward other research studies on AD. This investigation involved visiting certain AD e-blogs, where previous researchers had advertised their studies, and observe patients' responses/comments and participation rates. My observations from that investigation were that: a) the rate of patients' participation in most of those studies was very low; and b) the comments that many patients wrote with regards to most of those studies were mostly negative. However, a closer observation revealed that participation rate and negativity of comments was associated with the phrasing that each advertisement employed. Specifically, phrases like: *skin disorder, find a cure* and *get rid of AD* etc. were associated with lower participation rate and more negative comments compared to phrases like: *skin condition, I need help with my study* etc. It is possible that affected people's negative attitude was not generalized

but probably aimed towards specific situations that were perceived (by affected people) as overly promising or patronizing. As it has been well documented, there is no cure for AD as yet and clinical symptoms can only be managed instead of treated (Papadopoulos and Walker, 2003b). For people that have suffered the unpredictable/uncontrollable, disfiguring and painful nature of the condition, such overly promising or patronizing messages might run the risk of being confronted with resentment.

That assumption defined the way I phrased and structured the present study's ad. I decided to simply present a brief summary of the purpose (i.e identify how people adjust to eczema), the inclusion criteria, the ethical considerations and the credentials of the supervisors of the present study. My feeling was that that approach would be as clear, concise, realistic, ethically sound and professional as possible.

I was surprised to discover that participants were very willing to participate in the present study and that there was a very small drop-out rate, as I had expected that participants would resent the idea of participating in an almost half-an-hour study. In retrospect, I understand that my surprise and the overall way of dealing with this concern might have been influenced by stereotypical notions regarding AD patients' attitudes towards (medical) professionals that I developed whilst working in a medical setting.

Whether the high participation rate in the present study constituted the result of the phrasing that I used in the study's ad or the result of other factors is not really clear. It could be that the mere purpose of the present study (i.e. how people adjust to eczema) communicated an interest in identifying ways that could facilitate

coping with the condition instead of ways of curing or getting rid of it; which might have been perceived by people with AD as more realistic or less promising and directed attention towards different paths of dealing with AD. Additionally, it could be that having to complete questionnaires that did not revolve around a clinical, symptom-oriented model -but rather required participants to go back in their past and explore the contribution of past experiences in the development of core psychological themes in their present life or refer to the ways that AD has affected their current overall quality of life- might have operated as a means of shifting the focus away from diagnostic labels into a wholistic perception of one's own personality. This might have contributed to the low drop-out rate.

Reflecting back on the analysis, I acknowledge the possibility that the interpretation of results may have also been influenced by my own perspective and my own theoretical orientation. The present study's conceptualization of adjustment problems among people with AD was based on ST's perspective. ST posits that early experiences -and particularly experiences with significant others (i.e. parents) - constitute the most crucial parameter in the development of emotional and schematic processes. In retrospect, I realize that this position defined the emphasis I placed on the finding that early parenting experiences were associated with the development of emotional schemas and the under-emphasis that I placed on the finding that these experiences explained only a small percentage of the variance in schematic development [which means that there might be more factors (other than early parenting experiences) implicated in the development of schemas). I became conscious towards the later stages of the research process that the defining role of early parenting experiences on schematic development had become an a priori truth

for me. Discussing this issue with other professionals (i.e. supervisors, colleagues etc) though, was used as a method of self-reflection and perspective-broadening.

7.5. Future Research

The present study demonstrated that certain parenting experiences among people with AD, might contribute to the development of particular schemas that can further lead to condition maladjustment and perhaps even create a vulnerability to the development of the condition itself. It also presented the specific ways that maladaptive schemas correlated with disease-specific disability and maladjustment.

Nevertheless, it is acknowledged that much more research is needed in order to unravel the precise ways that early parenting experiences contribute to schema development and schemas manifest themselves and hinder adjustment to AD. Therefore, future research would be advisable to employ: a) longitudinal designs that could contribute to a better assessment of the possible variables that might have mediated/moderated these relationships and provide more reliable causal information; and b) qualitative work that could contribute to a more in-depth investigation of the core cognitive themes linked to the experience of adjusting to AD.

Moreover, according to Koo and Lee's (2003) latest taxonomy system of dermatological conditions, most cutaneous diseases – except from the ones that are self-induced- are also classified as psychosomatic and are considered to be influenced by patients' emotional states. Given this classification, future work should also investigate the degree to which the present study's results relative to the role of schemas on adjustment to AD could be generalized to other psychosomatic

dermatological conditions (e.g. acne, psoriasis, vitiligo etc). Such a possibility would open new horizons to the conceptualization and treatment of dermatological conditions.

Finally, future research needs to investigate the possible therapeutic effects of tailored schema-level interventions on the psychological adjustment of patients and their families (in case the afflicted is a child) and on the overall course of the condition. Specifically, it would be interesting to explore the impact of such interventions on variables such as: adherence to treatment, frequency of medical consultations, condition flare ups and disease severity and management of psychological symptoms. Such treatment outcomes would promote the importance of incorporating psychological work in the overall treatment of the AD patient and would advocate for the need of holistic care of these patients.

7.6. Summary & Conclusions

This study was designed to test the concurrent relationship between retrospective reports of early parenting, current schemas and endorsement of adjustment difficulties among people presented with AD. Results were really intriguing. Comparisons between groups and regression analyses converged to point out: a) the importance of certain schemas in the experience of AD and adjustment to it and b) the impact of early parenting experiences on the AD patients' cognitive (and perhaps physiological) vulnerabilities and underlying schemas that further impact on their overall ability to cope and consequently adjust properly to the condition.

These results suggest that adjustment to a chronic skin condition is mediated by personality-level factors rather than years of coping with the condition or other

condition-related dimensions. In fact, the presence of the condition can be conceptualized as an additional environmental influence that acts to reinforce already existing personality/schematic-structures rather than contribute to their development.

Additionally, it is argued that the role of early parenting experiences and schemas in adjustment to AD is circular. Not only certainly early experiences might increase a person's vulnerability to the development of certain schemas that further contribute to the perpetuation (and probably even the manifestation) of the condition (mainly due to its psychosomatic nature), but also the chronic, unpredictable, painful and disfiguring nature of the condition might produce a phenomenology that is consistent with the same early experiences and schematic constructs that are considered to be predisposing.

Recognizing the ways by which AD relates to the identity of the patient and how this relationship can affect the course of the condition and adjustment to it, is of utmost importance for counselling psychologists, and mental health professionals in general, in order to adequately address the complex needs of this population and ensure therapeutic integrity. The suggested integrative schema-level conceptualization of adjustment to AD contributes to current knowledge basis of counselling psychology and opens new possibilities in developing tailor-made therapeutic interventions that will be more effective in addressing psychological distress (or even AD symptomatology), than general symptom-driven treatment protocols, and lead to condition management.

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Figure Captions

Figure A: *Mean percentage of age and years in education as a function of group condition*

Figure B: *Mean percentages of gender, marital status and ethnic background as a function of group condition*

Figure C. *Mean scores of adjustment subscales as a function of age of onset*

Figure D. *Mean scores of YPI-R subscales for mothers as a function of group condition*

Figure E. *Mean scores of YPI-R subscales for fathers as a function of group condition*

Figure F. *Mean scores of YSQ-S3 subscales as a function of group condition*

Figure A. Mean percentage of age and years in education as a function of group condition

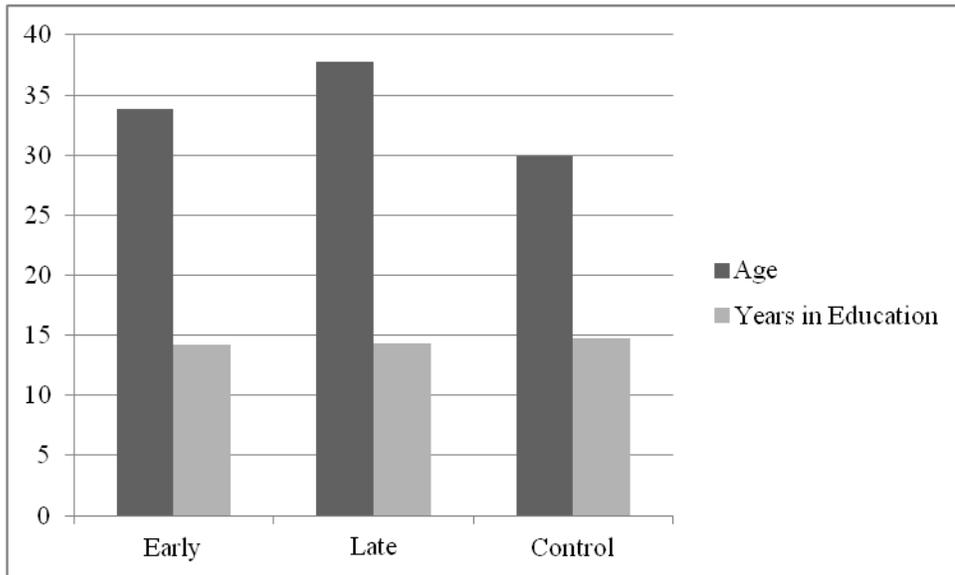


Figure B. Mean percentages of gender, marital status and ethnic background as a function of group condition

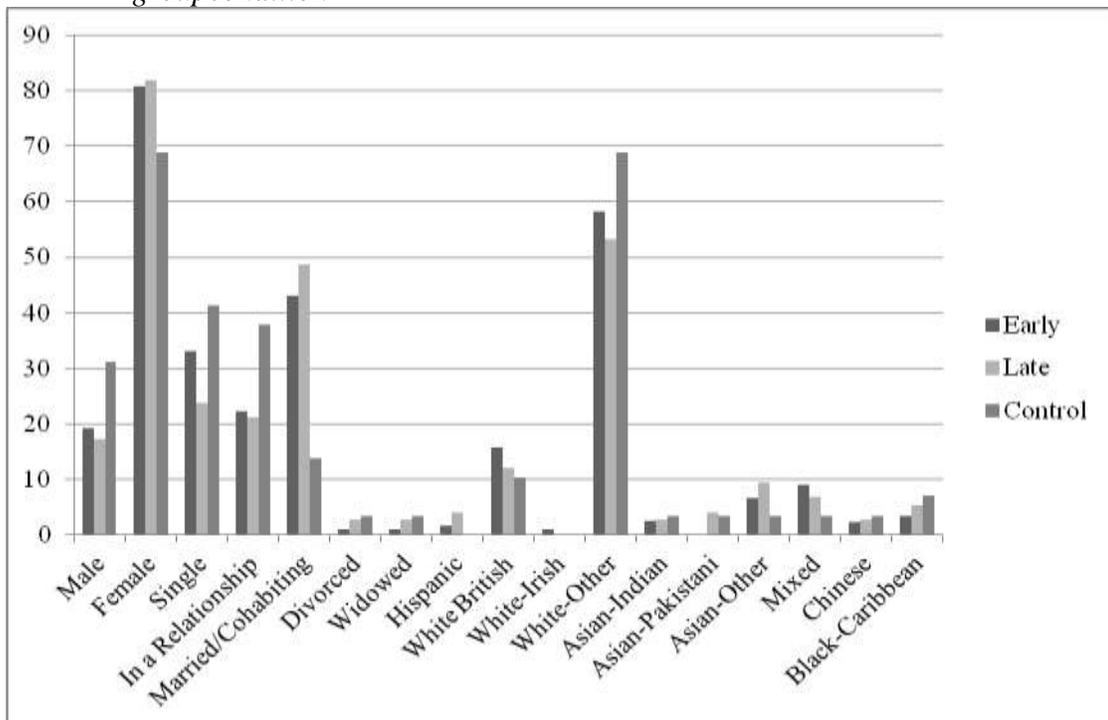


Figure C. Mean scores of adjustment subscales as a function of age of onset

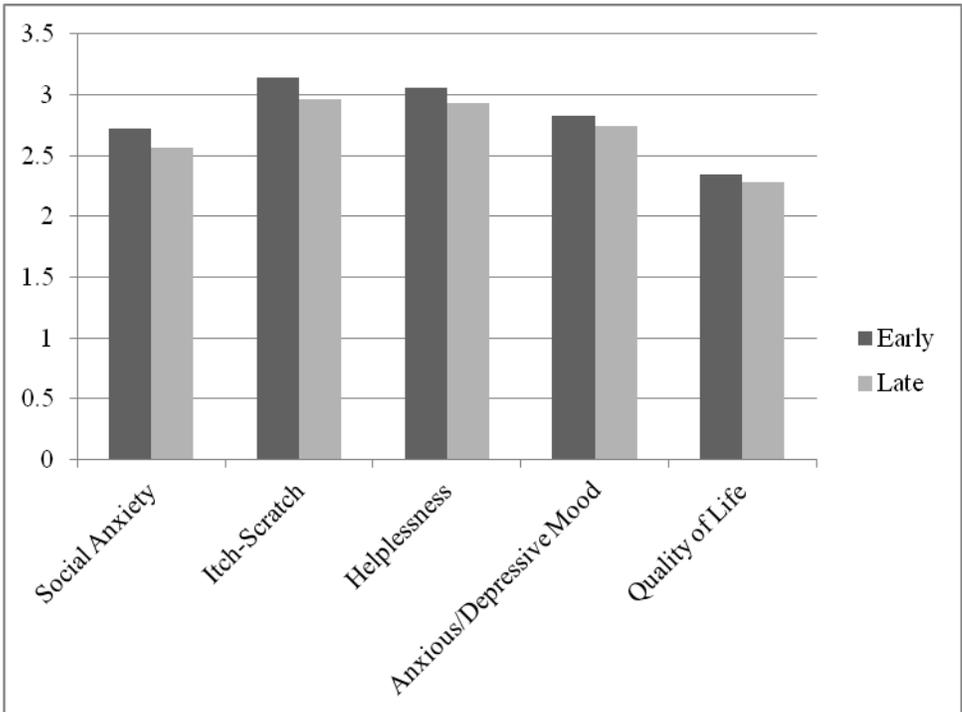


Figure D. Mean scores of YPI-R subscales for mothers as a function of group condition

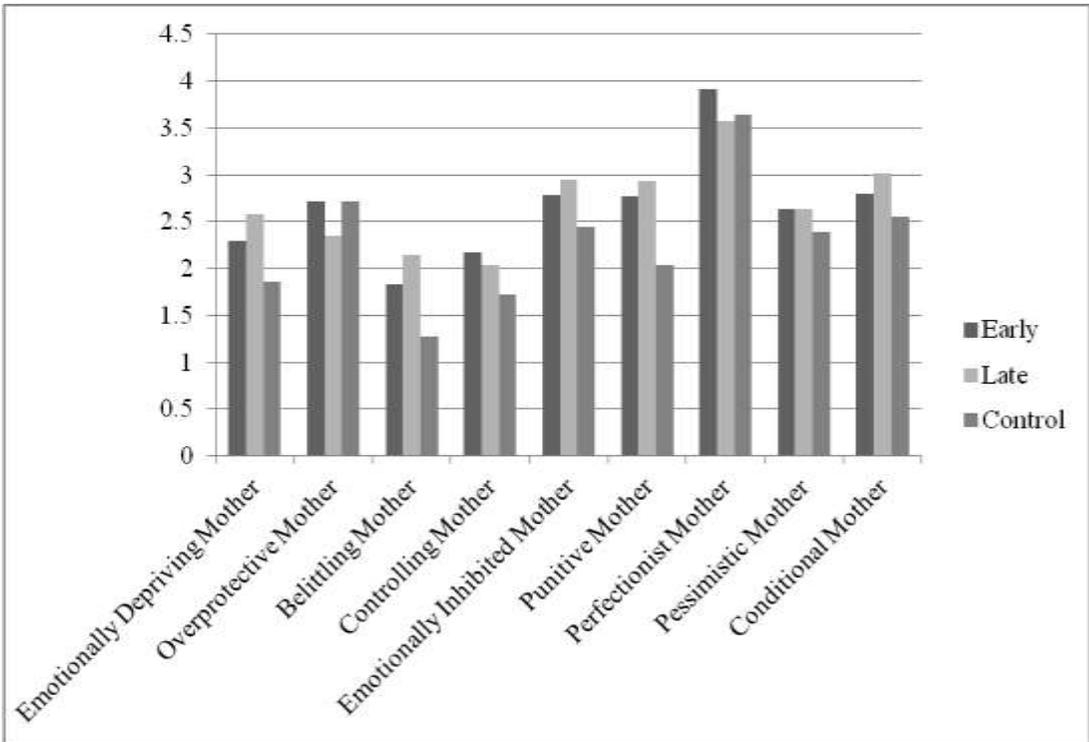


Figure E. Mean scores of YPI-R subscales for fathers as a function of group condition

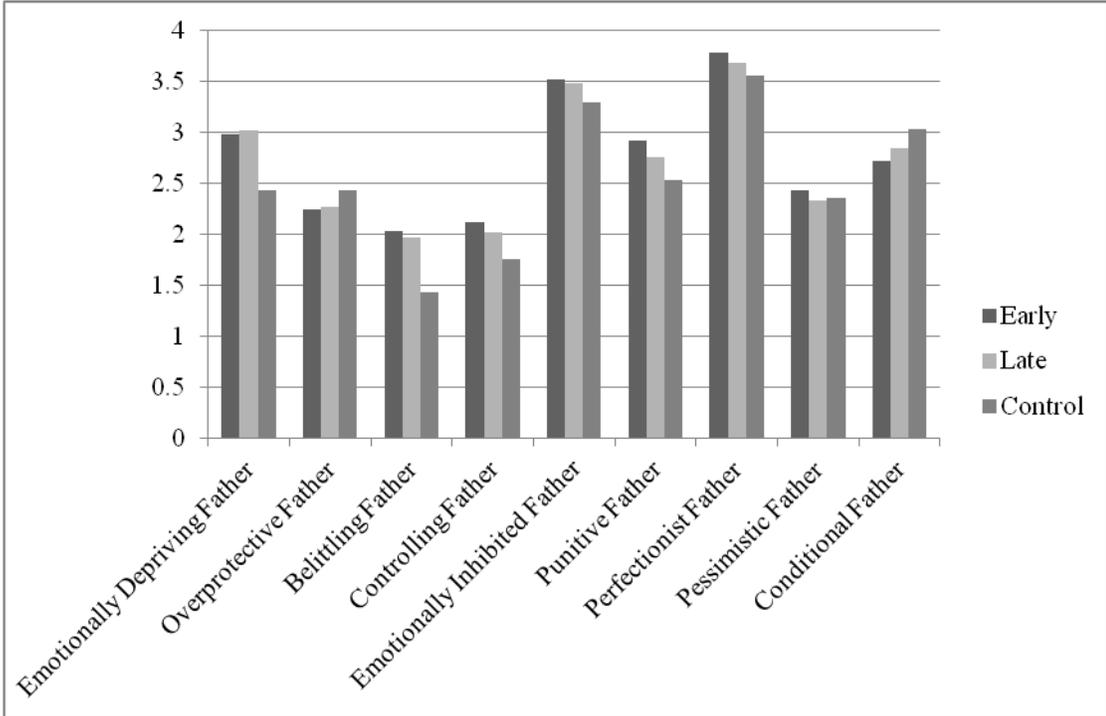
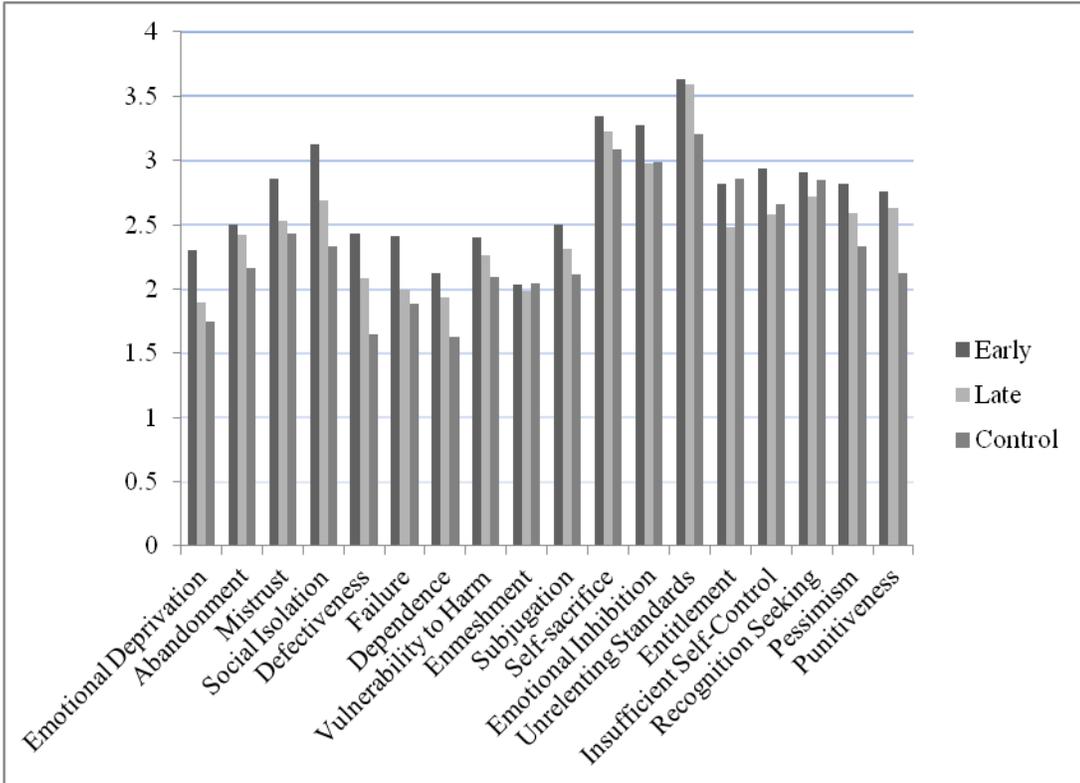


Figure F. Mean scores of YSQ-S3 subscales as a function of group condition



APPENDICES

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APPENDIX A

Early Maladaptive Schemas and Associated Schema Domains

(Young et al, 2003)

Domain I: Disconnection & Rejection

Individuals in domain I are unable to form secure, satisfying interpersonal attachments. They hold beliefs that their needs for safety, stability, nurturance and love will not be met. Specifically, domain I entails the following EMSs:

1. *Abandonment* entails the belief that those who provide support and connection cannot be relied upon.
2. *Mistrust/Abuse* refers to the belief that others will be hurtful, abusive, humiliating, cheat full, or manipulative.

3. *Emotional Deprivation* entails the beliefs that one's desire for a normal degree of emotional support will not be adequately met.
4. *Defectiveness* entails the belief that one is defective, bad, unwanted, inferior, or invalid or that someone will be unlovable to others if exposed.
5. *Social Isolation/Alienation* refers to the belief that one is isolated from the social world, different from other people and not part of a social network.

Domain II: Impaired Autonomy

People in this domain hold beliefs about themselves related to their ability to differentiate themselves from parental figures and to function autonomously. Specifically, this domain entails the following EMSs:

6. *Dependence* entails the belief that one is in great need of others' assistance in order to handle everyday responsibilities in a competent manner
7. *Vulnerability to Harm* is the unrealistic or disproportionate belief that a catastrophe is about to strike at any time
8. *Enmeshment* entails excessive emotional involvement and closeness to the point of losing one's own identity.
9. *Failure* refers to the belief that one will inevitably fail in areas of achievement (i.e. school, sport, career etc).

Domain III: Impaired Limits

People in this domain have not developed adequate internal limits with regard to reciprocity or self-discipline. They are often presented as selfish, spoiled,

irresponsible or narcissistic. Specifically, the EMSs in this domain are the following:

10. *Entitlement* schema refers to the belief that one is superior to others.
11. *Insufficient Self-Control* schema refers to the belief that one is unable to exercise sufficient self-control and frustration tolerance in order to achieve personal goals.

Domain IV: Other-Directedness

Individuals in this domain place great emphasis on meeting the needs of others at the cost of their own needs. They do this in order to ensure approval, emotional connection or avoid retaliation. Specifically, the EMSs in this domain are the following:

12. *Subjugation* schema refers to a passive surrendering of control to others because of feelings of coercion.
13. *Self-Sacrifice* schema entails a tendency to meet the needs of others at the cost of one's own needs.
14. *Approval-Seeking/Recognition* schema refers to the need of gaining other's approval or recognition in order to develop a secure sense of self.

Domain V: Overvigilance & Inhibition.

People in this domain mainly suppress to a great extent their spontaneity and impulsivity. They maintain rigid, internalized rules at the expense of their happiness, relaxation, close relationships or good health. Specifically the EMSs in this category are the following:

15. *Negativity/Pessimism* schema entails a pervasive lifelong focus on the negative aspects of life.
16. *Emotional Inhibition* schema entails an inhibition of emotional responses, impulses or communication, difficulty in expressing vulnerability and emphasis on rationality.
17. *Unrelenting Standards* schema refers to the belief that a person is not good enough and must perform at extremely high standards in order to avoid disapproval or shame.
18. *Punitiveness* schema is the belief that people should be harshly punished for making mistakes.

APPENDIX B

Young Schema Questionnaire-Short Form 3

(Young, 1994)

Instructions: Listed below are statements that people might use to describe themselves. Please read each statement, then rate it based on how accurately it fits you **over the past year**. When you are not sure, base your answer on what you **emotionally feel**, not on what you think to be true.

A few of the items ask about your relationships with your parents or romantic partners. If any of these people have died, please answer these items based on your relationships when they were alive. If you do not currently have a partner but have had partners in the past, please answer the item based on your most recent significant romantic partner.

Choose the **highest score from 1 to 6** on the rating scale below that best describes you, then write your answer on the line before each 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. ___ I haven't had someone to nurture me, share him/herself with me, or care deeply about everything that happens to me.
2. ___ I find myself clinging to people I am close to because I am afraid they will leave me
3. ___ I feel that people will take advantage of me
4. ___ I don't fit in
5. ___ No man/woman I desire could love me once he/she saw my defects or flaws
6. ___ Almost nothing I do at work (or school) is as good as other people can do
7. ___ I do not feel capable of getting by on my own in everyday life
8. ___ I can't seem to escape the feeling that something bad is about to happen
9. ___ I have not been able to separate myself from my parent(s) the way other people my age seem to
10. ___ I think that if I do what I want, I am only asking for trouble
11. ___ I am the one who usually ends up taking care of the people I'm, close to
12. ___ I am too self-conscious to show positive feelings to others (e.g., affection, showing I care)
13. ___ I must be the best at most of what I do; I can't accept second best
14. ___ I have a lot of trouble accepting "no" for an answer when I want something from other people
15. ___ I can't seem to discipline myself to complete most routine or boring tasks
16. ___ Having money and knowing important people make me feel worthwhile
17. ___ Even when things seem to be going well, I feel that it is only temporary

18. ___If I make a mistake I deserve to be punished
19. ___I don't have people to give me warmth, holding, and affection
20. ___I need other people so much that I worry about losing them
21. ___I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me
22. ___I'm fundamentally different from other people
23. ___No one I desire would want to stay close to me if he or she knew the real me
24. ___I'm incompetent when it comes to achievement
25. ___I think of myself as a dependent person when it comes to everyday functioning
26. ___I feel that a disaster (natural, criminal, financial, or medical) could strike at any moment
27. ___My parent(s) and I tend to be over-involved in each other's lives and problems
28. ___I feel as if I have no choice but to give in to other people's wishes, or else they will retaliate, get angry, or reject me in some way
29. ___I am a good person because I think of others more than myself
30. ___I find it embarrassing to express my feelings to others
31. ___I try to do my best; I can't settle for "good enough"
32. ___I am special and shouldn't have to accept many of the restrictions or limitations placed on other people
33. ___If I can't reach a goal, I become easily frustrated and give up
34. ___Accomplishments are most valuable to me if other people notice them
35. ___If something good happens, I worry that something bad is likely to follow
36. ___If I don't try my hardest, I should expect to lose out
37. ___I haven't felt that I am special to someone
38. ___I worry that people I feel close to will leave me or abandon me
39. ___It is only a matter of time before someone betrays me
40. ___I don't belong; I am a loner
41. ___I'm unworthy of the love, attention, and respect of others

42. ___Most other people are more capable than what I am in areas of work and achievement
43. ___I lack common sense
44. ___I worry about being physically attacked by people
45. ___It is very difficult for my parent(s) and me to keep intimate details from each other without feeling betrayed or guilty
46. ___In relationships, I usually let the other person have the upper hand
47. ___I am so busy doing things for the people that I care about that I have little time for myself
48. ___I find it hard to be free-spirited and spontaneous around other people
49. ___I must meet all my responsibilities
50. ___I hate to be constrained or kept from what I want
51. ___I have a very difficult time sacrificing immediate gratification or pleasure to achieve a long-range goal
52. ___Unless I get a lot of attention from others, I feel less important
53. ___You can't be too careful; something will almost always go wrong
54. ___If I don't do the job right, I should suffer the consequences
55. ___I have not had someone who really listens to me, understands me, or is tuned into my true needs and feelings
56. ___When someone I care for seems to be pulling away or withdrawing from me, I feel desperate
57. ___I am quite suspicious of other people's motives
58. ___I feel alienated or cut off from other people
59. ___I feel that I am not lovable
60. ___I am not as talented as most other people are at their work
61. ___My judgment cannot be counted on in everyday situations
62. ___I worry that I'll lose all my money and become destitute or very poor
63. ___I often feel as if my parent(s) are living through me- that I don't have a life of my own
64. ___I've always let others make choices for me, so I really don't know what I want from myself

65. ___I've always been the one who listens to everyone else's problems
66. ___I control myself so much that many people think I am unemotional or unfeeling
67. ___I feel that there is a constant pressure for me to achieve and get things done
68. ___I feel that I should not have to follow the normal rules or conventions that other people do
69. ___I can't force myself to do things I don't enjoy, even when I know it is for my own good
70. ___If I make remarks at a meeting, or am introduced in a social situation, it is important for me to get recognition and admiration
71. ___No matter how hard I work, I worry that I could be wiped out financially and lose almost everything
72. ___It doesn't matter why I make a mistake. When I do something wrong, I should pay the consequences
73. ___I haven't had a strong or wise person to give me sound advice or direction when I'm not sure what to do
74. ___ Sometimes I am so worried about people leaving me that I drive them away
75. ___I'm usually on the lookout for people's ulterior or hidden motives
76. ___I always feel on the outside of groups
77. ___I am too unacceptable in very basic ways to reveal myself to other people or to let them get to know me well
78. ___I'm not as intelligent as most people when it comes to work (or school)
79. ___I don't feel confident about my ability to solve everyday problems that come up
80. ___I worry that I'm developing a serious illness, even though nothing serious has been diagnosed by a doctor
81. ___I often feel I do not have a separate identity from my parent(s) or partner
82. ___I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account
83. ___Other people see me as doing too much for others and not enough for myself
84. ___People see me as uptight emotionally
85. I can't let myself off the hook easily or make excuses for my mistakes

86. ___ I feel that what I have to offer is of greater value than the contributions of others
87. ___ I have rarely been able to stick to my resolutions
88. ___ Lots of praise and compliments make me feel like a worthwhile person
89. ___ I worry that a wrong decision could lead to a disaster
90. ___ I'm a bad person who deserves to be punished

APPENDIX C

Young Parenting Inventory-Revised

(Sheffield et al., 2005)

Instructions: Listed below are statements that you might use to describe your parents. Please read each statement and decide how well it describes your parents. Choose the **highest rating from 1 to 6** that describes your mother, then your father, **when you were a child** and write the number in the spaces before each statement. If someone substituted as your mother or your father, please rate the scale for that person. If you did not have a mother or a father, please leave the appropriate column blank.

RATING SCALE:

1 = Completely untrue

2 = Mostly untrue

3 = Slightly more true than untrue

4 = Moderately true

5 = Mostly true

6 = Describes him/her perfectly

MOTHER

FATHER

- | | | |
|-------|-------|--|
| _____ | _____ | 1. Loved me, treated me as someone special. |
| _____ | _____ | 2. Spent time with and paid attention to me. |
| _____ | _____ | 3. Gave me helpful guidance and direction. |
| _____ | _____ | 4. Listened to me, understood me, shared feelings with me. |
| _____ | _____ | 5. Was warm and physically affectionate. |
| | | *ed |
| _____ | _____ | 6. Died or left the house permanently when I was a child. |
| _____ | _____ | 7. Was moody, unpredictable, or an alcoholic. |
| _____ | _____ | 8. Preferred my brother(s) or sister(s) to me. |

_____ 9. Withdrew or left me alone for extended periods.

*ab

_____ 10. Lied to me, deceived me, or betrayed me.

_____ 11. Abused me physically, emotionally, or sexually.

_____ 12. Used me to satisfy his/her needs.

_____ 13. Seemed to get pleasure from hurting people.

*ma

_____ 14. Worried excessively that I would get hurt.

_____ 15. Worried excessively that I would get sick.

_____ 16. Was a fearful or phobic person.

_____ 17. Overprotected me.

*vh

_____ 18. Made me feel I couldn't rely on my decisions or judgment.

_____ 19. Did too many things for me instead of letting me do things on my own.

_____ _____
 20. Treated me as if I were younger than I really was.

*di

_____ _____
 21. Criticized me a lot.

_____ _____
 22. Made me feel unloved or rejected.

_____ _____
 23. Treated me as if there was something wrong with me.

_____ _____
 24. Made me feel ashamed of myself in important respects.

*ds

_____ _____
 25. Never taught me the discipline necessary to succeed in school.

_____ _____
 26. Treated me as if I was stupid or untalented.

_____ _____
 27. Didn't really want me to succeed.

_____ _____
 28. Expected me to be a failure in life.

*fa

_____ _____
 29. Treated me as if my opinions or desires didn't count.

_____ _____
 30. Did what he/she wanted, regardless of my needs.

_____ _____
31. Controlled my life so that I had little
freedom of choice.

_____ _____
32. Everything had to be on his/her terms.

*sb

_____ _____
33. Sacrificed his/her own needs for the
sake of the family.

_____ _____
34. Was unable to handle many daily responsibilities, so I had to
do more than
my share.

_____ _____
35. Was unhappy a lot and relied on me for support and
understanding.

_____ _____
36. Made me feel that I was strong, and
should take care of other people.

*ss

_____ _____
37. Had very high expectations for him/herself.

_____ _____
38. Expected me to do my best at all times.

_____ _____
39. Was a perfectionist in many areas;
things had to be "just so".

_____ _____
40. Made me feel that almost nothing I
did was quite good enough.

_____ _____
41. Had strict, rigid rules of right and wrong.

_____ _____
42. Became impatient if things weren't done properly or quickly
enough.

_____ _____
43. Placed more importance on doing things well than on having fun or relaxing.

*us

_____ _____
44. Spoiled me, or was overindulgent, in many respects.

_____ _____
45. Made me feel I was special, better than most other people.

_____ _____
46. Was demanding; expected to get things his/her way.

_____ _____
47. Didn't teach me that I had responsibilities to other people.

*et

_____ _____
48. Provided very little discipline or structure for me.

_____ _____
49. Set few rules or responsibilities for me.

_____ _____
50. Allowed me to get very angry or lose control.

_____ _____
51. Was an undisciplined person.

*is

_____ _____
52. We were so close that we understood each other almost perfectly.

_____ _____
53. I felt that I didn't have enough individuality or sense of self separate from him/her.

_____ 54. I felt that I didn't have my own sense
_____ of direction while I was growing up because he/she was such a
strong person.

_____ 55. I felt that we would hurt each other
_____ if either of us went away from the other.

*em

_____ 56. Worried a lot about the family's financial problems.

_____ 57. Made me feel that If I made even a small mistake, something
_____ bad might
happen.

_____ 58. Had a pessimistic outlook; often
_____ expected the worst outcome.

_____ 59. Focused on the negative aspects of life or things going wrong.

*np

_____ 60. Had to have everything under control.

_____ 61. Was uncomfortable expressing
_____ affection or vulnerability.

_____ 62. Was structured and organized;
_____ preferred the familiar over change.

_____ 63. Rarely expressed anger.

_____ 64. Was private; rarely discussed his/her
_____ feelings.

*ei

- _____ 65. Would become angry or harshly critical when I did something wrong.
- _____ 66. Would punish me when I did something wrong.
- _____ 67. Would call me names (like “stupid” or “idiot”) when I made mistakes.
- _____ 68. Blamed people when things went wrong.
- *pu
- _____ 69. Was concerned with social status and appearance.
- _____ 70. Placed strong emphasis on success and competition.
- _____ 71. Was concerned with how my behavior would reflect on him/her in the eyes of others.
- _____ 72. Seemed to love me more or pay more attention to me when I excelled.

YPI-R Scales

- *Emotionally Depriving Parenting*: This scale reflects a pattern of parenting that deprives the child of emotional nurturing and affection. High scores reflect emotionally depriving parenting while low scores reflect appropriate emotional nurturing .
- *Overprotective Parenting*: This scale reflects overprotective parents who worry excessively and fail to foster the child. High scores indicate overprotective parents while low scores indicate normal levels of protection and worry

- *Belittling Parenting*: This scale reflects how much the parent belittles the child leading him/her to feel defective. High scores indicate high intensity of belittling behavior and low scores indicate no belittling
- *Perfectionist Parenting*: This scale reflects parents' expectations for both themselves and the child. High scores indicate more unrealistic and high expectations while low scores indicate more relaxed standards
- *Pessimistic Parenting*: This scale reflects anxious and fearful traits in both parents, high scores indicate angst-ridden, pessimistic parent while low scores indicate a more optimistic attitude toward life
- *Controlling Parenting*: This scale reflects parents that control or inhibit the child's independence. High scores indicate very controlling parenting that limits the development of sense of self while low scores indicate that the parent allows the child to become independent
- *Emotionally Inhibiting Parenting*: This scale reflects the parents' ability to share feelings with the child. High scores indicate great difficulty in sharing emotions while low scores indicate good ability in emotional sharing
- *Punitive Parenting*: This scale reflects parenting that is punitive of the child's mistakes. High scores indicate great levels of punitive behavior while low scores indicate low levels of punitive behavior
- *Conditional/Narcissistic Parenting*: This scale reflects parenting behavior that implies a conditional positive regard dependent on the child's success. High scores indicate high levels of conditional acceptance while low scores indicate more positive regard and unconditional acceptance

APPENDIX D

Adjustment to Chronic Skin Disease Questionnaire

(Stangier et al, 2003)

On the following pages you will find a number of statements that are concerned with different aspects of skin diseases. Please indicate how much each statement applied to you **in the last week**. There are no right or wrong answers, we are interested in your personal opinion

Please do not leave out any statement. If you are not sure put the number that comes closest to your opinion. Read the statements carefully, but do not spend too much time on single statements. Your first spontaneous statement is the best.

- 1 _ does **not** apply to me at all
- 2 _ applies **somewhat**
- 3 _ applies **moderately**
- 4 _ applies **much**
- 5 _ applies to me **very much**

1. ___ I am worried about my appearance.
2. ___ My skin condition prevents me from getting a good night's sleep.
3. ___ My skin condition makes me less attractive than most other people.
4. ___ I avoid certain situations because of skin condition.
5. ___ My skin prevents me from making new friends.
6. ___ I often feel nervous.
7. ___ I feel sexually inhibited because of my skin condition.
8. ___ Because of my skin condition I cannot realize many of my wishes.
9. ___ I often ruminate about why it is me who has the condition.
10. ___ I can't help looking at other people's skin.
11. ___ Because of the condition, it is difficult for me to find a (new) partner.
12. ___ In the morning I inspect my skin to look for new abrasions.
13. ___ I get easily upset.
14. ___ I can still make a lot of progress in coping with the condition.
15. ___ I can still improve my skin care.
16. ___ I withdraw from my family/partner out of consideration for them/him/her.
17. ___ It takes a lot of energy to resist scratching my skin.
18. ___ I do not pay enough attention to my nutrition.
19. ___ I avoid swimming or saunas because other people might be disgusted.
20. ___ I feel guilty when I have scratched my skin so it bleeds.
21. ___ I often feel tired.
22. ___ I would love to be as carefree as other people.

23. ___ I have the feeling that others stare at my skin lesions.
24. ___ My skin condition restricts my life.
25. ___ It bothers me that I cannot eat or drink some things that I like.
26. ___ I should know more about my skin condition.
27. ___ I often scratch myself without being aware of it.
28. ___ I feel that people treat me particularly delicately because of my skin condition.
29. ___ Being chronically ill is very expensive.
30. ___ I observe closely how others respond to my skin condition.
31. ___ I am afraid of being rejected because of my skin condition.
32. ___ I lack energy.
33. ___ I cannot do certain jobs because of my skin condition.
34. ___ When I look into a mirror I am mainly inspecting my skin.
35. ___ My family/my partner is also distressed by my skin condition.
36. ___ I am afraid that my skin condition will get worse and worse.
37. ___ The condition takes away much of my spontaneity.
38. ___ Itching is a sign that I feel uncomfortable.
39. ___ I sometimes feel desperate because of my skin condition.
40. ___ I worry about what other people think about my skin condition.
41. ___ I often think about what my life would be like without my skin condition.
42. ___ I feel uncomfortable when other people see me naked.
43. ___ Many things upset me.
44. ___ The itching makes me exhausted.
45. ___ I get angry with myself for making my skin condition worse by scratching it after I have put in a lot of effort making it better.

46. ___I should lead a less stressful life.
47. ___I often cannot concentrate.
48. ___I pay a lot of attention to my skin.
49. ___Sometimes I feel on the edge of having an anger outburst.
50. ___I feel dependent on cortisone.
51. ___I get into trouble at work because I am often off sick.

APPENDIX E

Demographic Questionnaire

1. Please indicate how good do you consider your knowledge of English to be

not at all

-

good

-

very good

-

2. Gender

Male

Female

3. Age

4. Marital Status

- Single
 In a relationship
 Married/Cohabiting
 Divorced
 Widowed

5. How long have you been in your current relationship?

6. What is your ethnic background?

7. What is your occupation?

8. Number of years in education

9. Do you suffer from a skin condition?

- Yes
 No

10. If yes, please describe the type of your skin condition (e.g. eczema)

11. Have you received a formal diagnosis by a dermatologist?

- Yes
- No

12. Do you suffer from any other condition/disease?

- Yes
- No

13. If you suffer from any other condition/disease, please describe

14. When was your skin condition first diagnosed (age of onset)?

15. What part/s of your body is/are affected by your skin condition? (e.g. legs, face, hands)

16. Please rate from a scale of 1-5 how severe do you consider your skin condition to be

- not at all
- slightly severe
- moderately severe
- severe
- very severe

17. Please rate from a scale of 1 to 5 how obvious do you consider your skin condition to be

- not at all
- slightly obvious
- moderately obvious
- obvious

very obvious

18. Does anybody else in your family suffer from a skin condition?

Yes

No

19. If yes, please explain (e.g. "mother-eczema")

20. Are you currently on medication related to your skin condition?

Yes

No

21. If yes, please give details of the medication used

22. Have you ever received psychological help? (e.g. seen a counsellor, psychologist etc)

Yes

No

23. If yes, for how long? (i.e. put "m" for months or "y" for years)

24. Have you ever been on medication related to a psychological condition? (e.g. anxiety, depression etc)

Yes

No

25. If yes, please explain (e.g. Lexotanil-anxiety)

APPENDIX F

Present Study's Advertisements on Eczema Web Sites and Facebook Groups

National Eczema Association-Research-Clinical Research Trials

Postdate: March 9, 2011

How People Adjust to Eczema

Participants in this study you will be required to complete questionnaires that will take approximately 20 minutes. Participants are free to withdraw at any time and, if any questions are particularly difficult to answer, the participant may opt not to answer

All information collected will be kept strictly confidential

To qualify you must:

Have eczema

Be over 18 years of age

Be interested in helping discover how to help people with eczema

To begin please complete a survey by visiting this link:

Surveymonkey.com/s/GDHF9MP

OR

Send an e mail to request a hard copy of the questionnaires:

ellikalaki@yahoo.com

Principal Investigator: Elli Kalaki, Doctorate Candidate, Counselling Psychology, London Metropolitan University, UK and is supervised by Chartered Psychologists:

Dr. A. Bucher

Dr, E. Murray

DermNet- Eczema, Dermatitis & Allergies

Postdate: March 4, 2011

Survey: How people adjust to eczema

If you are over 18 and you have eczema, you may be interested in participating in a doctoral student's research project investigating how people adjust to eczema. You will be asked to complete Elli Kalaki's on line eczema survey by visiting this link: <http://surveymonkey.com/s/GDHF9MP>. This project has been approved by the London Metropolitan University Research Ethic's Committee

Facebook Groups:

- 1. Support for eczema sufferers & others**
- 2. Eczema Community**
- 3. Talkhealth & Others**

Study: How people adjust to eczema

If you are interested in helping us please visit this link:

<http://surveymonkey.com/s/GDHF9MP>

This is a doctoral level study in Psychology (London Metropolitan University, UK)

Participation is anonymous and confidential

For more information please contact: Elli Kalaki, Doctorate Candidate in Counselling Psychology, ellikalaki@yahoo.com

Thanks in advance

Elli Kalaki

Talkeczema

Postdate: February 15, 2011

Study on adjustment to eczema

My name is Elli Kalaki and I am conducting a doctoral level study as part of a professional doctorate in counselling psychology, London Metropolitan University, UK

My study is aiming to investigate:

- 1) How/if eczema affects the psychological well being of people
- 2) How people adjust to eczema
- 3) What do psychologists need to consider when treating people with eczema

This study has been approved by the Research Ethics Committee, LMU and is supervised by chartered psychologists:

Dr. A. Baker

Dr A. Butcher

To participate in this study you will be required to complete some questionnaires that will take approximately 20 minutes

- If you decide to participate you are free to withdraw at any time
- All information collected will be held strictly confidential

Please complete this survey by visiting this link:

<http://surveymonkey.com/s/GDHF9MP>

or by requesting a hard copy version of the questionnaires at:

ellikalaki@yahoo.com

Thank you very much for your time

Kindest regards

Elli Kalaki

APPENDIX G

Advertisement that was Circulated at London Metropolitan University

- | | |
|---|---|
| ✓ | <i>Do you have eczema?</i> |
| ✓ | <i>Are you over 18?</i> |
| ✓ | <i>Would you be interested in helping us discover how to help people with eczema?</i> |

I am conducting a Doctoral level Research Project as part of my course:

***Professional Doctorate in Counselling Psychology
London Metropolitan University.***

This study has been approved by the

***Research Ethics Committee, London Metropolitan University, UK.
and is supervised by Chartered Psychologists:
Dr A. Baker, a.baker@londonmet.ac.uk***

Dr A. Butcher, anna.butcher@londonmet.ac.uk

The study is aiming to investigate: **How People Adjust to Eczema.**

To participate in this study you will be required to **complete some questionnaires** that will take approximately **20 minutes**.

If you decide to take part you are still **free to withdraw at any time** and if you find any of these questions particularly difficult you **do not have to answer them**.

All information collected from you will be kept **strictly confidential**.
It would not be possible to identify your name or any other information about you.

Please complete this survey by **visiting the link** presented below.

<http://surveymonkey.com/s/GDHF9MP>

please copy and paste this address in your web browser and click enter

or

By requesting a **hard copy version** of the questionnaires at:

ellikalaki@hotmail.com

Thank you very much for your time, it is very much appreciated.

Kindest Regards,

Elli Kalaki

APPENDIX H

Information Sheet

Please read the information sheet before proceeding with taking part in the study

Dear Volunteer,

I am conducting a doctoral level research project as part of my course “Professional Doctorate in Counselling Psychology” at London Metropolitan University (LMU), London, UK.

This study has been approved by the Psychology Department Research Ethics Committee at LMU.

WHAT IS THIS RESEARCH ABOUT:

The study is aiming to investigate the psychological processes that people use to adjust to a chronic skin condition.

Research has shown that some people may become psychologically distressed due to their skin condition which further impacts on condition severity and overall adjustment.

The present study believes that some key factors impacting on psychological distress and condition maladjustment are: a) early experiences, b) beliefs about one's self and c) ways of relating to others.

It is hoped that through this study, Counselling Psychologists will gain more knowledge on how to help people presented with a skin condition, overcome a possible psychological impact of the condition on their life.

More details are presented at the end of this study.

WHAT WILL I BE ASKED TO DO:

To participate in this study you will be required to complete four questionnaires that will take approximately 20 minutes. However, please feel free to take as long as you need to complete them.

The questionnaires are the following:

- a) Young Parenting Inventory: measures perceived parenting experiences (72 questions)
- b) Young Schema Questionnaire: measures beliefs about one's self (90 questions)
- c) Adjustment to Chronic Skin Conditions: measures the overall adjustment to a chronic skin condition (51 questions)

You can take a break at any point throughout this study. However, please try to make sure not to take more than two breaks for each questionnaire.

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and if you find any of these questions particularly difficult you do not have to answer them.

CONFIDENTIALITY:

All information collected from you during the course of this study will be kept **STRICTLY CONFIDENTIAL** to the research team and will only be used for the purposes of this study.

It will **NOT** be possible to identify your name or any other information about you.

WHAT WILL HAPPEN TO THE DATA ONCE THE SURVEY IS COMPLETED

The data that will be gathered throughout this study will be securely stored by the research team for up to five years. This will happen for the purposes of publication.

WHO CAN I CONTACT:

If you have any further questions regarding this study or if you are interested in the study's results, please contact the research team:

Researcher:

Elli Kalaki
ellikalaki@hotmail.com

Supervisors:

Dr Anna Baker
a.baker@londonmet.ac.uk

Dr Anna Butcher
anna.butcher@londonmet.ac.uk

Please complete the survey by using the buttons at the bottom of the page to navigate.

Thank you very much for your time, it is very much appreciated.

Kindest Regards,
Elli Kalaki

APPENDIX I

Consent Form

Consent Form

1. I confirm that I have read and understood the information regarding this study.
2. I understand that my participation is voluntary and that I can withdraw at any time without giving any reason.

3. I understand that data collected in this study will be strictly confidential to the research team and I will not be identifiable in any report of this study.

4. I also understand that at the end of this study I will be provided with more details regarding the aim and purposes of this study and I will have the opportunity to make any queries regarding this study.

I agree to take part in this study

- Yes
- No

APPENDIX J

*Ethical Approval of the Research Ethics Committee, Psychology Department,
London Metropolitan University*



Faculty of Life Sciences
Calcutta House
Old Castle Street
London E1 7NT
Direct: 020 7320 1067
Facsimile: 020 7320 1236

I am pleased to say that the following project;

Adjustment to Chronic Skin Conditions: A Preliminary Investigation of Perceived Parenting Experiences, Self-Schemas and Attachments Styles as Factors that Mediate Adjustment to Eczema. The case of Early vs Late Onset

*Researcher: Elli Kalakali,
Supervisor: Dr Anna Butcher*

Has received ethical approval to proceed, providing that it follows the ethical guidelines used by the Psychology Department and British Psychological Society, and incorporates any relevant changes required by the ethics panel. The researcher and supervisor are also responsible for conducting the research in an ethically acceptable way, and should inform the ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed: Chris Cocking

Dr Chris Cocking

(Chair London Metropolitan University Psychology Research
Ethics Review Panel)

Date: 21/12/2010

APPENDIX K

Debriefing

Thank you for taking the time to complete this survey.

So far, research has provided strong evidence related to the association between psychological distress (i.e. anxiety, depression etc.) and skin conditions.

Literature and research has suggested a strong "circular" relationship between psychological distress and condition severity.

By the word "circular" it is meant that condition severity impacts on psychological distress and vice versa. This circular relationship is what makes adjustment to a chronic skin condition difficult for some people.

It is believed that by managing psychological distress people might be more able to deal with and adjust to their skin condition both psychologically and physiologically.

But what determines the degree of psychological distress?

Theories of personality suggest that not all people presented with a skin condition are prone to psychological distress.

The levels of psychological distress are determined by the way people evaluate themselves with or without the condition.

On the other hand, the way people evaluate themselves is determined by early experiences and interactions with significant others (i.e parents).

On the basis of these arguments, the present study assumes that an early age of onset and perceived parenting experiences are important factors that influence the way a person will learn to evaluate his/her self and consequently the levels of psychological distress he/she will experience as an adult (with or without a skin condition).

Thus the present study aims to investigate how/if factors like: age of onset, early experiences, beliefs (evaluations) about one's self and intimate relationships interact to produce psychological distress and condition maladjustment.

It is hoped that through this investigation Counselling Psychologists will gain more knowledge on how people can be helped in adjusting to a chronic skin condition and receive appropriate help that will eventually lead to condition management.

If the questionnaires have raised issues or feelings which caused you some distress and you feel that you would like to discuss them further or receive some support; please see the list of available Counselling Services on the next page.

I would like to thank you again for your participation in this study.

If you have any further questions regarding this study or if you interested in the study's results, please contact the research team:

Researcher: Elli Kalaki

ellikalaki@hotmail.com

Supervisors: Dr Anna Baker

a.baker@londonmet.ac.uk

Dr Anna Butcher

anna.butcher@londonmet.ac.uk

Thank you for taking part in this study

List of Counselling Services

UK:

1. Your GP
2. Royal Free Hampstead NHS Trust

Clinic 6-Psychodermatology Service

Pond Street, Hampstead London, NW3 2QG

Tel: 0044(0)2078302376 ext. 38135

3. UK Council for Psychotherapy (UKCP)

Find a therapist:

http://www.psychotherapy.org.uk/find_a_therapist_search.html

4. Patient UK

Find me a (psychologist, psychotherapist etc):

http://www.patient.co.uk/find_me.asp

5. British Psychological Society (BPS)

Find a psychologist:

[http://www.bps.org.uk/bps/e-services/find-a-psychologist/psychoindex\\$.cfm](http://www.bps.org.uk/bps/e-services/find-a-psychologist/psychoindex$.cfm)

6. British Association of Counselling and Psychotherapy (BACP)

Find a therapist:

<http://wam.bacp.co.uk/wam/SeekTherapist.exe?NEWSEARCH>

7. The Samaritans

www.samaritans.org

SELF-HELP:

1. Centre for Clinical Interventions

Contains self-help modules for a variety of psychological disturbances

<http://www.cci.health.wa.gov.au/treatment/index.cfm>

2. Mental Health Foundation

Contains audio material with relaxation exercises

<http://www.mentalhealth.org.uk/relax/>

ONLINE COUNSELLING SERVICES:

1. The MoodGym

<http://moodgym.anu.edu.au/welcome>

Elli Kalaki

Student ID: 06032739

London Metropolitan University

Professional Skills Level 3

PYP051C

Module Leader: Dr Mark Donati

04.02.2010

Words: 4990

Introduction

This essay will explore the development of my own personal philosophy and orientation to counselling psychology. Section 1 describes the factors that impacted on my decision to

get CBT training and whether this approach really matches my personality. Section 2 describes the different philosophy of CBT disciplines and how I have used these in my own personal practice as a therapist. Finally section 3 is a small section where I describe my personal philosophy of therapy.

Section 1: Is traditional CBT for me?

Looking back at my training as a Counselling Psychologist I become more and more confident about my choice to study and practice Cognitive Behaviour Therapy (CBT).

In my country the need for a short term and immediate therapeutic approach becomes bigger and bigger as funding for mental health services is getting limited day by day. In addition, the poor politicosocioeconomical level of Greece has so strongly impacted on the individual level that people are experiencing high levels of anxiety and depression, as well as other psychological disturbances, related to practical issues of survival and maintenance of well being. The need for a short term therapeutic approach that is also cost effective is becoming more apparent day by day. Thus CBT is the approach most commonly used in my country in both the private and the public sector.

My decision to get trained in CBT, therefore, was partly influenced by the demands of the mental health field in my environment. In addition to that, I remember that during my undergraduate years in psychology, CBT attracted my interest for its simplicity, specificity and immediacy. Compared to other schools of psychotherapy and theories of personality, CBT was the easiest not only to comprehend but also to apply to my own personal life- to a certain extent, considering the fact that I had no training in any school of therapy back then-. Its simplicity made me realize how valuable this approach would be for many people presented with a wide variety of problems.

CBT also gave me the structure, organization and explicit meaning that I couldn't find in any other orientation. Later on, my two years training as an REBT therapist provided me with a solid frame of a personal and professional attitude. Being a "fresh", "tabula rasa" trainee the first person that I started practicing the techniques and the philosophy learnt was on me. That impacted not only on the professional identity that I developed later on, but also on my personal philosophy of life. These two (professional identity/practice and personal philosophy of life) have now been strongly blended to the point that I feel I am practicing my "own values" when I am practicing CBT.

My decision to pursue a career as a Counselling Psychologist with CBT orientation was primarily based on the most central philosophical tenets of CBT, the distinctive nature of Counselling Psychology from other mental health professions and my own personal values. CBT, in accordance with humanistic philosophy, argues that: 1) people are intrinsically good (although with a biological, innate tendency to dysfunctionality) (Walen DiGiuseppe & Dryden, 1992), 2) people are free and autonomous beings that exercise choice in determining their behaviour, 3) all people have the potential of growth and self-actualization, 4) people are internally motivated, can identify their own needs and can make decisions about what can help them best (Merriam & Brockett, 2007). These humanistic assumptions bring the focus on developing the potential of the client through an approach where the client is the expert of his/her experience and the therapist the "facilitator" of the client's development. This development necessitates affective, cognitive and behavioural involvement and its impact can be seen not only on the behaviour but also on the personality and the attitude of the client (Merriam & Brockett, 2007). One could argue that these assumptions go much more in accordance with Roger's client-centered approach than with traditional CBT. The difference however, in my personal opinion, does not lay on which approach holds these philosophical assumptions-as CBT also strongly relates to them (Walen DiGiuseppe & Dryden, 1992), but rather on the role the

“facilitator”/therapist has within the therapeutic relationship and throughout the therapeutic process.

CBT relies on collaborative empiricism according to which the therapist is active-directive and collaborates with the client on a rational approach to the client’s current life circumstances (Klosko & Sanderson, 1999). Therapist and client collaboratively identify the client’s thoughts and underlying assumptions and treat them as theories to be tested. To foster the spirit of collaborative empiricism, therapists start by clearly defining the problem to the client and by educating him/her recommending books and other resources of knowledge. Goals are specific and concrete and the therapist constantly helps clients evaluate their progress (Klosko & Sanderson, 1999).

Thus, a more active and directive approach who provides clarity and definition to the presenting problem can be as humanistic in its philosophy as an approach that is less-or even not at all- directive and active (i.e client-centered).

Moreover, understanding a person’s life experiences and facilitating him/her in achieving personal growth through the therapeutic relationship is what distinguishes Counselling Psychology from other models that try to diagnose and treat psychological imbalances (Strawbridge, Woolfe & Dryden, 2009). Thus, this basic tenet of Counselling Psychology that goes in accordance with the humanistic philosophy of CBT was what shaped my decision to pursue a career in Counselling Psychology with a CBT orientation.

The theoretical and practical training that I got throughout this programme has strengthened my choice of orientation. Throughout these three years of training I had the opportunity to acquire theoretical and practical knowledge related to different schools of CBT and I also had the opportunity to establish my personal philosophy of the theoretical orientation I have been practicing so far (discussed in section 3).

My supervision during my practical work has merely been an integration of CBT disciplines that has helped me achieve a deeper and more solid understanding of the model through the use of comparing and contrasting. Through supervision, practical work and theoretical knowledge, therefore, I have managed to acquire the skills of identifying and choosing the best possible intervention for each client and tailor made therapy according to clients' needs.

Section 2: Philosophical Basis of CBT Models and Personal Experience

CBT blends scientific, philosophical and behavioural aspects into one approach that aims at understanding and overcoming emotional barriers (Simmons & Griffiths, 2009).

The scientific aspect of CBT lies on the notion that all people are-or should be trained to become- scientists that treat their thoughts as theories and hypotheses about reality to be tested. The philosophical aspect of CBT recognizes that people have values and beliefs about themselves, others and the world. On the basis of this philosophical tenet CBT partly aims at helping people overcoming disturbed ways of thinking-expressed in negative automatic thoughts- and emotional disturbance in order to achieve personal life goals (Simmons & Griffiths, 2009).

CBT's core assumption is that thoughts, affect and behaviour operate in a reciprocal vicious cycle that perpetuate psychological disturbance (Willson & Branch, 2006). Identifying and labeling negative automatic thoughts (NATs) and distorted thinking is a key component of CBT as it facilitates the client in defining the problem and overcoming emotional blocks (Sanders & Wills, 2005). The aim of CBT is to provide an accessible and

practical form of therapy that can be related to common sense. This is achieved by the use of challenging of NATs and cognitive reframing (Sanders & Wills, 2005).

Empirical evidence shows that CBT is a very effective treatment, especially for Axis I disorders. Even though treatment outcome studies show a high success rate (Barlow, 2001) they also show that a relatively high percentage of clients is not really helped. For example in depression, studies have shown that the success rate is over 60%, however the relapse rate is almost 30% one year after treatment (Young, Weinberger & Beck, 2001 in Barlow, 2001).

Thus many theories that evolved from traditional CBT have attempted to develop the CBT tradition. For example, traditional CBT argues that emotional disturbance is the result of the content of distorted inferences-or NATs-about a specific situation (Walen et al, 1992). A good example of this would be to think of a person who finds a mole on his hand and thinks that this might be cancerous. This though might be an incorrect inference which takes the form of NAT. Traditional CBT argues that this inference is enough to cause anxiety as it involves a threatening content. Rational Emotive Behaviour Therapy, on the other hand argues that NATs and inferential contents are not central to pathology. Rather, it is the *evaluative beliefs*, and the meaning that people attach to these inferences that is central to emotional disturbance (Bond and Dryden, 1996a). According to REBT these evaluative beliefs (also know as core irrational beliefs) fall into four categories: a) demandingness, b) awfulizing, c) low frustration tolerance and d) global evaluations of human worth (Walen et al, 1992). In his writings, Ellis (e.g. 1987c) has argued that all emotional disturbance shares the common root of *demandingness* and that evaluative beliefs related to demandingness are always present in emotional

disturbance. The remaining three core IBs are thought to be logical derivatives of demandingness.

To illustrate this point even better, in the cognitive model of depression Beck (1976) hypothesized that people have stable cognitive contents that have been developed throughout their whole lives, as a consequence of early learning. These contents predispose people to negatively interpret and make inferences (in the form of biases) about life events which further lead to engaging in depressive behaviour. Ellis (1987c) however, argues that only the existence of demandingness (with a derivative of self-downing) differentiates normal, functional sadness from dysfunctional depression and the inferences that are drawn accordingly. Interestingly, Solomon, Bruce, Gotlib, and Wind (2003), found that demandingness seems to be the core belief in major depression.

In addition, in a recent randomized control trial on patients with major depressive disorder, REBT has been found to be as effective as Cognitive Therapy (CT), CBT and pharmacotherapy in a wide variety of psychological disturbances such as anxiety related disorders, depression, personality disorders, eating disorders, schizophrenia etc (Ellis and Dryden, 1997). However, REBT's efficacy and the aspect of challenging irrational beliefs have not been thoroughly studied so far. According to Dobson (2009), there is a need for component designs that isolate specific beliefs as well as efficacy studies based on well-controlled randomized clinical trials in order for REBT to scientifically and more strongly support its basic premises.

In my personal experience as a trainee, many times both my clients and I got stuck during therapy when we were using traditional CBT alone. In most cases, and according to the feedback I got from many clients, challenging NAT was helpful but "not enough". The identification of evaluative core beliefs-and especially demandingness- took us a step further as

this operated as a force of realization and reflection on the current situation from the part of the client. For example, many clients were absolutely “astonished” when they were helped to realize that in reality they are “demanding the situation to be different from what it really is”. Realizing the demanding nature of their beliefs, many of my clients were actually helped in “letting it go” and “accepting” the situation as it really is, without necessarily liking it.

Specifically, I remember the case of T who was suffering from depression for more than 5 years due to a diagnosis of Chron’s Disease and the implications of the condition on his life. T, aged 37, was unable to find a job due to his condition and was getting financial support from his parents. This was making him feel obliged towards them. His parents on the other hand, were over controlling making T feel guilty every time he was trying to assert himself to them. He had started studying photography which he never managed to finish due to his condition and on top of that he got TBT on a trip to South Africa that had further implications on his life. He also suffered from sleeping problems-partly due to TBT medication-, he had socially isolated himself because he felt that others were too demanding and he could not meet their expectations, and he had just recently broken up from a relationship because his partner could not stand his depression anymore. T had presented suicidal ideation and self harming behaviour in the past and had received both medical and psychological inpatient treatment. He had also received CBT counselling in the past which had helped him but relapsed few months after therapeutic termination.

T was also seeing a psychiatrist and was getting medication for his depression. T was presented in therapy very low, talking in a very low voice tone to the point that I could not hear what he was saying to me. He was constantly crying and was upset and was difficult for therapy to progress as we had to spend most of the time in relaxation techniques. Any attempt to identify NATs was mechanistically done by T who had already got “trained” (as he stated)

in identifying them throughout previous therapies. Case formulation did not reveal something new to him regarding the link between his presenting problems and underlying psychological mechanisms as, for one more time, T had “heard the story before” (as he described it). T was very consistent with his homework and in keeping his DTRs. He would realistically challenge all of his dysfunctional beliefs and establish alternative positive one. This however was done in a mechanistic way and T’s level of depression was sustained.

Throughout our sessions it was obvious that there was a huge, deep “WHY? WHY ME” behind T’s descriptions of situations. It was only when I helped T realize that he was not just “wishing” things could be different in his life, but rather that he was “demanding that things should be different in his life” that T’s attention was genuinely attracted and he got engaged in therapy. Along with each one of T’s NAT there was an underlying evaluative belief about how things ought/had to be (i.e “I shouldn’t suffer from my condition” (and it is awful that I do! I cannot stand it). Then therapy aimed at challenging these core evaluative beliefs rather than T’s distorted thinking and thinking errors; thus disputation became from inferential (targeted at inferences) to philosophical (targeted at the specific core evaluative beliefs). This turn in the therapeutic content significantly helped T to accept things in his life without necessarily liking them, to minimize the level of emotional disturbance (i.e feeling sad instead of depressed/annoyed instead of angry) and finally to overcome his passive copying style. By the end of therapy, T started going to the University again and started socializing more accepting the fact that he will not always be able to follow his friends in all activities. After his psychiatrist’s advice, T also stopped taking anti-depressants.

Looking back at this case now, I realize that some Mindfulness interventions could also be very helpful for T to stay focused in the present moment, observe the situation (inside or outside of the person), describe what is happening in a non- judgmental way, and unconditionally accepting how things are (Hayes, Follette & Lineham, 2004). However, in my personal opinion, it wouldn’t be indicative to use Mindfulness as a main approach for T’s

case. T was presented with core dysfunctional beliefs that would have been left untouched with a purely mindfulness approach running the risk of relapse. In addition, according to Ellis (2001), REBT promotes unconditional acceptance of reality and nonreactivity within a context of commitment to change, thus the model is very close to mindfulness based interventions, as well as other “third wave” approaches (i.e Acceptance Commitment Therapy).

REBT and CBT have many similarities as they both share the same roots and comprise advances of CT (Walen et al, 1992). The difference between the two models lays on the focus of different cognitive processes. According to Ellis (2001), rationality and irrationality is a concept applied to peoples’ beliefs. Rational beliefs (evaluative beliefs) are flexible and non-exaggerated, consistent with reality, logical as well as self and relationship enhancing beliefs about the self, others and the world. Irrational beliefs (evaluative beliefs) are rigid and extreme evaluations of the self, others and the world, inconsistent with reality, illogical as well as self and relationship defeating. According to Beck (1976) NAT are cognitions that are closest to the surface of consciousness and refer to certain situations. They are the final cognitive output of schema-based distortions about the self, others and the world (Blatt, Anerbach, Levy, & Schafler, 2005). Beck recognized however that there are deeper level cognitive processes that trigger people’s inclination to interpret different events in a fixed pattern. Such processes are called schemas (Sanders & Wills, 2005).

Schema Therapy has developed on the basis of the existence of these deeper level cognitive processes and constitutes another discipline of the CBT tradition. According to Young, Klosko and Weishaar (2003) a schema is defined as any “*broad organizing principle for making sense of one’s own life experiences*” (p.7). The main characteristic of schemas is that they are formed in early life and continue to exist and get triggered in adult years, even if

they are not applicable anymore. This tendency is referred as the need for cognitive consistency (Young et al, 2003).

Schema therapy was developed as an advancement of CBT for clients presented with psychological attributes that distinguish them from Axis I cases and make them a difficult case for straightforward CBT. According to Young et al (2003) traditional CBT holds certain assumptions that many times are proven to be untrue of patients with characterological problems (i.e personality disorders). These are: a) clients will comply with the treatment protocol, b) clients will be able to access their thoughts and emotions and be able to monitor and report them to the therapist after a short period of training, c) patients can change their problematic cognitions and behaviours through the use of empirical analysis, logical discourse, experimentation, gradual steps and repetition, d) clients can get engaged in a collaborative relationship with the therapist after few sessions, and e) the client is supposed to have problems which are apparent as targets of treatment (Young et al, 2003). More often than not, clients presented with characterological problems demonstrate a complicated motivation toward change and reluctance in complying with the treatment protocol. They often seem out of touch with their thoughts and emotions and get engaged in cognitive and affective detachment. In addition, most of the times, clients with personality disorders have a strong difficulty in forming relationships and trusting others and especially the therapist. Finally, due to their pervasive, long lasting and vague problems, clients with characterological problems are dissatisfied in most major life areas and are unhappy for as long as they can remember. This dissatisfaction takes the form of broad, hard-to define life themes that are usually very difficult to determine as targets of therapy (Young et al, 2003).

Schema Therapy is an integrative therapy developed by Young and colleagues. It has its roots in traditional CBT but significantly expands the model blending elements from

attachment, Gestalt, object relations, constructivist, psychoanalytic schools and CBT, into a unifying treatment model (Young, 1994). The theory suggests that schemas develop from unmet emotional needs-related to attachment, autonomy, expression of emotions, spontaneity, limits and self control- during early years. Thus schema therapy places much more emphasis on childhood and adolescent origins of psychological difficulties, on parenting styles, on emotions and emotive techniques, on the therapeutic relationship (limited re-parenting) and on maladaptive coping styles (surrender, overcompensation and avoidance) than other disciplines of CBT. It addresses core psychological themes, called Early Maladaptive Schemas (EMS) and its main goal is to help clients make sense of their chronic pervasive difficulties and organize them in a sensible manner. The model suggests 18 EMS that are categorized in 5 categories (due to word limits they will not be presented in this paper). The model also argues about the existence of certain modes defined as “*a set of schemas-or schema operations-that are currently active for an individual*” (Young et al, 2003, p. 271).

Several studies have examined the validity of schemas. In his investigation, Freeman (1999) demonstrated that the dysfunctionality of schemas was predictive of interpersonal adjustment confirming Young’s assumption that EMS are by definition negative and dysfunctional. Carine (1997) demonstrated a significant association between EMSs and personality disorder symptoms.

The model incorporates cognitive, experiential and behavioural techniques in its treatment protocol. The cognitive work is more focused on the schema rather than NATs and evaluative beliefs. The therapist helps the client to develop a healthy adult voice against his schema. Experiential strategies aim at triggering the emotion connected to the schema and re-parenting the client in order to meet unmet emotional needs and achieve schema healing. Behavioural strategies aim at replacing the schema driven behavioural patterns with more functional ones (Young et al, 2003).

For the last two and a half years, I have been working in a setting where clients are presented with chronic disfiguring conditions that many times have a very early onset. People with a disfiguring condition do not only experience the psychological and emotional implications of the condition per se, but also a wide variety of life adversities- either everyday and common life adversities or extreme and severe cases that many times are the result of the disfigurement-that are processed throughout the psychological development of the person in relation to the disfigurement. At this point it would be interesting to mention Thompson and Kent's study (2001) which demonstrated that parents of disfigured children tend to be more distant and less nurturing creating an insecure attachment bond, when compared to parents of non-disfigured children. Thus, it is understandable that these people have suffered a great deal of emotional trauma throughout their lives-with the most common ones: anxiety, depression, embarrassment and shame-that has been built up for many years.

In my experience, pure CBT has not been the most effective therapeutic approach with the majority of these clients. People that have experienced trauma, embarrassment and shame throughout their lives tend to block disturbed thoughts and emotions and avoid their own memories and experiences. Avoidance becomes a mechanistic strategy for coping with negative affect that is very difficult to change (Young et al, 2003). Through the use of limited re-parenting and the covering of emotional needs, Schema Therapy has proven to be more effective with this population than other disciplines of CBT, according to my experience. The emphasis of the model on emotions and ways of relatedness (elements of object relations therapy) facilitate the client in dropping resistances and unblocking emotions in an effort to achieve insight and confront-instead of avoid-emotional pain.

Empirical evidence demonstrate that the model is more effective for the treatment of borderline personality disorder, have a significantly lower drop-out rate and is more cost effective when compared with other approaches (i.e transference focused therapy)

(Dobson, 2009). However, considering that this model is relatively new, more studies are needed to evaluate its efficiency with other mental health problems. At the moment, several outcome studies that will shed light on Schema Therapy results are still in progress (Dobson, 2009).

Schema Therapy has been particularly helpful with one of my clients named D. D, a male at his 30's, had been suffering from chronic eczema since the age of 3. His condition was the cause of consistent bullying throughout his school years. In addition, D described his parents as very cold, distant, demanding and critical. He came to therapy because his skin condition had become uncontrollable and painful. D complained about feelings of loneliness and performance anxiety at work. In the Young Schema Questionnaire YSQ, D scored significantly high on the Unrelenting Standards, Emotional Deprivation, Social Isolation and Defectiveness schemas. D was very cold and distant during the first sessions and many times critical of me, just like his description of his parents. He was avoiding any kind of painful memories or emotions and the greatest difficulty during the first sessions of therapy was to train him in monitoring and writing down thoughts and emotions. However, he strongly related to the schemas that resulted from the YSQ. Mode work along with experiential techniques-that had him imagining himself as a child in a critical situation-helped him in recognizing his emotions. Through the use of limited reparenting, D had the opportunity to see a more accepting and supportive "parenting style" and not only recognize that his beliefs about himself were just an internalization of his parents' attitudes- that proved to be wrong through therapy- but also to perceive his emotional needs as acceptable and natural and nothing to be ashamed of. His behavioural patterns and ways of relating were identified through the therapeutic relationship and D was able to experientially recognize that the way he was relating to me in therapy resembled his interaction with others in a social environment. D's Defectiveness schema was significantly high. His Unrelenting Standards Schema (perfectionism) was simply a copying style and an

overcompensation of Defectiveness. D would respond in an aggressive way (copying response) every time he felt he was being “criticized” or every time he felt vulnerable, keeping both himself and others distant and perpetuating his feelings of loneliness and the belief that he is unlovable (Defectiveness). Behavioural work was aimed at breaking these patterns and baring “discomfort” without reacting in an aggressive way. Cognitive work was aimed at challenging his schemas. By the end of therapy D had started feeling more “complete” –as he stated- he was not feeling depressed and anxious anymore, he had started having a “good time” in his relationship, feeling loved and accepted and he had not had a flare up of his condition for more than 3 months (and 6 months at follow up).

In my opinion, D would not have progressed so much with a traditional CBT or REBT approach, or even with any other CBT discipline that keep the focus more on rationality than emotionality. D was a person who was using rationality as a means of detaching from emotions. In my personal opinion any other CBT discipline would just reinforce this dysfunctional attitude that in reality perpetuated his psychological imbalance.

Cognitive Analytic Therapy (CAT) could have also been helpful with D. CAT integrates cognitive and psychoanalytic ideas emphasizing not only self awareness and conscious choice, but also internal objects that are derived from early experiences and influencing current relationships (Bateman, Brown & Pedder, 2000). D’s problems were strongly related to his early relationship with his parents and significant others and were perpetuated through his ways of relating and interacting with other people in his adult life. His insecure attachment style determined the belief he held about himself (I am unlovable and alone) as well as his ways of copying with a potential threat to social criticism. D’s attitude is what Ryle describes as “reciprocal role procedure” (RRP) according to which the child learns to respond to or elicit reactions from significant others and generalize these to other people. A repertoire of reciprocal roles becomes internalized and determines future relationships. These roles are directly but carefully mapped out in CAT therapy through the

use of loops and arrows (i.e taps, dilemmas and snags) that demonstrate the recurring shifts between roles (Bateman et al, 2000). The explicit links between D's past and present relationships and roles would have given to D a deeper awareness of the internalization and object relations processes.

Section 3: Personal Philosophy of CBT.

I am aware of the fact that my experience as a counselling psychologist is still very limited. However, having been theoretically and practically trained for over three years as a CBT therapist I have come to the conclusion that there is no "right" or "wrong" intervention or approach, as long as these are suitable and respect clients' needs. The "key" is *how* the therapist uses the selected strategies to change either emotional, behavioural, or cognitive dysfunctionality.

As I have mentioned in this paper, there are different schools of CBT that are either developing or expanding the model borrowing elements from other orientations (i.e psychoanalytic) and integrating them into a unified model. Research has shown that complex problems require complex treatments, and the more impaired the client is the better he/she responds to a comprehensive and integrated treatment (Corsini, Wedding and Dumout, 2007). CBT has been able to address this need for complexity and comprehension by maintaining a more flexible position toward change and development compared to other schools of therapy.

The way I conceptualize integration is by parallelizing it with knowing how to speak foreign languages. For example you cannot speak English to a person who only speaks French because he/she will just not understand you. Many times throughout my practice as a therapist I realized that practicing an approach that the client does not understand or cannot relate is like speaking "a different language"; no matter how hard you try you can

never make this person understand even if you start from the most basics. Throughout my practical experience there were times where Schema Therapy would not work at all and clients could not relate to the model describing it as “too abstract/too theoretical”– especially the less complicated cases of anxiety. On the other hand, REBT was – interestingly enough- described by some clients as “*overly demanding*” – especially by those clients that had very low self-esteem and particularly impulse control difficulties. Traditional CBT has been described by some others as “too unemotional” and “mechanistic”; Mindfulness as “simply one more relaxation technique”. The same models however have been significantly helpful with other clients. Bottom line of these comments, according to my personal opinion, is that it is in the therapist’s skills to assess what could work best with whom and not just which model is more effective for each presenting problem.

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Year 3

CBT Level 3: Couples & Group Therapy

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29/04/10

Student ID: 06032739

Word Count: 5000**Introduction**

The case study that will be presented is a 6 session therapy with a mother and her adolescent daughter that presented significant communication difficulties. The daughter was referred to the psychodermatology service at RoyalFreeHospital due to her acne that had significantly impacted on the girl's psychological well being. Therapy was initially started with the daughter but the mother joined therapy after a few sessions.

This case has been my first attempt in practicing couples/family therapy, thus I have taken the opportunity to examine my own specific practitioner skills in greater depth by writing a case study than I would otherwise have done through supervision alone. The present case study focuses upon how Cognitive Behavioural Couples Therapy (CBCT) techniques have helped break dysfunctional interactional patterns between the couple in a relatively short period of time.

CBCT is considered to have strong empirical base. In addition, it has the advantage of a short-term, structured therapy, effective in situations that demand specific treatment plans and assessment of defined therapeutic goal attainment (Epstein & Baucom, 1998 in Freeman, Simon, Beutler & Arkowits). Considering the limited sessions that were offered according to the policy of the department, as well as the specific presenting problem in communication, CBCT was considered to be the most appropriate approach for this case.

Therapy was initially aimed at helping S overcome her social anxiety problems. However, it became clear, even from the first session, that family therapy would be most appropriate. I initially worked with S on an individual level for 6 weeks in order to build a solid ground for building her self esteem and working on her social anxiety. For the purposes of this paper the individual work with S will be summarized, while detailed information is going to be presented regarding the work with S and her mother.

Therapeutic Framework

A basic assumption of Cognitive Behavioural Couples Therapy (CBCT) is that there are certain cognitive, behavioural and affective factors that interact in a specific way so as to produce relationship distress and conflict (Patterson, 1982). The central tenet however, is that family member's evaluations and interpretations of each other's behaviour

have an impact on the nature and extent of their affective and behavioural responses to one another. The goal of CBCT is to address the pattern of interrelations among partners' behaviours, cognitions and emotions that impact on the quality of the relationship (Ellis, 1977 in Ellis & Grieger; Ellis & Harper, 1961).

On the cognitive level, CBCT suggests that family members' appraisals of one another's behaviour influence the behavioural and emotional reactions of one to another (Freeman & Dattilio, 1992). Appraisals are based on certain negative automatic thoughts and cognitive distortions that bias the information processing of each member (Ellis & Dryden, 1997). Negative automatic thoughts and cognitive distortions, on the other hand, are shaped by the individual's "schemas" (Young, Klosko, & Weishaar, 2003). Schemas are defined as stable underlying core beliefs regarding one's self, others and the world. Schemas about relationships, and family members' interaction are developed early in life and shape the way people believe things "should be" in a relationship. Schemas are the "tool" for coding, categorizing and evaluating new situations (Young, Klosko, & Weishaar, 2003). CBCT assumes that each member of a family has certain schemas about every member of the family as well as about family interactions in general. Additionally, when an individual enters a relationship he/she carries some schemas from his/her family of origin (Ellis & Harper, 1961b). Figure 1 illustrates the development of a family schema

According to Baucom and Epstein's (1998) Typology of Cognitions there are certain typologies that arise from schemas and automatic thoughts and are implicated in relationship conflicts and distress. Namely, these are:

- 1) selective attention → selectively noticing negative aspects in the interaction while ignoring the positives
- 2) attributions → negative attributions/inferences about the causes of events in the relationship
- 3) expectancies → about the probabilities of certain events occurring in the future
- 4) assumptions → beliefs about how relationships work
- 5) standards → beliefs about how relationships/families in general should be

These typologies have the potential to develop dysfunctional interactions among family members.

On the behavioural level, CBCT suggests that relationship distress is the product of the exchange of negative behaviour among family members. Literature has shown that

distressed couples engage in a circular escalating exchange of antagonistic behavioural patterns merely due to lack of communication and problem-solving skills (Dattilio, 1998).

CASE STUDY

Part 1: Initial Assessment

Referral:

S was referred at the psychodermatology service, where I work as a Counselling Psychology trainee, by a consultant dermatologist due to her acne. The referral letter was emphasizing the fact that S had difficulties in socializing and needed her mother in order to get out of the house. The referrer believed that S would be benefited by some counselling.

Therapist's First Impressions

From the referral letter it was clear that S was presented with social anxiety. The referrer's description of the mother's involvement gave me the impression that the mother was finding it difficult to deal with S's anxiety and was thus behaving in an over-protective manner, maintaining and perpetuating S's feelings of vulnerability and low self-esteem. According to literature, social anxiety encompasses feeling of vulnerability, a perceived sense of lack of coping skills, catastrophizing thoughts and an intense fear of negative evaluation by others (Leary & Kowalski, 1997).

On the assessment session, I saw S waiting with her mother at the reception. The mother seemed very concerned asking me to come in the counselling room with S. I invited the mother to come with us. When we entered the room, I explained to both of them what the process was going to be and then asked them whether it would feel "OK" to both of them if the mother left the room. They both said it would be "OK" and the mother left the room emphasizing to S that she will be "right outside". When S stayed alone with me she was avoiding eye contact. Nevertheless, she engaged well in the discussion.

The initial presentation of the mother-daughter interaction struck me that perhaps S had the role of the "vulnerable" child in the family whereas the mother the role of the protector who was trying to control for every perceived threat and take over any responsibility in the family. Later on, when only the mother was the one to join therapy it

stuck me that perhaps the mother felt she was the one to be blamed for her daughter's problems.

S's Background Information

S was a 16 year-old-girl. She developed acne at the age of 14. According to S, her acne had been uncontrollable and she was experiencing frequent and unpredictable exacerbations for one year. She started taking Roaccutane (appendix A) one year ago. S would avoid socializing without her mother's presence. She would also avoid going to social gatherings or meeting up with friends.

S was British in origin. She was the first child of two. Her sister was 9 years old. S described her sister as very "autonomous" and "out going" and their relationship as "very good". Her mother was working as a private secretary. The mother (Mrs T) was diagnosed with myasthenia gravis (appendix B) two years ago. S, described feeling very concerned about her mother's health. S described her relationship with her mother as a very close and "caring" one.

S's reported that her father had been unemployed for two years and that this was bringing a lot of stress in the family regarding the finances. She described her relationship with her father as good but she mentioned that she used to avoid discussions with her father ("he just does not understand"). She described her parents' relationship as "good but distant".

S mentioned that her mother was working for many hours before her diagnosis and thus S was actually raised by her grandmother who died two years ago. S described that when her grandmother died she felt "vulnerable" and "alone" thinking that she would have nobody to support her. She also mentioned that she didn't want to talk to her parents about her problems a lot as "they had a lot in their minds already".

Mrs T Background Information

Mrs T was 40 years old. Two years ago she was diagnosed with myasthenia gravis and she was feeling very concerned not only about her health but also about what impact this would have on the family.

Her father had died when she was 13 years old due to an accident at work. Both of Mrs T's parents were described as very "rigid" but "caring". Mrs T grew up with her mother. The two women were very close and when Mrs T got married her mother went to live with the couple. Mrs T described that her mother was a very "strong, rigid and autonomous" woman. She felt that they had to protect each other ever since the father died. She also stated that she was feeling different from other girls in her age because of her father's loss.

Mrs T started working as a sales-assistant at the age of 18 in order to assist the family financially. She met her husband at the age of 20 and they got married three years later because Mrs T got pregnant.

Her husband was 43 years old. He was the 2nd child of two. His father died from cancer one year after Mr T's wedding while his mother died from heart attack one year ago. His father used to be a doctor whereas his mother a school teacher. Both of his parents were described as very critical. Mr T did not have a job until he met Mrs T who managed to find him a job as a builder but he had been unemployed for the last two years.

Mrs T was currently working as a private secretary. After her mother's death, Mrs T started finding it really difficult to manage things alone. The diagnosis came as one more burden since Mrs T was getting physically exhausted year by year. In addition, ever since S developed anxiety problems she had to reduce her hours at work so as to be able and support S. The genogram of the family is presented at appendix C

Few Comments About the Individual Work With S

I initially worked with S on an individual level even though it was obvious from the first session that family therapy was needed. Considering S's possible role of the "problematic child" in the family, this run the risk of confirming S's role. However, considering S's dependency on the mother, I thought that having the opportunity to interact and relate with another person (the therapist) whilst working on her vulnerability and low self esteem before starting family therapy, would give her a sense of autonomy.

S and I worked on an individual basis for 7 sessions. Family therapy was suggested to her by day one, but S stated that she would prefer to work individually first as she was not ready yet to "confront" her parents.

Therapy with S was focused on her social anxiety and on her vulnerability and abandonment schemas that were related to her mother's sickness and the loss of her grandmother. The family responded to S's anxiety by constantly pleasing her needs so as not to make her upset. Through the use of relaxation training, re-examination of core beliefs, re-examination of cognitive distortions/negative automatic thoughts, continuum work, schema work and behavioural experiments, S managed to strengthen her self-confidence and self-esteem and significantly overcame her anxiety problems. Throughout therapy though, it was evident-even to S herself- that the family environment was blocking S's progress as they were negatively reinforcing S's cognitive and behavioural avoidance. For example, her mother would make sure to satisfy any of S's demands/wishes in order to avoid upsetting her. She would also take over any responsibility for her behalf perpetuating S's belief of being vulnerable.

On the 6th session, S told me that she was feeling strong enough to include her family in therapy.

Therapist's Impressions About The Family

The whole presentation of the family so far had given me the impression that there were certain interactions between the family members operating in a circular causality (Barker, 2007). The mother was presented as an over-protector who wanted to have the control over everything whereas the father as unreliable and uninterested, the younger daughter was presented as a very autonomous and strong kid something that was completely different from S presentation in the family. According to a family systems perspective circular causality views "every element of an interaction as a part of a sequence of simultaneous interactions that are all interconnected" (Yonkara & Dryden, 1997, p.101). Thus even though the focus was initially on S's dysfunctionality, it became clear to me that the primary emphasis should be placed on the interactional sequence among the family members. In addition, according to System's Theory, it seemed like there was a problematic "subsystems" pattern within the family between the mother and S, leaving the father and the younger daughter outside (Barker, 2007)

Clients' Perception of Problems

At this point it would be important to note that I arranged to individually see the mother for one session so as to introduce her to family therapy, about her own concerns and get a detailed background history. The mother stated that her main concern related to S was the fact that she didn't know how to cope with and appropriately support S. She also

stated that she could not “trust” her daughter in taking over responsibilities. S complained that her mother did not leave her space to “breathe” and was making her feel dependent and incapable.

Therapist’s Formulation

Mrs T’s early experiences led to the formation of certain schemas related to being a failure and defective. Her way of coping with these painful schemas was overcompensation manifested through perfectionism and a need to control. In order to achieve her high standards Mrs T was taking over all the responsibilities in the family and was being over-protective towards S who was supposed to be the “problem in the family”. This however was making Mrs T feel overwhelmed and exhausted. The more exhausted she would get the more worried she got about S. Situations that were getting out of Mrs T control (i.e S’s panic attacks/ her own physical exhaustion) were confirming her original belief of being a failure and were thus making her feel helpless behaving in a submissive way every time S would make a demands (even irrational i.e all the family will stay in the house).

On the other hand S’s early experiences had led to the formation of schemas related to been vulnerable, incompetent and unsupported. S coped with these beliefs by completely surrendering to her schemas and becoming dependent on others and specifically on the mother. Her schemas of being incompetent were triggered every time her mother was acting over-protectively towards her whilst her schemas of being vulnerable and unsupported were triggered every time her mother was “giving up” not knowing what to do. The more vulnerable and incompetent S was feeling, the more the mother believed that S cannot cope with any situation and the more over-protective she was becoming strengthening S’s dependence and self-schemas. This process operated in a “circular causality”. This causality was the product of certain dysfunctional interaction patterns, among the two women, developed by each member’s maladaptive schemas and negative automatic thoughts/cognitive distortions.

Therapy Contract

Issues of confidentiality were explained. The service allowed for six 90 minutes-long sessions on a weekly basis.

SESSION 1:

The father stated that he would not be able to join therapy due to practical difficulties (that were never explained), and S's younger sister was about to go to a summer camp where she would stay for 3 months. Therefore, therapy continued with S and Mrs T only.

I explained to both of them how therapy would help them identify any dysfunctional interaction patterns and substitute them with more functional ones. Then I asked each one to define what the problem was. I did this in an effort to get a clear understanding of each member's perceptions. The mother took the initiative to talk first, which suggested to me not only her role in the family but also the overwhelmed emotions that she experienced. She stated that she was very concerned about S's problems, specifically about what she is going to do if something bad happened to her. She also mentioned that she didn't know what to do and how to deal with S's difficulties. She described herself feeling helpless and depressed. Mrs T believed that S was not able to look after herself and take responsibilities. She did acknowledge though the progress S had made so far which had given her hopes.

S stated that she was feeling pressured by her mother's overprotection but believed she wouldn't be able to cope without her. S believed that her mother's thought of her as "useless" and believed that there's nothing that can be done to overcome her problems.

I discussed with them the circular causality of their interaction drawing a small diagram (figure 2) and they both agreed that it was a good summary of what was going on between them.

I then introduced Cognitive Behavioural Therapy model to both of them. Taking an incident that had happened recently as an example, I illustrated how certain thoughts (automatic thoughts/cognitive distortion) were leading to certain behaviours (control/avoidance) that were further leading to emotions (anxiety, helplessness). Using the downward error technique I demonstrated to each one of them how certain automatic thoughts (i.e She needs me again) are really linked with core beliefs about the self (i.e I am not a good mother if my child has problems). I also introduced to them the Dysfunctional Thought Record and illustrated an example. I also presented to them a list of the most common negative automatic thoughts asking them to try and identify some of their own until the next session.

SESSION 2: Setting Goals and Structuring Therapy

Session 2 started with Mrs T' a statement that she had found the previously presented formulation very helpful. She stated that the mere problem was related to a lack of "trust" which was further (and after discussion) redefined as a "lack of communication". Enhancing communication then became the primary goal of therapy.

Throughout that session, I noticed that Mrs would respond with a sigh, every time S would describe her problems. This impacted on S's behaviour, who seemed reluctant to talk more and maintained a submissive attitude (i.e looking down when talking and maintaining a reserved body posture). Mrs T would then start talking on S's behalf and S would withdraw even more. I asked them to discuss what was going on at that moment. Mrs T replied that this sigh was a sigh of relief feeling good about the fact that they had finally started doing something about S's problems. On the other hand, S perceived this sigh as a sign of hopelessness by her mother and felt ashamed and bad about her self thus maintained a submissive attitude. Mrs T perceived S's withdrawal as an indifference to talk and took over the responsibility of explaining things to me. Mrs T stated that that incident was a very good illustration of what was going on at home. That was a very good illustration of the lack of communication that existed between the two women as well as the pattern of their interaction.

The incident was used as an example of how to identify automatic thoughts and how these were linked to negative emotions and dysfunctional exchange of behaviours. Guerney's (1977) educational approach on communication skills was introduced and I asked them to take the pre-mentioned incident as an example and engage in a discussion that would reflect more appropriate communication skills. This was similar to what Minuchin (1974) has termed as "enactment" with the only difference that my role was more directive and active.

As a homework I asked them to practice the new communication skills at home and complete a DTR form every time they felt overwhelmed or unable to practice the new communication skills. In addition I asked each one to write a list of the positive characteristics of the other.

SESSION 3

On the third session they both came in saying that their communication within the last week had been partially effective. Mrs T described an incident when the family was about to go at a friends's house but S changed her mind the last minute. No matter how hard Mrs T tried to convince S, she would not accept to follow. As a result the rest of the

family left but Mrs T stayed behind with S. Mrs T reported feeling very sad and angry towards S thus she was avoiding talking to her daughter. The automatic thoughts/cognitive distortions that had been identified were: “She never thinks about me”, “She always causes problems” “She is so weak”, “She will never become well”, “I must be doing something wrong”.

On the other hand S reported that she was just not in the mood of going out and that it had nothing to do with being anxious. She felt very sad because her mother stayed behind her but she could not express her regret because the mother was not talking to her. As a result she stayed locked in her room. The automatic thoughts/cognitive distortions that had been identified were: “She thinks I am too sick to go out”, “May be I am, that is why I do not want to go out”, “I will never get well”.

Through Socratic questioning and cognitive restructuring the two women managed to dispute their cognitive distortions and gain an understanding of each other’s perspective. It struck to both of them (as they reported) my note on how S’s mood is not always related to her anxiety problems and in fact there could be occasions that she did not feel like socializing; this did not mean however that S was relapsing or was not progressing. Through functional analysis both of them were able to realize that in fact S had managed to go out/socialize with her friends in several occasions within that week and that these positive occasions had just been ignored by both of them. This was particularly revealing for S who had started fearing that she will relapse.

We then discussed about what was it specifically in each one’s behaviour that triggered the other person’s negative reaction, and how each of them would have liked the other to have responded in that situation. Specific undesired behaviours/reactions were identified from both sides and were written down on a piece of paper. Alternative, desirable responses were established and written next to the “undesirable” ones. A role play of the situation applying the new functional behaviours was conducted. We then formulated a behavioural agreement that each member had to sign and follow. Monitoring both the “undesirable” and “desirable” behaviours and responding according to the behavioural agreement was put as a homework for next session.

SESSION 4

On the 4th session S appeared to be “furious” towards Mrs T. She described that the same morning her mother had arranged for S to see a private teacher without asking her opinion first. She went on saying that she (the mother) always neglected S’s opinion. Mrs T

replied that she just believed that this would support S at school as she had missed many lessons due to her anxiety. S insisted that her mother kept treating her like a “baby” and that this was exactly how she was feeling like. We worked first on a cognitive level trying to identify both women’s cognitive distortions and automatic thoughts that elicited anger (for S) and desperation (for Mrs T). The focus however was shifted on the objective problem which was that S was actually left behind in terms of lessons and that this was making her feel “incompetent”. This incident was used as an opportunity to implement problem solving skills in the therapeutic content. This is a complex set of skills that includes communication, negotiation and contracting skills (Bedel & Lenox, 1997). We therefore, identified the problem by achieving a clear definition of it, generated different solutions, evaluated each one, agreed on the most appropriate one and finally agreed on a trial period for implementing the solution.

Discussion then was shifted on how important it would be for both of them to include S in the family’s responsibilities. Mrs mentioned that S didn’t even know when the bills had to be paid. Thus, we developed a list of all the responsibilities that S and Mrs T felt that S could take over. Emphasis was given on how often the family (or at least the two of them) had to meet within a week in order to discuss and find solutions about problems and responsibilities. A weekly plan was established in which the two women had to meet and discuss important issues such as the alteration of house rules, negotiations of responsibilities, and-most importantly-fun family events.

We didn’t have time to discuss about the previous week’s homework but it was put on the next week’s agenda. In the meantime, monitoring of how successful and pleasant the above mentioned activities would be was set as homework for next week along with continuing exercising last week’s behavioural agreement.

SESSION 5

By session 5, Mrs T and S had already managed to significantly improve their communication which was strengthening not only their relationship but also their positive beliefs about themselves. S had started realizing that the only reason her mother saw her as “problematic” and “irresponsible” was because she was “choosing” to behave likewise and that this was in her control to be changed. Mrs T had started realizing that her daughter was capable of looking after herself and that this could be strengthened by leaving some space to S for autonomy.

Session 5 started with a discussion on the homework. Mrs T stated that the homework of the last two weeks had been very helpful for both of them. Mrs T had managed to include more pleasurable activities in her agenda as she was not feeling obliged anymore to look after S all the time. S had managed to strengthen her autonomy and self-confidence by staying home alone and in some occasions invite some friends over when she was feeling bored. In addition, both women stated the weekly meetings had managed to bring the whole family closer and S reported that throughout these meetings she was feeling a “member” of the family and not the “problem” of it. I continued to monitor both members in challenging their beliefs. During this process, feelings and emotions were also addressed as well as communication skills and problem-solving strategies. The two women continued to have some interaction problems, but in general they reported that the quality in their relationship had increased and both women were feeling emotionally closer to each other.

We started discussing about next week’s ending. They both expressed a concern over relapsing but mutually agreed that they were feeling more confident dealing with their problems.

SESSION 6

Session 6 was the last session. We summarized the progress both women had noted so far and the skills each one and both of them together had acquired. We also discussed about possible drawbacks and the most important one that was mentioned was Mrs T’s health related problems that could put both women into a very difficult situation triggering dysfunctional interactions. Ways of dealing with certain difficulties related to the situation described were examined through a problem solving approach. Possibility of future personal therapy for Mrs T related to her health-related concerns was also discussed. A follow up session was arranged

Evaluation of Therapeutic Work and Therapist’s Comments

I am aware that there were certain important issues that were not appropriately addressed in therapy like the mother’s health related problems and the insecurity these were triggering to both S and the mother herself. This became most apparent in the last session when the problem was addressed through a practical approach, leaving the cognitive and emotional aspects of the situation partially unaddressed. I consciously decided however to focus on bringing the two women closer and facilitating their communication patterns believing that this could empower them in dealing with difficult

situations later on in their life. Reflecting on it now, it could be my personal insecurity to deal with such a painful situation in a short period of time and as inexperienced as I was in practicing family therapy.

Reflecting on this case again, I see that I could have worked more on the dynamics of this couple through a social constructionist/narrative approach which perceives mental phenomena as merely social and has accordingly categorized interaction patterns that promote pathology (Hoyt, 2001)). Accordingly, in this case, the pervasive pattern of acts of “dominance and control” by the mother, coupled with acts of “submission and compliance” by S were leading to a “pathologizing interpersonal pattern” (PIP). According to social constructionist/narrative approach (ST/NA), pathology exists primarily in the disembodied interaction rather than the persons who interact. Part of the goals of therapy is then placed on facilitating the couple to perceive PIPs as located between them and not inherited within them, a process that is called “externalization”. This approach could have been very useful in my work with this couple as one of the main difficulties I encountered was to persuade both Mrs T and S that the problem was not related to their personalities but to the way they interacted with each other.

Another difficulty that I encountered was working with two people simultaneously. Having worked with S in the past I had to keep reminding myself that my client is not S alone but the couple as a whole. In addition, there were many instances that I felt I was “colluding” with either Mrs T or S and I had to keep reminding myself to maintain an objective attitude. Nevertheless, I do believe that this case was an “easy” case as both women were very cooperative and psychologically minded, taking on board and processing even further what was discussed in therapy. I also believe that both women got something important out of therapy both on an individual and on an interactional level, and that my first attempt in family therapy has been efficient enough.

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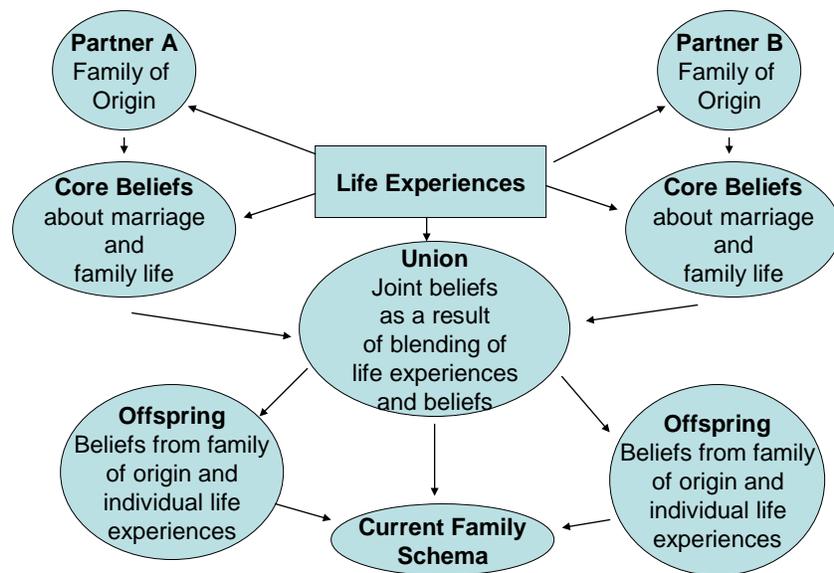


Figure 1. The development of a family schema (Dattilio, 1998)

Mrs T and S in a dynamic interaction
“When I treat you like a baby, you behave like a baby, and then I treat you like a baby even more
and you behave even more like a baby”
“When I behave like a baby, you treat me like a baby, and then I behave like a baby even more”

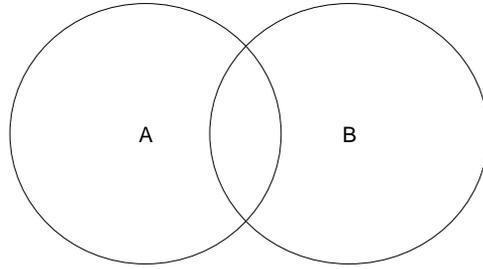


Figure 2. Circular Causality Between Mrs T and S.

APPENDIX A

Side Effects of Roaccutane/Isotretinoin Therapy

(http://en.wikipedia.org/wiki/Isotretinoin#Adverse_effects, 25/04/2010)

Increasingly higher dosages will result in higher toxicity, resembling vitamin A toxicity.

Adverse drug reactions associated with isotretinoin therapy include:

- Common: Mild acne flare, dryness of skin, lips and mucous membranes, infection of the cuticles, cheilitis, itch, rosacea, skin fragility, skin peeling, rash, flushing, nose bleeds, dry eyes, diffuse alopecia areata, eye irritation, conjunctivitis, reduced tolerance to contact lenses, hyperlipidaemia, raised liver enzymes, permanent thin skin, headaches, temporary/permanent hair thinning (this could start or continue after treatment), myalgia and/or arthralgia, back pain.
- Infrequent: severe acne flare, raised blood glucose level, decreased libido/erectile dysfunction, increased erythrocyte sedimentation rate, fatigue.
- Rare: impaired night vision; cataracts; optic neuritis; menstrual disturbances; inflammatory bowel disease; pancreatitis; hepatitis; corneal opacities; papilloedema; idiopathic intracranial hypertension; skeletal hyperostosis; extraosseous calcification; psychosis; depression

There are spontaneous reports of premature epiphyseal closure in acne patients receiving recommended doses of Accutane. The effect of multiple courses of Accutane on epiphyseal closure is unknown.

The following adverse effects have been reported to persist, even after discontinuing therapy: alopecia (hair loss), arthralgias, decreased night vision, inflammatory bowel disease, degenerative disc disease, keloids, bone disease. High dosages of isotretinoin have been reported to cause rosacea (a disease of severe facial skin redness and irritation).

Patients receiving isotretinoin therapy are not permitted to donate blood during and for at least one month after discontinuation of isotretinoin therapy due to its teratogenicity.^[35]

Depression

There seems to be a link between isotretinoin and clinical depression.

Crohn's Disease and Ulcerative Colitis

Several scientific studies have posited that isotretinoin is a possible cause of Crohn's Disease and Ulcerative colitis in some individuals.

APPENDIX B

Myasthenia Gravis

http://en.wikipedia.org/wiki/Myasthenia_gravis#Prognosis, 25/04/10)

Myasthenia gravis is an autoimmune neuromuscular disease leading to fluctuating muscle weakness and fatigability. Myasthenia is treated medically with cholinesterase inhibitors or immunosuppressants, and, in selected cases, thymectomy. At 200–400 cases per million it is one of the less common autoimmune disorders.

With treatment, patients have a normal life expectancy, except for those with a malignant thymoma. Quality of life can vary depending on the severity and the cause. The drugs used to control MG either diminish in effectiveness over time (cholinesterase inhibitors) or cause severe side effects of their own (immunosuppressants). A small percentage (around 10%) of MG patients are found to have tumors in their thymus glands, in which case a thymectomy is a very effective treatment with long-term remission. However, most patients need treatment for the remainder of their lives, and their abilities vary greatly. It should be noted that MG is not usually a progressive disease. The symptoms may come and go, but the symptoms do not always get worse as the patient ages. For some, the symptoms decrease after a span of 3–5 years.

Applied Therapeutic Practice

PYP 047C

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28/07/10

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Word Count: 5000

INTRODUCTION

This process report examines a transcript from a fourth counselling session with a 35 year old woman presented with Crohn's Disease (CD), acute urticaria and clinical depression. This client was referred in the past to our service for Cognitive Behavioural Therapy. However, two years after therapy had ended she experienced a relapse and was re-referred.

The aim of the present transcript is to present the processes involved between me and my client in an attempt to facilitate my client overcome her resistance in getting close to her emotions towards her mother. For purposes of confidentiality, my client will be named "Anna".

Section 1 overviews the main principles of Schema-Therapy (ST), the biopsychological model of CD and the rationale behind choosing ST for Anna. Section 2 is an outline of psychological assessment. A 10-minute transcript is presented at section 3. Section 4 presents the evaluation of that session.

Why I Chose This Case

The use of this case for my process report will help me develop a more thorough understanding of the relational processes that affected the therapeutic progress. The detail of a process report will help elucidate these processes (elaborated on the evaluation section).

PROCESS REPORT

Section 1

Theoretical Orientation: Schema-Therapy (ST)

Young (1994) developed ST and offered the term Early Maladaptive Schemas (EMS) which are comprised by self-defeating, emotional and cognitive structures of the "self" that begin early in our development and repeat throughout life.

EMSs represent reality-based representations of the child's environment (Young, Klosko and Weishaar,2003). The dysfunctional nature of schemas becomes apparent later on in life when individuals continue to perpetuate them in their interactions with others.

Young and colleagues (2003) proposed the existence of 16 primary EMSs (appendix A). Once activated schemas generate high levels of affect and individuals often develop self-defeating emotional/behavioural cycles that perpetuate them.

According to ST (Young et al.,2003) there are three major schema processes: a) schema maintenance, b) schema avoidance and c) schema compensation. Hence, schemas are held firmly in place through these processes that may be either behavioural, cognitive or affective (Young & Behary,1998).

Finally, ST suggests that there are certain schema-modes, described as: the predominant mood/behavioral state that people are in at any given point. These are: a) The Angry Child, b) The Vulnerable Child, c) The Detached Protector, d) The Punitive Parent and e) The Healthy Adult (Young et al,2003).

The Biopsychological Model of Crohn's Disease

From a psychological point of view, people with CD experience, high levels of depression and anxiety (Tresigni and Prantera,2009). Tersigni and Prantera (2009) have stated that people suffering from CD face a number of challenges that contribute to disturbed affect, namely: a) physical symptoms, b) uncertainty about illness, c) change and loss.

These challenges however, are implicated in the maintenance and exacerbation of CD. Bitton, Dobkin, Edwades, Sewitch, Meddings, Rawal, Cohen, Vermeire, Dufrense, Franchimond and Wild (2008) described that high levels of stress and affect contribute to neuroendocrine and immune responses that may ultimately affect health outcome and disease relapse.

Generally, Tersigni and Prantera (2009) suggested that when treating people with CD therapy should aim at: a) psychologically integrating the disease with the limitations it puts on physical functioning and self-image, b) acceptance of long-term treatment, c)

balancing relations with emotions, d) re-engagement with pleasurable activities, e) letting go of resentment and dependency and f) redefine life goals.

Literature however, argues that self-schemas mediate how successfully a person will meet these goals. Schemas might pre-exist the condition or might be shaped by the presence of the condition and define the way the person will adjust to the condition (Kent and Thompson,2002).

Why I Chose ST for Anna

My client was presented with a condition that led her to experience stigmatization. I believed that through the use of ‘empathic confrontation’ and ‘limited reparenting’- significant tenets of ST- as well as through working on self-schemas my client would be facilitated in shifting her focus away from labels related to her disease and explore her self behind the condition.

Section 2

Client Profile

Anna, is a 35 year-old lady presented with CD, severe depression and past deliberate self-harming behavior and suicidal ideation. The onset of CD was at 10 years of age and she had been suffering from depression ever since. She had been hospitalised at a psychiatric clinic for 6 months due to her depression and self-harming behaviour (age 29). Anna described still feeling depressed when she left the hospital. However, she had stopped self-harming. She was given a diagnosis of clinical depression by a psychiatrist who was following her up every three months and was under medication (appendix C).

As Anna stated, she received psychodynamic and person-centered therapy in the past but both of them were “not helpful” and she dropped out. However, she described that CBT (two years ago for 10 sessions) had been very helpful.

Referral and Service

I work as a Counselling Psychology trainee at Royal Free Hospital-Psychodermatology Department. People are referred to this service by dermatologist mainly due to skin conditions.

Both times Anna was referred to our service due to acute urticaria by a special-Registrar in dermatology. However, it quickly became clear that the implications of CD were more intense than urticaria. Thus therapy focused on CD and depression.

Therapist's First Impressions

Anna came to therapy crying. She seemed very weak and thin and admitted that she had not been eating properly for the last 4 months. Assessment revealed no symptoms of distorted body image perception, or any type of eating disorder [DSM-IV (APA, 2004)]. Risk assessment also revealed no intentions of self-harm or suicidal ideation. I contacted her psychiatrist who confirmed that Anna had stopped self-harming 6 years ago.

Client's Description of Problems

Regarding her CD, Anna described that she was experiencing extreme pain and physical discomfort. Regarding her depression, Anna complaint about constant crying and feelings of hopelessness related to having a “normal life”.

Anna described that the main reason of her depression was her mother's attitude towards her. She stated that she avoided getting involved in any kind of activity or socialization out of fear that she would be blamed for a disease relapse by her mother. This however, was making her feel depressed and incompetent. Anna also stated that she could not argue her mother as she was feeling financially “dependent” on her.

Overall, Anna described that she perceived herself as “boring, incompetent and victim”. She believed that she looked “sick, boring and uninteresting” to others. Anna also complained for not being able to find a partner. She stated that “everybody was giving-up” on her due to her condition.

She also mentioned that six months after our last therapy she started feeling depressed again. She explained that her progress (psychological and physiological) had made her family pay “less attention” to her. Anna started doubting her ability to cope on her own. As she described, this doubt triggered her depression and CD relapse.

Background History

Anna was white-British. She was the second daughter of three. She described that her relationship with her sisters was not a good one.

Anna described her mother as “critical and uncaring” and their relationship as “bad”, while her father as “supportive and sweet” and their relationship as “good. The couple had taken a divorce when Anna was 8 years old and the father had been living outside the UK ever since.

Anna was diagnosed with CD at the age of 10 and she became depressed ever since. She described that there was nobody to support her emotionally. She also described that her first suicidal attempt (took pills) was at the age of 15 after a “huge” fight with her mother. Anna described the suicidal attempt as one way to show to her mother how much she was suffering. According to Anna, there were two more suicidal attempts, one at the age of 16 and one at 20 that aimed at getting her mother’s attention.

Anna’s first relationship was at the age of 26, it lasted 3 years, and she described her boyfriend as critical and domineering. She started self-harm during these three years (i.e. cutting wrists, banking head on the wall). The couple broke up because her partner “could not deal with her CD and her dependency”. As a consequence, she fell into severe depression and got hospitalized. Anna never got in a relationship ever since.

Formulation & Hypotheses

According to Young et al (2003), unmet emotional needs and “toxic” childhood experiences shape the person’s self-identity and bottom line schemas. Anna’s negative were related to rejection (by mother, boyfriend etc), stigmatization (due to CD), physical pain and loss (parents’ divorce, father leaving the country, boyfriend leaving her).

These early experiences and unmet emotional needs constituted the origins of Anna’s EMSs related to *Dependency/Incompetence* (I cannot take care of myself) *Abandonment* (others will abandon me), *Defectiveness* (I am not good enough/unlovable) and *Emotional Deprivation* (I am alone/unsupported).

Anna’s schemas determined the establishment of certain unhelpful predictions that further determined Anna’s coping behaviour (discussed below). Namely these predictions were: a) If I am perfect then I will not be a failure/worthless, b) I need others in order to

survive, c) If I assert/express myself others will reject/abandon me d) I need to appear as needy in order to maintain other's attention.

Certain situations, like: a) real/perceived threat of failure (e.g. failing a course); b) decision making; c) everyday hassles (e.g. housework); d) being criticized/rejected/shouted at; e) getting better and losing other people's attention acted as triggers for Anna's underlying self-schemas that generated high levels of affect (anxiety, depression, anger) and further lead to the development of self-defeating cycles that perpetuated the schemas.

Specifically, Anna was excessively preoccupied with perfectionism (schema overcompensation) and was constantly feeling pressured and disappointed by her self. This confirmed her schema of defectiveness that further lead to emotional (anxiety, depression), behavioural (avoidance) and physical (stress, CD exacerbations) implications.

Anna would also avoid expressing any kind of emotion or need (schema avoidance). This however perpetuated and confirmed her emotional deprivation schema making her feel "alone" that further lead to depression and again to CD exacerbations.

Feeling depressed and "incompetent" to support her self, Anna was relying on others (i.e mother) for support appearing as "needy".

In situations where others (i.e. mother) were taking the full control of Anna's life, her dependency/incompetence schema was confirmed and perpetuated. At the same time though, Anna was getting angry at others (i.e. mother) for being overly critical and "restricting" her life. Anna's anger then would trigger her abandonment schema as she feared of a possible abandonment in case her anger was expressed. Thus Anna was emotionally coping with her anger by internalising anger, blaming herself and feeling guilty. Guilt further confirmed her defectiveness and dependency schemas.

On the other hand, in cases where the control of her life was left on her, her abandonment and emotional deprivation schemas were triggered. The idea of

becoming independent and taking the control of her life was terrifying to Anna since it implied that by becoming less needy she would be abandoned without feeling equipped to work on her own. This could possibly explain Anna's full relapse, 6 months after the end of the initial therapy.

Consequently, once Anna's abandonment and emotional deprivation schemas were triggered she would overcompensate by clinging on the other person and appearing even needier. This however, not only lead to other people's dissatisfaction but also to the strengthening of her belief that there is something fundamentally wrong with her (defectiveness) and that others cannot understand her (emotional deprivation) or will abandon her (abandonment).

All these cognitive, emotional and behavioural processes operated in a reciprocal cycle making Anna feel "stuck" and experience helplessness/depression. The cycle though operated even further bringing additional disadvantages to Anna. Anna constantly avoided confronting situations (i.e. arguing mother) or exercise assertion out of fear that she would jeopardise her relationships and be left alone. In addition, she appeared so needy and desperate that it was very difficult to find a partner who would be willing to meet her needs.

Contract & Therapeutic Goals

Anna strongly related to her schemas. Therefore it was collaboratively agreed that therapy should aim at: For Emotional Deprivation → a) becoming aware of emotional needs and accept them as natural and right, b) becoming aware of and control behaviours that blocked the satisfaction of emotional needs. For Defectiveness → a) accept the fact that her "defect" is actually a limitation that is far less important than she originally believed, c) maintain a sense of her own value regardless of others' criticism. For Dependency/Incompetence → a) increase her self-confidence and skills and b) overcome avoidance of taking on responsibilities and trying out activities without mother's approval

Therapy's rules and regulations were discussed. Confidentiality and DNAs were addressed and a consent form related to confidentiality, anonymity and audio-tapping was signed by her. 15 CBT (ST) sessions were offered to Anna, with the possibility of extension. Even though Anna had overcome her self-harming attitude and suicidal ideation,

a contract was established stating what actions she would have to take in case she felt suicidal or self-harmful again.

Section 3

Lead in Into Session 4

The goal of the fourth session was to facilitate Anna in identifying her schemas, the triggers of her schemas and her copying styles, by recognizing her emotions.

Anna started by describing how the realization that her mother had contributed to her current difficulties was making her upset. The transcript begins at the point where she talks about that.

(1.36)

C1: *(cries)*...It is just the neglect, you know, it is always something that I thought..you know...she knew I was so ill as a child and she just...didn't care, felt like she didn't care...and then I would have gone to try and make her feel better and all she did was just blame me and scream at me and destroying me... *(small pause)*

T1: Hm hm...So what is the thought, the mere thought that makes you so emotional at that moment? I mean the fact that your mother was...

Comment 1: *At C1 Anna gives me a description of how neglected she felt by her mother. She starts crying. Anna's presentation and description made me think that her emotional deprivation schema had been triggered making her feel vulnerable and alone. According to Young et al (2003) when schemas are triggered the emotionality experienced resembles the one that had been experienced in the past. My goal at T1 was to get the focus back to Anna (not the mother) and to the present moment and explore the core thoughts that were making her so emotional.*

C2: *..(interrupts)..what did I do?... (crying, very low voice)*

T2: Sorry?...

C3: What did I do that was just ...*(small pause)* so awful... and it wasn't like that for my other two sisters when they were growing up...and you know after learning all that stuff now to see how it has affected my life..it's, it's hard to take on

Comment 2: *At C2 Anna's tone of voice becomes low and I couldn't hear what she was saying, thus at T3 I asked her to repeat. At C3 Anna described that she had realized how her mother had affected Anna's life. I thought that the most "logical" feeling would be anger towards mother and this was what she subtly meant when she said "It is hard to take on". However, Anna appeared as helpless and vulnerable. I realized that this resembled Anna's emotional way of coping with anger. Anna tended to mask her anger with self-blame and guilt. Guilt however was also making her feel "unloved" and vulnerable which was what she was experiencing at the present moment. She also compared her self to her sisters. This signified to me that her defectiveness schema had also been triggered as Anna probably believed that she was not good enough (like her sisters) to get her mother's love. I also noticed that Anna had avoided a) answer my question and b) focus on the present moment. I thought that Anna was just resisting describing her emotions that could reveal her "forbidden" anger. At the same time though, this "forbidden/masked" anger was keeping her focused in the past making her feel vulnerable. I could have asked Anna what was the difficulty in "taking on" such a realization as this could help her recognize her anger. However, I thought that by providing a more realistic perspective of her mother's situation first, would reframe her perceptions, facilitate her to empathize with the mother, feel less angry and less resistant to explore her emotions. My attempts to do that are presented from T3 to T19.*

T3: One thing that...you remember in the previous session we had an imagery, do you remember that?

C4: *Nods head*

T4: Do you remember that I got in the picture and I talked to your mother?

C5: Yes

T5: OK. There was one thing that I was thinking later and I didn't address when I was talking with your mother and it was a very significant point, OK? The fact that when I started confronting your mother and when I started blaming your mother she became very critical of me

Comment 3: *In the previous session we had imagery between "Little Anna" and the "Critical Mother". I had gone into the picture as the "Healthy Adult" who supported "Little Anna" and confronted the "Critical Mother" (Young, 1994). At T3 and T4 I remind Anna of the imagery. At C4 and C5 Anna demonstrates to me that she is paying attention.*

At T5 and T6 my goal was to illustrate to Anna that the mother's attitude was the same towards me as it was towards Anna

C6: Yeh

T6: By saying...by minimizing my job and saying that you psychologists you don't...you know...you do not really understand what happens to other people...

C7: ..(interrupts)...yeh...OK

Comment 4: *At C6 and C7 Anna demonstrates to me that she is paying attention and relates to what I am saying. At T6 I try to make my point (comment 3).*

T7: OK. So what I thought later on was that actually this was...this is...one way for your mother to cope with difficult situations. Your mother is coping by minimizing others and by criticizing others

C8: *Nods head*

T8: OK? When I say cope, I mean cope with difficult situations and a feeling of personal failure.

C9: *Nods head*

Comment 5: *At T7 I actually make my point to Anna: her mother's criticism both to myself and to Anna demonstrated her way of coping with difficult situations. At T8 I emphasize that this coping was related to feelings of personal failure. My goal was to help Anna realize that her mother's criticism/rejection was not related to whether she loved Anna or not but to her way of dealing with personal feelings of failure. At C8 and C9 Anna responds by simply nodding her head which made me think that she had probably not fully related to my point.*

T9: OK? Now when it comes to you...how do you think having a daughter with Crohn's disease let's say, would make your mother feel in terms of herself not in terms of you

C10: Yeh

T10: And how do you think going to her every time proving her..you know..by asking for her support and proving her that she is not able to give it to you, would make her feel?

Comment 6: *At T9 and T10 I invited Anna to put herself in her mother's place and imagine how she would feel in an effort to strengthen her empathy. I remember that at that point I was concerned about how my intervention would come across to Anna. Tresigni and Prantera (2009) have stated that the chronic nature of the disease might negatively impact on the person's self-identity and the person perceives the condition as a fundamental part of his/her personality. Thus, I feared that my intervention would run the risk of communicating to Anna that the problem was actually "her self". That is why at T9 I emphasized the statement: "In terms of herself not in terms of you". At C10 Anna replies with a "Yes" however it was still unclear about whether my fears were true.*

C11: Worse, weaker

T11: About herself?

C12: Yeh. I mean, I know for a long time she blamed herself that it was her fault that I was like this

Comment 7: *Anna's answer at C11 and C12 disconfirmed my fears (comment 6). At T11 I wanted to clarify whether she refers to herself or her mother. Her answer at C12 made me realize that she has started recognizing her mother's feelings of personal failure and self-blame. This was the first time that Anna acknowledged her mother's experience.*

T12: Hm hm...so one way of coping with the feelings of defectiveness that she was experiencing was to criticize you, to ignore the situation

C13: OK

T13: OK? To pretend...as if nothing was wrong

C14: Yeh

Comment 8: *At T12 I attempt to re-present to Anna the link between mother's schemas (defectiveness) and ways of coping [criticism/neglect (ignore)]. The mother's coping had actually contributed to the development of Anna's schemas. Thus, my goal was to communicate to Anna that in reality her mother's attitude/coping was not due to Anna's "defaults" but due to her owns.*

T14: But every time you were going to her... remember the formulation that we did for your schemas?

C15: Yeh

T15: OK? There are situations that trigger your schemas, OK? Every time you were going to talk to your mother and to ask for her support you were triggering her schemas

C16: Aa... OK!

***Comment 9:** At T14 and T15 my goal is to present to Anna what Epstein and Baucon (1989) described as “circular causality” (dysfunctional interaction patterns). Anna’s neediness was a trigger for mother’s criticism/rejection. Anna’s response at C16 signifies to me that she had started realizing my point. I remember though that I was still not sure of whether Anna had actually related to my point. Thus I decided to re-present the pieces of the puzzle together (T16 to T18).*

T16: This by itself was a trigger and when the schema is triggered the behaviour comes out

C17: OK, I understand

T17: Her behaviour is to judge others and to avoid the situation

C18: And she is very defensive

T18: Exactly! So in reality Anna, what you got from your mother is not something that you deserve to get, and it is not related to whether you are worth-full or not as a person, is related to how your mother copes with things, with her difficulties. The other sisters were not such a difficulty for the mother

***Comment 10:** From T16 to T18 I try to make my point (com. 9). At C17 and C18 Anna disconfirms my worries on comment 9. She seemed to have understood my point and added to the formulation of her mother’s reactions. At T18 I make my point more explicit and move on addressing her comparison with her sisters in order to reframe her beliefs related to not being good enough/unloved.*

C19: Yeh! I remember that they were still married while they were growing up

T19: Hm hm..so it was much easier for her and what you experienced as a child is not related to you is related to how she feels inside, how defective she feels and how she copes with this defectiveness. This was a bad way, I am not saying...

Comment 11: My goal to reframe Anna's defectiveness distortions has been successful as at C19 she comes up with realistic explanations of her "differences" with her sisters. At the same time her comment justified mother's difficulties. At T19 I try again to make the picture more explicit to Anna and acknowledge to her that I was not supporting mother's behaviour. My goal was to acknowledge the realistic component of Anna's point of view (she was treated badly) and at the same time explain how "bad behaviours" do not make "bad people". This would validate Anna's experience and lead her to minimize her guilt about thinking "bad" of her mother and feeling angry. Then we would address Anna's demandingness, unrealistic expectations and anger toward the mother. However I was interrupted by Anna.

C20: ..(interrupts)..yeh yeh.. I know, I can see, I mean I do that when I am really stressed and someone asks me for something and I am just..it's just..it's too much it's too much to handle and then I shout. But it's just..I understand this now but still I am so...she really let me down and for so long she made me believe that it was my fault, I believed it was my fault (crying voice)

T20: Hm hm... What would you, would you have liked her to have done?

Comment 12: At C20 Anna seems that she has fully understood my point however she still feels "disappointed" by her mother. Again, I thought that her "disappointment" (anger) is perpetuated by the high expectations she holds and her demandingness toward the mother to be "perfect" regardless of her own difficulties. As her disappointment was so strong and Anna appeared resistant to explore that, I thought that if I was directly saying this to her she would respond either by feeling more guilty or by getting defensive and arguing back. Thus, I decided to just facilitate her in realizing that on her own. By asking her what she would have liked from her mother (T20) my goal was to get her expectations out. Then we would address the validity of each one of them.

C21: To take an interest, to talk...

T21: ..(interrupts)..considering your mother's self-schemas, considering how she perceived the situation, what would you like her, how would you like her to have behaved?

Comment 13: *At C21 Anna gives me a general answer. At T21 I interrupted her. The reason was that I thought of getting the expectations out whilst reminding her of the realistic situation. My goal was to get Anna's high expectations about the mother out first and then evaluate Anna's own reactions on that moment reflecting on the fact that (given that both women had difficulties) as Anna was not able to be "perfect" (cried and avoided talking about feelings) in the same way the mother was not able to be "perfect". This would facilitate Anna in realizing how her demandingness and self-blame perpetuated her anger.*

C22: *...(long pause 10")....more like an adult*

T22: Like?

C23: *Em...just to be more rational and less extreme and to ... (small pause)...*

T23: Like?

Comment 14: *Anna's long pause at C22 signified that she tried to reconsider her answer based on the realistic perspective. She gives me a general answer without specifying what she wanted. At T22 and T23 I invite her to be more specific. I realized that Anna was emotionally calmer than before, signifying that she had started filtering information in a less biased way. Thus, my "invitations" were short as I feared that longer questions would make Anna lose track of the realistic way of thinking and get involved in black-and-white thinking that would disturb her emotional state again.*

C24: *(small pause 8")..em ...she doesn't try... like if something was bothering me she... she couldn't talk about it calmly ...or if someone was being mean to me she was just... I mean what she gave wasn't good...wasn't helpful...em ...I would have liked her to ... (long pause 11")...I would have liked her to stop screaming this is all I can remember (starts crying)...(long pause 32", takes a tissue)...(cries) I just go back and I do not remember even one time when she spoke to me in a descent tone of voice...(small pause)...*

T24: *At this moment, now, that you have become so emotional what is it that hurts you the most in the fact that your mother was always screaming at you, shouting at you?*

Comment 15: *At C24 Anna does not describe what she would like but rather how her mother did treat her. She starts with "I would have liked her to" and then there is a long pause. This signified to me that Anna actually didn't know exactly what she wanted from*

her mother. This was probably due to the fact that she was so emotionally deprived that she didn't really know what would be a "proper" way of responding to a child. I decided not to intervene and leave her the space to explore her thoughts. After the pause, Anna specified her answer stating that she would just have liked her to stop screaming. Then Anna started crying. I realized that my question had brought hurtful memories to Anna that made her emotionally upset again. At T24 I decided to invite her to discuss her emotional experience believing that having reframed her perceptions about her mother first, would probably make it easier for Anna to explore emotions. I chose to focus on the present moment as this would bring Anna back to the here-and-now and discuss how her issues are impacting in the present moment (Fall, Holden & Marquirs, 2004).

C25: It's the things that I was shouted about, or, you know, as I was growing up still some things were new to me and I got excited about it still and I would go to her cause there was no one else around and she would just be so mean about it or just cut my aspirations off...

T25: Hm hm.. this is a description...

C26: ..(interrupts)... OK

T26:..of a situation, OK? I want you to tell me what does it mean to you in order to make you so emotional when you think about it

C27: ...(long pause 5")...it feels chaos..em...

Comment 17: *At C25 Anna continues describing how bad her mother was treating her and does not answer my question again. She also cannot focus on the present moment. Her focus is on the mother and not her self and it seemed as if she really wanted to "accuse" the mother which further confirmed her angry-although masked- feelings. At T25 I decide to bring the focus back on her and reflect that what she is giving me is a description and not an evaluation. Anna seemed to realize that (C26). The long pause at C27 made me think that Anna is really trying to understand her experience at that moment. Her description "feels like a chaos" does not answer my question again. However, I thought that it described Anna's inner experience at that moment.*

T27: But what does it mean to you. The fact that your mother had difficulties and was shouting at you and she was nasty towards you, OK? And not supportive, what does it mean to you now, today at that moment as we speak and makes you feel so emotional?

C28: ...*(pause 7")*...em...*(pause 7")*..I don't understand what it means to me, it is just..I know I should just get over it...

Comment 18: At T27 I shift the focus again on her and on the here-and-now. Anna's answer for one more time seems resistant to me. However, I also had in mind that she might be too confused to articulate her experience.

T28:OK. Let me put it in another way then. You remember the schemas that you read.

C29: Mmm

Comment 19: Having in mind Anna's "chaotic experience" and resistance, at T28 I decide to facilitate Anna in getting some clarity by identifying her schemas first and then move on to emotions as this transition would be smoother and safer for Anna. As Young (1994) have stated emotions can help identify schemas but many times it can be the other way around.

T29: At this moment, now, which schema do you think has been triggered?

C30: I do not know...the defectiveness one?

T30: OK. What makes you say that?

C31: Because...I feel she dismissed me the whole time there was never any...em...nothing I did was important. I never came first (11.38)

Comment 20: At T 29 I invite her to identify her schema keeping the focus on the here-and-now. At C30 it seemed like Anna made a guess; that is why I ask her to explain her self at T30. At C31 Anna goes back to the past signifying her resistance for one more time.

Ending

Anna started identifying her schemas and slowly moved into recognizing her emotional experience. She admitted feeling angry and guilty. Overall, Anna described feeling afraid, angry, lonely, unloved and humiliated. Towards the ends of the session Anna managed to empathize with the mother and decrease her anger to being "crossed". She also recognized that one of her difficulties in letting go of her anger was because she felt like it was the first time that she was allowed to feel "upset" or to feel sorry for her self. She also managed to realize how dependent she was feeling on her family and how this perpetuated her emotional disturbance. Anna left the session continuing feeling upset about her mother.

Section 4

Evaluation and Reflections

Writing this process report, I realize that there were many points that my own schemas had been triggered making me feel frustration and anger toward Anna and probably impacting on the therapeutic progress.

Young (1994) talked about the importance of therapists' own schemas and coping styles in the therapeutic relationship. From personal therapy and supervision I have come to realize that my core personal schema is related to Unrelenting Standards and my way of coping is to overcompensate by becoming angry. I was aware that my schemas run the risk of appearing as "critical" toward my client confirming her owns. However, there were some points throughout this transcript that I failed to recognize that. Nevertheless, counselors are also humans and they too have areas of sensitivity that inevitably interact with client's problems (Wills and Sanders,1997)

At C20 Anna started becoming emotional again. I remember that at that point I was feeling frustrated toward Anna loosing my empathy for her emotional experience. Thus, regardless of how aware I became of my personal reactions, my abrupt interruption at C21 probably communicated a subtle "criticism" to Anna that she was being too extreme or unrealistic. This might have impacted on Anna's reaction who gave me a general answer without really presenting her true specific expectations of her mother.

At T22 and T23 even though I describe that I wanted to maintain Anna's emotional calmness (com14), on reflection I realize that I was actually feeling uncomfortable with her emotional overwhelmness. Thus, I was trying to avoid bringing it onto the surface again. However, at C24 Anna becomes overly emotional again. At T25 I remember feeling frustrated toward Anna. I actually empathized with the mother at that point thinking how difficult it must have been for her to deal with Anna's emotionality. This was a very interesting point as it actually mirrored Anna's relational patterns. Anna's "neediness" was actually triggering other people's negative responses that further led Anna into feelings of victimization. At C25 Anna continues not answering my question and being overly emotional. Feeling frustrated toward Anna my intervention at T25 was kind of abrupt as I did not acknowledge Anna's emotions before proceeding to reflect on the fact that she was giving me a description and not an evaluation. Thus, my response might have signified to her that she was giving me the wrong answer and might have triggered her defectiveness schema. This is mostly apparent at C28 when Anna makes a long pause before giving me

an answer and then moves on saying that she does not understand what it means to her but knew that she had to get over it. Reflecting on her answer, I think that Anna communicated to me that she knows what the right answer is. I realize that my response at T25 impacted on Anna's further responses as at C30 she attempts to make a "good guess" without really being sure about her answer. Anna's pause at C28 gave me the time to realize where my frustration was coming from and how it had impacted on Anna. This gave me the space to find different ways of approaching Anna's resistance (com 18).

Even though there were times that the subtle processes impacted on the way Anna and I related, I believe that Anna has been significantly helped from that session which constituted a key learning experience for both of us. However benefits were mostly apparent on the next session.

On the next session, Anna appeared significantly calmer than the previous sessions. She demonstrated a level of awareness that was very surprising for me given her presentation so far. She specifically stated that her anger had actually helped her "detach" from her mother and acquire a more "independent" sense of her self. She stated that the reframed way of perceiving her mother's attitude had helped her to empathize with her, forgive her and let go of anger. As she stated, going through her anger and eventually letting it go contributed to her realization that in reality she was the "stronger" one in that relationship. For me it was very enlightening the fact that what I considered to be a dysfunctional emotion so far had actually been a functional means to Anna's independency and self-reliance.

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Appendix A

Early Maladaptive Schemas with associated schema domains
(Young et al., 2003).

Early Maladaptive Schemas	
Schema Domains	
I. Disconnection & Rejection	Emotional Deprivation
	Abandonment
	Mistrust/Abuse
	Defectiveness
	Social Isolation
II. Impaired Autonomy & Performance	Dependence
	Vulnerability to harm
	Enmeshment
III. Impaired Limits	Failure
	Entitlement
	Insufficient Self-control/Self discipline
IV. Other-Directedness	Subjugation
	Self-sacrifice
	Approval Seeking

V. Overvigilance & Inhibition

Emotional Inhibition

Unrelenting Standards

Pessimism/negativity

Punitiveness

Appendix B

Summary of Initial Therapy with Anna

Anna was referred to our service due to acute urticaria. However from the first session it became clear that urticaria was not her main difficulty and that she was in reality struggling with the psychophysiological implications of CD. Anna's also suffered from clinical depression secondary to CD. She had made several suicidal attempts and was involved in deliberate self-harm before but she claimed that the only reason she was being so depressed was her CD. Anna came with one goal in therapy: To increase her quality of life and adjust to CD.

Given the short availability of time (10 sessions) and Anna's concrete goals, therapy focused on the cognitive distortions Anna held about her condition and specifically the beliefs of being "incompetent" and "disgusting". Anna also believed that she was so vulnerable due to her condition that she could not work or start any other activity. Avoidance and procrastination were used by Anna as ways of coping with possible failure and threats of physical harm (Anna was afraid that if she gets tired her CD will relapse). Anna's beliefs were addressed and dysfunctional behavioural patterns were substituted by alternative more functional ones.

Anna responded well in therapy and managed to overcome significant difficulties within a short period of time. She started taking photography courses and joined volunteer work. She started socializing more and managed to arrange a long trip with some friends. Anna stated that what had helped her a lot in therapy was her relationship with the therapist who was the second person in her life (first being her father) who demonstrated confidence in her and supported her.

However, two years after the end of therapy, Anna was re-referred to our service again for the same reasons.

Appendix C

Anna's Medication

Crohn's medication:

1g Pentasa morning and evening
 100mg Azathioprine
 10mg Prednisolone

Calcium
 Infliximab infusionsrepeated every eight weeks.

Depression medication:

300mg Venlafaxine
 50mg Quetiapine

Paracetamol

Anti-emetics

7.5mg Zopiclone (*sleeping tablet*)