Early maladaptive schemas and parental bonding in skin disease: Investigating the role of schemas and early attachment in Greek patients with psoriasis and eczema.

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Schema focused therapy and early childhood trauma

Authors note

My introduction to schema focused therapy (SFT) during a one-day workshop had a transforming effect on my clinical practice and understanding of client difficulties. It continues to be my main theoretical framework. This case study was poignant for me, in that I worked with a 'complex' client shortly after I began grasping the ideas and strategies of the model. This is her story. It captures the complexities inherent in the human condition and shows the power of the alliance in creating new possibilities. Work with Jade exposed me to the depth of inner suffering and to the resilience of the human spirit. It is about helping and discovering the freedom to change meanings from the past.

Structure of case study

Beck's (1979) cognitive behavioural therapy and Young's (1980) schema therapy was used as a framework for intervention with a client in primary care that presented with a history of depression and childhood abuse. This case study focuses on providing a succinct overview of the schema model and its application in a long-term therapeutic relationship. The initial assessment and schema case conceptualisation is presented, followed by a summary of sessions, including interventions and difficulties encountered with the client. Attempts at overcoming obstacles are discussed and an evaluation of the counselling process is provided. Although extensive analysis of dynamics in the alliance go beyond the remit of this case study, efforts have been made to provide a review of therapist and client development on a content and process level in relation to counselling practice.

Theoretical framework: Schema Focused Therapy (SFT)

Personality refers to distinct traits, behaviours, attitudes and feelings that form a person's character. While people with healthy personalities cope with life stresses and effortlessly form relationships - individuals with 'personality disorder' or AXIS II difficulties (DSM-IV, American Psychiatric Association, 1994) experience chronic interpersonal problems that cause serious distress and impair living (Freeman & Jackson, 1998). These difficulties often spill into counselling, and inevitably the client's personality impacts helping and the therapeutic alliance. Standard short-term, cognitive behavioural therapy (CBT) has proven effective in treating Axis I disorders, however clinical practice reveals that clients with characterological difficulties make insufficient progress using this approach alone (Barlow, 1993).

Greater interest in core structures affecting personality development led to the development of treatment approaches that better suit the needs of clients with chronic difficulties (Beck et al., 1990). Schema Focused Therapy (Young, 1980) evolved out this effort. The model is not an inclusive theory of psychopathology, but a working theory that integrates and guides clinical interventions using early maladaptive schema (EMS) as its unifying element. As such it extends rather than replaces Beck's (1979) original theory. SFT has been applied to a range of DSM IV personality disorders and is also used in other chronic conditions such as eating disorders, chronic pain, depression, substance abuse in the recovery phase, childhood abuse and post-traumatic stress disorder (McGinn, Young & Sanderson, 1995).

In cognitive theory schemas are 'mental frameworks' that form the basic units of personality. By processing information and life experiences they construct a perception of reality and influence psychological functioning (Beck et al., 1995). It is thought that schemas also play a role in maintaining personality difficulties and damaging emotional/behavioural patterns that create long-term distress (Padesky, 1994). In this respect Young (1980) claims that early maladaptive schemas (EMS) [1] lie at the core of character pathology as they represent the deepest level of cognition and affect. EMSs originate in early life through the interplay of a child's innate temperament and ongoing noxious experiences with parents or significant others. Schemas form over time via verbal, visual and sensory channels and are significantly dysfunctional as they interfere with an individual's ability to satisfy core emotional needs (Grigoris, 2001). They function as templates in adulthood and manifest as implicit, enduring themes about the self, relationships with others and the world.

Through clinical practice Young identified eighteen EMSs and classified them into five Domains corresponding to the unmet needs of the developing child. In principle, schemas remain dormant when individuals are not faced with situations that trigger personal areas of vulnerability; when activated however, they evoke unbearable affect, dysfunctional thoughts and dominate living. EMSs 'survive' through a blend of maladaptive copying styles known as schema processes and schema modes. Schema processes include: *Maintenance,* which involves perpetuating the schema through cognitive distortions and maladaptive behaviours; *Avoidance* - escaping the schema, by

[1] The term 'schema' in this case study will be used to refer to 'early maladaptive schemas'

blocking thoughts or images and *Overcompensation* - adopting styles of functioning opposite to the schema to get needs met. A mode is a part of the self, that consists of a natural group of schemas and processes that are not integrated with other facets of the self e.g. the *vulnerable child mode* or *punitive parent mode.* These modes are consequently cut off from each other and individuals act differently in each (Young & Flanagan, 1994). Overall, coping styles and modes aid adaptation by minimising painful affect but they do not alter schemas. Instead they reinforce them by preventing opportunities for corrective cognitive, behavioural and affective experiences. They also lead to difficulties such as addiction, depression, dissociation and suicide. Young states it is vital to understand schemas, schema modes, the processes operating and their interaction to fully conceptualise a client.

SFT consists of an assessment phase, which identifies and activates client schemas and a change phase that attempts to modify schemas and dysfunctional copying. During assessment, active schemas and processes are identified through the client's past, developmental history and life patterns. This information is then conceptualised and fed back to the client to show how schemas maintain difficulties. The change phase uses cognitive, behavioural, experiential techniques and the therapeutic relationship - as all four elements are seen as necessary and sufficient for change. Intervention thus differs from CBT as more time is devoted to childhood issues; greater focus is placed on the alliance and in confronting and overcoming cycles of avoidance. Emotive techniques like imagery are used to address early and later life problems. Imagery is especially useful in SFT as it alters schemas more powerfully than

cognitive techniques alone (Young, 1998). Initially, counselling is therapist led but as the client develops skills to assess and modify schemas they become more active in directing treatment (Layden, 1993). The model promotes flexibility when working with complex clients and the course of counselling is longer. The goal of SFT is to enable clients to evaluate themselves objectively and gain the confidence and know-how to address life problems more constructively and more hopefully.

Client Details

Organisational Setting

The Brief Intervention and Counselling Service, offers short-term counselling in primary care. Referrals are received from general physicians (GPs).

Biographical Details

Jade[2] is a 36-year-old Caucasian female. She has a Masters in business, works as a consultant and is financially secure. She is married and has few friends out of work. Since young she wanted to become a teacher.

Reasons for referral

The client was first referred to the service in 1999 and I saw her for 8 sessions of CBT for depression. Two years later, she was urgently re-referred due to recurring feelings of depression and anxiety. In the referral letter it was stated she wanted to see the same psychologist she had seen before.

[2] Name of client has been changed

Appearance and Behaviour

Jade arrived on time. Dressed casually, she was of small build with dark hair and blue eyes. In reception she smiled and looked pleased to see me. Non-verbally, however, a troubled look and quick body movements signified an urgency to enter the counselling room. When seated her facial expression conveyed a mixture of familiarity and apprehension. Sitting on the edge of her seat, Jade rested her arms on her lap and spoke in a low hesitant tone.

Presenting problem

For the past 2-months Jade reported *difficulties in coping with life* as a *terrifying sense of doom* had led her to become very anxious. These feelings started during a hospital admission for her endometriosis. Since then she felt unsafe and despite her skills struggled with fluctuating moods of depression. Jade suspected these 'familiar' feelings were linked to her childhood, which she had not fully disclosed in our previous work. Unable to confide in others, the client had returned to counselling, with a need to address her past.

Background and family history

Jade comes from a working class family and grew up on a council estate. She is the eldest and is close with her brother who is also married and has a 3-month baby. As a child her parents whom she *loathes* were unavailable, demonstrative in their anger, critical and violent towards her on a daily basis. Her alcoholic father, whom she described as *a nasty piece of work* had a criminal record for grievous bodily harm while her manic-depressive mother, *floated like an iceberg* and self harmed. Her home she portrayed as a *sterile*

place filled with an atmosphere of dread. She often witnessed violence between her parents and was left to fend for herself not knowing their whereabouts. In this unpredictable world, Jade functioned on *constant alert*.

School became a haven where she excelled academically and in sport. Her efforts focused on gaining her parents' approval but when she won a scholarship, they refused it and accused her of being difficult. At 18 Jade left home and at college was exposed to how other families functioned. Soon after this, she cut-contact from her parents and has not seen them for over 15 years. In early adulthood her personal relationships were turbulent and violent. As a newly wed she drank heavily, was aggressive and self harmed. These behaviours numbed Jade temporarily, but caused cycles of depression. Her *chaos* lessened when she stopped drinking and channeled her energy into sport. Two years ago Jade had an affair and her husband found out. On its ending she got clinically depressed and was seen for therapy at BICS.

Medical History

Following three miscarriages Jade has decided not to have a family. While she is able to love other children she felt that she could not love her own. The client works hard to maintain a balanced lifestyle through regular exercise, diet and rest as any form of ill-health leaves her feeling vulnerable.

Schema Therapy Case Conceptualization Form

Revised January, 2007 Jeffrey Young, Ph.D.

Current difficulties

The coinciding of Jades hospitalization and her nephew's birth precipitated the client's depression. Jades vulnerability intensified in hospital as the setting triggered memories around motherhood, her past, and treatment she had as a child for injuries. Whilst recovering at home her memories did not abate. She became increasingly overwhelmed and retreated from those around her. In isolating herself, Jade stopped getting positive input from her spouse and colleagues. She then came to perceive her self-initiated reduction of contact and withdrawal, as them rejecting her. Consequently, her sadness and depressive symptoms intensified. Objective measures on the BDI (Beck Depression Inventory) and BAI (Beck Anxiety Inventory) revealed scores of 39 and 35 respectively, which is indicative of severe depression and anxiety.

Overall level of functioning

Jade has a successful career and works hard to stay at the top. Her marital relationship is stable but not close. The client is also isolated and suffers with depression due to intense self-loathing. Due to her abusive background Jade has difficulty in trusting others and believes that if her past was ever revealed, it would expose her defectiveness and lead to further rejection.

Axis I symptoms

1. Depression (crying, insomnia, poor concentration, low mood, weight loss)

2. Low self esteem (feels worthless, bad and unlovable)

3. Social anxiety (avoids going out with friends, colleagues and does not like meeting strangers)

Current major problems and life patterns

Problem 1: Chronic depression

Life Pattern: Jade has suffered with severe depression since adolescence. Her inability to cope with her emotions and intimacy was perpetuated by a series of difficult and violent relationships prior to her getting married. At the ending of her affair, she also reached a point of suicide.

Problem 2: Social isolation

Life Pattern: Jade has no close friends and cannot speak to her husband about her past. This pattern of emotional and physical withdrawal is evident in all her life areas because the client finds intimacy frightening. She avoids affection or discussing her feelings as this leaves her feeling vulnerable.

Problem 3: Perfectionism

Life Pattern: Jade has to do things perfectly and sets very high standards for herself. This is especially evident at work wherein she takes on too much responsibility and pushes herself to excel. The client cannot tolerate failure and works towards goals that are over and above what she is expected to do.

Developmental origins of schemas

- *Unsafe and unstable family environment*

Jades lack of safety began with the abuse she suffered as a child. Within her home, acts of explosive anger from her father and violence between her parents perpetuated the view that the world was a dangerous place. Equally frightening experiences were that Jades mother self-harmed in front of her and did not protect Jade when her father hit her. Severe emotional and sexual abuse by her mother promoted the development of mistrust/abuse and emotional deprivation schemas as her core needs for love, protection and safety were never met. As a result, instead of feeling secure with her parents Jades attachments were unstable and terrifying.

- *Emotionally depriving parents*

Developmentally, Jade experienced persistent rejection and neglect from her parents. She was often left to fend for herself and her brother, which created the foundation for her abandonment schema. While she did her best and always tried to please them, inevitably nothing she did was good enough. The client's emotional development was thus very impoverished as she never received nurturing, physical warmth, empathy or forgiveness from her parents. Instead she experienced rejection, deep loneliness and terror. Both parents were emotionally unavailable since their own mental health and marital difficulties took precedence over their children. Jades description of her mother as an 'iceberg' and her home as a 'sterile place', signifies the depth of her deprivation.

- *Harshly punitive and rejecting parents/peers*

Jade also felt humiliation, persistent annihilation ('her mother wished her dead') and was repeatedly bullied by her father because she was seen as 'bad and evil'. As such she was never loved by her parents who were harshly retaliatory and punishing. Their punitiveness was so extreme and dangerous that Jade did not dare to misbehave as most children do. Given their parental stance, she felt worthless, dirty and anything but normal in their eyes. Jade was also bullied at school by estate rivalries who taunted her about the strangeness of her parents. These events and resulting feelings of low self worth contributed and reinforced her Defectiveness schema.

- *Family environment is subjugating*

In this unstable world Jade had no choice but to suppress her needs and feelings, and she learnt to adhere to the implicit and explicit rules laid down by her parents. She was not allowed to cry, get angry or complain when treated unfairly or hurt. She could not want for things, be herself or have friends over. As such she remained emotionally and socially isolated. At times, when she asked for things, her needs evoked anger and she was punished for being selfish. Jade thus kept a low profile and spoke only when she was spoken to.

Core childhood memories or images

1. Father broke her ribs whilst beating her with a newspaper; he then locked her in her room and she was punished further by not being given any food.
2. Mother's hand and skirt (fragment of a memory) – part of a sexual abuse the client experienced at a very early age.

Core unmet needs

1. Secure attachment
2. Freedom to express needs/emotions
3. Spontaneity and play
4. Protection and safety
5. Sense of identity
6. Stability

Most relevant schemas with origins

Jades EMSs mostly fall in the early domain of *Disconnection and Rejection,* which embodies the expectation that ones basic needs for safety, acceptance, nurturance, stability, protection and guidance will not be met in a predictable manner. Her schemas include:

1. Defectiveness (Punitive and rejecting family environment; physical abuse)
2. Abandonment (neglectful parenting)
3. Mistrust/abuse (sexual, physical and emotional abuse)
4. Emotional deprivation (lacked nurturance; subjugated needs and feelings)
5. Social isolation (never had childhood friends; locked in room)

Current schema triggers (Specify M-F if limited to men or women)

1. Physical ill health
2. Not meeting responsibilities at work
3. Intimacy: emotional and physical closeness (men)
4. Being left alone

Surrender behaviours

1. Submissive – chose violent and destructive partners in the past that reinforced her defectiveness schema
2. Clinging – cannot tolerate any separation, seeks reassurance.

Avoidance behaviours

1. Social isolation - avoidance of intimacy with others keeps client deprived and lonely. Cut off from parents to avoid criticism;
2. Psychological withdrawal – dissociation, numbness
3. Exaggerated focus on independence – has a secret bank account in case husband left her.

Overcompensating behaviours

1. Recognition seeking – keeps striving towards higher positions at work to counterattack feelings of defectiveness.

2. Obsessionality - maintains high level of predictability through order and planning in her home and work environment.

3. Hostility: at times blames, attacks, criticizes others verbally and physically.

Relevant schema modes

1. Angry Child
2. Lonely Child (Little Jade)
3. Punitive Parent
4. Detached Protector
5. Healthy Adult (Jade)

Possible temperamental / biological factors

Jade has a labile personality. Her active temperament may have served as a biological predisposition to developing borderline personality disorder. In addition a history of sexual, emotional and physical abuse wherein Jade was subjugated and severely mistreated, may have contributed to her outbursts and impulsivity in adulthood as she had no outlet as a child.

Core cognitions and distortions

1. 'I'm bad - evil' (all or nothing; discounting the positive)
2. 'I will never have a normal life, the damage is done' (overgeneralization)
3. 'If I work less, I'm worthless' (emotional reasoning)

Therapy relationship

Jade does not trust others easily and has a self-concept where she sees herself as inherently flawed and unlovable. Her experience however, of our previous work when she was clinically depressed and our nurturing therapeutic relationship benefited our current work as it reinforced a sense of safety in counselling. My personal reaction to the client was that of deep sadness for her suffering and a need to nurture her as she appeared so fragile and vulnerable. Her defectiveness schema was activated throughout our sessions, in particular as the client revealed the very disturbing events of her childhood. She vehemently expressed hatred toward her parents for ruining her life and wished them dead. Periods of dissociation and pain in the vulnerable child mode, made the process of disclosure difficult for Jade. Providing her with safety and stability was thus essential throughout our work.

Focus and plan for change

Jades most powerful schemas are defectiveness and mistrust/abuse. When triggered they evoke depression, strong feelings of shame and prevent her from experiencing intimacy and having a healthy view of self. In order to decrease these feelings and to promote self-disclosure, the initial focus of counselling aimed to explore the client's past and the responsibility her parents and family environment had in the formation of her schemas. During this beginning phase, insight was promoted through discussions of current difficulties, use of assessment imagery, and identification of life patterns that indicated how the client's schemas are perpetuated in adulthood. Conceptualizing Jades difficulties in schema terms thus aimed to increase understanding of how schema processes contribute to her life long difficulties. Developing a collaborative plan for change consequently required increasing the client understanding of her schemas and motivation to fight against them.

During the change phase, interventions initially focused on developing cognitive strategies to challenge negative thinking styles and maladaptive responses that occurred during schema activation. This entailed finding evidence that contradicted her defectiveness schema, use of flashcards and learning to place greater trust in the therapist and others by asking for her needs to be met. Experiential strategies such as 'imagery' were chosen to target the client's worst childhood memories that reinforced her feelings of defectiveness through physical and emotional abuse. Imagery, in this instance activated emotional components of the client's schemas and allowed her to fight back against the harm she endured. In culmination these interventions were chosen to progressively empower the client by strengthening her ability

to respond from a healthy adult mode and in so doing, contribute to restructuring and healing her schemas. To further weaken her schemas, Jade was continually encouraged to try new coping styles (behavioural pattern breaking) on a personal level and interpersonally in order to foster a better quality of life, wherein her needs could be met. The alliance remained a crucial component of the change process, since limited reparenting is aimed to provide a stable base wherein Jade receives within the boundaries of the therapeutic relationship, the safety, acceptance, nurturance and protection she needs, but did not get as a child.

Contract

Given the short term nature of the service, permission was obtained to work long-term with the client. Weekly, one hour meetings took place for 10 initial sessions and the contract was then extended to 25 sessions. Confidentiality was addressed in terms of self-harm, supervision and correspondence with the clients GP on her progress.

Content of sessions

Assessment phase: Session 1-4

Jade disclosed that as a teenager, in self-defence she stabbed her father and mother in the arm and threatened to do it again if they ever lifted a finger against her. In tears she disclosed a childhood of severe physical abuse. She was hit daily by her father and during particularly brutal beatings she would disconnect from her body *like it was not happening to her*. Unable to walk she would then drag herself mechanistically to safety, propelled by the thought '*I won't die…I'll mend'.* Only her brother helped her by wiping the blood that was left behind and by sliding biscuits under her bedroom door.

Despite staying out of trouble and doing her chores, her mother haunted her. Late at night - outside Jades room she would hiss horrible things and wish her dead. This hatred Jade explained started at birth not only because she was *an unwanted baby,* but calcium deficits in pregnancy led her mother to lose her teeth. Jade was visibly shaken in sharing her past. Empathising and reducing her distress in sessions was thus vital in providing a sense of safety.

Jades anxiety rose in-between our sessions; automatic thoughts when she felt dysphoric included *I'm bad,* feelings of *fragmentation* and fear that her *resilience of keeping things together would run out*. Overview of the SFT model enabled Jade to reflect on the roots of her distress, but initial interventions focused on stress inoculation and planning pleasant events to follow sessions. When her symptoms lessened Jade recounted her worst

memory, when her father beat her unconscious while her mother watched. She was only taken to hospital 2-days later due to pain caused by broken ribs.

Emergency

The clients GP called me at home and said Jades husband had come to the surgery very distressed as Jade could not stop crying and had locked herself in her room. I called Jade and she came to the phone …and spoke in the voice of a small petrified child. In tears she explained that she *was terrified of drowning* as a *lid was over her, it would not go away*. In a gentle voice I comforted her, and reassured Jade she was not alone. I spoke of good things in our counselling and encouraged her to be strong. Nurturing the client had a soothing effect as after a while she stopped crying, was less childlike and agreed to have some tea. Her GP did a home-visit that afternoon, and a session was arranged for the following day, further to our weekly session.

Sessions 5-9

Jade looked drained and pale when she came to the session. Taking time-off work due to flu and a torrent of memories had combined to create a toxic emotional experience. Disentangling the meaning of the 'lid feeling' revealed parallels between feeling ill (sensori-motor) and *fight-flight* emotions she had during beatings where she could not escape. Jades beliefs were also alike, *it's my fault* but in adulthood Jade blamed herself for not missing work and feared criticism from her boss. This belief had formed from repeated childhood events, wherein she had learnt that *if I don't do things right, something awful will follow*. As such in adulthood Jade put herself through

sheer hell to succeed since achievement reinforced feelings of *self-worth* and overcompensated for her belief *I'm bad (defectiveness schema)*. While sessions elucidated Jades schemas, interventions focused on fostering safety skills[2] using a grounding-object (bear-*Woofle*) and imagery of a *safe place* in case the *lid* returned. As Jade managed her anxiety, the lid lifted and was replaced by a background *white noise.* Modifying destructive thinking patterns focused on forming an alternate belief *I'm good enough* and reinforcing evidence consistent with her real self. Through experiments Jade *made time to meet her needs,* declined a promotion at work and started working part-time. Discovering that *doing less* did not equate with badness, validated a healthier thinking style and helped Jade realise her worth was not defined by her job. The client also had new *good memories* of teachers who cared for her and she subsequently visited her school.

Sessions 10-13

Feelings of *abandonment* and disproportionate agitation were triggered when Jades husband spent a week away on business. In this state of distress, Jade explained that ensuring her *safety* meant being ready *to cope with any disaster.* This included a *secret bank account* in case her husband left her. Despite evidence of his loyalty *(e.g. he did not abandon her after the affair)* activation of Jades schema led her to continue citing examples of rejection, including her parents who *pretended not to know her* when she called from college and numerous ex-partners who left her because of her behaviour.

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[2] PTSD: Dissociation Questionnaire (Bernstein & Putnam, 1986) showed Jade did not have Dissociative Disorder

For Jade rejection was inevitable as *sooner or later* her *'badness'* would be exposed. The client's thoughts were used to demonstrate schema activation and schema maintenance. For example, prior to her marriage Jades *choice of demeaning partners* made her hostile, which maintained her schematic view that she was bad. When these relationships failed it confirmed that people abandoned her. Her husband, unlike her parents and ex-partners however did meet her needs and was not critical of her. Our conceptualisation revealed Defectiveness was a primary schema underlying the client's distress and interpersonal style as it triggered the highest affect followed by her schema of Mistrust/Abuse and Abandonment. These developed at a young age in the hands of her parents. Through sessions, Jade hinted there was an area she was unable to discuss as she lacked the words but that it involved her mother.

Change phase: Interruption to counselling

A personal bereavement in November meant I had to go overseas. My manager informed Jade of this. On my return I wrote to Jade apologising for my departure, and explained I needed some time off before seeing clients.

Sessions 14-16

I suspected the sudden break activated the clients abandonment schema, thus I shared my feelings with Jade and invited her to do the same. Jade said she got anxious but had lessened her feelings by seeking comfort from her husband. Time was then spent looking at the alliance and how Jade had behaved differently by placing greater trust in people. Christmas neared and

the client started becoming agitated again and avoided her diary. In session 15 I invited her to report images she had around the distress she was feeling.

The client said that *every Christmas her father got plastered and dinner would land on the wall. Often she was alone and her gifts were denigrated and if they were new they were taken back afterwards*. These memories left Jade *physically cold*. While she wanted to escape this unbearable feeling by changing conversation the client was encouraged to stay with it and to connect with her primary emotions. Jade expressed sadness, anger and realized that Christmas reminded her of the awfulness in her childhood. By repeatedly acknowledging her experiences but not buying into her schema of defectiveness each time she felt upset (empathic confrontation) – over time the *coldness* (detached protector) lessened and her emotions stayed. This allowed schema work to proceed. By problem solving in Healthy Adult Mode Jade planned festive events and for the first time did not let the past define the meaning of her Christmas. Through this she *enjoyed the celebrations* coped with flu and listed *things to do* with her husband in the New Year.

Sessions 17-18

As Jade became less afraid of her childhood memories she spoke of her mother. For her father she felt rage but for *her* – it was pure cold hatred. Living far from them was a relief because Jade worried that if she released her anger it would be evil. When I asked her to clarify, in tears she said *I'll do something terrible…Lose control…..I could kill her and feel nothing.* Jade then disclosed that *her mother had sexually abused her*. Time was needed to

contain the emotional upset that followed. In session 18, Jade told me that her aunt (father's side) had died and nobody in the family wanted to inform him. Subsequently, the client sent a two-line note to her father saying this and that she would attend the funeral with her husband. This meant Jade would see her parents. Interventions focused on developing coping skills for the funeral. In picturing her parents Jade could not conjure a whole image of her mother - only *a dark thing* with *hands* and *parts of a dress*.

Sessions19-20

Standing on the church steps Jade saw her parent's approaching, now old and frail. As they neared, she went white and her body stiffened. Her father walked right past her but her mother came closer - put her hands on Jades face and said: *It's so nice to see you again*. The contact on her skin made Jade dissociate and she ran to the toilets where she burst into tears and banged her handbag repeatedly on the wall. Reading her flashcards and breathing techniques helped her calm down. In church Jade remained grounded and at the cemetery she deliberately stood by her father and used her skills to lower her anxiety. Jade thus coped with the funeral, but was ill and anxious for the next week. In session 20 she spoke more of her mother and suggested that *by allowing it to go on she had colluded in the abuse.* The client did not wish to discuss this issue further in case memories returned. She consented, however, to doing imagery with my supervisor on her worst memory of physical abuse to address her Defectiveness schema. This decision was reached by challenging Jades shame-based thoughts of involving another adult who would hear her story, and by listing the pro's and

con's of doing imagery. Collaborative decision making reinforced that Jade had choices and that no intervention would take place without her permission.

Sessions 21-22

I introduced Jade to my supervisor, who covered safety issues and explained how imagery would help Jade process her traumatic memory and thus help modify her schema. Sitting next to the client I sensed her trying to be strong. The imagery started and as Jade went into image her voice became childlike. After describing sensory and peripheral details of her home, the scene focused on *Little Jade* (aged 5) who was in the kitchen cleaning, when her mother came home and asked if she had woken her father for his shift?. *Usually a note was left for Jade but today there was none*. When *Little Jade* tried to explain, her mother became furious. She went upstairs and on seeing her husband asleep, woke him up by shouting how late he was. Petrified *Little Jade* started crying, fearing and knowing what was to follow. Desperately, she ran to her father and profusely apologized for forgetting. As he roused he screamed at her to get lost but minutes' later, seething in anger he descended to the living room and her brother was sent outside. Holding a rolled newspaper he approached Jade, while she hid behind a chair trembling. At this point the image was frozen and Jade was asked what she wanted to happen? She entered the image as *Adult Jade* and confronted her father telling him *he was a bully* with *no right to mistreat a child*. The client continued expressing her anger until she overpowered him. In image she took *Little Jade* and her brother out the house and drove to her current flat. *Adult Jade* comforted *Little Jade* and put her in bed where she fell asleep safely. The

image closed with this scene. Exhausted, Jade shared how real and frightening it had felt. On follow up, Jade felt better and had not had any other distressing memories. Imagery work thus enabled Jade to visualize a different reality and in doing so, the power of her schema was weakened.

Session 23-28

The last sessions focused on relapse prevention and termination as the client's symptoms had reduced significantly. Jade still found it difficult to talk about the sexual abuse but reported the white noise had stopped. She decided to train as a teacher and had completed the application form that requested her parent's names and background without getting anxious. The client was accepted onto the course and began pursuing a goal that actually made her happy. In discussing the alliance Jade shared feelings of loss but this was balanced, with the reality of having had the opportunity to work twice together. Jade also felt confident that she could ask for help from another therapist if the need arose. Feeling more whole, counselling provided Jade with a 'new lease on life'; one-she had never imagined possible. At 3 and 6-month follow-ups Jade had maintained her gains.

Psychological interventions

Cognitive strategies: thought diary and flashcards

Cognitive strategies improved Jades internal processing by identifying and reconstructing distorted views of her self and others. For example: the clients diary revealed her *avoidant coping style* acted as an interpersonal distance

regulator i.e. *at times when she would have benefited from social contact, she withdrew in fear of rejection.* Isolation offered Jade safety, but loneliness reinforced her defectiveness schema. Flashcards consisted of the strongest counterevidence to her schema. Jade prepared for the funeral by reading them before and after the event. This sustained accurate perceptions of her self, distanced her schema and helped the client see that she could respond differently to situations in a more adaptive manner.

Behavioural strategies: pattern breaking

Behavioural techniques supplemented cognitive skills to alter self-defeating patterns of coping. Jade evaluated *the pros and cons of her avoidance style* and practiced relating differently to people through cognitive rehearsal and behavioural experiments using *graded exposure.* Jade thus asked her husband to help her with chores, progressed to sharing personal details and eventually to accepting physical comfort when feeling low. Through this Jade discovered she could tolerate her discomfort of intimacy. Relaxation skills were also used to manage anxiety and increase self-enhancing experiences.

Experiential techniques: imagery

Imagery modified Jades worst memory of physical abuse and her Defectiveness schema. The client captured a time she felt defective as a child and described her feelings and thoughts at that age. This image activated the highest schema affect. As *Adult Jade* the client confronted her father, stopped the abuse and declared that she had a right as a child to be loved, nurtured and protected. This work aided Jade in understanding her father's role in the formation of her schema (vs. attributing badness to herself). She overcame her

emotional avoidance by tolerating the anxiety her schema evoked. Cognitively, empowering *Little Jade* with the knowledge, rationality and compassion of *Adult Jade* reconstructed and reinforced a healthier information processing.

Interpersonal techniques: limited reparenting

Limited re-parenting in the alliance counteracted Jades early experiences with her parents. In offering the client an *approximation of her missed-out nurturance* - the alliance, helped provide a corrective affective experience that endorsed schema change. Through my availability, acceptance and concern in all our sessions Jade got the protection and care she lacked as a child.

Outline of process within sessions

Jades return to counselling symbolized an important step in her life. Two years ago, a compelling need to avoid anything that triggered shame affect prevented the client from sharing her childhood trauma. Empathizing with her pain and creating, safety by gently soliciting her story enabled Jade to trust the alliance. Overview of CBT principles ensured Jade was socialized into the model and how it would be extended with SFT to address early experiences. As such the first ten sessions focused on symptom reduction and linking past experiences to current problems. Identifying Jades schemas and situations that triggered them occurred as her story unfolded. Recurrent themes in thought records also suggested several EMSs i.e. Defectiveness and Abandonment underpinned the client's difficulties.

Whilst teaching Jade about schema development, exploring the past was a tricky process. Jade was wounded by her childhood and *seeing herself* on

paper reinforced the amount of damage done. By steadily developing skills to cope with negative affect rather than reacting on a schema level - Jade was able to divulge increasingly painful information. Her ability to process events differently was evident when counselling was interrupted by my bereavement. Jade tolerated her feelings and trusted that despite life's unpredictability that our bond was not lost. *Under normal circumstances* this event would have confirmed her Abandonment schema. Gathering client information remained ongoing and was integrated into a schema conceptualization form to guide interventions. In the change phase, Jade accessed and processed previously avoided thoughts and emotions and this modified her Defectiveness schema. It goes without saying this was facilitated by events in the client's life. Seeing her parents again, triggered powerful affect and proved Jade could modify a schema that wreaked havoc in her life. The imagery session was perhaps the most frightening intervention Jade experienced - but the most rewarding as it faced her past. The final phase focused on addressing termination issues.

Counsellor's view of the problem

Borderline personality disorder (BPD)

Jades difficulties suggested she had features of Avoidant-Borderline Personality Disorder (Layden, 1993). The DSM IV defines BPD as '*a pervasive pattern of instability in mood, interpersonal relationships and self-image, beginning by early adulthood and present in a variety of contexts*' (American Psychiatric Association, 1994). Jades personality included at least 5 BPD criteria such as affect instability, intense anger, unstable relationships,

impulsive self-damaging behaviour, frantic efforts to avoid abandonment and suicidal threats. Jade commented *'she had always been this way'*. She held a rigid cognitive style, demonstrated vulnerability to any form of criticism or disapproval and avoided activities that involved significant interpersonal contact. Her ambivalence in relationships was typified by a tendency to over-idealise people, for example her brother or to reject significant others. Despite the negative effect these behaviours had on Jades life, the clients current functioning was not severely impaired due to compensatory strengths such as her ability to take on responsibility, economic stability, a non-critical spouse, her intelligence and years of professional success. Erikson's (1963) stage theory and Piaget's (1952) model of cognitive development show how Jades schemas and early trauma interfered with her ability to master 'normal' developmental tasks.

Critical Life Event and Hypothesised Developmental Issues	
Critical event	Father beat Jade unconscious, while mother watched.
Chronological age	4-5years
Eriksonian Stage	Initiative vs. Guilt
Piagetian level of cognitive operation	Pre-operational stage (2-7 years)
Perceptual channels	Verbal, visual, kinesthetic
Schemas	Mistrust/Abuse Defectiveness/Shame Abandonment
Associated beliefs	I'm bad; I'm unlovable; others cant be trusted

Life problems leading to BPD often start before the age of seven during the first four Eriksonian stages, which act as pre-cursors to schema formation (Layden, 1993). For Jade mistreatment began in infancy in the stage of *'Trust vs. Mistrust'* as her mother's personality difficulties and depression, rendered her unable to meet the client's physical and emotional needs. Being told she was *bad* and *unwanted* laid the foundation for her defectiveness schema, which was reinforced in the stage of *'Initiative vs. Guilt'* (4-5 years) by severe neglect and abuse. The cruelty Jade endured from both parents was devastating as it diminished her self worth, instilled shame and destroyed trust in the very people who were meant to protect her. During the stage of '*Industry vs. Inferiority'* Jades need *to do things right* to gain approval and avoid punishment gave rise to 'unrelenting standards' which became a coping style to her defectiveness schema. At school, teachers were validating but her parents belittled her successes. Jades schemas were solidifying at this time and since she did not mix with other families, the client did not get corrective feedback. Repeated physical, sexual and emotional abuse stunted Jades ability to mature optimally and by adolescence her schemas were fixed.

These experiences also impeded Jades cognitive development. For example, in adulthood Jade used formal operations to do intellectual tasks at work but when EMSs were activated interpersonally she regressed to preoperational thought i.e. emotional reasoning or catastrophic thinking. Repeated trauma had formed and deformed the client's personality so that in adulthood she displayed concomitant schemas of 'defectiveness', 'abandonment' and 'mistrust/abuse. These worked destructively by conflicting with each other

leading to schema antagonism, a common phenomenon in BPD. To cope the client avoided and flipped between 4 modes: Detached Protector, Vulnerable Child, Angry Child and Punitive Parent. For example, Jade agonised over her isolation - but when she started getting close to others her abandonment and mistrust/abuse schema got activated and she disengaged *(Detached Protector)* or became hostile *(Angry Child).* Resulting relational difficulties would confirm her 'defectiveness' and the client suffered depression and self-hatred *(Punitive Parent)*. These processes and their bi-directional influence were responsible for Jades difficulties and ill-defined sense of self as she struggled to identify a consistent set of personal needs, wants and goals.

Difficulties experienced in working with the client

Shame can influence the alliance *as client and therapist dance around the other, in concealed efforts to avoid being shamed or have their inadequacies exposed* (Kaufman, 1989). In some sessions cycles of victim, persecutor and rescuer were created as I felt pulled into shaming interactions with Jade through her disclosures. As the client described the violence or how her mother self harmed in front of her, she subtly invited me to collude against her parents in a tacit agreement *they were bad*. The unspoken nature of this 'dance' became apparent in-session where in midst sentence I said *'your mother…'* and Jade reacted angrily saying she found it hard to hear me say *'mother'* as she only spoke of *'her'* as in *object.* In that moment it felt like I was being shamed (*bad therapist)* for not validating '*her evilness*'. My words flipped Jade into *Angry Child Mode* and I repaired things by reassuring her I meant it as her biological mother.

Later in session 14, I noticed we were focusing less on her the diaries and discussion revealed that Jade feared *I would force her to talk about the sexual abuse*. This was interesting as 'force' was incongruent with our collaborative alliance. Recognising, that schema avoidance protected Jade from shame and rejection I assured her we would only discuss her mother when she felt ready. I was curious on what she feared would happen if we did? Emotionally, Jade feared that *'letting everything out'* would unleash the hatred she held inside and unravel her badness. It was uncanny, at that point just after Jade expressed vigilance in finding any indication of her fears being realised that *abandonment* did occur due to my personal bereavement.

Attempts to overcome difficulties

Separation: The break in counselling was dealt with practically and sensitively. Firstly, through immediate contact with the client and secondly, on my return Jade and I worked on schema reattribution. We discussed mutual feelings on the separation and examined the alliance objectively. Evidence was gathered on all the times that I had been available for the client and times she had benefited from coping on her own. Demonstrating that my commitment, concern and involvement in her care did not end even when sessions temporarily discontinued - enabled Jade to see more strongly the benefit of combating her schema and applying her learning to other important relationships in her life e.g. with her husband and friends.

Shame: Sensitive use of the alliance assisted in healing feelings of shame. Bringing attention to the difficulty of revealing i.e. *it must be painful and lonely*

having to carry so much... all the time, facilitated empathic exploration of thoughts and feelings in Jades *Vulnerable Child Mode* that kept her isolated. As the client's avoidance lessened, she expressed shame over the abuse she endured, which she felt was not only unjust i.e. *'the punishment never met the crime'* but it had also *'robbed her of her good self'.* Maintaining an empathic bridge between the past, the present and the client involved validating her worth and re-labeling destructive feelings as the *Angry Child that* grew out of hurt and fear. Educating Jade on schema modes enabled us to work through *the injustice* and *her grief at not having a real mother.* By giving up and letting go of the battle against her parents Jade strengthened her Healthy Adult.

Sessions also required delicate ingenuity in creating interventions that circumvented the client's need for collusion. For example, the metaphor *'beautiful flowers can grow out of compost'* and *'some gardens have more compost than others'* acknowledged how bad things were in Jades family, but that change was possible. This image introduced flexibility to her rigid thinking and was built on in latter sessions. For example, on seeing the film *'American Beauty'* Jades believed *she could never be normal*. By exploring the director's motives for exposing family secrets (*to overcome powerlessness)* and personalizing the title '*American*' (books we used) and '*beauty*' (flower) Jade reframed her perception so the film so that it encapsulated courage and survival. While Jade re-evaluated the past, working on forgiveness remained a complex issue that was not directly broached, as the stage of counselling indicated it was too early for the client to consider such a notion.

Work with other professionals and supervision

Supervision was valuable in developing my skills in SFT but also provided a safe harbour wherein I expressed difficult feelings about the client and our work. In particular, the first assessment session with Jade was difficult as it challenged my faith in humanity. When it ended, just after 5pm I had no colleagues to debrief with and I left work feeling 'upset'. Whilst family provided the support I needed that evening, weekly supervision enabled me to process my sadness, as a person vs. fearing my resilience as helper was being jeopardised. Negotiating interdisciplinary confidentiality created a safe context for our work; Jade was thus informed about supervision and gave permission for her GP to be kept updated. Involving others, including my manager ensured my safety, in case the client needed support I could not provide. Such explicit contracting proved invaluable, during Jades emergency and when my supervisor joined us for the imagery. Therapeutically, clear boundaries gave Jade a sense of protection and stability.

Effectiveness of counselling: schema reinterpretation and modification

Jade reinterpreted her 'defectiveness' by developing alternate views such as *I'm good enough*. Instead of striving to prove herself, Jade reframed her efforts to symbolise independence, strength and tenacity. Accepting, her inherent worth thus enabled Jade to decline a promotion at work. Imagery assisted in 'undoing' the pictorial component of her schema by allowing the client to re-enact the past, to re-evaluate her memory and thus validate herself as a separate person to her parents, who was *not at fault* for the abuse. As time went on, circumscribed changes in Jades interpersonal life,

provided evidence that her schemas had begun to modify. Gradually, her shame lessened and the client changed her responses to the world.

Interpersonally, she disclosed more of herself to friends and discovered they did not abandon or think less of her; thus from believing '*people can't be trusted at all'* she shifted to '*in many cases people can't be totally trusted'*. Making her schema less absolute provided flexibility in how the client reacted and interacted with others. Furthermore, trusting her husband fostered physical and emotional intimacy and allowed them to care for each other in a fulfilling way. Jade thus moved steadily towards finding a sense of inner peace and began to feel connected with those around her. Most importantly, for the first time, she verbalised that she *felt more content with her life*.

Significant changes also involved Jades decision to train as a teacher and fulfil her dream. Placing herself in an environment surrounded with children countered her schema by providing her with an opportunity to receive innocent affection on a regular basis. By accepting children's love, Jade took responsibility in meeting her need to be loved. This was reinforced using the phrase '*I need a lot of love from many people in order to feel lovable* ', which moved the client closer to believing she was lovable. By the end of our counselling sessions Jades distress had reduced significantly. On the BAI and BDI she scored twelve and fifteen respectively, which is indicative of mild-moderate anxiety and depression.

Critical assessment of the counsellor's interventions

The backdrop of our previous counselling facilitated collaboration and saved time as Jade had experienced a safe alliance and was familiar with CBT. Consequently, introducing concepts like EMS inspired interest and hope in the client, which improved commitment and advanced her progress. SFT essentially invites clients to step out their safety zones, *'to give up who they are'* in order to change. Soliciting feedback and suggestions on how to make counselling more comfortable for Jade thus improved trust and enabled her to risk more. For example, having options with regards to approaching upsetting topics gave Jade control over what occurred in sessions. This allowed the alliance to act as *a schema laboratory* where ideas on interpersonal dynamics were tested in relative safety, using a working style of empathic confrontation i.e. a careful balance of validating Jades needs and reality testing, how her schemas and coping styles interacted in our work.

As sessions progressed however, it became evident Jade had several active and compelling schemas and that more preparatory work was needed in the assessment. The *emergency phone call* exemplified how Jade flipped into *Vulnerable Child* and felt threatened after revealing so much. I did not foresee this, as I had not fully conceptualized her schemas or how they operated and I was also not aware that her reaction was typical of BPD. Although, at the time it felt natural to be nurturing, which is what is required to help clients in this mode, I was on a learning curve and got anxious over my competency. A more skilled approach would have entailed, enhancing the client's functional cognitions prior to exploring schema functioning.

Jades schemas also operated in the alliance and were evident when she rejected, the self help book on schemas 'Reinventing your life' - *'who are they to tell me to reinvent my life? I've worked so hard just to survive!* Jade went into *Detached Protector* (default mode in BPD), which stopped her from experiencing her defectiveness. The client's reaction did surprise me as I had not considered this possibility. This time however, I weaved concepts of protection and anger into our work as my understanding of SFT and Jades copying styles had improved. Comprehending the client in this mode allowed me to be creative. Instead of fearing how I would proceed without the book, I encouraged expression of Jades fears of letting her guard down and reassured her that I would help her deal with the overwhelming affect.

In working with Jade, I discovered SFT is more difficult to do than it initially appears. Consequently, assessing my skills throughout counselling was crucial so that I did not attempt work outside areas of my competence. Inviting my supervisor to do the imagery demonstrated such caution. Reading about the technique seemed deceptively straightforward in contrast to experiencing in-session how easily powerful cognitions and affect were elicited in the client. Finally, after counselling ended I realized my own avoidance in exploring some sensitive issues with Jade was possibly due to vicarious traumatization, caused by over exposure to childhood abuse in my ongoing reading and work with the client (McCann & Pearlman, 1990).

At times I protected myself from the images Jade was struggling with, even though I encouraged expression as a vital part of her recovery. A battle inside

me, between encouraging the healing process and protecting myself from further exposure possibly explains why I blocked out – the fact that Jade had stabbed her parents. The event did not enter my mind, nor were the circumstances revisited with the client. Only on reflection and with greater understanding of vicarious trauma, gleaned from the work of Pearlman and Saakvitne (1995) did I later recognize my own struggle and the cost of trying to balance my needs and the clients at the same time.

Development of ideas over time

The development of SFT has had a positive impact on cognitive therapy as it has enabled clinicians to form comprehensive conceptualisations when working with complex clients. The focus on schemas has been useful in explicating the development, maintenance of client difficulties and in identifying obstacles that can impede change. While clinical practice attests to the benefits of schema work several points need mention.

Firstly, controlled clinical outcome studies comparing the relative efficacy of SFT vs. standard CBT are still underway (McGinn et al., 1995). Secondly, SFT is a content-based model and while much effort has gone into proposing cognitive profiles of personality disorders, these have limited supporting data (Dobson 1988). This makes SFT vulnerable, compared to other process-based models whose efficacy rests on empirical evidence such as Linehan's (1989) treatment of BPD and Rothstein & Vallis (1991) process model of personality disorders. Thirdly, Young outlines a protocol for therapy yet in practice - work with clients often deviates from this structure. For example,

whilst learning about Jades schemas we also explored her reaction to being in counselling and how this related to intra-and interpersonal processes in her life. During this time, we were *'not doing therapy by the book'* - yet sessions indicated we were *moving in the right direction and in the right way.*

Rothstein & Vallis's suggest that relevant process issues in contrast to protocols should guide the structure of individual sessions as the therapeutic relationship with personality disorder clients is often tenuous. Current literature also highlights the importance of establishing a functional alliance, which in itself acts as a powerful tool for change and the healing of trauma (Safran & Segal, 1990; Herman, 1992). A recent shift in schema addresses these difficulties by promoting greater use of mode work in BPD.

Literature on interpersonal violence shows that the long-term effects of childhood sexual abuse are significant and varied. Symptoms such as anxiety, depression, self-blame, guilt, nightmares and intrusive thoughts are so common among survivors that many clinicians and researchers advocate a PTSD diagnosis (Briere & Runtz, 1987; Roth & Liebowitz, 1988). The family context has also emerged as a critical influence on post abuse adjustment. In particular, researchers found that parental emotional distress, lack of maternal support and maternal depression exacerbates emotional and behavioural disturbances in sexually abused children (Anderson, et al., 1981).

Yet, many survivors, like Jade do not exhibit PTSD symptoms in adulthood (Murphy et al., 1988). Instead the long-term effects of sexual abuse are

interpersonal in nature (Conte & Shuerman, 1987) or reflect pervasive disturbance of the self as in BPD and other Axis II diagnoses (Wheeler & Walton, 1987). The notion of avoidance in and sexual abuse memories deserves further mention as SFT advocates that clients must stop avoiding schemas as it is a form of maladaptive coping. A study of abuse survivors (Alexander, 1993) found that coping methods developed to deal with sexual abuse experiences i.e. avoiding vs. confronting trauma memories, did not necessarily translate into a style of relating or personality structure. This is interesting as many clinicians advocate that effective treatment of sexual abuse requires a focus on the abuse. It seems however, in itself, this is not necessarily the magic key. Instead *a feeling of security* established through the support of a current relationship or trust in the therapist is necessary for a client to be willing to talk about the abuse. Trust is a prerequisite to the important work of remembering abuse thus interpersonal security and establishing trust in the alliance, is a legitimate goal of therapy itself, for certain clients, at certain points in the course of recovery. This was pertinent to the progress of the client as firstly, she generalised to other relationships and secondly, the experience of the alliance increased her sense of security in herself and others despite us not working through the sexual abuse.

Finally, counselling with Jade spanned almost a year and this has to be juxtaposed against the setting within which it took place. Conducting SFT in primary care is unusual given it is a short-term service. Practitioners in secondary settings have the resource for long-term therapy, yet it may be worth considering, that many clients find attending surgeries less stigmatising

than hospital based psychology departments. SFT has brought an explicitely acknowledged that structural changes are necessary in therapy, i.e the number, length and frequency of sessions when helping individuals with chronic difficulties. Enabling clinicians to balance caseloads with long and short-term work may provide an avenue for 'holding clients' that get 'lost in the system' due to their interpersonal difficulties. Furthermore, if randomised clinical trials prove SFT effectiveness, several long-term benefits could emerge. SFT may reduce hospitalisation of clients with disorders like BPD by providing cost effective outpatient treatment thereby reducing the length of treatment for clients who relapse chronically (McGinn et al., 1995).

On a clinical level, clinicians have been cautioned *to take care when working with schemas, if clients are not to come to harm.* This warning comes with the realisation that trainees use SFT techniques in isolation without considering the impact these may have on clients (James, 2001). Competence in SFT requires several complex skills: starting from conceptualising a case in schema terms to creating a nurturing therapeutic environment that is tailored to fit the clients need. Eliciting negative cognitions in Axis II clients in contrast to changing them is often easy, even by counsellors with limited experience. The alliance with its potential for therapeutic change is vast thus it must be used respectfully to identify and modify dysfunctional interpersonal patterns. This should only happen once a counsellor is clear on the ramifications of having schemas exposed, challenged or weakened. Jade taught me this lesson; she challenged me, stimulated my thinking, loved and hated me at times, probably in equal amounts. I have been privileged to know her...

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Using CBT to address guilt over sexual fantasies

Authors note

In the course of clinical practice, every counsellor will recollect a handful of clients that remain memorable for different reasons. Usually, these clients symbolise a turning point in learning, encapsulate a deeper understanding of the therapeutic process or have in some way fostered the development and growth of the therapist. I encountered such a client in my training. His presenting problem was not traumatic, nor horrific, but very human as he searched to find answers to the notion of commitment within a long-term relationship. His source of distress centred on his sexual fantasising of other women, which he deemed incompatible with true devotion. I have chosen this case and the specific session, as the themes and questions it evoked opened up a personal journey that continued long after our sessions ended.

To begin with, I reflected on the broader meaning of counselling, which led me to the realms of philosophy that many consider is the birthplace of psychology. I also questioned how 'process' is used in the course of helping. As counsellors we engage with the internal world of clients. At times, we encourage clients to express their feelings about the therapeutic relationship or us in order to facilitate learning and insight. Very often this is a reciprocal process and skilled therapists, legitimately use this information to deepen the experience of counselling. Most counsellors feel 'comfortable' exploring their own and client's negative or positive feelings in the alliance. We answer questions on competency or address clients' interest in our personal backgrounds. These areas are somewhat familiar and are guided by personal rules and a theoretical framework.

Conversations that concern physical attraction between client and counsellor pose a different challenge and can feel unfamiliar. A danger lies in counsellors segregating ideas or feelings because the content is, or seems sexual. This is a prejudice that I realised can stem from biased training or discomfort in discussing such issues. This experience touched my past as in my MSc I explored ethical beliefs and behaviours of helping professionals. I learnt that there are very few 'always' or 'nevers' in counselling other than fundamental ethical issues. Capturing my internal 'process' has firstly, highlighted that self-awareness and the value base of counsellors are tools that can translate counselling into an act of helping or harming; and secondly, that once in a while each of us will come across a case that must be handled differently to others. Sometimes we may not be able to say why at the time, but it can become clearer in retrospect if self-examination remains a guiding force in personal and professional development.

Structure of process report

In this process report CBT was used as a framework for intervention with a client who presented difficulties relating to sexual fantasies. While extensive analysis of the model is beyond the remit of this report in Part 1, an effort is made to provide a succinct overview of the main principles and techniques. Emphasis is placed on interventions relevant to the session and in providing a brief presentation on the area of work relevant to the client. Part 2, outlines the psychological assessment and Part 3 includes a 10-minute transcript with commentary from the 7th session. In Part 4, an overview and evaluation of the work is provided. Finally the development of ideas is discussed.

Part 1: Theoretical Framework

Cognitive Behavioural Therapy

The basic premise of cognitive behavioural therapy (Beck, 1976) is that there is an essential interaction between how individuals feel and behave and the way they construe their world, themselves and future prospects (Freeman, 1987). According to the model the tendency to adopt dysfunctional thinking patterns stems from irrational beliefs consisting of assumptions that determine *'a way of being'*. Automatic thoughts are the most accessible and identifiable cognitions while core beliefs (or schemata) formed in early childhood lie at the deepest level. Typically, core beliefs consist of absolute statements and exert ongoing influence over the perception of events in fairly fixed ways. Thus when external events stimulate irrational core beliefs, distortions are observed through patterns of negative automatic thoughts (NATs). For example, dichotomous thinking is the tendency to evaluate personal qualities or performance in all or nothing terms; while emotional reasoning uses emotion as evidence for the way things really are, on the logic 'I feel therefore I am' (Wills & Sanders, 1997).

The process of counselling entails working collaboratively with a client in uncovering and challenging dysfunctional thinking, using guided discovery, Socratic questioning, 'thought diaries' and behavioural experiments (Freeman, 1987). Guided discovery involves asking questions aimed at understanding the client's framework. It is an investigative process whereby client and counsellor join forces to see if a different way of seeing things is possible

(Beck & Young, 1985). A key tool in this process is the Socratic Method, which uses systematic questioning and inductive reasoning to draw general inferences from experiences within specific events. In turn, this helps clients distinguish between facts, beliefs and opinions (Overholser, 1993). Padesky (1993) also stresses importance on asking synthesising questions to help clients draw conclusions from their explorations. The aim of guided discovery is to help the client learn how to question thoughts and beliefs and 'thought diaries' allows the skill of challenging to eventually become automatic. Specific cognitive strategies include: questioning evidence that maintain ideas, looking at advantages and disadvantages of specific beliefs in order to create a fair perspective, reattribution, labelling distortions, guided association using the downward arrow technique and imagery. Behavioural strategies that facilitate learning include bibliotherapy, social skills training and experiments to test beliefs by discerning their relative validity (Beck et al., 1979).

Homework consequently forms a vital part of cognitive therapy as it advocates the idea that counselling is not a weekly occurrence but a process wherein client and counsellor work in partnership to bring about change. Safran & Segal (1990) stress the importance of the 'cognitive interpersonal style' so that in addition to the counsellor's cognitive behavioural conceptualisation an assessment is made of how the client's enduring patterns are replayed in the therapeutic relationship itself. The overall goal of counselling thus aims at building more adaptive and functional skills for responding on an interpersonal and intrapersonal level by endorsing a model of coping and adaptation.

Threats to self-esteem: subjugation and defectiveness

All humans hold the capacity for personal evaluation; namely the ability to form an identity and attach value to it. Self-esteem or self-worth creates a context of personal freedom and is necessary for psychological survival. Its earliest foundations lie in parental affirmations of worth, and in time depends heavily on the values of others (McKay & Fanning, 1992). Humans however, also hold the capacity to distort reality and the perceptions they hold of themselves. This may occur in a positive or a negative way, but distortions in the latter direction invariably devalue self-esteem and perpetuate emotional problems.

Schemas that threaten self-worth include a defectiveness/shame and subjugation (Young, 1994). Subjugation relates to self-sacrifice and a conviction that '*others needs are more important than ones own*'. This cognitive style however characterised by an imperative to please other people, leads to feelings of being trapped as it deprives personal freedom by dictating personal choices according to the effect it has on others. Consequently, a clear sense of ones own wants and needs is often missing. Stepping out of the subjugated role leads to guilt and reversion to self-sacrificing behaviour, which over time fosters a passive attitude to life and low self-esteem. Injuries to self-esteem can create feelings of shame; this is especially evident with defectiveness where the need to hide an inner conviction of 'being inherently flawed' leads to a fear of being loved and expectations of rejection. This is based on the idea '*the more deeply someone knows you, the less loveable you are'* (Young, 1994).

Sexual fantasies

Sexuality is woven densely into the fabric of human existence. Sex is a motive force, bringing two people together into intimate contact. Mutual sexual interest may lead to brief encounters or to a principal relationship, and while sexual pleasure may be seen as an uncomplicated positive consequence, the binding effect of sexual intimacy and emotional security is vital.

Another important thread in sexuality is the internal and private world of fantasy, even if it only involves imaginary behaviour (Bancroft, 1989). A distinction must be made between sexual fantasies during sexual activity and those that occur at other times such as daydreaming. Research shows that men generally have more erotic fantasies than women and spend more of their general daydreaming on sexual topics (Wilson, 1980). The content of fantasies also differs as men tend to lay emphasis on visual aspects whilst women accentuate accompanying emotions (Wagman, 1967; Barclay, 1973). It has been suggested, that male fantasies are expressions of a sex-drive that is not fully fulfilled, whereas women fantasise more when their sex life is going well. Interestingly, research on whether pornography has an undesirable effect on sexual behaviour shows that while erotica induces a degree of sexual arousal exposure to new sexual ideas does not result in such activity, though it may do in fantasy (Yaffe, 1973; Bancroft, 1978). In relationships, mood and its impact on self-perception i.e. whether a person feels desirable or worthy of love also influences sexual desire and intimacy. Fantasy can thus act as a stimulus to sexual pleasure or be a response to an inner emotional state or external circumstance (Bancroft, 1989).

Part 2: Psychological assessment

Referral

Michael (M) asked his general practitioner for a referral to the Brief Intervention and Counselling Service. The letter stated M was stressed and was seeking help due to problems with his girlfriend.

Appearance and behaviour

Michael[1] is a 32 year-old single male. He is of medium build with short black hair and blue eyes and works as an actor. At assessment he was wearing a large jersey and jeans and his manner was polite and friendly. On first impression I sensed he was burdened. Non-verbal communication indicating this included intense eye contact and a thoughtful facial expression. For most the session he leaned forward, spoke rapidly and at times when pausing between thoughts he sighed heavily and held his head between his hands.

CBT case-formulation

Presenting problems and current functioning

The client presented with feelings of low self worth, depression and anxiety due to his inability to take the decision to get married to his long term partner. More specifically, this problem related to feelings of shame that stemmed from having sexual fantasies about women, other than his girlfriend. This fixation he explained occurred on a daily basis, whilst observing different women. The client's desire for these fantasies he juxtaposed against the love he felt for his

[1] The client's name has been changed.

partner who he described as 'pure' in her essence. The client has kept his fantasies to himself, in fear of hurting his partner. Arguments however on 'the future' of their relationship and his procrastination, perpetuate ongoing stress and an inner conflict over his needs and inability to make a commitment.

Diagnoses (DSM-IV)

Axis I: Major depression, single episode, moderate

Axis II: No personality disorder

Axis III: No physical disorders or conditions

Axis IV: Severity of psychosocial stressors: moderate

Objective scores

BDI - Beck Depression Inventory

(35) at intake; session 4 =(31); at session 7 = (25)

BAI - Beck Anxiety Inventory

(21) at intake; at session 4 = (18); at session 7 = (15)

Developmental profile

Michael had a conservative upbringing in a small 'old fashioned' town in the United States, where emphasis was placed on religious values and notions of 'right and wrong'. He is an only child, who functioned well at school and was socially popular. His artistic inclination and need for 'freedom of expression' was evident since young through his desire to try different and new things. In early adulthood a need to escape his restrictive environment and explore the world propelled him to leave home to attend drama school in England. His

parents were not overly supportive and did not approve of his need to become an actor. The client has been in the UK now for 4 years and works in a theatre company. He has no past history of psychiatric or medical difficulties.

Family and other relationships

In childhood the client idolised his father, who was a successful financier and traveled extensively due to his work. As such he was often absent from the family home. Although Michael's mother was his main carer, the client never felt close to her due to her over-protectiveness and perfectionistic demands. Since leaving home, their relationship has improved and now he feels closer to his mother. His father is still not very close to him. Regarding his current circumstances both his parents are frustrated with his indecisiveness and want him to make a decision on his relationship. The client feels pressure from them to do the right thing i.e. get married and thus ultimately not disappoint them. He has always been popular among his social network of friends and was taught to always be respectful and giving towards others.

Significant events and traumas

In early adolescence, Michaels father falsely accused and shamed him for looking at magazines of women (even though he had not), and made him feel that he had done something very bad and dirty. The client remembers that he felt humiliated and insulted that his father thought he could do such a thing. Within his family environment the client experienced ongoing criticism from both his parents when he did not do as he was told. Pleasing them was a means of gaining their approval and love.

Cognitive profile

Typical problematic situations

- Discussing marriage with his girlfriend
- Fantasizing about women during the day
- Explaining to his parents why he cant make up his mind

Typical automatic thoughts, affect and behaviours in these situations

Automatic thoughts:	Cognitive distortions
'Commitment is a *death sentence* '	Catastrophizing
'She is miserable because of me'	Personalization
'It's wrong that I'm fantasizing about other women'	Dichotomous thinking
'I'm disgusted in myself''	Emotional reasoning

Affect: Escalating feelings of shame, anxiety, depression and guilt result as the client finds himself caught in cycles of surrendering to the excitement of his fantasies and resisting them in order to be faithful.

Behaviours:

- Avoids conversations on commitment by spending time 'away' from home or absorbing himself in work
- Avoids calling parents
- Speaks to friends about his predicament and asks what they would do?

Physical symptoms:

- Tiredness, physical tension, poor concentration, stomach upsets and sleep disturbance.

Core beliefs

- 'I am bad ' (seedy)
- 'I am selfish'

Conditional beliefs

'If I have sexual fantasies about other women then I'm disturbed'

'If I make such a commitment, my life will be a barren landscape'

'If I think of only myself then I can never be true to someone'

Rules

'I must do what is right '

'I must not hurt other people's feelings'

'I must not lose my personal freedom'

Integration of cognitive and developmental profiles

Michael's feelings of low self-worth and thinking style have been triggered by his inability to commit. In facing this decision the client has become confused over his 'needs' and 'desires' and is unable to find a balance that does not leave him feeling bad. Antecedents such as his family and social background predisposed him into developing strong moral standards over sexual practices and his concept of self. These beliefs are now challenged by sexual fantasies that the client deems 'morally wrong' but exciting at the same time. Michael's low self-esteem is maintained by a critical voice that he has internalised from his parents. Personal freedom seems to be a core value in him as he envied the freedom his father had and detested his mother's over-protectiveness and conservatisms of his home town. Thinking about and meeting his own needs however, is often difficult as it makes him feel like he is being selfish.

Relationship difficulties: Cognitively, negative thoughts about himself lead to feelings of shame and limit communication with his partner, due to a fear of being judged unworthy. Procrastination on the issue of marriage leads to fights with his partner, who gets upset because he is distant and she feels that he does not love her. As a result Michael feels guilty for hurting her, becomes more avoidant and has gradually become more depressed over his dilemma. His partner has however shown interest in trying to understand him.

Pleasing parents: The client also experiences pressure from his parents to make up his mind. He cannot bring himself to say that he is not ready to make a decision, as this would displease them. His parents have the expectation that given he has been in the relationship for 4 years, he should know what he wants. According to them, Michael is also at an appropriate age to get married and is repeatedly told that this is the right and mature thing to do. On the phone Michael often feels that he should comply and do what they say.

Depression: Overall, Michael feels ashamed and dissatisfied with himself, is hopeless about his ability to make the right decision and sees the future as negative. This inner world is juxtaposed by vivid fantasies that symbolically represent a need to preserve his personal and sexual freedom.

A central idea underlying the client's difficulties is that '*unless I do things perfectly and conventionally, I will be rejected by others*'. In considering the origin of this assumption it seems Michael's early environment and parental relationships played a central role. He was criticised harshly by his father for

exploring 'dirty' magazines and forced by his mother to remain by her side and uphold social norms and practices. The nature of his parents' relationship also modelled the importance of traditional roles and painted a conservative and negative picture of marital life. From these experiences the client may have learned that tradition and conservatism is stifling and that deviance of any sort eventually leads to criticism and rejection by important others. Equally it seems the only way that Michael secured his personal freedom was by being selfish and doing what he wanted, like becoming an actor and eventually leaving home to explore the world.

Interaction of life events and cognitive vulnerabilities

The client' current depression was precipitated by his girlfriend's ultimatum. His ambivalence over 'what to do?' is fuelled by a fear that if he does not do the conventional thing, he will be judged negatively. To stall the decision and avoid rejection the client is trying 'to buy time', to resolve this dilemma through counselling. Anxiety over his dilemma is perpetuated through emotional reasoning and dichotomous thinking. This is evident as Michael believes that if the cost of his private fantasies is losing his partner, this would transform his feelings of shame, into a factual existence; and yet to deny his fantasies and marry (just to please everybody) - would lead to him being trapped forever.

Compensatory and coping strategies

- Works more than he should at the theatre
- Spends time away from home with friends and colleagues
- Is hypervigilant of his shortcomings
- Avoids expressing difficulties to his partner

Development and maintenance of current disorder

Michael's dilemma stems from his inability to tolerate inconsistency in his thinking, over his own sexual views and values of self. As such global negative self-evaluations maintain his upset and lead to emotional and behavioural avoidance of intimacy. In the short-term, 'stagnation' detracts from making a decision - based on the rationale that he must find inner consistency. In the long-term however, this has created turmoil in his relationship and stopped him from moving forward. As the client focuses more on his inner fantasies and withdraws from his partner to gain relief, his mood has worsened. Furthermore, core beliefs like 'I'm selfish' and 'I'm seedy' perpetuate self-loathing and shame. His depression can be understood as an indirect result of a lack of gratification and satisfaction of experiences in his life, coupled with criticism levelled at himself for having a 'deviant' sexual interest. The formulation suggests Michael perceives his inability to make a decision as a direct result of personal inadequacies and his character flaws.

In relation to the clients assumption and beliefs, it can be predicted that in the course of therapy he may adopt pleasing behaviours e.g. by doing homework, to gain approval. Since Michael has a dichotomous thinking style, it can also be predicted that he may seek or expect a solution to come from the therapist i.e. on what is the right thing to do? Feelings of shame may also deter the client from fully disclosing the nature of his fantasies and if for example, he masturbates excessively in response to them as this would lead to further shame. The implication for therapy is that he may become frustrated or drop out, if he is not given an answer that will resolve his dilemma.

Suitability for CBT

1. **Psychological mindedness -** High: open and insightful
2. **Objectivity -** High: is keen to get alternate views
3. **Awareness -** High: clear understanding and presentation of difficulties
4. **Belief in cognitive model -** High: wants to learn why he thinks and behaves the way he does
5. **Accessibility and plasticity of automatic thoughts and beliefs** Medium: tends to be rigid on what he considers as right and wrong
6. **Adaptiveness -** High: tries to integrate new learning
7. **Humour -** High: can see the lighter side of life and the situation he is in

Part 3: Process of session

Aims of session seven

1. Review homework from last session.
2. Explore client's core beliefs.
3. Discuss relationship and fantasy issues, in relation to beliefs.
4. Feedback and set homework for next session.

Lead into session

The transcript is taken from session seven a few minutes after starting. Prior to this Michael and I were reviewing homework. The client explained he attempted disputing his core beliefs and the idea of 'I'm bad' was now not as strong. He reported however that 'challenging' was difficult and that he

struggled to understand and doubt his belief of being 'selfish'. When M mentioned this I recalled past sessions in which we had rigorously explored evidence for and against this belief. I started feeing slightly frustrated and thought: '*We are going round in circles*', '*Has he shifted at all?*' While aware of my inner dialogue I decided to take things slowly, to identify possible maintaining factors. I lowered the tone and pace of my voice and asked an open question aimed at inviting Michael to explore his belief. This is where the transcript begins:

Transcript

C1: Let's try and understand what the word selfish means. What does it mean to be 100 % selfish?

Instead of telling M he was not selfish I used questioning to elicit realistic alternatives. This would enable him to think through issues and generate his own evidence, which would also be more convincing.

M1: Hum, it means that you really... just think about yourself.

I wondered after eliciting his automatic thought whether my question was perceived as patronising, since the answer was obvious. Then again, I felt this was necessary when moving from general to idiosyncratic meanings.

C2: Only?

This punctuation checked if M believed what he said or whether he was just answering the question.

M2: Mmm…

M indicated he believed it but his face expressed doubt. Possibly stronger evidence was needed to challenge his belief. Counselling - came to mind as the idea of being totally selfish was not quiet congruent when he was trying to improve his own life and how he cared for others.

C3: Is that what you do?

Narrowing the focus allowed M to evaluate whether his definition was a fair and honest view of himself. I hoped this would start clarifying the distinction between having self-interest and being selfish.

M3: Sometimes, yea..

I inferred M's belief (C1) had shifted slightly; before he would have said 'yes'.

C4: Mmm

My facial expression insinuated 'okay, sometimes he could be selfish' which made him laugh and kept the climate light. It also encouraged him to go on.

M4: And you know sometimes I.. I don't know…

M realised he was thinking in all or nothing terms. His pause signified some confusion about this.

C5: So coming to counselling is also selfish isn't it? cause you are just talking about yourself?

I could have explored unselfish behaviours, but I was aware in the homework he had listed a page on this. Instead I used the 'here and now' by offering a distorted and emotive idea aimed at distinguishing facts from ideas. My 'So' may have seemed aggressive but I think my humorous tone averted this.

M5: Well that's true...yes that's true, it can be regarded as self-centred...navel watching or as well..

M reciprocated in a whimsical manner and showed cognitive flexibility as he pondered one possible meaning and moved away from all-or-nothing thinking. To exemplify this, I could have reflected, 'It seems as if you think it is, but you're not sure?' but non-verbally a sadness come over M. as if he believed the above was true. I also thought after 7 sessions he was still struggling to make a decision.

C6: Mmm.. Well is it?

I pondered over the progress of counselling, as M paused to think. My feelings of helplessness mirrored the clients, which increased my anxiety on the quality of helping. This concern detracted from my empathy maybe because my belief on 'doing my best to help clients change' was triggered.

M6: No... no it's not.

Questioning M's perception led to him negating his belief, as his own counselling did not fit his initial hypothesis.

C7: Why not?

I kept my questions short, as I knew this was an emotive area for M. My aim was not to intrude with words, by allowing him to consider the impact of his ideas. I also had confidence in the alliance to know, this line of 'why questioning' would not be perceived as aggressive.

M7: Because...because it's trying to make me a better person and not to be you know to actually, to actually try and make a change to make you know, try and be a better person I suppose...

M provided evidence against his belief. From his lowered tone, I sensed an emotional shift-taking place. He didn't finish saying, what he did not want to be, which I thought was because even verbalising his beliefs was at times painful. We had now come closer to the considering the difference between having self-interest by wanting to improve one-self and being selfish. I should have reflected this back, but I was thinking of how to expand understanding of the client's framework to the outside world vs. focusing on using this line of questioning to change his mind.

C8: Mmm...I'm thinking of this 'unselfish' because I think this is something that came up, a lot in terms of how you handled your relationship and this whole notion of commitment - which was a very strong construct in your mind. okay ..uhm You often said to me that you felt selfish in the way you reacted or .. in the fact that you hadn't made up your mind and somebody else's life was on line because of you. uhm . ...If you view yourself, as such a selfish person what do you think

Donna, lets say likes about you? .....uhmm.....Because that would also be evidence against ...I'm bad.

This response was clumsy and verbose. I was clarifying my thoughts instead of checking them out with the client. On a process level, my comment depicted the same conflict M experienced, namely trying to continually hold in my mind the dichotomous nature of his thinking e.g. Instead of saying selfish I said 'unselfish' because of how I perceived him. I should have slowed down and articulated a simple question. My anxiety on confusing him was also evident when instead of allowing M to provide opposing evidence I justified my intervention to clarify the purpose of my question.

M8: Yes

M said this quiet strongly and I felt some relief because despite my long-winded monologue he understood my point. His gaze shifted to the floor, where he seemed to be, trying to understand.

C9: So, given the difficulties in this relationship, what is it that actually keeps it, what is it that she likes about you?

I wanted to contrast M's outlook with the qualities others valued in him, in order to create a more realistic viewpoint.

M9: Uhm..she thinks I'm kind and uhm ….that she can trust me.

(C9) enabled the client to recognise others saw him differently. Acknowledgment of this, I thought was good progress.

C10: Okay.

This prompt communicated that was 1 piece of evidence and possibly there were more. Expanding evidence, using factual data from his relationship I hoped would show how his dichotomy blurred his perception and sustained his core beliefs.

M10: Uhm …and she loves me so…you know, she loves me so that's like holding her on, you know….

As M searched for evidence, I sensed doubt in his voice. The word 'holding' implied in my mind, she was uncertain and could still abandon him? Yet in M9 he provided evidence, why she wanted to stay with him. I chose not to explore this further because M was making an inference about his girlfriend behaviour, which would have made it difficult to find evidence for and against. Instead I focused on how it contradicted his belief.

C11: So is it possible to be kind? …because kind implies you are kind… toward others or kind to yourself. How does that fit in with this notion of selfishness?

This was a good question in leading M toward understanding how he combined contradictory notions. Although he behaved in a kind and

trustworthy way he still chose to perceive himself as selfish. He agreed non-verbally, as I spoke.

M11: Uhm…..mmmm

M became very thoughtful at this point, which indicated he was thinking about his dichotomy. His affirmation I found hopeful as it pointed towards new understanding.

C12: It's a completely different perception to what you're seeing yourself.

This reflection confirmed M's nonverbal agreement and brought attention onto what he was not noticing.

M12: Yes……yes….mm….I'm sure she doesn't think I'm really that selfish, you know. I spoke to her before about it you know, …. And she doesn't…no...no.

M was now realising evidence from his life contradicted his belief. He responded with confirmatory information and his tone when he said 'no' made me think, his girlfriend had substantially verified this point. An important shift had also occurred in session as M was now taking more responsibility in providing evidence against his belief. Moving from a personal to an interpersonal level, provided increased insight thus I continued with guided exploration.

C13: I read that you have started talking to her more about what is going on, in counselling.

This was an apt time to link the homework as I noticed M had recorded the above in his diary as evidence against being selfish. This was vital as it was new behaviour, which in the past frightened him.

M13: Yes...yes

Something important seemed to have occurred and M wanted to talk about it.

C14: What's that been like?

My curiosity prompted the client to expand and assisted in moving the counselling process forward.

M14: Its been its been good, I mean because it felt like..uhm ... I was saying these shocking things you know....I've said them before in a way, but it was actually met, with more kindness it was met with an openness...which maybe, once I can get more you know...cause I think I was thinking the other day sometimes I'm really petrified of the outcome of saying these things. I'm worried of the attack I'm going to get, so it stops me from opening up but ...uhm.. I really came across something that really made me think about wanting to be closer to Donna..uhm.. It's something I read in the Feeling Good Handbook. It was about a man who...uhm he was married and he didn't want to be married anymore because he..wasn't liking what was happening. So then eventually he went single and...and it made me think that, ...I think I've got another

core belief, or I've got something that's stopping me from moving forward. It's just a feeling that you have to have many relationships before you settle down you know what I mean?

M's self-disclosure was illuminating. A dam of information had burst through demonstrating the conflict he faced. He spoke in a slow and reflective manner, signifying a strong need to understand his thinking and possible links with his fantasies. The homework and bibliotherapy had further facilitated this insight. I felt compassion for M as I observed him confide his struggle. On a process level, this communication signified for me the safety he felt in the therapeutic alliance.

C15: Mmm....

I continued listening without interrupting his thinking.

M15: and that's so rooted in me? It's gone deep you know, deeper than I thought...

By identifying the meaning of his fantasies M unravelled the dichotomy created in his relationship. This understanding was facilitated by the emotional distress experienced in session, which provided greater access to his beliefs. It also informed the conceptualisation as I speculated fantasising distracted M from emotional intimacy. They also created deep guilt and shame as he was caught in a viscous cycle where they were both a product of his thinking and an activating event for further distress. It dawned on me I did not know their content, as earlier efforts were spent on normalising the idea of fantasising.

C16: Mmm, ... that notion I think came to ..uhm ...sort of the first issues we were talking about when you first started coming here about ...the sexual fantasies ... you know, and were they normal, were they not normal? And how did they leave you feeling? And it was about your internal battle about what it is that you want ?...so if we revisit that area now, okay?

I now wanted to link this in but as I embarked into this territory I got slightly anxious, because I knew where I wanted to go but was not sure what I would find. Asking permission to do this helped reduce my anxiety and reinforced collaboration.

M16: Mmm (nodded, several times)

Non-verbally the client expressed he also thought this was an important area to look at.

C17: Given that you have probably identified an important belief, that you know, 'I must sleep around with a lot of people before I can get married' ..uhm what are your thoughts of it now,... in terms of fantasising, in terms of Donna?

Via a synthesising and more Socratic question I pursued the 'reality-fantasy' theme and encouraged M to draw conclusions. Asking two questions however may have confused the client by not allowing him to focus on one area. During the transcript I realised counter-transference had taken place. M disclosed earlier 'he needed to have many relationships before he settled down', yet when discussing his fantasies (due to his limited sexual experiences) I

paraphrased this as 'sleeping around' and instead of saying women, I said 'people'. My language was impersonal and objectified his perception of women.

M17: Well my thoughts… are that uhm that if that belief if, …I can believe that that is not necessarily true…it's a way to actually go forward in a way…..uhm…..cause actually saying it to Donna made me feel a lot more,… I'd said it before anyway, but it was in the way I said it differently to her, this time it was …'I really think its deeper than what I thought it was …this belief, you know…'

M drew a conclusion and for the first time offered a solution. I sensed that he recognised the importance of communicating effectively and exploring self-defeating thinking, but was ambivalent on whether he could do this.

C18: Mmm

I listened, conveying interest and trusting in the client to identify, what he wanted. I noticed M felt increasingly safe to share feelings with a female because they were accepted in a non-judgmental way. I wondered how successful he had been in replicating this quality of communication in his relationship. I also felt relieved we were closer to making a decision.

M18:….and it makes me think that if I can get closer to Donna.

My thoughts were confirmed and I realised this was M's first expression of wanting to make a commitment.

C19: Mmm

I wondered if he also wanted to be 'pure'. Were his fantasies like a contamination?

M19: Actually be more open, express myself more easily, I wouldn't it would be easier not to be so worried about it...

I felt hopeful at this point, because our work was engendering cognitive flexibility. M was generating hypothesis and actively imagining a different reality that involved risk.

C20: Mmm..... could we maybe hypothesise that in actual fact, what it is about, what you are actually trying to improve is the quality of you relationships with people... and Donna has been the first person you know, you fell in love with and considered to share your life with and there have been obstacles there,.. that it's not necessarily about commitment...in the way you were looking at it, at first.

A positive reframe ascribed new meaning to M's dilemma, namely an interest in relationship quality vs. 'damning himself' as defective. I stressed the notion of devotion because he had not faced it before. Thus it was normal to be anxious. This was an appropriate time to explore M's fantasies as they represented the most important obstacle to his commitment.

M20: Mmm

While M agreed to this. His manner conveyed a sense of expectation, which made me continue.

C21: Remember you were saying you saw this barren land....if, if you got married...remember when we did that imagery stuff... that it felt barren...which is interesting, because barren is what you use to perhaps describe a sexuality you know what I'm saying...somebody is barren they cannot give life, they cannot produce.

By focusing on the image M placed on commitment, (which in-itself had a sexual and emotive overtone) I hoped to elicit automatic thoughts on his fantasies. Yet my zeal prevented me from getting feedback and made me insensitive to the impact my thoughts had on M. He may have found them, confusing and despite the strength of the alliance, quiet threatening.

M21: Mmm...

M indicated I continue. I hoped my next question, which was my point - would make things clearer. The danger in doing this however is I ran the risk of losing the client at the expense of my agenda.

C22: I'm going to ask you a difficult question. If you think I'm prying you don't have to answer it but I think on some level maybe, it will help us understand how you see yourself in this whole situation, Okay. We often talked about sexual fantasies; yea...I never asked you directly what they were about. All I knew really was, they were troubling you and .. You really didn't want to have them or you felt bad you were having them on some level. What were those fantasies like I mean, how did you see yourself in those fantasies ....because that might give us a clue into how you see yourself handling this situation?

This was a difficult but important question to ask, as I felt it would enable M to express exactly what he feared he would get rejected for. My explanation was wordy because my anxiety had risen over the past few minutes and I wanted to remain respectful towards the client. Thus I provided my inner rational vs. just saying light-heartedly 'What are your fantasies about?' Again, my process mirrored the clients as I was trying to render 'unspeakable' aspects of his world into a forum where it could be spoken about, but like M I was struggling to ask the question that would do this.

M22: uhm....it's the ...well the fantasies really are just almost, it's, ...its just very strong it's almost as if I'm ..If I see somebody sexually attractive I just want to have sex with them and some days it feels so, strong, I'm just looking at women you know ...looking, ...you know.....

Possibly, my long response in (C22) eased M into exploring this stream of thought.

C23: Mmm....

As M related his fantasies I noticed a change in posture and tone of voice. He became more free, more animated and descriptive on a visual and physical level; almost lustful. His dichotomous thinking re-emerged, through the lack of emotional involvement with the women in his fantasies. I chose not to reflect on this, in order to understand their content.

M23: I even went swimming the other day and there was this really attractive woman just swimming past me and I really wanted to keep

looking and then as soon as I looked, I said to myself What are you doing? You know she must really be uncomfortable going swimming.. looking... you know ...but its really strong it feels... it was that week that I felt, you know, why am I doing this, you know?

M's exasperated facial expression revealed he was disgusted by his reaction. Although he experienced discomfort in relating this event, I hypothesised it was also a relief to have things out in the open.

C24: Mmm

I kept direct eye contact and non-verbally my facial expression conveyed understanding of the distress it caused him. Demonstrating acceptance, I felt was crucial when M had made himself so vulnerable.

M24: It feels really....I just want to have sex with her, I want to... almost... feel... that you could just.. have sex with them ....and leave them.... and then its finished... do you know what I mean

I felt my stomach tighten when M referred to women as them; I thought: 'He is objectifying the whole female population into a sexual commodity'. I realised however I was overgeneralising.

C25: Mmm

I tried to prevent this from obstructing my listening by communicating empathy to M on the guilt these thoughts created.

M25: As if you were just a walking sex machine or something...you just...see something that you like sexually you have sex with them, fantastic and you go away and that's it.... and you're just, constantly doing that, you know..

This sexual freedom returned my mind to the conceptualisation. The content of M's fantasies seemed to protect him from being vulnerable, via the assumption 'he could use women sexually if he was not emotionally connected to them'.

C26: Do you think though, if you challenge your belief about having to sleep with a whole bunch of women before you actually make a commitment....Do you think that's going to change the fantasy about women?

I contrasted M's idea on intimacy hoping it would lessen the impact of his fantasies on his defectiveness. In the transcript I noticed how I phrased my question 'a whole bunch of women' and wondered if counter-transference was still taking place.

M26:.....I think I'm...just crystallizing something...its just.....its really like... a curiosity...to actually see lots of different bodies....

M did not answer but my Socratic question and the contrast helped him identify a cognition maintaining his fantasies. I wasn't sure whether what he shared was as simple as he presented it or if it would develop into something quiet different.

C27: Mmmm

I encouraged him to go on.

M27: It seems to me a curiosity to see different breasts, different legs, different.. Everything ....do you know what I mean...

This provided evidence of M's tendency to objectify women, which in turn made him a 'bad' person.

C28: Mmm....mmm

While my body language and facial expression remained neutral, M's comments made me feel uneasy again. Sitting before him I thought, 'Was he doing the same thing to me, looking at my body and fantasising what I looked like?' and 'should I ask this? Despite my irritation I rationalised 'it was not the end of the world even if he did' and remained focused on the client. 'Looking at it now, I may have avoided an area I felt awkward in because of ethical implications. It was also not an easy question to ask because I was not sure if it would have therapeutic value and I did not want to open up an area that would trigger another set of fantasies. With all these thoughts in my mind I wondered if M sensed I was uncomfortable.

M28: ...and what I sometimes try and do is, I sometimes try and look to prove for me that it's not worth looking at. No I don't want that ...and I really feel good when I don't... you know, and I find a fault in it.

Typically M corrected his thoughts due to feelings of guilt. Was the problem his desire or his inability to act on it?

C29: Mmm...mmm

Maintaining an accepting 'open' stance was vital in allowing the client move closer to aspects of himself he did not like. Yet the very thoughts that frightened M in real life, he was expressing freely in-session.

M29: You know..uhm... it's a curiosity and as it builds up... I've even gone I've gone into a kind.. into magazine shops with these porno mags I'd love just to pick ...that out and just look at bodies...

M provided a new activating event but this time, based on actual and potential behaviour. It created an image in me of an adolescent boy and I suspected picking up a magazine, would confirm the idea this type of sexuality is bad.

C30: So why don't you?

I wanted to explore the automatic thoughts that prevented him from carrying this out.

M30: Because I'd feel dreadful in doing that.

Challenging the client was aimed at uncovering the meaning behind this event. I could have asked 'what would have made it so dreadful?' but I kept my questions short, to keep our rapport spontaneous.

C31: Why?

I hoped this would allow M to become more focused on what his feelings meant.

M31: Because, I'd feel seedy and dirty, and despicable.

M's emotional reaction and the emphasis of his words indicated core beliefs of defectiveness had been triggered as negative thoughts, which aided in invalidating his self-esteem, emerged.

C32: How come?

I wanted to uncover why he believed this.

M32: Because (laughs) when I see middle-aged men taking those things down and looking right, I think God that's really sad....

The client communicated something very powerful namely that people who could not have real relationships could only have them through objects or magazines. To be like those people for M was more than bad or selfish it was incredibly sad and pathetic. I wondered were he got this meaning from- was there something in his parent's relationship.

C33: Mmm

I followed his train of thought but had an image of a 'free' father and a 'house bound' mother.

M33: I know its not...I mean I'd think good luck to you mate but .....I view it as that, by me taking that down what if someone walks in and says 'Hi Mark how you doing? And I've got this thing in my hand you know what are they going to think of me?

It was evident M placed value on external validation for his self worth. I could have used the downward arrow to explore this meaning further but at that moment, through our guided discovery I got a childhood image of an event he shared in a past session. It made sense; M's views may have been shaped by his conservative upbringing. Growing up in an environment so 'contained and rigid' no wonder he predicted his own family life would be 'barren' dull and stifling. His fantasies on the other hand encapsulated the exact opposite – an emotional and sexual freedom.

C34: You know what you're making me think of?

I wanted to set a new tone to share this connection. Looking back however, I feel it detracted from the client in the 'here and now' and could have been construed as if I had some deeper insight into his life than he had. I was also not sensitive to M's last question. Maybe M thought I was going to tell him what I thought of him. This could have been quiet frightening.

M34: What?

My question did evoke curiosity. We had moved from changing the clients mind on his beliefs, to identifying meaning.

C35: That experience you talked about when you were or 10 years old.. with your father ...when he said have you got a girlfriend? ....and What are you up to? ... It was the same type of thing .....you're saying .....'That's disgusting!' .... 'I would never, do that!'

Part 4: Overview of work in session

This session met the aim of exploring Michael's core beliefs *'I'm selfish'* and *'I'm bad'* and their meanings as they related to his relationship and sexual fantasies. At the start of session, time was spent reviewing homework and associated difficulties were problem-solved i.e. listing evidence 'for' and 'against' his belief and separating facts from emotional opinions. Identifying these obstacles provided opportunity for guided discovery and Socratic questioning, which helped Michael explore the notion of selfishness (C1). In particular, by using the milieu of counselling and reasons for seeking help Michael challenged his belief that he was 100% selfish (M7). Generally, because sexual fantasies can and usually do remain concealed their frightening significance may continue unchallenged; consequently, in the middle phase events mentioned by the client, pornographic magazines (M29) and looking at women's' bodies (M27) were used to draw inferences about himself e.g. *'if I had several relationships then I could settle down'* and about others (M 31, 32).

Examining these ideas led to identifying significant childhood events and to discussing how his fantasies fuelled his belief (M33). Furthermore, exploring the advantages and disadvantages of commitment and staying single, revealed the importance Michael placed on pleasing others. Finally, evidence from a behavioural experiment (M12, C13) and reattribution of his dichotomous thinking - enabled the client to offer a potential solution to his problem. Namely, fostering emotional intimacy with his partner could decrease

his fantasizing. At the end of the session, Michael reflected things still felt 'cloudy' but he realized the process of change was often slow and difficult. Homework for our next session was set.

Evaluation of session and self assessment of counsellor

Corey et al., (1988) write the role of counselor, as a *person* in the therapeutic relationship cannot be separated from the practical and theoretical knowledge made available to clients during counselling. In fact he claims '*since counselors are asking clients to take an honest look at themselves and to make choices concerning how they want to change, it seems critical that counselors' themselves be searchers who hold their own lives and work open to the same level of scrutiny*' (p27). Reflecting on this session and on the moment-to-moment interactions has been a process filled with a myriad of emotions. At times in the transcript I was filled with anxiety concerning the adequacy of my work. At other times the contents of the discussion touched a chord with my values and simultaneously our evident collaboration inspired hope. As such I recognized how the therapeutic relationship remains a central arena where clients (and counselors) can practice alternative or new behaviours (Wills & Sanders, 1997).

Michael's disclosures exemplified our strong therapeutic bond. Not only was he able to share 'hidden' parts of himself that evoked shame, but a non-judgmental climate allowed him to progressively achieve deeper insight. Reflecting on this session requires consideration of previous sessions, since they encapsulate an important process that took place. As work with the client

moved into his beliefs, my feeling of going around in circles increased despite Michael's progress. I now realize his subjugation schema had influenced counselling. In the manner he pleased others he pleased me by diligently doing all the homework. My irritation was triggered by his ambivalence and interpersonal style of needing me to direct counselling. Within this and other sessions, I strove to understand Michael's idiosyncratic meanings, which only fuelled hope in him that eventually I would tell him what to do or instead - in the next session, everything would fall miraculously into place. Interpersonally, individuals with subjugation beliefs often choose partners with a strong sense of self (Young, 1994). As a person I hold this quality to a degree and in our sessions it perpetuated the above process.

Counselors' are also human and they too have 'blind spots' or areas of sensitivity that inevitably interact with client problems (Wills & Sanders, 1997). This was evident in the counter-transference (C17, 26) which in CBT is valuable in providing deeper insight of process issues. A clue to its presence is often 'irritation' and by definition embodies all the counselor's responses to a client including thoughts, schemas, emotions, actions and intentions (Layden, 1993).

Exploring Michael's fantasies was valuable firstly, in aiding the conceptualization by providing a window into his private world and its relation to women; and secondly, it highlighted my dilemma on asking if his fantasies influenced our work. Usually when clients say or do something that creates a hunch about the alliance, I use the 'here and now' to address it. Michael

stated he fantasized about sexually attractive women but he did not do or say anything in sessions to make me think or feel he was sexually attracted to me. My thought (C28) was based on the fact I was 'a woman'. To assume he might be, I felt was dubious. On the other hand, whilst very aware of the difference between a therapeutic and personal relationship, if Michael was not offended (based on our trusting alliance) and answered yes, could that be used as evidence that he could experience intimacy without his fantasies intruding? If he answered no, could that suggest (*the alliance as a parallel*) that striving to get emotionally closer to Donna could lessen his fantasy, which was devoid of emotion? In retrospect, I could have used another female he was emotionally close with vs. me to test this assumption. In the end, I did not ask because on weighing it up, I thought it best not too. I did not want to shame or cause the client any harm by putting him on 'the spot'. But most importantly, I could not act irresponsibly by introducing an intervention, whose purpose I was unclear about.

If I was prejudiced because it was a sexual issue, maybe it was because I found it more difficult to introduce the topic rather than to discuss it. Furthermore, I may have projected my own values on the features of Michael's fantasies. Inevitably, the morals and conflicting opinions that encase human sexuality reflect the inherent complexity of these issues. These no doubt continue to change in counselors' and clients with life experience, or simply by getting older. Self-awareness and a flexible self-concept enabled me to accept my unease without detracting from the goals of counselling. Evaluating the transcript also highlighted skills I need to improve when

working with clients. When responding I can gain brevity by following as Wills & Sanders suggest a 'three sentence rule,' namely not saying more than three sentences at any point in time and constantly seeking client feedback. The danger of not doing this (as the transcript shows), is a monologue/didactic style that follows the counselor's pace and is less empathic to client need. Supervision provided a possible way of introducing sexual fantasies that helped put me at ease: "*I assume you have sexual feelings about me, I may be wrong... but I guess you have LOTS of feelings about me, both comfortable and uncomfortable. Why wouldn't you? It's all-okay with me. In fact, we'll talk about some of those periodically. It may be uncomfortable for you when we do, and that's okay with me also".* Finally, I observed how quickly I spoke, which made me race ahead of the client. This may have contributed to Michael's 'cloudy' feeling, as moving from one area to the next was not always clearly demarcated or brought to a logical conclusion. A slower pace and more use of reflecting responses could enhance clarity, empathy, collaboration and the overall delivery of my counselling style.

Development of ideas

Commitment to self-exploration and inspiring self-search in clients is not an easy task. In fact it is often fraught with difficulties and similarly, so is the self-search of the counselor. Working with Michael has challenged me theoretically and personally. In terms of the former, it inspired me to search the literature on issues affecting human sexuality, which provided guidance on sexual fantasizing (Masters & Johnson, 1970; Bancroft, 1989). In turn CBT provided a frame for conceptualizing this knowledge and its role in emotional

disturbance. For example, Bancroft (1989) suggests identifying discrepancies of the real world, the fantasized world and ideal can be invaluable in helping people with sexual problems, and CBT provides tools for such an exploration. Yet despite the knowledge I gained, I still felt something was missing in my understanding of Michael. Possibly, because at the end of counselling - the client had not reached a decision on what to do. This led me to depart from the 'content' of therapy to contemplating more deeply the 'process' of our sessions in terms of what it signified for the client and my role as helper.

An answer came from my reading on existential psychology and in it I found parallels to the humanistic underpinning of counselling psychology, which essentially involves helping clients, fulfill their potential. The centrality of this value-base is emphasized by Duffy (1990) who suggests that the way, counselling psychologists think about what they do is very important. Client's crises and problems are not seen as evidence of pathology but as normal human experiences, which pose a challenge for developmental adaptation. Cognitive behavioural therapy, as a method of working upholds this tenet by promoting change through adoption of meanings that foster personal growth. Yet Viktor Frankl makes the important claim (which CBT possibly neglects) is that what characterizes, human beings is a *"will to meaning"* (Frankl, 1969). By this he essentially means that the striving to find meaning in life is a primary motivational force in all man and needs to be understood also as an existential phenomenon. The client's request for counselling signified this need and over and above the contents of his thoughts, Michael used sessions to explore his *freedom of will* through his sexual values. Namely, the stance

he would take toward himself and his conscience. A tension or 'existential angst' had been created between - a relationship that required the responsibility of commitment and the freedom to explore or act on his sexual desire. Choosing the relationship for Michael ultimately spelt acting in *'bad faith'* - a self-deception that restricted his freedom and escaped the responsibility of being an individual; but not to choose it spelt choosing an existence that he deemed had no essence. Eventually his decision would determine his meaning, which in turn was indispensable to his mental health. Understanding the meta-communication of 'essence and existence' and identifying its paradoxes helped me realize the phenomenology of human experience present, in all counselling.

Spinelli (1996) writes that in addition to sound theoretical knowledge - counselling psychologists should demonstrate suitable maturity and life experience that infuses their ability to confront and deal with their own existential dilemmas. A complex interaction exists between knowledge and personal values and in any emotive area these cannot be separated (Bancroft, 1989). On a personal level, not surprisingly, this case re-entered my thoughts following my own life experience of questioning the repercussions of commitment to a partner. This work cultivated understanding of my strengths, vulnerability and it enhanced my belief in the fact that without self-awareness and a deep curiosity in the human condition, psychologists can obstruct client progress and their own professional development. Above all I now sense and know that the *'will to meaning'* is inextricably linked to the therapeutic relationship and emerges existentially through the steps that lead to change.

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The psychological impact of acne and Isotretinoin

Authors note

When I was 16 like other teenagers I had acne. My ongoing distress over my blemished face and unattractiveness warranted a visit to a dermatologist. Embarrassed and self-conscious I remember dreading the appointment. I wasn't sure, what to say. As I entered the doctor's office I stood and waited, feeling tearful, embarrassed and vulnerable. Without looking-up from his notes he asked me what the problem was. I mumbled 'my skin', and he lifted his head and glanced at my face. Five minutes later, I left his office with a prescription for antibiotics, a face wash, and I was told to come back in 3 months. My experience of acne and my first contact with a dermatologist was uncomfortable, but I suppose I considered my self 'lucky' as my condition did resolve and I forgot about the experience. This personal memory and my interest in skin disease spurred me to explore the psychological impact of acne and current efforts to provide effective medical treatment.

Summary of review

Acne is a serious skin disease. Distress over acne related appearance can foster body image disturbance and poor quality-of-life. Many sufferers thus go to any lengths to achieve a clear skin. Isotretinoin revolutionized the treatment of acne by offering such hope. Reports on adverse reactions, however have increased concern over the drugs ability to induce depression and suicide. These concerns led to revised product labelling and intensified regulatory interest. This literature review explores research on the benefits and dangers of isotretinoin and suggests that screening is needed to ensure patient safety and competent dermatological practice.

Introduction

Acne is one of the most common diseases in dermatology and affects more than 80% of the population (Bondi et al., 1991). Onset coincides with puberty wherein most teenagers experience the discomfort of a 'spotty skin'. Yet in relation to other diseases acne is often 'trivialized' possibly, because it is a normal part of development and common sense dictates that despite its chronicity, the physical results are short-term and can be managed through medication. While this may be true, the psychological impact of acne varies. Many individuals cope with the disease and live fulfilling lives but others feel disfigured and suffer deep distress. In a society that idealizes physical perfection, coping with the aesthetics of acne can be emotionally consuming. Psychological factors appear significant as patients report stress exacerbates their skin; many develop emotional difficulties and some present with psychiatric illness related to appearance (Koo & Smith, 1991). Concern about the impact on psychological or social well-being is often the prime motivation behind patients seeking medical treatment (Koo, 1994).

Isotretinoin (Accutane[1]) has been licensed in the United Kingdom (UK) for over twenty years. It is very effective drug in treating severe acne and for a large proportion of patients it offers a cure. The potency of this treatment however, seems to be 'more than skin deep'. Disturbing reports are claiming that patients taking the drug experience serious side-effects that are not only physically and psychologically damaging but even fatal.

[1] Marketed as Accutane

Clinical features

Acne occurs on the face, neck, chest, back and groin. It is a disorder of the pilosebaceous unit where increased sebum excretion, follicular plugging and increased microbial load result in inflammation. Diagnosis of the disease is based on the morphology of lesions being either inflammatory or non-inflammatory. Inflammatory 'spots,' resolve in a few days, while non-inflammatory cysts need weeks to heal (Rothman & Lucky, 1993). Most sufferers have a mixture of types and presentation varies from few lesions on one site to numerous on multiple sites; consequently the disease may be mild, moderate or severe (Shalita, 1988).

Severe acne consists of cysts that are disfiguring on the face, and disabling when they affect the torso due to pain or bleeding (Rubinow et al., 1987). Deep pits occur when lesions resolve leaving an 'ice pick' effect on the skin. White scarring is also common in extensive acne. The disease is more frequent and severe in males and scarring affects up to 95% of patients irrespective of severity (Layton et al., 1994). Acne usually heals spontaneously in early adulthood but a rising number 'don't grow out of it'. In the absence of successful treatment acne runs a chronic course and may persist for eight to twelve years. Early treatment can shorten the course of the disease, reduce severity and avoid scarring (Jackson, 2000).

Psychological consequences

Emotional stress

It is well known that having a bad skin is a stressful experience. It is also frequently observed that high emotional strain can lead to break outs and a worsening of lesions. Psychological stress is thus incriminated as a causative factor in acne and secondary reactions such as anxiety and depression are frequently mentioned as exacerbating factors by patients (Kenyon, 1966; Shalita, 1988). Whether emotional stress itself perpetuates or exacerbates the expression of acne is a question that has received much research attention.

Early studies noted the role of stress by showing that acne lesion-counts increased a few days after subjects partook in 'stress interviews' in which anger was deliberately induced (Lorenz, 1953). Reporting bias however made these results dubious. Later studies (Greisemer, 1978) used interviews and reported that in 55% of dermatology and acne patients, close chronological links between episodes of emotional distress and onset or exacerbation of their condition were observed. This particular study however diluted the role of psychological factors by only detecting emotional stress patients were willing to discuss and avoided discussion of sexual conflicts. In relation to this psychodynamic theories would argue that acne is a manifestation of unconscious processes that find a way to express themselves physiologically (Grossbart & Sheriman, 1986; Fried & Shalita, 1992). More recently a study exploring stress in students with mild to moderate acne, found that although breakouts were more likely to occur prior to examinations, levels of sebum

production remained much the same, irrespective of whether students were experiencing high or low levels of stress (Chiu et al, 2003). This suggests that overproduction of sebum does not play a role and that the worsening of acne may be related to inflammation. Numerous studies have shown that stress provokes inflammation, which fits with the fact that acne is an inflammatory disease (Toyoda & Morohashi, 2003; O'Connor, 2007).

Other researchers fail to link emotional factors with acne. Using the Maudsley Personality Inventory, Lucas (1961) found no difference in personality or frequency of psychological symptoms in students with or without acne; similarly, Medansky et al. (1981) found no correlation between anxiety and acne. More recent research suggests emotional stress and thinking styles may accumulate and lead to physiological changes in the skin and immune system (Bilkis & Mark, 1998). While there is no proof such induced changes are sufficient to generate acne, it can be hypothesised that emotional stress increases peripheral bodily activation and these psycho-physiological changes may over time exacerbate disease (Kleinman, 1998).

Psychiatric disorder

Acne's ability to create stress and damaging effect on body image can also lead to psychiatric disorders (Gupta et al., 1996; Krowchuck & Jowett, 1991; Koo, 1995). Avoiding social contact could lead to social phobia, depression and other mental health difficulties that perpetuate low self-esteem. Teenagers for example, are naturally prone to mood swings, sensitive to

appearance and seek approval from their peers. Thus when acne triggers negative self-perceptions the consequences can be serious (James, 1989).

16 year-old with severe acne "*Other lads dream of playing for Man. United. All I ever wish is that my face will be normal again, that I'll be able to look in the mirror without cringing, that I'll be able to walk down the street and look people in the eye…sometimes I see people in wheel chairs and I think.. '..They're luckier than me at least they have good skin'. My skin is the last thing I think about when I go to bed and the first thing I think when I wake. It's always on my mind*" (Papadopoulos et al., 1999).

It is estimated through the literature that 40-80% of dermatology out-patients have comorbid psychiatric difficulties (Coterill 1989; Medansky & Handler, 1981) and that psychological distress is greater, if disfigurement is visible (Papadopoulos & Bor, 1999). Using semi-structured interviews Rubinow et al. (1987) found that patients with mild-to-moderate facial acne, suffered significant emotional anguish and body image concerns prior to treatment. These lessened after treatment, which suggests that a 'fixation with acne' can be a psychologically disabling symptom of the disease. Inner turmoil over acne-related issues is further confirmed by research that shows that acne patients' display poorer adjustment than skin cancer patients (Van de Meeren et al., 1985); score lower on measures of well-being than the general population, and depression and anxiety is repeatedly reported relative to controls. The degree of disturbance is positively related to severity, the worse the acne the greater the distress (Van de Meeren, 1985; Wu et al., 1988).

Severity however also has a variable effect as Gupta et al. (1998) found in exploring depression, wishes to be dead and suicidal ideation in 480 young adults with skin disease linked to cosmetic disfigurement. Mild acne produced profound morbidity with high depression scores (range of clinical depression) and higher rates of suicidal ideation, than general medical patients.

Psychiatric conditions like acne excoriee and body dysmorphic disorder typify the more serious interplay between acne and primary psychiatric disorder where the severity of the disease is less crucial. *Acne excoriee*, focuses on acne, but diagnostically refers to behavioural symptoms of obsessive compulsive disorder, where urges to pick lesions cannot be resisted. Attempts to 'treat' spots by squeezing or picking them, inevitably leads to scarring. While in such patients excessive concern may be inferred, most people with spots on their face or body behave in a similar way (Wu et al, 1988). Bach & Bach (1994) suggest that *acne excoriee* could represent symptoms of underlying depression or personality disorder. In their study, of 12 patients *with acne excoriee* four had a comorbid personality disorders and two had dysthymia. Psychological factors may thus fuel syndromes like *acne excoriee* as poor self-image, compulsiveness and perfectionism correlate more strongly with self-excoriation than with disease severity (Gupta et al., 1996).

Body dysmorphic disorder (BDD) in the DSM-IV, is a somatoform disorder and refers to Individuals who feel hideously disfigured where 'little or no acne is apparent' (Phillips, 1996). Diagnostically, it is the extreme obsession with a defect in appearance that causes significant distress and impairs normal

functioning. A retrospective analysis of 16 dermatology suicides revealed 7 patients had acne and most had BDD (Cotterill & Cunliffe, 1997). The link with BDD is significant as it indicates that negative body image creates depression and that intense self-loathing is life threatening. Overall, few studies exist on psychiatric disorders in dermatology and the findings are mixed; some report no correlation with disease location or severity (Wessley & Lewis, 1989) and others using generic mental health measures show that comorbidity exists (Hughes et al., 1983). While no causal relationship has been directly observed, if psychiatric disorder can play a primary or secondary role in acne, then a bi-directional relationship may well exist between dermatological illness and psychological distress (Aktan et al., 1998; Johnson, 1998).

Body image disturbance

Body image is a core part of an individual's identity and refers to the inner self-portrait each of us holds. It includes how the self is viewed socially, physically, psychologically and incorporates cognitive, emotional, behavioural and perceptual dimensions (Phillips, 1996). Drawing from the disfigurement literature it is evident that facially disfigured persons are very aware of others reactions to them (Kellet & Gawkrodger, 1999). As such acne can be very damaging since lesions and scars cannot be disguised. A poor self-image (Jowett & Ryan, 1985) often fuels shame and can amplify vulnerability to rejection (Motley & Finley, 1989). If distress over acne related appearance surpasses the disease itself, hiding from a portrait of unattractiveness may become a behavioural solution to coping with a demoralized self concept. Cognitive approaches on psychopathology (Beck, 1976) provide a theoretical

account for differences in adjustment to acne by operationalising cognitive phenomena. It is hypothesized that negative thought patterns translate personal experiences (e.g. onset of acne) into a level of emotional distress that is somewhat independent of disease severity. Acne patients that hold perfectionistic views on appearance for example, are likely to perceive the most skin disturbance and thus report higher levels of disturbance.

Not surprisingly, acne is also linked to eating disorders, primarily a female disease where body image disturbance is a core feature. In anorexia extreme dieting can limit acne as starvation lowers androgen levels and results in less secretion of sebaceous glands (Gupta et al., 1992). In bulimia, the impact of acne on appearance may further damage body image and self-esteem (Lee et al., 1991). Schuster et al., (1978) explored psychological distress in acne, eczema and psoriasis patients and noted that as acne severity increased, self-image declined and patient perceptions of what others thought of their image worsened. This was more marked in females perhaps because self-worth is ascribed to 'perceived attractiveness'. Eczema and psoriasis patients showed less damage to self-image, which may be due to different sites of involvement. While gender differences have not emerged in the disfigurement research - if acne transgresses 'rules' on female appearance then this may exert differential psychological strain (Kellet & Gawkrodger, 1999).

The findings on body image disturbance are circumscribed as they do not depict the extent to which 'dissatisfaction with appearance' has risen in the last three decades. In 1972, 15% of American men were dissatisfied with their

appearance; by 1997 this rose to 43%, which suggests men's self-worth is increasingly relating to body image (Castle, 2001). In acne observed differences in distress may occur because females report higher levels of embarrassment (Krowchuck et al., 1991) and often present with psychodermatological problems related to body image (Gupta et al., 1990; Isometsa et al., 1995). Stereotypically, men may not report or talk about body image difficulties as readily, due to feelings of embarrassment and shame. Furthermore, they may not recognize that their beliefs about their appearance are inaccurate or due to a psychiatric disorder (Phillips & Castle, 2001) In a recent article on BBC news called '*Body image problems hit men too'* (2001) the British Medical Journal estimated that the number of men suffer from body dysmorphic disorder has tripled compared to 25 years ago; and that the condition is often under-recognised and under-diagnosed.

In acne men are likely to be preoccupied with their skin, due acnes effect on appearance, and scarring, which causes long-term psychological trauma. Not seeking professional help in this instance may serve to increase feelings of low self-esteem, helplessness and depression. Coterill & Cunliffe (1997) identified scarring as a risk factor for suicide in acne and particularly in men, possibly because they tend to suffer alone. Interestingly, a study exploring cultural differences is body image disturbance found that Western men have more distorted views of their bodies than Asian men. This east-west divide was explained through the role of the media and how in Western countries there is increased exposure of attractive, naked men in magazines as having a perfect skin and body; this emphasis is less evident in Asia (Yang, 2005).

Quality of life

In some instances the impact of acne upon body image, has a more acute and profound impact on well being and can impair interpersonal interaction. Jowett & Ryan (1985) explored quality-of-life and social functioning in 100 dermatology out-patients receiving treatment for acne, psoriasis or eczema. Using structured home interviews subjects were encouraged to openly discuss the impact the disease had on their lives. When asked *'What was the worst aspect of having the condition?'* acne patients stated 'skin appearance' and the ensuing lack of self-confidence, which negatively influenced relationships. Many reported public misunderstanding, spending hours 'concealing' mostly unsuccessfully; lack of awareness on acne's physical and emotional effects and refusal of time-off work to attend hospital appointments. These findings can once again be contrasted to socially advertised moulds of beauty that emit a 'promise of happiness' and from an early age propel a need for individuals to make flaws invisible. Under such pressure, the onset of acne clearly represents a deviation from the 'norm'; denotes social exclusion, emotional torment and like the disease itself, it can leave scars that never heal. The stigma of acne also places sufferers at a social disadvantage if it comes to dominate every aspect of living. Measures comparing morbidity in severe acne with other chronic diseases show that psychosocial stress is on par with epilepsy, diabetes and arthritis (Ginsburg, 1996; Mallon et al., 1999).

In summary, it appears that biological vulnerabilities can lead to the onset of acne, which once expressed varies in severity and duration. The disease is not 'trivial' but can have a profound impact mental health, body image and

social functioning. As acne severity, disability and distress increase so does the risk of developing enduring negative outcomes including psychiatric disorder, suicide and functional disability. The biopsychosocial model (Engel, 1977), views biological, psychological and social factors as interrelated dynamic influences on health and illness. Moderating variables in acne can potentially regulate severity, disability or disease-related stress. These include life events, personality traits, social competence, stress management skills, social support and a sense of control over the condition. While biological moderators are likely, less is known about these. The biopsychosocial model predicts that effective medical intervention can profoundly effect patient functioning if the stress of a disfigured appearance is removed (Rapp et al., 1997). Dermatological treatment is thus for most sufferers the first step toward addressing the stress that acne engenders.

Medical treatment

Compared to most skin diseases, acne has been subjected to an astonishing variety of therapeutic assaults. Treatment is classified into topical and systemic therapies. Topical treatments encompass prescription and non-prescription gels, washes and lotions that are placed on the skin. Systemic treatment (oral) includes antibiotics, hormonal preparations and retinoids. It is used when topical therapy fails in severe or widespread acne and in scarring neck or truncal acne where topical therapy is ineffective (Jansen & Plewig, 1997). Of all the systemic therapies, isotretinoin a retinoid derivative revolutionized the treatment of acne in 1982 when the American Food and Drug Administration (FDA) approved it for the treatment of cystic and scarring

acne, resistant to conventional therapy. The drug is available on prescription, in 80 countries and has been used by over 8 million people worldwide. It is the most effective treatment available as evidence shows a single course over 4-6 months produces complete and prolonged remission for as many as 90% of patients (Rothman & Lucky, 1993). The drug is used as a monotherapy and alters the course of acne by changing skin cells to make them less likely to cause eruptions. Although the exact mechanism of action unknown, isotretinoin is unique in its ability to reduce sebum production and inhibit inflammation making it the only drug that curtails acne. Results are often dramatic with 100% improvement in appearance. Dermatologists' even use the word 'cure' to describe the treatment, and for many sufferers the drug offers hope that 'their days of having problem skin, will soon be over'.

The benefits of isotretinoin

Physical improvement in acne should be linked to reduced depression, anxiety and greater satisfaction with body image unrelated to skin appearance (Gupta et al., 1990). As such interest in the psychological benefits of using isotretinoin has ensued. Findings on the benefit of the drug across patients with various degrees of disease severity, is discussed below.

Severe acne

Rubinow et al. (1987) explored if isotretinoin could improve mood and self-esteem in severe acne; as such psychiatric morbidity was assessed in 72 young adults, pre-and-post treatment using self-report measures and semi-structured interviews. Subjects had mostly severe facial or truncal acne. Prior treatment, patients had no excess psychiatric morbidity but were substantially

distressed. After a 4-month course, treatment satisfaction was rated and skin improvement was judged by decrease in cysts compared to baseline count.

Results revealed a significant reduction in anxiety and depression, especially in facial patients who underwent the most dermatological improvement (75% or more). Many sufferers said the drug changed their life and liberated them from the incessant need to monitor their skin. Self-esteem remained in normal range and did not improve, replicating Wu's (1988) finding but contrasting Mylhill et al.'s (1988) who noted changes in self-esteem and social assertiveness after treatment. Only patients' with truncal acne, scores did not change possibly because their acne fares less well to medication, which left them feeling they still had a problem and little emotional relief. In Saudi Arabia positive results were reported in 156 patients with severe acne (al-Khawajah, 1996) and in a Dutch study reduced anxiety was observed a year after treatment (Van der Meeren, 1985). Improvement was also reported in sixty moderate-to-severe acne patients following isotretinoin treatment compared to oral antibiotics (Layton et al., 1997). Using the Assessment of the Psychological and Social Effects of Acne (APSEA) patients with few psychosocial effects were discerned from those disabled by acne. The questionnaire was administered pre-and-post treatment and repeated at 6-months. At the end of treatment clinical improvement in isotretinoin patients was significantly better but APSEA scores in both groups were similar. At 6-months isotretinoin patients showed much reduced scores indicating benefits continued to accrue. This 'delay' may have arisen as at the end of treatment many users still had side-effects and feared their acne might relapse.

Mild acne

Use of isotretinoin has also been explored in patients with chronic mild-facial acne but with symptoms of acne dysmorphobia (Macdonald Hull et al., 1990). These patients did not benefit from long-term topical or antibiotic treatment and displayed inappropriate levels of depression and anxiety despite minor degrees of acne present. Their mood was deemed sufficiently disturbed to warrant use of isotretinoin. Treatment led to almost all subjects (14/16) achieving a totally clear skin. While at first, most were pleased with the cosmetic results this group relapsed more than conventional patients. Relapses were equal or less than original severity, however due to the 'perceived extent' of acne, most remained unsatisfied with treatment. It was concluded this acne group could benefit from the drug, but isotretinoin was only part of the answer and psychological consultation was suggested to accompany treatment.

Chronic acne

Whilst acne is not usually associated with the elderly, a minority suffer even in the 6^{th} and 7^{th} decades of life. These individuals, have lived with the disease most their lives and commonly tried multiple oral and topical treatments. Acne seems to cause long-term damage even in older patients'. Studies show they have significant psychological disability vs. controls (Layton et al., 1997) and suffer poorer quality of life than younger patients, even when controlling for severity (Lasek, 1998). These findings are interesting since the prevailing conception is that younger patients are more susceptible to the damaging

effects of acne. In a small study 9 elderly patients with chronic moderate-facial acne (average duration 44 years) were treated with isotretinoin (Seukeran & Cunliffe, 1998). Acne cleared in all patients and remained so for 3 years but for one patient who needed a second course and then remained clear, indicating this group benefited from treatment.

Kellet & Gawkrodger (1999) assessed dermatological and psychological symptoms (using self-report measures) in 34 chronic acne patients, over four-time points during isotretinoin treatment. Prior therapy 44% had clinically significant levels of anxiety, 18% depression and females reported greater embarrassment. As treatment brought forth skin improvement, positive changes occurred across various psychological functions including: embarrassment, body image, unattractiveness, how patients believed others saw them and how they viewed themselves. These changes confirmed that effective dermatological interventions can improve self-perception. Emotional distress however, reflecting patients' interpretation of acne was more resistant to change perhaps because as in Layton et al.'s study, data was recorded right after treatment instead over time. Possibly positive affect is based on long-term psychological change. This fits with cognitive theory, which states emotional change can be slower due to the restructuring required to shift cognitions and in this case the personal meaning of acne and its related disfigurement over many years.

Impact on quality-of-life

Most studies exploring the impact of isotretinoin have used values from measures dispensed during or just after treatment, which arguably would show a positive result. To overcome this bias, Newton et al., (1997) showed that patient assessed outcomes could also respond to quality of life change over time and discriminate between treatments of differing effectiveness. Generic measures were sent to 130 patients prior attending a dermatology clinic, and then at 4 and 12 months. In the sample 79 patients were prescribed isotretinoin and the rest were treated with other acne drugs.

Findings showed, acne related disability was largely reversed with treatment. At 4 months 75% of isotretinoin patients felt results were excellent or very good vs. 23% of patients treated in other ways. A year later, 74% were still pleased or very pleased with the impact treatment had on their lives and reported excellent/very good results vs. 35% of the others. Acne grades also improved in the isotretinoin group at 4-months. In general, better scores on all measures indicated isotretinoin improves social functioning and quality-of-life.

Cost effectiveness

So far research indicates that isotretinoin improves the mental health of acne sufferers; after a few months patients are usually symptom free; remission is long, often years and in many forever. Dermatologically, the drug is thus considered curative. A review of isotretinoin's comparative cost effectiveness to other drugs (using clinical and patient assessed outcomes) showed that it is more cost effective than available alternatives and while treatment may cost more in the first year, savings accrue in subsequent years (Newton et al.,

1997). As a medical treatment it produces global financial savings and bigger personal savings in terms of emotional distress and physical discomfort (Layton et al., 1997; Cunliffe et al., 1997). Prescription has thus been advised 'sooner than later' to patients with severe disease; and also in milder acne if scarring or significant psychological distress is present (Leyden, 1997).

The dangers of using isotretinoin

Whilst the psychological and medical benefits of isotretinoin are evident, much controversy also exists over the drugs potential to cause psychological harm. Since 1982 Hoffman La Roche has amended the warning passed to doctors several times. In 1986 the phrase '*depression has been reported by some patient's'* was added on the label. In 1997 based on a longitudinal French study on isotretinoin's link with depression, French health authorities made Roche add *'suicide attempt'*. In the same month, the FDA unaware of the French warning, initiated discussion with the company concerning reports of serious psychiatric disorders linked to the drug. In 1998 the FDA made Roche add a new bold face warning to the physician package insert **"WARNINGS–Psychiatric disorders: Accutane may cause, depression, psychosis and rarely, suicidal ideation, suicide attempts and suicide"** and in May 2000, the warning on the package label was changed making this the first time the actual box contained the full psychiatric warning. Despite the fact that such side-effects have been known for twenty year's isotretinoin has remained the drug of choice for severe acne. The FDA stresses that as no cause-effect mechanism has been established the discontinuation of therapy may be insufficient. Escalating and alarming reports however, on isotretinoin's

ability to induce severe depression and suicide are seriously challenging this idea and dermatologists popular view that their patients never die.

Teratogenicity

Isotretinoin's most significant known side-effect, teratogenicity became evident in the mid 1980's. The drug is thus contraindicated in women who are or may become pregnant during treatment. Embryopathy related to drug exposure during pregnancy includes cardiac, craniofacial and central nervous system defects. Following this finding, La Roche began a pregnancy-prevention program (PPP) in 1988, consumer print adverts in 1996, added television and radio to selected cities in 1997 and expanded the campaign to the entire US in 1998. In disseminating education material for patients and physicians it was stated only doctors well versed with isotretinoin's effects should prescribe it. Strict guidelines for sexually active females were drafted including informed consent, monthly pregnancy tests and physician reimbursement for contraceptive counselling (Chan et al., 1996).

These efforts aimed to prevent risk of pregnancy during treatment. Yet exposure still occurs today. In the US fourteen cases of pregnant women taking the drug have been reported; the result four live infants with no major deformity, one with major defect and 9 ended in miscarriage or abortion (Goulden et al., 1995; Holmes et al., 2001). Experts in the US Center for Disease Control and Prevention believe despite extensive warnings too many doctors are prescribing isotretinoin to women outside the recommended population. In fact half of the 14 women studied said 'they didn't have severe

acne' which the drug is targeted to treat. One patient, who aborted her baby, obtained the drug to stop menstruation related acne. The number of reproductive aged women on isotretinoin in the US is unknown, but between 1989 and 1999 a voluntary survey identified 454,273 women. While the PPP undoubtedly prevented many problems, 900 exposed pregnancies have been reported (unpublished data). Reasons for exposure include failure in using contraception and reinitiating old prescriptions. Physicians are also blamed for poor monitoring of pregnancy tests and insufficient patient education.

Depression and suicide

In the UK isotretinoin is prescribed by dermatologists and dispensed only at hospital pharmacies (Lowe, 1993). Health services were shifting toward allowing more patients to be treated earlier before the publicity of increased suicides. Isotretinoin prescriptions via the National Health Service (NHS) are around 12,400 (2% of acne prescriptions) and a recent study found 23 reports for depression, suicidal ideation, suicide attempt or suicide.

In the US between 1982 - 2000 the FDA received 431 reports; 37 patients committed suicide (84% male, median age 17), 24 while on the drug (median duration, 3 months) and 13 after stopping (median time 2.5 months after discontinuation); 22% had prior psychiatric history and 57% had other contributing factors such as stressful life events and relationship difficulties. Interestingly, almost half of these suicide reports were made after suicide and depression warnings were added to the label in 1998 (Wysowski, 2001). Overall, 91 Americans and 42 people from other countries have committed

suicide while on the drug. The FDA has also received 110 reports of users hospitalised for severe depression, suicidal ideation and suicide attempt; 85 while on the drug (56% female, median age 17) and 25 after stopping; 67% had a history of past psychiatric illness. Only a third experienced symptom relief after discontinuation. An additional 284 patients (non-hospitalised) were diagnosed with depression while on the drug and 24 had positive re-challenges (i.e. return or worsening of depressive symptoms after restarting isotretinoin). Yet not one case exists for any of the other major acne drugs where prescriptions exceed 220 million. According to a pharmacoepidmiologic analysis, isotretinoin is 900 times more likely to cause depression than other acne medication (Josefson, 1998; Middlekoop, 2000).

In response, Hoffman La Roche criticized the above data as proof of poor reporting. They argued it is impossible to conceive that in the millions of users of other acne treatments, there are absolutely no incidences of depression and suicide. Nevertheless, adverse drug reactions (ADRs) in national and international government health agencies reveal that as of August 2000 over 500 formal reports exist on suicide ideation, suicide attempts and suicide. ADRs are also not being dismissed by hundreds of sufferers who are taking landmark legal action against Hoffman La Roche by upholding isotretinoin triggers traumatic side-effects, including suicidal depression. This group argues that a causal link is not needed before a drug is deemed dangerous enough to be taken off the market.

Drug induced depression

If psychiatric symptoms are truly attributed to isotretinoin (Bruno et al., 1984; Bigby & Stern, 1988) they should commence when the drug is started and return when resumed. As early as 1983, Hazen et al., reported isotretinoin-induced depression in 5.5% (6/100) of acne patients within two weeks of starting the drug manifested by symptoms of malaise, crying spells and forgetfulness; only one patient had a history of depression. In 1989 Vilaboos, reported onset of hallucinations, paranoia and impaired speech in a 16-year-old male on the eleventh day of treatment. This behaviour subsided when isotretinoin was stopped but recurred shortly after resumption of the drug. In 1990 Scheineman et al., observed depressive symptoms, severe enough to interfere with normal functioning in 1% of patients during clinical trials of isotretinoin. Depression was confirmed by a psychiatrist and cessation of the drug led to symptoms resolving within 7 days. Ten weeks later on resuming treatment depression was confirmed by rechallenge as symptoms reappeared in the third month of the second course. Discontinuation was followed by rapid disappearance of symptoms. The authors concluded that depression was an idiosyncratic vs. predictable side effect in patients predisposed to major depression. This trial however was not aimed at examining psychiatric adverse events of isotretinoin and not all patients had acne.

More recently, Wysowski et al. (2001) detail two dramatic cases of positive rechallenge occurring in asymptomatic individuals whose symptoms of depression mirrored the time course of isotretinoin use. Re-challenge cases, provide strong evidence to support a relationship between isotretinoin and

depression and currently 41 cases have been reported; 76% with no past psychiatric history. Moreover during these re-challenges, depression in some patients persisted even after drug discontinuation.

Case reports

ADRs may paint an incomplete picture of isotretinoin's negative impact, as the number of reports filed each year, signify a fraction of actual occurrences. Only 10% of serious ADRs are ever reported and Goldman (1996) describes major underreporting in the US. In reality the problem is far worse. Adding to the evidence against isotretinoin is a growing number of case reports that show depression is not a rare phenomenon (Chu & Cunliffe, 1998). Bravard et al. (1993) reported parasuicidal acts and completed suicide in three cases with no history of depression; one patient attempted suicide in the 4th month and one committed suicide three months after stopping isotretinoin. Similarly, Gatti & Serri (1991) describe a suicide, 2 months post-treatment:

A 17-year-old boy affected by severely disfiguring cystic acne achieved a clear skin after 4-months on isotretinoin. One month after treatment was stopped the patient began having difficulties in social readjustment, still had problems in finding a job, was unsettled at home, frequently argued with his father and had difficulty in relating to girls. The patient was deeply disturbed by these problems. During the following month the boy unsuccessfully attempted suicide and received psychiatric care; three weeks later he succeeded in killing himself.

Byrne et al. (1998) reviewed 3 case histories of patients who used isotretinoin and developed persistent depression. Onset of symptoms was variable and in two cases life threatening. All required antidepressants even after treatment ceased. In one patient a relapse in acne showed no return of depressive symptoms as confirmed by the Hamilton Depression Rating Scale.

Media reports have also highlighted the plight of those who have suffered on the drug. The Daily Mail (*'Should this Acne Drug be Banned?* December 7, 1999, by G.L Epstein) described the torment of a male patient, who used isotretinoin at fifteen and still suffered harrowing side-effects thirteen years later. At 2-months he had a near fatal thrombosis and after a 4-month course his skin failed to improve. Isotretinoin was stopped but his health deteriorated and his mental state became unhinged; he suffered violent headaches, became obstinate, spoke incessantly and feared sleeping. US News also linked isotretinoin to the suicide of a teen pilot Charles Bishop who killed himself in January 2002 by crashing a small stolen plane into a skyscraper. Police found a note on his body expressing his support for Osama bin Laden and the 9/11 attacks. Apparently, he had no history of psychological problems or suicide attempt. His family, friends and flight instructors were shocked and described him as intelligent, friendly and unlikely to take his own life.

No causal link

While cases of patients' private turmoil make for shocking reading, others suggest that isotretinoin's association to depression and suicide is not causal (Peck et al., 1991). In reviewing episodes like the 17-year old suicide, it is

argued improbable that isotretinoin played a direct role as depressive symptoms began a month after treatment. Traditionally, isotretinoin-induced depression develops during treatment. A more likely explanation is that the clearing of a disfiguring disease made it more difficult for the patient to overcome general psychosocial difficulties which were previously attributed to appearance. The resolution of severe acne may thus precipitate emotional crises in some patients, who see isotretinoin as a panacea (Rubinow et al., 1987). In Bishops case, other reports state he was a troubled individual, a loner and that his parents had previously attempted a suicide pact. Isotretinoin stays in the body for at least two days and toxology reports of Bishops blood sample found no trace of the drug, which suggests that he had not taken isotretinoin in the days before his death. His best friend said:

"Charles hated Bin Laden, (despite the note); had plans for the future and was passionate about flying ...The best explanation that I can think of is that he wanted attention and he was willing to commit suicide to get it" .

Despite the publicity surrounding isotretinoin, Jacobs (2001) a senior consultant in Hoffman La Roche reiterated psychiatric events in isotretinoin users are below the incidence of depression and suicide for the general population. Suicide rates in the US have not changed since 1979, but the demographics of suicide as Jacobs quoted have changed substantially. Currently, 50% of all suicides are under the age of 40. The rate of suicide in 15-19 year olds has risen with 1.2 million teenagers attempting suicide each year and of these 6000 die. Suicide is thus the third leading cause of death in

a group most likely to use isotretinoin. Suicide is also a multi-causal event and no single variable not even psychiatric illness, can predict who will commit suicide and who will not. Recorded cases of death and isotretinoin are also consistent with facts known on suicide: they entail multiple scenarios of psychiatric illness, family history of depression or suicide, family problems, concurrent medication and other confounding factors. The average age and gender of victims (i.e. young male) is also consistent with the typical profile. It is further pointed out that clinical depression, which is a pervasive disorder involving mood disturbance and may include suicidal ideation or suicide is different from the 'blues' (i.e. mood fluctuations). The 'blues' is experienced by 25% of the population and rarely leads to suicidal thoughts; 6.1% (aged 15-24) suffer depression vs. 4.9% of the total population. Most people this age also get acne and some develop severe forms for which isotretinoin is suitable; untreated acne, is itself a risk factor for depression

Drawing from the original controlled clinical trials of isotretinoin, Jacobs states there were no diagnoses of depression. Furthermore, in later studies (Hazen et al., 1983; Scheineman et al., 1990) none of the patients required antidepressants indicating low symptom severity. So while patients may have symptoms of depression there is no evidence they had clinical depression. Re-challenges suggest a link between isotretinoin and mood, but serious questions remain as most reports do not have full patient histories detailing other psychopathology, pre-existing depression or genetic susceptibility, thus they cannot be used to diagnose drug-induced depression.

No evidence

Most data suggesting a link with depression comes from small case reports thus Hoffman La Roche funded a large population based cohort study to retrospectively explore the use of isotretinoin and risk of depression, psychotic symptoms, suicide and suicidal attempts (Jick et al., 2000). Data was collected from over 20,000 health records in the UK and Canada. Prevalence rates of neurotic and psychotic disorder, suicide and attempted suicide were then compared between isotretinoin and oral antibiotic users and within isotretinoin users (pre vs. post treatment) as their own comparison. All subjects had computer histories between 6-months and 5 years before and at least 12 months after their first isotretinoin or antibiotic prescription. Results indicated that 1% of users in both groups reported diagnosed depression, the same as for people who did not use isotretinoin or antibiotics. Similarly, about 1% of isotretinoin users and nonusers committed or attempted suicide. As such no evidence was found that use of isotretinoin is linked with increased risk of depression, suicide or other psychiatric disorders.

Wysowski (2001) argues however that these findings are questionable due to methodological problems that limit the study's ability to conclude 'no increased risk'. In particular, only diagnosis codes and no psychoactive drug prescriptions or interviews were used to define cases. Death certificate data was not included as a source of information on suicide; there was limited information on acne severity; duration of isotretinoin treatment and there was no control group. A result of 'no difference in depression' between the groups may have thus been due to an effect of acne.

Controversy

At present disparate views prevail in dermatology and psychiatry on isotretinoin's psychological impact. Some authors argue there is no convincing evidence to advocate a strong relationship between mood and using the drug. They insist isotretinoin is safe, cost-effective and depression is a rare side-effect. Most symptoms reported are mild, do not meet the full criteria for depression and subside within a week of stopping treatment. Relapses are less severe than the original acne, easily managed with other topical or oral treatments and since improvement in acne is linked with decreased depression and anxiety, isotretinoin is more successful in preventing depressive episodes than in causing them (Citrome, 1998). Given the insufficient evidence to suggest a causal relationship between the drug and the reactions reported, isotretinoin is and remains the treatment of choice.

Others argue a specific syndrome occurs in adolescents especially in males and that the impact may be life threatening. Supportive evidence for an association is based on, positive re-challenges; on patients (with no prior psychiatric history) who have used the drug and developed symptoms; on the large number of ADRs and on patients who have needed psychiatric care after stopping treatment (Gatti & Serri, 1991; Wyoswski, 2001).

Factors complicating conclusions surrounding the safety of isotretinoin includes the fact that 12 million patients on isotretinoin have not developed depression; many achieve a clear skin and lead satisfying lives. Yet others suffer symptoms that do not abate with drug cessation. Equally, high

depression and suicide rates exist in the age groups isotretinoin treats and acne remains a risk factor for depression. In reviewing the literature on depression and isotretinoin, methodological flaws confound large studies and case reports lack a full array of controls (Ng & Schweitzer, 2003). Whether isotretinoin really causes depression and suicide in patients thus remains inconclusive.

Another important area of contention in clinical practice lies in the prescribing of isotretinoin (Ortonne, 1997). Despite the known side-effects and exposed pregnancies there is evidence of prescription outside the specified guidelines. Published accounts document high rates of use in non-severe acne and many authors endorse isotretinoin claiming an excellent safety profile. Guidelines however state that isotretinoin should only be used in severe acne and as a treatment of last resort. Yet a vast amount of patients prescribed the drug e.g. 74% in the UK have mild or moderate acne - which is in clear violation of the licence (Layton & Cunliffe, 1992).

At a congress meeting exploring isotretinoin's link to suicide, the FDA and American Academy of Dermatology were reprimanded for not explicating isotretinoin's mental health risks. The committee heard from parents whose children committed suicide while on isotretinoin; these parents all said they had no warning on a likely link with depression from their physician. It was stated that while many patients benefit from the drug - to ignore reports of depression and suicide was to continue placing this population at risk.

As a result of the controversy surrounding isotretinoin, the Internet now hosts several patient led web sites were users share treatment experiences and provide support or warnings on the drug. While some individuals express miraculous results, many are confused about starting isotretinoin, due to rumours on its use. The idea that the drug continues to harm the body even after treatment perpetuates further alarm in those who have used it. A lack of clarity on isotretinoin's safety is thus creating stress that may prevent patients' who could benefit from the drug from using it (Magin et al., 2005). Most recently, Hoffman La Roche has been confronted with a list of accusations that are creating a stir in the research world. Some of these include: failing to disclose isotretinoin's serious side effects at pre-trial studies in order to obtain licence for its sale; not adequately disclosing information on ADRs to national authorities and dermatologists, and funding researchers to advocate the drugs safety when no studies were commissioned to investigate the drugs mechanism of action. All these issues remain to be investigated.

The current situation

The distress acne creates and the impact it can have on a person's life cannot be ignored. In dermatology the reality is also that effective treatment depends on the extent that drugs like isotretinoin can meet patient need. Yet good clinical judgment requires knowledge of individual psychological profiles and the success treatment may have for particular patients. Furthermore, relative to other medical conditions, acne is increasingly being juxtaposed to psychiatric disorders by virtue of the mental health concerns it creates (Kellett & Gawkrodger, 1999). This reality confounds how the psychological impact of

isotretinoin will be eventually evaluated, as acne patients are usually not assessed psychiatrically prior disease onset to identify pre-existing morbidity.

Research on acne treatments has been progressing, but knowledge on the psychosocial implications of the disease has ebbed. In most of the current literature the scant regard for theory, has further limited the development of psychological models in dermatology to guide patient care (Kellet & Gawkrodger, 1991). Only recently has the biopsychosocial model emerged as a framework in identifying processes that engineer the heightened reactions recorded in patients (Papadopoulos et al., 1999; Cotterill, 1989). This has led to several developments in current research practice.

Newer studies have incorporated the use of patient outcome measures to identify dermatological and psychological change, a trend that was largely absent in early literature. Longitudinal studies on the impact of isotretinoin have also allowed for links to be made between psychological and physical process over time. Research on quality-of-life is using specific (Girmam et al., 1996) and generic measures (Muldoon et al., 1998) on acne disability which provides scope for comparison with other patient groups (Guyatt et al., 1993) and most importantly, the use of interviews has provided more in-depth data on patients' real experiences of acne and the use of isotretinoin. This shift in research focus has been strengthened through the recognition that medical care alone cannot fully address the complexity of dermatological conditions and overlooks the impact psychological and social dimensions have on the onset and exacerbation of disease (Medansky, 1980). This transition in

thinking has been welcomed and some professionals have even claimed that incorporating psychological models in dermatology is of greater relevance than other specialties such as cardiology and renal dialysis, all of which have received considerable attention in the literature (Van Moffaert, 1992).

Pharmaceutically, ongoing concerns over the use of isotretinoin has impelled Hoffaman La Roche to seek FDA clearance to finally, conduct a psychiatric study on the drugs mental health effects, with a focus on depression. In particular, the study will explore if isotretinoin has some type of trigger causing psychiatric conditions that increase suicide risk. The study will probably compare reactions of users on different doses, with those on other acne drugs. One problem is that isotretinoin has visible side-effects, dry lips and skin, so volunteers may be able to detect who is on the drug; furthermore if subjects know the aim of the study psychiatric symptoms may develop merely through the power of suggestion.

With regards to teratogenicity the FDA has given the go-ahead for a risk management programme called iPLEDGE (Appendix 1) to start by December 2005 to ensure females do not become pregnant while on the drug. By March 2006 only doctors registered and activated in iPLEDGE will be able to prescribe isotretinoin and only patients registered on iPLEDGE will be dispensed the drug. The FDA mandated this since educational programmes currently in place are not working. If pregnancies continue to occur however, the next step could involve withdrawal of the drug from the market.

Clinical practice and psychodermatology

Dermatologists work in a visual world and diagnose acne and its treatment from viewing patients across the room. A belief that the eyes alone can diagnose risks perpetuating careless practice, as inevitably the meaning a disease holds for a patient is more than the spots on their face. Good dermatologists need to know what they see and need to see many patients, not only to recognise patterns and configurations of disease but also the accompanying psychosocial consequences. This will entail embracing psychological techniques like screening patients' pre-and-post isotretinoin treatment using tools like the Hamilton Depression Scale in order to identify distressed individuals who may need monitoring. If left unattended such patients could develop problems that may necessitate psychiatric referral.

In this respect psychologists' occupy a valuable position in the healthcare system as they are in a position to assist patients through counselling and professionals via consultation. Fostering alliances between psychology and dermatology services could open pathways of care that are often sought by dermatologists wanting to refer patients with acne, but who previously had few options or none at all (Humphreys & Humphreys, 1998). By developing a supportive doctor-patient relationship and gaining patient confidence to seek psychological care dermatologists can ensure successful referrals are made.

Unfortunately, this does not reflect current dermatological practice as a recent survey of acne patients showed, nearly a quarter reported their doctors were not interested or sympathetic to their skin condition, which fostered in them

pessimism in gaining any form of help (Acne Support Group). This highlights a divide that may exist in dermatology between practitioners who view the treatment of acne from a multidisciplinary perspective and those who do not. Not surprisingly, a devotion to 'miracle cures' may lead to a bias against counselling and rigid adherence to prescribing. Yet, it is this very rigidity that bypasses the psychological sequeale acne patients present. Research shows that isotretinoin alone may not address psychological effects that may persist during treatment and long after the skin has cleared. Similarly, counselling will not provide a clear complexion. Too great a gap exists for either to work alone. Only conjoint work will suspend the 'trivialisation of acne' by recognising the disease as a medical condition with biopsychosocial consequences. A treatment algorithm as described by Van Moffaert, (1994) could be a useful tool in unifying medical and psychological management:

Step 1:	Diagnosis and commitment to treat both dermatological and accompanying psychological symptoms
⇩	
Step 2:	Evaluate if psychological symptoms and/or psychiatric disorder are part of the etiology or a secondary reaction to acne
⇩	
Step 3:	Make differential diagnosis of the psychiatric factor as the basis for psychopharmacotherapy
⇩	
Step 4:	Initiate a multimodal treatment programme consisting of psychotropic drug treatment and psychotherapeutic strategies (cognitive, behavioural, or insight orientated)
⇩	
Step 5:	When symptoms improve or stabilize, taper medication to zero or lowest effective dose

Finally, while the trivialisation of acne masked the psychological distress patients endure, ironically the very controversy surrounding isotretinoin has recognised it as a serious medical condition with severe psychological consequences. Discovering if there is a group of individuals who show unique side-effects to a drug is ultimately, the 'Holy Grail' of drug-risk management because doctors will know who not to prescribe it to. Since, the Hoffman La Roche study is unlikely to provide the last word on life and death issues in relation to isotretinoin, practitioners must foster adequate patient care. Education and correct regulation may be the key to safer usage, given that isotretinoin does transform acne and the lives of people who suffer from it.

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APPENDIX 1

Patient Information Sheet (updated 11/2005)

Isotretinoin (marketed as Accutane)

This is a summary of the most important information about isotretinoin. For details talk to your healthcare professional.

FDA ALERT [11/2005]: Start Dates Have Been Changed for the iPLEDGE Program. FDA approved a strengthened risk management plan for Accutane and generic isotretinoin on August 12, 2005, to make sure females do not become pregnant while taking this medicine. Isotretinoin causes birth defects. This new plan is called iPLEDGE. For details go to: http://www.fda.gov/cder/drug/infopage/accutane/default.htm **The iPLEDGE program was originally scheduled to begin on November 1, 2005. To allow more time for registration and activation, the implementation dates of the iPLEDGE program have been revised. The date by which wholesalers and pharmacies must be registered/activated in iPLEDGE has been changed from November 1, 2005 to December 30, 2005. The starting date to begin patient registration and qualification in iPLEDGE has been changed from November 1, 2005 to December 30, 2005. By March 1, 2006, only prescribers registered and activated in iPLEDGE will be able to prescribe isotretinoin and only patients registered and qualified in iPLEDGE will be dispensed isotretinoin.**

[07/2005]: Suicidal Thoughts or Actions: In addition to the strengthened risk management program for pregnancy, FDA continues to assess reports of suicide or suicide attempts associated with the use of isotretinoin. All patients treated with isotretinoin should be observed closely for symptoms of depression or suicidal thoughts, such as sad mood, irritability, acting on dangerous impulses, anger, loss of pleasure or interest in social or sports activities, sleeping too much or too little, changes in weight or appetite, school or work performance going down, or trouble concentrating, or for mood

disturbance, psychosis, or aggression. Patients should stop isotretinoin and they or their caregiver should contact their healthcare professional right away if the patient has any of the previously mentioned symptoms. Discontinuation of treatment may be insufficient and further evaluation may be necessary. [Action taken 08/12/2005: Labeling revision]

This information reflects FDA's current analysis of available data concerning this drug. FDA intends to update this sheet when additional information or analyses become available.

What Is Isotretinoin?

Isotretinoin is used to treat the most severe form of acne (nodular acne) that cannot be cleared up by any other acne treatments, including antibiotics. Isotretinoin is only for patients who understand and agree to carry out all the instructions in the iPLEDGE program, because isotretinoin can cause serious side effects.

Who Should Not Take Isotretinoin?

Isotretinoin should NOT be used by pregnant women.

Do not take isotretinoin if you are:

Pregnant, plan to become pregnant, or become pregnant during isotretinoin treatment

Breast-feeding

Allergic to anything in it. Isotretinoin contains parabens, which are used as preservatives in the gelatin capsule.

What Are The Risks?

Birth defects (deformed babies), loss of baby before birth (miscarriage), death of baby, and early (premature) births. Female patients who are pregnant or who plan to become pregnant must not take isotretinoin. Female patients must not get pregnant: For 1 month before starting isotretinoin; While taking isotretinoin and for or 1 month after stopping isotretinoin

If you get pregnant while taking isotretinoin, stop taking it right away and call your doctor.

Serious mental health problems: Isotretinoin may cause:

Depression

Psychosis (seeing or hearing things that are not real)

Suicidal thoughts or actions

Aggressive and violent behavior

Stop taking isotretinoin and call your doctor right away if you:

Start to feel sad or have crying spells

Lose interest in activities you once enjoyed

Sleep too much or have trouble sleeping

Become more irritable, angry or aggressive than usual

Have a change in your appetite or body weight

Have trouble concentrating

Withdraw from your family or friends

Feel like you have no energy

Have feelings of worthlessness or wrong guilt

Start having thoughts about hurting yourself or taking your own life (suicidal thoughts)

Start acting on dangerous impulses

Start seeing or hearing things that are not real

Serious brain problems: Isotretinoin may increase the pressure in your brain, possibly leading to permanent loss of eyesight, or in rare cases, death. Stop taking isotretinoin and call your doctor right away if you get any signs of increased brain pressure such as bad headaches, blurred vision, dizziness, nausea or vomiting, seizures (convulsions) or stroke.

Stomach area (abdomen) problems: Certain symptoms may mean that your internal organs are being damaged. These organs include the liver, pancreas, bowel (intestines), and esophagus. Stop taking isotretinoin and call your doctor if you get severe stomach, chest or bowel pain, trouble swallowing or painful swallowing, new or worsening heartburn, diarrhea, rectal bleeding, yellowing of your skin or eyes, or dark urine.

***Bone and muscle problems*:** Tell your doctor if you plan any vigorous physical activity during treatment with isotretinoin. Tell your doctor if you get muscle weakness, back pain, joint pain, or a broken bone.

***Hearing problems*:** Stop taking isotretinoin and call your doctor if your hearing gets worse or if you have ringing in the ears.

Vision problems: Isotretinoin may affect your ability to see in the dark. Stop taking isotretinoin and call your doctor right away if you have any problems with your vision or dryness of the eyes that is painful or constant. If you wear contact lenses, you may have trouble wearing them while taking isotretinoin and after treatment.

Lipid (fats and cholesterol in blood) problems: Isotretinoin can raise the level of fats and cholesterol in your blood.

Allergic reactions: Stop taking isotretinoin and get emergency care right away if you develop hives, a swollen face or mouth, or have trouble breathing. Stop taking isotretinoin and call your doctor if you get a fever, rash, or red patches or bruises on your legs.

Blood sugar problems: Tell your doctor if you are thirsty or urinate a lot.

Decreased red and white blood cells: Call your doctor if you have trouble breathing, faint, or feel weak.

The common, less serious side effects of isotretinoin are dry skin, chapped lips, dry eyes, and dry nose that may lead to nosebleeds.

What Should I Do Before Taking Isotretinoin?

Tell your healthcare professional if you or someone in your family has had any kind of mental problems, asthma, liver disease, diabetes, heart disease, osteoporosis (bone loss), weak bones, an eating problem called anorexia nervosa (where people eat too little), or any food or medicine allergies.

By March 1, 2006, all patients must be registered and activated by their doctors in iPLEDGE to get isotretinoin. You must sign the Patient Information/Informed Consent form. You must agree to or follow all the instructions in the iPLEDGE program. By March 1, 2006, only prescriptions from iPLEDGE doctors will be filled by iPLEDGE pharmacies.

If you have sex anytime without using 2 forms of effective birth control, get pregnant, or miss your expected period, stop using isotretinoin and call your doctor right away.

Females who can become pregnant must:

Agree to use 2 separate forms of effective birth control at the same time 1 month before, while taking, and for 1 month after stopping isotretinoin. You must also call and enter your 2 types of birth control each month into the iPLEDGE system by telephone or the internet.

- Have negative results from 2 pregnancy tests before receiving the initial isotretinoin prescription.
- Have a negative pregnancy test before each refill
- Sign an additional Patient Information/Consent form that contains warnings about the risk of potential birth defects if the fetus is exposed to isotretinoin.

Are There Any Interactions With Drugs Or Foods?

Tell your healthcare professional about all the medicines you take, including prescription and nonprescription medicines, vitamins, and herbal supplements. Isotretinoin and other medicines may affect each other sometimes causing serious side effects. Especially tell your healthcare professional if you take: Progestin-only containing birth control pills ("minipills"), Vitamin A supplements, Tetracycline, Dilantin (phenytoin), Corticosteroid medicines, St. John's Wort.

Is There Anything Else I Need to Know?

Do not give blood while you take isotretinoin and for 1 month after stopping Isotretinoin. If someone who is pregnant gets your donated blood, her baby may be exposed to isotretinoin and may be born with birth defects.

Do not drive at night until you know if isotretinoin has affected your vision. Do not have cosmetic procedures to smooth your skin, including waxing,

dermabrasion, or laser procedures, while you are using isotretinoin and for at least 6 months after you stop. Isotretinoin can increase your chance of scarring from these procedures.

Avoid sunlight and ultraviolet lights as much as possible. Tanning machines use ultraviolet lights.

Do not share isotretinoin with other people. It can cause serious birth defects and other serious health problems.

You will only be able to get up to a 30-day supply of isotretinoin at one time. Refills will require you to get a new prescription from your doctor. The prescription must be filled within 7 days of your office visit.

You should receive an Isotretinoin Medication Guide each time you receive isotretinoin. This is required by law.

This information reflects FDA's preliminary analysis of data concerning this drug. FDA is considering, but has not reached a final conclusion about, this information. FDA intends to update this sheet when additional information or analyses become available.

Early maladaptive schemas and parental bonding in psoriasis and eczema

Preface

This thesis represents a journey that began whilst working therapeutically with individuals that had disfiguring vitiligo. My experience of these clients and the difficulties they faced - opened a path into the human psyche that went beyond the physical manifestation of skin disease. My first lesson was the simple realisation that a healthy skin is essential for a person's physical and mental well-being. When disease, alters the normal functioning of the skin the results are inevitably visible and often distressing. I also became more conscious that the meanings surrounding skin disease are multi-layered. For example, in the early stages many skin conditions reveal themselves symptomatically. The first observation of symptoms gives rise to a period, where individuals attempt to appraise the meaning of the change taking place. Dermatological consultation provides a medical meaning in the form of a diagnosis. This explains the nature and causes of the disease, its course and most importantly for the patient, the options of treatment. Society also dictates its own meaning. When the skin's appearance or texture deviates from the norm it labels it disfigurement. How individuals cope with their altered appearance, the symptoms of skin disease, and the stigma of disfigurement is a complex issue that has inspired studies in psychology, psychiatry, sociology and medicine. Understanding how this process unfolds on a personal level and in relation to previous developmental experiences is critical, because the evolved motives of life such as the need for love, attachment, power and sex can be threatened by chronic skin disease.

Abstract

This study sought to examine the relationship between early maladaptive schemas (EMSs) and recalled patterns of maternal and paternal bonding in Greek patients with psoriasis, eczema and healthy controls. It was hypothesised that early developmental difficulties can lead to the formation of EMSs that have the potential in adulthood, to influence the meanings surrounding skin disease. In a series of studies the relationship between schema domains, EMSs and parental bonding was explored. Results on schema domains showed psoriasis and eczema patients had significantly more negative experiences in childhood vs. controls. Investigating the nature of this difference revealed EMSs consistently, distinguished dermatology patients from controls. Common schemas of 'emotional deprivation', 'mistrust/abuse' and 'self-sacrifice' emerged as significant in psoriasis and eczema. In considering the relationship between schema domains, parental bonding and skin disease – dermatology patients emerged as more insecurely attached vs. controls and an interaction between father-bonding was observed for both eczema and psoriasis in the domain of disconnection and rejection. The results of this study provide new evidence that sub-optimal early parenting perpetuates formation of early maladaptive schemas in patients with psoriasis and eczema and that reactivation of these schemas in adulthood can influence the concept of self and adjustment to skin disease.

Context of study

Currently there are about 900 registered dermatologists in Greece who serve a population of 10.5 million people and more than 70%, practice in Athens and Thessalonica (Stratigos, 2004). This uneven distribution has led to an over-saturation of dermatology practices in cities and an under-representation of such care in rural areas and the islands. Hospital-based dermatologists, practice as part of the National Health System and mostly offer out-patient care, with some in-patient care for complex conditions. The spectrum of skin diseases in Greece is similar to that of other European countries. While a number of patients are referred by physicians, most patients are self-referred.

In contrast, the UK has a well developed infra-structure of dermatology services in the private and public sector. There is also wider availability of charities like the Skin Alliance Campaign and self-help organisations for various skin disorders. These services provide information and support to patients, the wider public, other professionals and most can be accessed through the internet. In Greece, efforts to improve dermatological care are being made through the European Dermatology and Venereology Association (http://www.eadv.org), which aims to link patients and professionals to wider international resources (Stratigos, 1988). While such efforts are valuable, a reality of the Greek medical context is that the discipline of psychology and psychological services as a whole, have not been

integrated into the National Health Care System. Consequently fields like psychodermatology have not had the opportunity to develop. The need however for empirical research on the psychological impact of skin diseases and the establishment of services that can support patients, is well recognised by Greek dermatologists. In the UK psychodermatology has gained greater momentum, and is supported by a body of literature that highlights the importance of understanding the reciprocal relationship between the mind and skin and how this impacts patients psychosocial functioning. This thesis was thus motivated not only by the need to promote psychodermatology services and research in Greece, but also by a growing need for research that provides further insight into cognitive structures that shape perceptions of 'self' in patients with skin disease.

Main Thesis and Assumptions

In the psychodermatological literature there is consensus that skin disorders can have a negative impact upon the psychosocial and emotional functioning of patients. Evidence based on the biopsychosocial model shows that appearance altering diseases like psoriasis and eczema can have profound implications on how sufferers view themselves, relate to others and cope with the disease. Much of this literature however has focused on illness perceptions, emotional distress and quality of life issues in relation to patient functioning. Little attention has been given to the question as to why some patients cope better than others. This study aimed to address a gap in the literature by exploring how dermatology patients may be understood on a cognitive level in light of developmental experiences that influence perceptions of self. The schema model recognizes that the past can

have a powerful and continuing influence over the present. Consequently, an individual's developmental history and view of self are vital to understanding the meanings surrounding skin disease. The incorporation of a theoretical model in psychodermatology that integrates the formation, activation and maintenance of schemas in relation to skin disease is advocated, as it allows for more complex formulations of client difficulties.

The main thesis outlined in the research herein, is that the concept of 'self', attachment security, and the experience of illness are interdependent experiences. Based on this premise it was hypothesised that 'early maladaptive schemas' when triggered by stressful events in adulthood can influence the meanings placed on psoriasis and eczema, and how patients adjust to skin disease. With this notion in mind a series of studies were undertaken to investigate if 'early maladaptive schemas' and recalled patterns of parental bonding were relevant in distinguishing patients with psoriasis and eczema from healthy controls. This research was deemed necessary as these concepts have not been investigated in the psychodermatological literature nor on other medical populations and could thus substantially contribute to the field.

In using the biopsychosocial and schema models as a conceptual foundation certain assumptions underlie this research: Firstly, the relationship between psychological states and skin disease is multifaceted. Secondly, the concept of self is influenced by schemas that an individual may or may not be conscious of but which can shape adjustment to stress; and thirdly, the quality of parental

bonding in childhood can influence psychological health in adulthood. These assumptions guide the research described and their validity is examined in the studies that are presented.

Two central hypotheses are postulated:

1. Early maladaptive schemas contribute to chronic difficulties in patients with psoriasis and eczema and this will be evident developmentally across schema domains.

2. Sub-optimal parental bonds in early life contribute to the formation of early maladaptive schemas and father bonding will have a differential impact on patients with skin disease.

Research design and methodology

The research presented is cross-sectional in nature, which means data on a number of different variables was collected at one point in time, creating a 'snap shot' of the population studied. In this case, by using one set of instruments over a brief period, the characteristics of patients with eczema, psoriasis and healthy controls could be compared to identify individual differences. This research design is economic in terms of cost and time, and served the purpose of fulfilling requirements for this doctorate. In studying the association between early maladaptive schemas, perceptions of parental bonding and skin disease, the aim was to 'freeze' at one point in time, the same kind of relationships that might be

observed by the 'moving picture' of this cohort. Out of a population of dermatology patients attending 'A. Syngrou Hospital' in Athens, a convenience sample of consecutive psoriasis and eczema out-patients were chosen for comparison, together with a randomly chosen sample of healthy controls drawn from the local community. Data collection consisted of three instruments: a demographic questionnaire, Young's Schema Questionnaire-Short Form and the Parental Bonding Instrument. Statistical analysis of the collected data was conducted using SPSS software that investigated the reliability of the instruments used as they were administered to a Greek sample; and a series of ANOVAs with appropriate post-hoc tests were subsequently used to identify differences between the three sample groups. The specific statistical analyses used for each hypothesis are discussed in the main body of this work. To convenience the reader, the overall structure of the doctorate is outlined in detail below.

Outline and structure

This thesis is structured into a progressive series of chapters, given that the combination of concepts under investigation have not been previously explored in a dermatology population and thus needed to be examined separately. Each chapter builds on the next and explores core concepts in the literature and research in the field, as pertaining to the main hypotheses. Chapter 1 provides a broad overview of the biomedical and biopsychosocial models and describes how paradigm shift in medicine shaped understanding of health and illness. The applicability of these models is discussed within the field of dermatology and their strengths and limitations are outlined. A new integrative paradigm that considers

literature across disciplines is advocated as a path by which in-depth knowledge can be gained on how the mind-body connection is moulded by biological, family and environmental influences. The field of psychodermatology fits within this paradigm, as it upholds an integrative perspective when considering the manifestation of skin disease. The absence of research, on how dermatology patients view their concept of 'self' is identified as a gap in the literature.

Chapter 2 looks at the clinical features of psoriasis and eczema, two chronic skin conditions that commonly present in dermatological practice. These differ in terms of onset, with eczema first appearing in childhood and psoriasis in adulthood. They were chosen for comparison as they provide a unique opportunity to examine the meanings that individuals hold about themselves given the different developmental implications of each disorder. Both conditions alter the normal appearance of the skin and since there is no cure, patients have to cope with ongoing periods of remission and exacerbation. Based on the biopsychosocial model, which promotes a holistic understanding of illness, Chapter 3 considers the notion of adjustment in skin disease, by exploring how disease variables and psychological morbidity impact patient functioning. A review of this literature reveals that the chronicity and depth of distress experienced by patients with psoriasis and eczema, is not adequately explained by current models in the field. The need for an integrative model that can elucidate how specific cognitive and developmental variables are implicated in the personal meanings that surround skin disease is identified.

Embarking into the field of cognitive psychology, Chapter 4 introduces such a framework, firstly, by considering the value of the schema concept as a 'heuristic' and secondly, by outlining Young's schema theory that uses the concept of 'early maladaptive schemas' (EMSs) i.e. deep seated beliefs about self, to explain the maintenance of chronic psychopathology in adulthood. EMSs are thought to evolve in early life through unhealthy experiences with attachment figures wherein core emotional needs go unmet. The detrimental influence of these 'schemas' is most apparent in adulthood when emotional difficulties are replicated on a personal and interpersonal level with others. Herein it is advocated that the presence of EMSs in dermatology patients may explain chronic adjustment difficulties, through their reactivation in adulthood. Particular attention is thus paid to schema activation, to describe how cognitive mechanisms maintain psychological distress. This framework allows for the investigation of the first main hypothesis, which states that due to levels of psychopathology observed in dermatology patients, these individuals will have more EMSs than individuals that do not suffer with skin disease.

To investigate this claim Chapter 5 proceeds to the first study, which establishes the reliability of the Greek translation of Young's Schema Questionnaire–Short form (YSQ-SF). This was necessary as the research was carried out in Athens, on a Greek population of clinical and non-clinical samples. Using the concept of schema domains, that represent unmet core needs in childhood Chapter 6, examines if dermatology patients are significantly different from healthy individuals on a developmental level. Piaget and Erikson's theories provide a

backdrop to how developmental deficits in early childhood, continue to impact adult development. Establishing whether differences exist in relation to unmet core emotional needs provides justification for examining more specific schemas in this population group. This is examined further in chapter 7, given that psoriasis and eczema patients emerged as having similar developmental difficulties in early childhood. In this study, isolating the specific EMSs in each patient group, for the first time, indicated that psychological difficulties regarding maladaptive perceptions of self are similar in psoriasis and eczema patients, despite the differences in disease onset. This finding begins to explain how EMSs can contribute to adjustment difficulties in adulthood, as mentioned in the dermatology literature. However since, any number of life factors can lead to schema formation, the only way to link the developmental difficulties identified is to explore whether difficulties in early parental bonding contribute to schema formation in dermatology patients. If this is so, it would substantiate that EMSs play a role in the distress that surrounds skin disease. Prior to addressing the second hypothesis on the nature of parental bonding in dermatology patients, Chapter 8, discusses attachment theory and suggests that sub-optimal care in childhood fosters a poor concept of self. In addition it is highlighted that mother and father figures have a differential impact on childhood development, and that there is limited literature on the role of fathers in the psychodermatology.

As such the study in Chapter 9, proceeds to examine the reliability of the Greek translation of the Parental Bonding Instrument, which identifies secure and insecure forms of maternal and paternal care as recalled up to the age of 16

years. Having established its reliability in a Greek population, Chapter 10 explores how culture influences parental practices and how poor parenting is implicated with mental health difficulties. Within this context the second hypothesis, investigates the association between parental bonding, skin disease and schema domains. Based on the previous studies on EMSs, it is predicted dermatology patients will be more insecurely attached than controls, and that father bonding will have a differential impact vs. mother bonding in these patients. Results of this study on insecure parental bonds are discussed in relation to childhood development and adjustment to skin disease.

Chapter 11 draws together, the main findings in the series of studies described above. The core unmet developmental needs and 'early maladaptive schemas' pertinent to patients with psoriasis and eczema are discussed in more detail. These findings are new and unique as they provide greater understanding of the nature and depth of distress patients with skin disease endure on a personal and interpersonal level. Sub-optimal parental care is linked to the impact this has on emotional regulation in early life. Factors contributing to poor parental care are also explored with a specific emphasis on father bonding, since this interacted with skin disease. Within this chapter the impact of Mediterranean culture is considered with particular reference to the concept of 'honour and shame', and the stigma evoked by skin disease in Greek culture. Finally, chapter 12 returns to the conceptual models that guided this thesis and re-considers how the biopsychosocial model, the schema model and the current findings have enhanced knowledge in psychodermatology and understanding of patients with

skin disease. The broad limitations of the overall study are also discussed, as are suggestions for future research. Since the ultimate aim of empirical research is to enhance practice, Chapter 13 in this thesis discusses the clinical implications of using schema therapy in psychodermatology, and ends with the authors concluding thoughts.

It is anticipated that the findings of this research will be of interest to psychologists and counsellors working on a clinical and research level in the field of disfigurement. It will also be useful to dermatologists, general practitioners, psychiatrists and other health professionals that have face-to face contact with dermatology patients. More importantly, it is hoped this investigation will inspire further research, and will contribute towards providing improved clinical services to patients, by promoting understanding and interventions that focus on the amelioration of the distress that skin disease can engender.

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List of abbreviations

BDI: Beck Depression Inventory

CBT: Cognitive behavioural therapy

Schemas

EMS: Early maladaptive schema

EMSs: Early maladaptive schemas

YSQ-SF: Young Schema Questionnaire - Short Form

Schema Domains

DR: Disconnection and rejection

OD: Other directedness

IA: Impaired autonomy and performance

IL: Impaired limits

OI: Overvigilance and inhibition

Parental Bonding

PBI - Parental Bonding Instrument

OP - 'Optimal parenting' = high care and low protection;
AT- 'Affectionate constraint' = high care and high protection;
AL -'Affectionless control' = high protection and low care;
NP - 'Neglectful parenting' = low care and low protection.

Chapter 1| Models of health and illness

A paradigm shift from the biomedical, to the biopsychosocial model profoundly shaped the conceptualisation of health and illness. Knowledge on skin disease thus evolved from a focus on pathology, to the recognition that psychosocial factors influence disease processes and patient functioning. Psychodermatology centres on understanding the mind and skin relationship and variables impacting patient adjustment. This chapter outlines the main theoretical underpinnings of the biomedical and biopsychosocial models within the context of dermatology.

1.1 The biomedical model

For centuries the biomedical model has been used by physicians in the diagnosis of disease. Its roots date to 3000 years ago when philosophers such as Plato, Aristotle and the physician Hippocrates introduced the theory of holism. Hippocrates held the belief that the body must be treated as a whole and spoke of '*...health being related among environmental influences, ways of life and the various components of human nature'* (Capra, 1983). Holism rests on the assumption that in-sickness and in-health, the mind and body are inseparable. During the 17th century the science of Isaac Newton and the philosophical ideas of Rene Descartes forged a dualistic view of the world that separated the 'mind and body'. Descartes likened the body to 'a living machine' that could be understood by the structure and function of its parts. As such Cartesian dualism

led to studying disease and its physical causes. This view was propelled further by the experimental research of Pasteur (1870) and Koch (1880). Pasteur introduced 'germ theory', which showed that germs are the cause not the product of disease, and Koch's 'doctrine of aetiology' demonstrated that disease is caused by specific micro-organisms. Soon enough, medicine acquired a scientific base and clinical techniques became more sophisticated and disease-specific.

The emergent view stated that biological malfunctions were responsible for physical and molecular changes that reflect disease. Diseases could be triggered by external variables like viruses, or internal factors such as genetic disposition. The 'mind' was seen as abstract, relating only to thoughts or feelings and incapable of influencing physical matter. The model accepted that diseases had psychological consequences, but not psychological causes e.g. cancer could cause depression but mood, was unrelated to disease onset or progression. Since physical processes were beyond a person's control, scientific research centred on areas like biochemistry and disease pathology (Sadler & Hulgus, 1992). Over time the model crystallized into the foundation of medicine, where treatment aims to restore health; this rests in the hands of medical professionals, who have split into as many specialisations as there are parts to the body.

1.2 The field of dermatology

Dermatology is a branch in medicine that focuses on the diagnosis and treatment of skin disease. Dermatologists are trained to diagnose and treat paediatric and adult patients with benign and malignant skin disorders including diseases of the

mouth, external genitalia, hair and nails (Resneck, 2001). According to the British Association of Dermatology the number of dermatological diagnoses is estimated at 3000, and each can present in numerous ways. Fortunately, less than ten diseases represent 70% of dermatological practice i.e. acne, bacterial, viral and fungal infections; tumours; eczema; psoriasis and leg ulcers (Ryan & Sinclair, 2003). In hospitals most individuals are seen as out-patients, but some require in-patient care for surgical procedures such as biopsies or excision of malignancies.

Dermatology is different from other specialities as most disorders are visible. The sharp eye of a dermatologist, aided by a magnifying glass is all that is needed for a complete examination. The key to successful treatment is accurate diagnosis. This entails examining the patient's body to classify the distribution, morphology and configuration of lesions. Treatment may be topical where ointments are applied onto the surface of the skin; systemic as in the use of oral antibiotics or a combination of both. While dermatologists see some skin diseases that are fatal, many conditions are curable and most are at least treatable (Hunter et al., 1989).

1.3 The case of leprosy

The successful evolution of the medical model and fields like dermatology is highlighted by the cruel legacy that diseases like leprosy left behind. During the 19th century thousands of hospices and islands known as leprosariums were created to house individuals afflicted with the 'living death'. Some countries created laws that required those infected to walk on opposite sides of the road depending on the wind direction, and to identify themselves by wearing special

clothes, or bells to warn of their approach. The treatment of 'lepers' equated with those of criminals as many were mistreated, exiled from society and confined until their death (Kaplan, 1993). These merciless practices continued until the pathology of leprosy was better understood in the late 1800's.

In 1940 a treatment for leprosy was discovered. Biomedical investigations revealed that leprosy is a systemic infectious disease caused by mycobacterium leprae (*M.leprae*) that targets peripheral nerves and cool regions of the body such as skin on the face, hands, feet and mucous membranes of the upper respiratory tract. These areas are below core temperature and provide optimum conditions for *M. leprae* to proliferate. Myths on leprosy were thus dispelled as evidence showed the disease was not contagious and disfigurement ranged from moderate to severe. Leprosy is now non-existent in developed countries, due to improvements in medical care, living standards and sanitation (Kaplan, 1993).

1.4 Limitations of the biomedical model

The benefit of finding a 'cure' for leprosy is obvious. It is also evident however, that the linearity of the medical model precluded consideration of the personal and social ramifications of disease. As such, it simply ignored the human suffering that conditions like leprosy caused. This is the strongest criticism of the model -namely that by separating the mind and body, on the basis that the body is 'real' and more worthy of scientific attention, it de-humanised patient care. Engel (1977) strongly rejected its reductionistic principles and argued that by focusing on disease to the exclusion of personal suffering, doctors failed in their

fundamental duty to care. The biomedical focus also neglected the prevention of disease, preservation of health and discounted psychosocial components that distinguish patients with the same diagnosis (Smith & Nicassio, 1995).

1.5 The biopsychosocial model

In light of these limitations a paradigm shift began in 1948 when the World Health Organization (WHO) proposed that health is "a complete state of physical, mental and social well-being and not merely the absence of disease". With this definition, WHO replaced the biomedical view with a biopsychosocial perspective and challenged practitioners to develop a more holistic approach to care. Health was now to be measured by a patient's ability to cope with daily life and function fully on a physical, social and emotional level (Eisenberg et al., 1993). This definition echoes Hippocrates' thoughts wherein he articulated health, as related to the environment, ways of life and components of human nature. The biopsychosocial model conceptualised illness by attending to biological (e.g. age), psychological (e.g. stress) and social issues (e.g. economic status) as *systems* of the body, similar to physical systems like the cardio-vascular network. It proposed that diseases displayed multifactorial etiologies and argued that the manifestation of symptoms was a complex interaction of all systems. The scope of the model was thus limitless, as it could be applied to any individual in any state without having to isolate specific biological causes, which at times is impossible to do. In accepting the unique dependence of different systems in each patient - a broad conceptual framework emerged wherein, the dynamic nature of disease, and its management could be understood (Deep, 1999).

1.6 The case of acne

Application of the biopsychosocial framework in dermatology can be illustrated by a disease like acne, which affects almost 85% of the population:

The dictionary states: '*Acne is a disorder of the skin, the commonest of which is acne vulgaris in adolescents, characterised by the presence of pustules and blackheads. Sebaceous glands in the skin become overactive (because of hormonal influence) and there is a greater production of sebum and proliferation of bacteria which cause infection. The hair follicles become blocked and pustules form which eventually turn black. The condition resolves with time but can be eased with creams and sometimes antibiotics*' (Medical Dictionary, 1997).

This definition provides a description of the disease but does not recognise that the experience of acne varies. Addressing how pathological processes and subjective meanings of illness intertwine - lies at the heart of the biopsychosocial model (Mechanic, 1968). Consider two patients diagnosed with moderate acne. Patient X tolerates the appearance of his skin, such that his psychological state is unaltered and he socializes with friends. Patient Y obsesses over spots, feels ashamed, is preoccupied with how others may react and is isolated. Essentially, both have the same biological problem but their experience of acne is different. Patient X sees himself as healthy, whereas Patient Y sees himself as diseased. A dermatologist using a biomedical approach may suggest topical creams to both patients. A dermatologist following the biopsychosocial model, may suggest the same treatment but will delve into the patients history by asking, why the patient

choose to seek help now, (*I hate how I look*), how this affects his life, (*I can't go out*) and well-being (*I'm depressed*). Since mental health difficulties can effect treatment compliance and coping, the biopsychosocial model shows that disease is better understood as a multilevel phenomenon. Within this framework McDaniel et al., (1995) describe the doctor-patient relationship as a tool that should monitor not only the disease, but the role illness plays in the emotional and interpersonal life of the patient. This is substantiated by studies on adjustment in acne, which show that many patients suffer with both poor quality of life and low self-esteem (Mallon et al., 1999; Smithard et al., 2001; Koo, 1995)

The trend of incorporating psychiatric liaison services in dermatology, verifies that while medical treatment can help resolve various skin conditions, it does not always 'cure' the inner torment sufferers endure (Layton, 1998; Newton et al., 1997). Currently, dermatology departments are beginning to offer cognitive behavioural therapy as an adjunct to traditional medical treatment. This has proven successful in facilitating adjustment and in improving patients' functioning (Root et al., 1994; Fortune et al., 1998b). The emergence and rising application, of fields like health psychology and behavioural medicine are further examples of how the biomedical model is still challenged today.

1.7 Limitations of the biopsychosocial model

Despite its holistic focus, the biopsychosocial model has been criticised for being deficit focused i.e. the locus of the problem returns to the individual so that something about the person remains amiss, whether it is 'under their skin' or in

their relation to the world. This has been likened to blaming the victim (Sadler & Hulgus, 1992). Critics also argue the model conveys a message of weakness and leads to labelling of individuals who do not cope with physical or mental illness. Medical professionals transmit such messages for example, when a patient is non-compliant they are called 'difficult' or if they are 'too needy' they are labelled 'the worried-well'. In relation to optimal health Banyard (1996) maintains that a state of complete physical, mental and social well-being is very difficult to achieve and that while the model sounds good in theory, it ignores the reality of wider socio-political and economic factors. Despite these criticisms proponents of the approach justify its application based on empirical data that demonstrates interventions targeted at a biological, psychological and social levels lead to improved health outcomes (Gilbert, 2002; Borrell-Carrio et al., 2004).

1.8 An integrative paradigm

Recently an integrative paradigm has emerged not because of some single breakthrough but due to increasing collaboration and developments in disciplines such as psychology, neuroscience, psychoanalysis and biochemistry. In developmental psychology, for example, Bowlby (1969), Ainsworth et al., (1978) and Stern (1985) provided a more thorough understanding of early life. They observed mother-infant relationships and used attachment theory to integrate scientific thinking with psychoanalytic ideas. This showed that emotional life could be understood in a biological and social context. In medicine, where thoughts and feelings were shunned as unquantifiable, technological progress has made it possible to map activity in the brain. This advancement has revealed

that thoughts elaborate emotional processes and that cognition cannot exist without emotion. The brain constructs representations of inner bodily states - links them to other stored representations and signals back to the body in a process of internal feedback, which triggers further bodily feelings in a cyclical process (Le Doux, 2002). Such developments would shock philosophers and scientists of the Enlightenment. Their hard stance on pure neuroscience has taken a turn, as researchers of this generation are expressing renewed interest in measuring emotions and bio-chemicals involved in human responses.

In integrating biomedical and biopsychosocial perspectives, Gerhardt (2004) draws findings from various fields to describe the development of the 'social brain' and how biological systems, the family and environment are involved in emotional regulation. She argues that human beings are open systems whose physiological and mental systems develop in relation with other people and 'this happens most intensely and leaves its biggest mark in infancy' (p10). This perspective brings to the fore that early development, psychological factors within the individual and the family system are all important determinants in health. Equally, they are integral components of illness. In the field of dermatology, increasing attention on the interaction of emotional and biological systems has generated interest in psychiatrists and dermatologists alike, on the role of 'self'. More specifically, research has started to explore how factors such as personality variables, stress and the immune system interrelate in the exacerbation and expression of various skin disorders (Hashiro & Okomura, 1998; Gupta & Gupta, 2003; Sampogna et al., 2004; Zachariae et al., 2004; Russo et al., 2004).

1.9 Psychodermatology

Psychodermatology was thus bourne out of the need to develop theoretical and clinical bridges between the psyche and dermis. The fact that dermatology patients frequently present with high rates of depression and anxiety suggests as Gerhardt mentions, that cognitive and emotional mechanisms are at work. Koblenzer (1987) a substantial author in the field divides skin diseases into three groups: purely dermatological, purely psychiatric or a combination of both. Primary psychiatric disorders: include conditions such as neurotic skin picking and trichotilomania. In these skin diseases, the underlying cause is psychiatric where patients harm their skin due to 'unconscious defences' and create a dermatological problem that requires treatment (Koblenzer, 1983).

Secondary psychiatric disorders entail dermatological diseases that are strongly influenced by psychosomatic factors. The etiology of the disease is physical, but stress and psychological variables exacerbate symptoms and increase psychosocial consequences. Disfigurement is often the key variable in triggering susceptibility to emotional distress and the magnitude of this is often related to the patients' perception of self and others. For example, studies on body image show that in some individuals, skin disease threatens the 'self' and any imperfection is experienced as devastating; while others, are less affected, because appearance plays a smaller role in sustaining a healthy identity (Cash & Pruzinsky, 2002). Finally, the third combined group is the most complicated and least understood. The etiology of skin disease in this population is multifactorial as stress, physiological and psychological factors all interact and contribute to

disease expression. Furthermore, psychiatric difficulties are also thought to influence onset and relapse of the disease (Wessely & Lewis, 1989). Conditions that fall in this group include, eczema, psoriasis and alopecia aerate. The wide acceptability of Koblenzer's classification signifies that individual characteristics are important variables in understanding psychological factors in skin disease.

1.10 The role of self

Except for psychoanalytic theories that interpret the manifestation of skin disease as expressions of unresolved psychic conflict - little attention has been given to how perceptions of 'self' influence adjustment. Knowledge on psychological variables has accumulated from health psychology models that draw on general conceptual frameworks and typically highlight the role of stress in effecting health outcomes. These models use informal constructions of self, without reference to a theoretical framework (de Ridder, 2004). The biopsychosocial model for example, would claim the experience of skin disease arises through the interplay of biopsychosocial factors, and that the whole person must be treated. While the 'self' is somewhere in the conceptualisation it is not represented explicitly anywhere. In explaining variability among patients, the model is vague and only hypothesizes that any number of moderating variables can influence adjustment (Kihlstrom & Canter Kihlstrom, 1999). This omission is reflected in other models of illness. The health belief model (Becker, 1974) for example, has been applied to diseases like acne (Tan et al., 2001) and psoriasis (Fortune et al., 1998a); the model outlines individual perceptions on their susceptibility to illness to explain health-related behaviour, but it ignores how beliefs about the self impact coping.

In a similar way, Leventhal's self-regulation model (1980) explores the links between emotion and health. The model shows that patients form illness-beliefs along four dimensions: the type of illness, how long it will last, its consequences and causes. These influence the meaning of illness, and trigger illness behaviour by influencing patients' problem-solving capacities in self-regulatory manner (Leventhal & Cameron, 1987). While 'self' is in the title, the model does not invoke the self at any stage except implicitly in the perception of symptoms and appraisal of coping. Research based on these models displays a similar trend. Kent & Smith (2002) explored adjustment in vitiligo, and verified Leventhal's idea that coping for these patients, is a problem-solving process as participants reported that living with vitiligo was a continuous strain. The authors outline the nature of this struggle, but how patients view themselves is not addressed. These omissions are problematic in that firstly, identity, illness beliefs and coping are not separate entities but combine to form a complex view of self and secondly, to understand self-regulation it is necessary to understand what the concept of 'self' is (Kihlstrom & Canter Kihlstrom, 1999). To date, how adult dermatology patients' view their concept of 'self' and what factors shape such perceptions in relation to skin disease has only gained superficial attention in the literature.

1.11 Summary

In the last century medicine has evolved and become more sophisticated. The challenge to gain more knowledge on illness and improve methods that facilitate patient functioning however remains. This chapter highlighted the strengths and limitations of the biomedical and biopsychosocial models when considering the

meaning of ill-health. It introduced psychodermatology to contextualise the importance of psychosomatic factors in skin disease and the need for a holistic focus in the understanding and management of patients. This emphasis is strengthened by new paradigms that integrate the influence of biological mechanisms in emotional and social development. Despite these advances in understanding the mind-body connection, there is still a temptation in dermatology to ignore psychological factors in patients and to treat only the manifestation of disease. This has occurred because overall there is no integrative theory in psychodermatology to elucidate how chronic skin disease is processed in relation to cognitive constructions of self, and in light of patients' interpersonal experiences. Such a theory could enhance current literature, by determining if cognitive and developmental factors lead some individuals to struggle more than others with the experience of skin disease. Ingram (1933) states that the association between the dermis and brain stem, begins in embryo as both biological systems are affected by the same hormones and neurotransmitters. The skin is thus an extension of the mind, and for this reason, is an essential part of character and personality assessment.

Prior to considering adjustment and the concept of self in dermatology patients, it is necessary to understand the clinical features of two common skin conditions, namely psoriasis and eczema, which form the basis of this investigation.

Chapter 2 | Physiology of skin disease: psoriasis and eczema

Psoriasis and eczema are two common skin disorders that alter the normal appearance of the skin. Both diseases run a chronic, episodic course and can challenge individual functioning by virtue of their symptoms. The clinical features and treatment of each disease are presented in this chapter.

2.1 The skin

The skin, the outer envelope of the body acts as the interface between man and his environment (Hunter et al., 1989). It has received attention for reasons of attraction or imperfection and for centuries has been a motive for punishment and segregation among nations. The psychological importance of the skin is evident throughout the lifespan, as the simple act of caressing favours emotional development, learning and growth in newborns (Schanberg & Kuhn, 1980). Homer initially used the word 'chrotos' to describe the skin surface, which alludes to 'colour'. The commonly term used in medicine, the 'dermis' means 'to flay' - carrying the nuance of pain and its origin dates back to Hippocrates.

2.2 Structure and function

Structurally, the skin is a complex organ, made up of glands, nerves, muscles and blood vessels, many of which are controlled by the autonomic nervous system. It is the largest organ in the body, weighing an average of 4 kg and

covering an area of $2m^2$. It is composed of the outer *epidermis,* which is firmly attached to an underlying layer the *dermis* that supports the epidermis structurally and nutritionally. Beneath the dermis lies the *hypodermis* that contains abundant fat (Hunter et al., 1989). The epidermis (or skin surface) consists of closely packed cell layers that are flattened and filled with keratin that give skin its smooth texture. It contains no blood vessels and varies in thickness from less than 0.1mm on the eyelids, to nearly 1mm thickness on the palms and soles. As dead surface cells are shed, the thickness of the skin is kept constant by cells dividing in deeper layers. The journey from the basal to the surface layer takes approximately four weeks. The underlying *dermis* varies in thickness and in old age becomes thinned and loses its elasticity (Schanberg & Kuhn, 1980).

The skin has an immune function and protects the body from foreign antigens that threaten it. Consequently, any reaction occurring in the skin is readily seen as disease. Acute rashes following use of certain cosmetics or detergents are good examples of immune mechanisms at work. As an organ of perception, the skin senses touch, temperature, pain and is a powerful erogenous zone. It acts as a site of emotional expression, and is influenced by psychological stimuli as is evident when embarrassment, leads to a discharge of anxiety through blushing. Chronic skin disorders often occur due to a malfunctioning in the immune system.

2.3 Prevalence of skin disease

In the UK 20% of the population suffers with some skin disease at any given time with eczema, psoriasis, acne and infectious disorders being the most common

complaints to dermatologists (Papadopoulos et al., 1999). Similar trends are observed in Athens (personal communication) but there is no reliable data on prevalence rates in Greece. In fact there is no inclusive epidemiological evidence on skin diseases in Europe (Burkhoter & Schiffer, 1995); apart from studies on diseases like infantile eczema, none have been conducted in more than one country. Trends in consultations rates suggest however, that a hidden iceberg of unmet dermatological need will surface, as diseases like skin cancer increase (Williams, 1997). To date surveys in various countries highlight that psoriasis and eczema are in fact a large and important problem (Dalgard et al., 2003).

2.4 Classification of skin disease

Skin disorders differ in onset, course and severity. Onset is congenital or acquired. Congenital conditions like albinism occur at birth and are genetically inherited. Some diseases e.g. strawberry birthmarks arise temporarily. are treatable and require little adaptation from the individual. Others such as vascular disorders e.g. port wine stains, cause permanent disfigurement. Skin diseases may also onset as a symptom of another medical condition, like digital sclerosis in diabetes, or they may emerge as a separate condition, as in vitiligo. Severity ranges from mild to severe and while most diseases are not life threatening, many can be debilitating. The course of a disease is episodic, progressive or acute. Progressive conditions have a predictable course that worsens over time e.g. melanomas. Episodic diseases such as acne can be chronic, but fluctuate between periods of activity and dormancy; and acute conditions, e.g. uriticaria (hives) or measles, have a predictable course and are short-lived.

2.5 Psoriasis

2.5.1 Clinical features and course

The term psoriasis originates from *psora,* which means *to itch.* It is a non-contagious episodic condition characterised by flaky lesions resulting from the rapid proliferation of the epidermis. In normal skin, the epidermal turnover rate is 4-weeks but in psoriasis cells mature and move to the surface in 3-4 days. A reddish build-up of skin results as the body cannot slough off so many cells as efficiently and unnoticeably as it does normally (Dungey & Buselmeier, 1982). Typical lesions are well-demarcated raised patches with loosely bound silvery scales. Gentle scratching leads to flaking, which increases whiteness of lesions and if all scales are removed, capillary-bleeding points may be seen.

2.5.2 Epidemiology

Psoriasis occurs in 2-3% of the population and affects both sexes equally (Fortune et al., 1998a), although some studies indicate a higher prevalence in men. In Britain, psoriasis affects about 1-2% of adults (Camisa, 1994; Williams, 1999) and a similar trend is reported in Western Europe (US Census Bureau International Data Base, 2004). Climate can also play a role as the condition develops earlier in colder regions (Farber & Nall, 1998).

2.5.3 Aetiology and onset

Psoriasis is an 'autoimmune disorder' and while there is a genetic predisposition to the disease, the exact mode of inheritance is unknown. In principle, psoriasis

can develop at any age but studies show about 40% of patients report onset in adulthood and 10% before the age of 10. Early-onset is seen in 15 to 25 year olds and late onset usually affects individuals between the ages of 50 and 60 years (Henselers & Christophers, 1985).

2.5.4 Precipitating factors

Stress, injury to the skin and infection are cited as common precipitating factors in psoriasis. Many patients report emotional distress triggers their disease (Jobling, 1976; Rapp et al., 1997) and life events, such as bereavement or work pressures are linked to disease onset (Al Abadie et al., 1994). The emergence of psoriasis following injury is known as the Koebner phenomenon and occurs in 30-50% of patients. Lifestyle issues e.g. alcohol and diet can worsen the disease.

2.5.5 Sites of Involvement

In some individuals psoriasis is limited to a few localised patches on the scalp, elbows and knees, while in others it is extensive and can involve the entire skin surface, nail dystrophy and psoriatic arthritis. Lesions are symmetrically distributed and located on the ears, elbows, knees, umbilicus gluteal cleft and genitalia (Fortune et al., 1998a). Factors influencing the persistence of lesions are not known but lesion quality portrays disease activity. If psoriasis is extensive or new lesions are forming the disease is active; low activity is evident if lesions are not spreading. Disease severity depends on skin coverage; mild psoriasis covers less than 5% of the body, moderate 5 - 20% and severe psoriasis, affects

may be obtained with the same treatment. While topical steroids, ultraviolet therapy and PUVA control psoriasis, there is no cure. About 40% of patients undergo spontaneous remission (Root et al., 1994; Weinstein & Gottlieb, 2003).

2.6 Eczema

2.6.1 Clinical features and course

Eczema comes from the Greek word *ekzein* meaning 'to boil over' and refers to a non-contagious inflammatory skin condition (Hunter, 1989). The disease appears as a rash that becomes inflamed, causing redness, swelling, weeping, crusting and scaling of the skin. 'Itching and scratching' may lead to bleeding or infection. It has an episodic course, hence periods of remission alternate with periods of activity; and rashes may fluctuate both seasonally and daily (Bondi, 1991).

2.6.2 Epidemiology

Eczema is very prevalent in Western countries and accounts for 20% of patients treated in dermatology clinics (Buske-Kirschbaun et al., 2001). In the UK it occurs equally in males and females; it affects 3-5% of adults and up to 20% of children by the age of 7. Worldwide variations on childhood prevalence show high rates in Australia and Northern Europe and lower incidence in Eastern Europe and Asia (Williams et al., 1997). In Greece 5% of children aged 13-14 are affected (ISAAC, 1998). Adult population-based studies on eczema are available, but comparisons between countries are difficult due to the lack of standardised diagnostic criteria needed for epidemiological research (Burkhoter & Schiffer, 1995).

2.6.3 Aetiology and onset

Children are mostly affected by eczema (Quielle-Rousel et al., l985), but the condition can continue into adulthood. Approximately 75% of children are clear by adolescence but relapses are common. Persistence into adulthood tends to occur, if the infantile experience of the disease was severe (Lammintuasta et al., 1991). The aetiology of eczema is complex as environmental, biological and lifestyle factors seem to work in concert in the expression of the disease (Williams, 1995; Schultz Larsen et al., 1986). Eczema can run in families and twin studies suggest a genetic predisposition is important.

2.6.4 Precipitating factors

Extreme temperatures, sweating, medication, clothing, grease and environmental allergens can trigger eczema. As with other skin conditions, psychological factors such as stress also aggravate symptoms (Bondi et al., 1991).

2.6.5 Sites of involvement

The distribution of eczema varies with age. In infancy, it affects the forehead cheeks and scalp and appears as a red scaly rash (Archer & Hanifin, 1987). To relieve itching infants often rub their head, with their hand or pillow. As a child grows the distribution changes; in adults lesions are dry, thick and grey in colour and there is greater involvement on limb surfaces (hands, feet) and flexural areas i.e. elbow creases, behind the knees and around the neck (Rystedt, 1985).

Both conditions alter appearance and many individuals have to preserve a sense of 'self-worth' without always relying on physical attractiveness (Cash, 1990). While medicine measures success by the absence of disease, psoriasis and eczema cannot simply be eradicated, and treatment only relieves symptoms. Since both conditions are chronic, they challenge the idea that health is an 'all-or-nothing' phenomenon. In this respect health exists on a continuum; patients' lie somewhere along this line and coping successfully is the best outcome that can be expected (Rapp et al., 1998; Broome & Llewelyn, 1989). Research exploring the psychological impact of skin disorders, has focused on disease variables, which are assumed to be all-important; and studies in psychodermatology have highlighted that psychosocial factors surrounding disfigurement also play an important role in adjustment. The next chapter considers these issues in more detail as literature suggest that psychological stress related to skin disease, can impact patient functioning and the progress of the disease itself.

CHAPTER 3: Adjustment to skin disease

The impact of skin disease revolves around the theme of adjustment. Adjustment to feeling unwell, to reduced activity and capability; changes in self-image, in priorities and relationships, can all come to the fore at once. Adjustment in this sense refers to a continued need for emotional, physical and mental adaptation over the course of the disease. This chapter considers medical and psychological issues related to skin disease. Disease variables, such as age of onset, severity and visibility are discussed in terms of their usefulness in predicting patient adjustment. It is suggested that body image disturbance and personality factors play an important and often defining role in shaping the meanings patients hold.

3.1 Age of onset

The age at which skin disease onsets, may determine the severity of difficulties experienced (Dungey & Busselmeir, 1982). A condition that appears in infancy, can effect early attachments, social encounters with other children, the child's body image and psychological development (Titman, 2005; Field & Vega-Lahr, 1984). Children with moderate to severe eczema for example, are reported to have twice the rate of psychological disturbance vs. controls (Absolon et al., 1997) and intractable eczema in childhood, is reported to be indicative of dysfunctional family dynamics (Lewis-Jones, 2006). Onset of skin disease in adolescence, when individuals are consolidating a sense of self and sexual identity can also be damaging since puberty involves dating and peer acceptance

issues where appearance is crucial (Ginsburg, 1996; Cash & Pruzinsky, 2002). In adulthood, the onset of skin disease can lead to difficulties like adjusting to an altered body image, loss of salary from missed work and expenditures on emollients or alternate healers (Graham-Brown, 1996).

3.2 Visibility and severity

The visibility of disease i.e. size, contour and location of lesions also impacts adjustment. Skin disorders involving the face have more negative consequences than body areas that can be concealed (Jowett & Ryan 1985; Papadopoulos & Bor, 1999). One exception is the genitals, as any involvement impairs patient comfort with intimacy. Quality of life is also eroded if coverage of the hands or feet is intense (Hughes et al., 1983). While lesion sizes vary, patients' psychological reaction to altered appearance, is often shaped by the extent of underlying psychopathology (Papadopoulos et al., 2000). In comparing the impact of vitiligo and psoriasis, Wessley & Lewis (1989) reported that vitiligo patients adjusted better to visible changes vs. psoriasis patients who had to cope with the discomfort of their skin, suggesting that 'disability' may act as an intervening variable. Elderly patients seem less affected by visibility issues, possibly because social pressure related to appearance is less prominent at this age. Some argue, the longer someone lives with a skin condition the easier it is to cope with (Patterson, 1993). Studies attesting to this however use cross-sectional vs. longitudinal designs and it is difficult to discern if individuals become better adjusted over time or whether they had always been able to adjust to illness-related issues (Papadopoulos & Walker, 2003) Interestingly, in a study

exploring illness appraisals of patients with alopecia showed that patients' beliefs were not related in any significant manner to severity of the disease (Firooz et al, 2005), and comparable results are reported in psoriasis (Fortune et al., 1998). Instead, 'perceived severity' mediated adjustment, indicating that severity of skin disease is not always linked linearly to subjective distress (Albadie et al., 1994). From a psychological perspective, the absence of 'a cure' in psoriasis and eczema is of interest as this impacts the possibility of influencing symptom severity and visibility, by performing self-care behaviours like applying creams regularly. Actual control in this instance increases *perceived* control over the disease, and lack of it can evoke feelings of helplessness (de Ridder, 2004; Lamb et al., 2004). Despite the various challenges skin disorders pose over appearance, many individuals also adjust well, report minimal effects on their self-concept and cope satisfactorily (Landsdown et al, 1997; Blackeney et al., 1988). This indicates that disease variables can only partly explain the variance observed across patients (Kent & Keohane, 2001). Increasing evidence, that emotional and psychological stressors are implicated in the process of adjustment suggests that cognitive variables may have a determining role in how patients cope with illness.

3.3 Psychiatric morbidity

In dermatological practice, approximately 30% of patients present with major psychiatric disorder that adversely affects adjustment and response to standard medical treatment (Picardi et al., 2003). Eczema and psoriasis have a particularly strong psychosocial component (Russo et al., 2004; Zachariae et al., 2004) and

some patients endure emotionally devastating consequences that are on par with heart and renal failure (Ryan, 1991). In eczema, the prevalence of stressful life events prior to disease onset is 70% (Faulstich et al., 1985). Stress related to the disease or to social factors plays an important role and can increase severity (King & Wilson, 1991). Depression, hypochondrial symptoms, chronic anxiety and anger difficulties are also significant, and occur more frequently in eczema patients vs. controls (Ginsburg, 1993). Psychosocial factors also influence the onset of psoriasis in 40%-80% of adults, and the rate rises to 90% in childhood cases (Gupta et al., 1987). In adulthood psoriasis has been linked to problems in expressing anger (Gupta et al., 1996; Fortune et al., 1997), a personality trait that increases vulnerability to stress. Others have found no direct link between psoriasis and stress (Al'Abadie, 1994), which suggests individual differences may mediate perceptions of the disease and the coping mechanisms used.

The multidimensional relationship between a disease like psoriasis and mood disorder is evident, as many patients present with psychological difficulties that impact the disease process (Vidoni et al., 1989; Rubino et al., 1989; Higgins & Du Vivier, 1994). Although psoriasis is not usually associated with pruritus, findings show when depression increases, scratching severity, insomnia and suicide-risk increase. Following anti-depressant treatment, these symptoms disappear. Similarly, alcohol usage decreases response to treatment and symptoms of insomnia and pruritus develop (Gupta et al., 1994). Given the level of emotional distress observed in psoriasis and eczema patients, both conditions have been identified as risk factors for poor quality of life and persistent episodes

of depression (Gupta et al, 2004). Other psychiatric disorders seen in dermatology patients include eating disorders and dysmorphobia. Personality disorders especially the narcissistic and obsessive-compulsive types also present with various skin conditions, and social phobia is common in patients who have been ridiculed earlier in their lives. Psychiatric comorbidity is thus identified as one of the most important indices of disability and adjustment difficulties in skin disease (Picardi et al., 2000; Woodruff et al., 1997).

3.4 Impact of skin disease on relationships

A neglected area involving adjustment is exploration of the impact skin disease has on close relationships. The inability to enhance appearance often fosters feelings of self-consciousness in patients and this can jeopardise emotional security in existing relationships, or affect how new romantic encounters are approached (Lansdown, 1997; Bradbury, 1996). In couples, the perceptions partners have of one another, and feedback they give on appearance impacts how each will feel about themselves, their bodies and relationship (Tantleff-Dunn & Gokee, 2002). Sixteen percent of dermatology patients investigated by Hughes et al. (1983) reported that their condition affected their marital life. Lannigan & Coterill (1989) found 9% of women would not reveal their birthmarks to their husbands, and Koo (1996) showed many psoriasis patients felt their disease was an obstacle in forming or sustaining intimate relationships. Skin disease of any severity can thus be shaming on an interpersonal level, and may create adjustment difficulties when it fuels insecurity on how desirable or attractive individuals feel they are to their partners and significant others (Anthis, 2004).

3.5 Meanings surrounding skin disease

It is evident from the data on adjustment, that skin disease carries its own brand of emotional torment. Yet despite the dearth of empirical studies available on patient morbidity, these are limited in guiding clinical practice since most papers offer very little theoretical development. A starting premise in cognitive theory is that how individuals adjust to skin disease will be shaped by their ongoing perceptions of the condition and not necessarily by the objective characteristics of the disease (Cash, & Puzinsky, 2002). Clinical practice with eczema and psoriasis patients reveals common cognitive patterns and emotional reactions that are indicative of altered perceptions of self and interpersonal difficulties.

1. *"I'm bad. No one will love me."* Patients often reproach themselves with terms such as 'disgusting,' 'outcast,' 'damaged goods' or 'reject'. They feel defective, hopeless and for some, the more visible the disease, the worse they feel.

2. *"I hate the world. I hate myself."* Patients with hereditary diseases like eczema may rage against their parents. Pain, itching and disability can provoke anger against the disease and the world. The anger sometimes turns inward. While few are at risk of suicide, many despaired sufferers kill off parts of themselves, so that passions are 'cooled' and opportunities for pleasure or success are ignored.

3. *"I'm so alone."* Many sufferers withdraw socially, casting themselves as lepers who have no place among normal people; the insensitive reaction of others further compounds the problem. *'Anybody who doesn't have my disease cannot*

understand how I feel' thus patients typically make no new friends after disease onsets, and exchange social activities for solitary pursuits.

4. *"My life is hopeless."* Powerless to change symptoms and appearance for the better, many patients extend a feeling of impotence to all challenges of adult life. A lengthening history of unsuccessful treatments can deepen this hopelessness.

5. *"It's all because of my skin."* Sufferers blame their skin disease for everything wrong in their lives. A man may believe his social isolation is due to eczema when in fact he was withdrawn and fearful of dating long before symptoms got troublesome. Pre-existing sexual problems, depression and anxiety are easily lumped together as fault of the disease, thus making it doubly difficult to relieve either skin symptoms or real-life problems.

6. *"My disease means..."* The search for meaning in misfortune is human and healthy, but when it creates long-term distress it becomes maladaptive. Well-meaning friends may offer support, but some patients falsely conclude they are being punished for their sins or victimized by a malevolent fate.

7. *"It's an avalanche."* In diseases like psoriasis where emotions play a role, anxiety about flare-ups, can trigger what is feared in a self-fulfilling manner. Panic about the illness can infect all of life, but less dramatically, the perpetuation of the anxiety-disease-anxiety cycle can simply prevent symptoms from improving.

3.6 Body image and disfigurement

Only a few authors have paid attention to cognitive structures in dermatology patients (Walker & Papadopoulos et al., 2005; Cash & Puzinsky, 2002) and most of the work available, centres on the role of body image. Myers & Biocca (1992) claim body image is a mental construction, not an objective evaluation and that individuals' draw from a various sources when constructing a model of appearance. These include the 'socially represented ideal body image' (ideals advocated by the media, family, peers), the 'objective body image,' and the 'internalised ideal body' (a compromise between the objective and socially represented body ideals). They argue that body image is elastic as its reference point's change depending on mood and the presence of social cues. Cash and Pruzinsky (1990) support this view and have shown that specific contextual events activate such self-appraisals. For example, individuals with skin disease, who have a negative body image, often have internal private dialogues that reflect habitual patterns of faulty reasoning and cognitive errors. Behaviours that arise from such cognitions are avoidance, concealment and social reassurance seeking (Cash & Strachan., 2002). Other authors' have focused on impression management (Kent, 2000) and include work on social anxiety (Leary & Kowalski, 1995), stigma (Goffman, 1968) and social skills training that assists patients to deal with others responses towards altered appearance (Rumsey et al., 1986).

Kent (2002) tested the applicability of these four models in vitiligo and found that while they overlapped, each contributed to understanding the disfigurement experience from the patients' perspective. The conclusion to emerge from this

body of work is that how people think about illness governs their reactions. Individuals' who tend to create more severe, more frequent and enduring stress through their thoughts and actions tend to run a greater risk of chronic illness and suffer poorer adjustment (Smith, 1992). These difficulties have been observed in other medical populations. For example, personality variables such as hostility, loneliness, low perceived emotional support, negativity and social inhibition are characteristic behaviours of individuals who are at greater risk of cardiovascular disease (de Ridder, 2004).

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3.7 Moving towards the self

While it is evident that body image disturbance and the implications of disfigurement are important correlates in skin disease, at the same time they only represent one aspect, of the many that constitute the self. In considering how broader personality factors influence adjustment, there are two positions in the field. The first claims pre-morbid personality factors determine how individuals are affected by skin disease and subsequent coping (Rubino et al., 1995; Pulimood et al., 1996); and the second that patient's emotional difficulties are secondary, and a consequence of the chronic course many conditions run (Hughes et al., 1983). Neither position provides an all-encompassing explanation, but once again a point of agreement – is that a personality, beliefs and behaviour are the strongest determinants in adjustment. Glimpses into the private meanings of dermatology patients, as seen earlier, also indicate that an exclusive focus on disease variables or body image provides an inadequate explanation of what drives the depth of the distress observed. Arguably, this is because adjustment is

an idiosyncratic process and has to be understood within the personal and developmental context of each patient. The absence of causal links in the literature between adjustment and disease severity further indicates that the interaction of psychobiological factors is multifaceted (Aktan et al., 1998) as core aspects of self may also influence body image and illness representations. On the basis of this complexity, many authors have argued that personality factors warrant further study, in order to determine if specific cognitive structures in dermatology patients represent underlying personality traits or if they are in fact situationally applied coping mechanisms (Thompson et al, 2002). The application of a broader model in psychodermatology that relates to how the self is viewed, during times of personal emotional stress and not only in relation to illness and disfigurement, could thus be useful in explicating factors that contribute or maintain chronic adjustment difficulties in patients with skin disease.

To expand knowledge on how dermatology patients represent constructions of self this investigation continues into the field of cognitive psychology where mental structures regarding perceptions of self, will be explored within a developmental context. This is guided by the fact that chronic psychological adversity, often resonates with experiences from the past by triggering specific autobiographical memories and general cognitive-affective schemas that form part of self (Andrews, 1997). Young's schema theory will thus be used to explore schemas in patients with psoriasis and eczema. The model is discussed in the next chapter, but theoretically, is well suited to psychodermatology as its principles are integrative, drawing form various schools of thought and its

philosophy supports the biopsychosocial approach. It is important to note that thus far there is no available research on 'maladaptive schemas' in dermatology patients. This research exemplifies the first attempt to suggest a coherent framework that explains how broad self-defeating cognitive mechanisms can contribute to psychological morbidity and differences in adjustment in medical populations. By identifying schema processes in patients with psoriasis and eczema, this study consequently opens a new area of research and widens application of theoretical concepts in psychodermatology.

Chapter 4 | Theoretical Framework: Schema theory

'Schemas' form a normal part of cognitive development and create the foundation of ones identity. Young's schema model predicts that the frustration of core needs in childhood lead to the formation of 'early maladaptive schemas' that have a negative impact on 'self' and increase vulnerability to psychopathology in adulthood. This chapter briefly outlines the history of the schema construct and the main concepts and processes involved in their formation, activation and maintenance. In doing so a theoretical framework is presented that can firstly address core aspects of self in dermatology patients and secondly, can explain what factors may contribute to chronic adjustment difficulties in adulthood.

4.1 Schema constructs across disciplines

Philosophy has long pondered over the minds' representation of the world. Kant (1781) first introduced the schema concept to discuss knowledge, by claiming that schemas mediate between properties of the mind (apriori categories) and raw sensory data from the environment (posteriori experience). Since then 'schemas' have developed a rich history. In developmental psychology, schemas are central to Piaget's work. He argued that a child's initial schemas are sensori-motor reflexes that coordinate interactions with the environment. These biological schemas promote adaptation via two processes: using 'assimilation' the schema grasps novel aspects and modifies to cope with its surroundings and through

'accommodation' it differentiates and elaborates to be consistent with the environment (Piaget, 1952). Piaget describes developmental transformations of these schemas from sensori-motor to adult formal thought. In cognitive psychology, schemas were introduced by Bartlett (1932) who showed how a culturally alien folk tale, changed in its re-telling to fit the listener's expectations. Since then, the schema construct has been used to study memory (Schacter, 1989), language (Arbib et al., 1987) and other areas like problem-solving (Van Lehn, 1989). In neuropsychology, schemas have been used to study the spatial perceptions patients have of their bodies, on the basis of the 'postural schema'. For example, damage to the parietal lobe destroys the postural schema, with the outcome that patients ignore parts of their body, as if it was not their own. In contrast an amputee, with an intact brain schema still experiences movement in the missing phantom limb (Stein, 1992). Neuroscience has now advanced into considering biological underpinnings of complex cognitive and affective schemas, and this will be discussed further in this chapter.

4.2 Schemas in clinical practice

In cognitive therapy, Beck (1967) considered schemas central to identity and noted their importance in his theory of depression. He defined schemas as 'an abstract cognitive structure used for the screening, coding and evaluating of stimuli that impinge upon an individual'. Beck argued that depression-prone individuals held more negative self-schemas (I'm worthless); negative views of the environment (seeing it filled with failure) and the future (as hopeless). When activated by critical events, this 'cognitive triad' guided perception, interpretation

and memory for personal relevant experiences. Beck (1967) suggested that early parenting influenced schematic levels of cognition. Most diathesis-stress models elaborate on this cognitive-specificity hypothesis, and outline how dysfunctional beliefs act as vulnerability factors for a wide-range of psychopathology. Whilst immensely useful and amenable to research Beck's model is criticized for focusing on negative thoughts in depression and taking little account of biological variables or rates of reinforcement (Gonca & Savasir, 2001). Vagueness on how schemas form undermines his theory, and the model has also proved limited in addressing chronic psychological difficulties. These limitations have led to a need for a theoretical model that can address schemas on a more substantial level.

As such Young (1990) extended Beck's work by integrating knowledge from range of theoretical sources including neuroscience, attachment theory, object relations and constructivism. His model differs from Beck's, by focusing on 'early maladaptive schemas' (EMSs)[1] that are seen to represent the deepest level of cognition and affect. Unlike Beck who listed specific beliefs relating to DSM-III-R disorders, Young proposes that a set of EMSs underlie all personality pathology. This is supported by research that has shown EMSs are core in personality disorders (Jovev & Jackson, 2004), chronic anxiety (Hedley et al., 2001), depression (Evans et al., 2005), substance abuse, (Brotchie et al., 2004) bulimia (Waller, 2003) and psychosomatic disorders (Taylor, 2000). These psychological difficulties also present in dermatology patients, which suggests EMSs may be relevant in understanding medical populations that suffer chronic distress.

[1] EMSs will also be referred to as 'schemas' throughout this document.

4.3 The schema heuristic

As seen, the 'schema' construct has been used historically, and across disciplines to explain concepts in cognitive functioning. Some argue that this diversity points to its problematic nature of the construct as different scientists are operationalising and measuring the concept in different ways; and this versatility reflects a lack of theoretical vigour (Stein, 1992). Arguably for the same reasons, the schema concept also has value, as it allows different researchers to theorise about mental structures from the particular perspective of their sub-discipline. Furthermore, as an integrative construct it allows for questions such as, how do structures of the mind enable representation, how are they based in biology, how do they develop and change, and how do they account for various phenomena observed in medical and psychiatric populations to be explored.

Certainly, given the obvious diversity of the schema construct and its application in different fields, there is room for progress in schema research in both theoretical rigor and empirical measurement (Fiske & Linville 1980; Williams et al., 1988). As a heuristic however, schemas represent a general shift from a molecular approach in cognitive science to considering the large scale properties involved in cognitive processing and a concern with investigating day-to-day human activities (Stein, 1992). These shifts are further marked by the rising use of schema theory in psychology to investigate phenomena of self, and the representation of emotion (Leahy, 2007; Layden, 1993). It is also of interest that as science begins to research these subjects, scientists' interests start to approximate those of clinicians.

4.4 Young's schema model

4.5 Characteristics and formation of early maladaptive schemas

Young's schema theory forms the conceptual foundation of this study. In this model EMSs are defined as pervasive self-defeating themes that encompass memories, emotions, cognitions and bodily sensations regarding an individual's self-concept and environment. They form in childhood primarily as a result of repetitive damaging interactions with parents, siblings or significant others (Young et al., 2003). EMSs that develop earliest are typically the strongest and most traumatic. Once formed EMSs act like maladaptive templates in processing experiences and are thus more powerful than automatic thoughts because they obstruct the meeting of core needs. Young's has identified 15[2] EMSs and classified these into five broad developmental domains that correspond directly to unmet childhood needs (Table 1).

Apart from toxic family relationships, other factors also contribute to schema formation such as difficulties at school, peers, learning or physical difficulties and the influence of cultural norms. The child's temperament (passive, aggressive, calm or anxious) is also significant in schema formation as it can expose children to different life circumstances. For instance, an aggressive child is more likely to elicit physical abuse from a violent parent than a passive child; and reciprocally, a child's temperament can influence how it responds to parental behaviour.

[2] In this study 15 schemas instead of the original 18 schemas have been used based on the factor analyses of previous research see (Schmidt et al., 1995).

Domain 1: Disconnection and rejection

Abandonment/instability (the belief that close relationships will end imminently)

Mistrust/abuse (the belief that one will be taken advantage of by others)

Emotional deprivation (the belief that ones emotional needs will never be met)

Defectiveness/shame (the belief that one is internally flawed);

Social isolation (the belief that one is different and isolated from the world);

Domain 2: Impaired autonomy and performance

Dependence/incompetence (the belief that one is not competent and cannot be independent);

Vulnerability to harm and illness (the belief that one has no control over the threat of disasters).

Enmeshment/undeveloped self (the lack of identity, due to emotional over-involvement with others)

Failure to achieve (the belief that one is incapable of performing well)

Domain 3: Impaired limits

Entitlement/grandiosity (the belief that one can act without the consideration of others)

Insufficient self-control/self-discipline (the belief that one cannot control one's impulses or feelings)

Domain 4: Other directedness

Subjugation (the belief that one must submit to the control of others to avoid negative consequences);

Self-sacrifice (the belief that one must sacrifice one's own needs to help to satisfy others' needs);

Domain 5: Over-vigilance and inhibition

Emotional inhibition (the belief that one's emotions must be inhibited to avoid adverse consequences);

Unrelenting standards (the belief that one should strive for unrealistic standards)

Table 1: Young's early maladaptive schemas and schema domains

Maternal rejection for example, may lead a shy child, to hide from the world and become dependent; or it may lead a sociable child to venture and make more connections. In studying temperament in infancy, Kagan et al. (1988) generated a body of research and found it was remarkably stable over time. Young's model would argue that skin disease in childhood can influence schema formation, if it impacts the child's physical well-being and elicits negative reactions from parents and the environment. There is some support for this view as a controlled clinical trial on mothers and infants with eczema showed mothers were very distressed and perceived infants' as negative in their emotional behaviour (Paulli-Pott et al., 1999). This suggests illness in early life and a child's temperament can escalate negative interactions in the parent-child relationship and create difficulties that may continue to impact later life.

4.6 Biological basis of schemas

In line with the biopsychosocial model, the schema model upholds a biological position on schema formation based on research exploring emotional processing and biological functioning in the brain (LeDoux, 1996). Recent studies show there is not one emotional system in the brain, but several. These systems are linked to different emotions and survival functions e.g. caring for offspring. In relation to EMS the system involved with the 'fear and conditioning of trauma' is of particular interest (Young et al., 2003). In summarizing the research LeDoux, has shown brain mechanisms that register and retrieve memories related to the *emotional significance* of traumatic experiences, are different from those that process conscious memories and cognitions of the same event. In other words, it is

proposed that emotional and cognitive memories of 'trauma' are stored in different parts of the brain (Glaser, 2000). The amygdala in the limbic system store emotional memories, and the hippocampus and neo-cortex stores cognitive memories. Due to the structural nature of these systems, emotional reactions and bodily sensations are activated more rapidly than cognitions (Zajonc, 1984). Based on this view, emotions have primacy over cognitions in the schema model. The implication is that if adults encounter events reminiscent of early trauma, associated emotions are automatically activated in the limbic system. This is especially so for EMS which form in the pre-verbal period as these only contain memories, emotions and sensations of the event; cognitions are added later when the child can think and speak in words (Layden et al., 1993). Biological underpinnings in schema formation is supported by research that shows primates separated form their mother endure elevated cortisol levels and other physiological changes; if separations are repeated such changes become permanent (Coe et al., 1983). The potential reactivation of traumatic emotions thus remains a permanent feature of a person's life given the survival value of never forgetting dangerous stimuli. This is illustrated clinically:

I was counselling a client with eczema who was abandoned as a child. In our sessions we observed a pattern wherein at different times she felt a sense of 'emptiness' to which she reacted with 'shivers' or by scratching her skin. Verbally the client could not explain these sensations and feelings – as they came out of the blue. A functional analysis revealed that her reactions occurred when she feared rejection. Her eczema also flared when she felt disconnected from others.

By acknowledging EMSs operate non-verbally, there is scope for understanding the link between skin disease, EMSs and emotional distress. Biological changes due to poor early bonding could create a diathesis to skin disease by impacting the immune system; the notion of separate memory systems also explains why strong emotions emerge during schema activation, which in turn could influence the disease process. As knowledge on emotional systems and unconscious processing increase, it may transpire that many aspects of self-construction are actually end points of complex social-physiological interactions (Gilbert, 2002).

4.7 Unconditional and conditional schemas

EMSs are present in all individuals but are exaggerated, rigid and extreme in clinical populations. Most people struggle with 1 or 2 schemas whereas persons with personality difficulties have several or all the schemas listed (Table 1). The dimensional nature of EMSs also means, they exist on a continuum and vary in severity and pervasiveness (Young, 1990). Usually the more severe a schema is, the more number of events activate it, the stronger the negative affect and the longer it lasts. Schemas are superimposed onto life experiences in adulthood based on the need for 'cognitive consistency', which allows individuals' to retain a stable view of self, others and life, even if these views are distorted (Young et al., 2003). EMSs formed early in development, are seen to represent 'unconditional' beliefs of self. The *schema simply is* and encapsulates the trauma done to the child without it having any choice. These schemas are primary, as they hold no hope and are forceful. No matter what the individual does or what other people do, the outcome will be the same e.g. they will always be 'abandoned'.

'Conditional' schemas form later in development e.g. adolescence, and are considered secondary because if adhered to then bad outcomes can be averted. Skin disease in adulthood can activate both types of schemas, which may explain why some patients are more distressed and vulnerable than others.

Unconditional Schemas	Conditional Schemas
Abandonment/instability Mistrust/abuse Emotional deprivation Defectiveness/shame Social isolation/alienation Dependence/incompetence Vulnerability to harm or illness Enmeshment/undeveloped-self Failure Entitlement/grandiosity Insufficient self-control/self-discipline	Subjugation Self-sacrifice Emotional Inhibition Unrelenting standards/hypercriticalness

Table 2: Unconditional and conditional schemas

4.8 Schema coping styles

Schema activation refers to the triggering of schemas. This is a very disruptive experience for the individual because the 'self' feels threatened. If the schema activated is 'unconditional', the stress generated is pervasive, charged and difficult to manage (Bricker & Young et al., 1993). In a maladaptive way the schema then governs the monitoring of information and influences how a person feels and relates to others (Freeman & Jackson, 1998; Stein & Young, 1993). Schema activation thus leads individuals to adopt coping styles of 'avoidance'

'overcompensation' and 'surrender', which are analogous to the threat responses of fight, flight and freeze. In childhood, these mechanisms operate unconsciously and are somewhat adaptive, but in adulthood their continued use strengthens EMSs (Young et al., 2003). Differentiating EMSs from schema coping is vital, as individuals may use different coping styles in various life stages to cope with the same schema. In other words, the coping style for a schema may not remain static over life but the schema itself will. In dermatology patients, these coping styles can manifest in various ways. A person with an 'abandonment' schema may 'avoid' relationships (to prevent rejection) using the logic their skin disease deters them from being intimate. If they 'overcompensate', a pattern of pushing others away may emerge, and 'surrendering' to the schema would entail selecting partners that are unavailable which also serves to maintain the schema.

In discussing schema processes, the broad suggestion being made in this study, by use of the schema model, is that adjustment difficulties reported in dermatology patients could represent the activation of EMSs and schema coping styles. This is supported by the literature in chapter three, which showed that many studies on adjustment in skin disease report similar themes of emotional distress, avoidance and interpersonal difficulties. To give a further example, Hill & Kennedy (2002) explored coping in psoriasis and found that mental disengagement (avoidance) and venting emotions (overcompensation) were significantly linked with subjective disability and distress. These coping styles explained more variance than age, gender or chronicity of disease. Acceptance of psoriasis (surrendering) was also not predictive of less distress. The study had

no control group thus findings cannot be generalised, but if schemas and coping styles are active in dermatology patients they are capable of generating chronic distress, because like traits they are part of a person over a long period of time.

4.9 Schema activation

To further develop and understand the role of EMSs in skin disease it is thus vital to consider the principles of schema activation in more detail. In the schema model, EMSs are said to be activated by idiosyncratic events that relate to a person's unmet core emotional needs. In theory, the onset and exacerbation of disease may thus activate schemas in some individuals and create strong emotional distress, which may then exacerbate the disease. To alleviate this distress, maladaptive copying styles that relate to and reinforce the schema come into play and thus make the schema rigid and resistant to change. Through this mechanism, this study suggests that chronic adjustment difficulties in dermatology patients may in fact represent the activation of schemas and their associated coping styles. While this is plausible, the difficulty with the schema activation view is that individuals', who are currently vulnerable, cannot be readily differentiated from individuals who are not vulnerable to depression or other emotional disorders prior to onset (Williams et al., 1997). As such, identifying dermatology patients who are at risk of adjustment difficulties is equally problematic. The brief explanation offered by Young and Beck on this issue is that schemas cannot be detected until active, because they are latent cognitive structures that only become reactivated when the patient is confronted with certain internal or external stimuli. More recently, however several investigators

have attempted to expand ideas on the schema activation process, which was not fully addressed in earlier work. These views are important as the provide insight into how EMSs may operate in patients with skin disease. The authors argue that when EMSs are activated in vulnerable individuals, they provide access to a complex system of negative personal themes that give rise to a pattern of negative information processing that eventuate in various emotional difficulties (Segal & Shaw, 1986; Teasdale, 1988). Segal and Ingram (1994) claim there are two specific pathways in schema activation; firstly, as suggested by Young 'direct activation' can occur when a critical event corresponds to the content of an existing negative schema (e.g. interpersonal loss due shame over appearance). This event provides enough energy to exceed the threshold needed for the schema to become fully active and perform its functions.

Secondly, 'indirect activation' can set a schema into motion through its relationships to other more activated schemas. Schemas are essentially, linked to one another based on similarity of content; thus when a schema becomes fully activated, activation spreads to associated schemas. If the link is sufficiently strong, the associated schema may also become fully activated. If the link is weak, the associated schema is partially activated, and does not exceed the threshold required for full activation (Bower, 1981; Ingram, 1984). This provides a fuller explanation of schema activation and is both useful and transposable to adjustment difficulties in skin disease as many patients suffer with depression, anxiety and other emotional disorders.

4.9.1 Empirical evidence on schema activation

Research exploring depression and priming effects strongly support the schema activation views. The weight of this research shows that vulnerable individuals, namely those who are at cognitive risk due to their schemas, report more dysfunctional attitudes when they experience negative mood states (Miranda & Persons, 1988; Roberts & Kassel, 1996; Solomon et al., 1998; Gemar et al., 2001). This implies that emotional distress in patients with psoriasis and eczema may activate EMSs and lead to a bias in information processing. Research exploring how schemas bias information shows more specifically, that self focused attention (e.g. when a person with psoriasis focuses on appearance) activates a network of cognitive and emotional processes that lead to feelings of depression. Recall bias, has also been found to be activated in vulnerable individuals (Ingram, 1990; Hedlund & Rude, 1995). In dermatology patients the latter process, may manifest by increased recollections of stigmatising or rejecting events. Studies on memory lend support to this notion, as a bias for negative stimuli has been found in primed adults, and some data shows this bias can occur in children as young as eight (Timbremont & Braet, 2004). The trend in these studies on a relationship between cognitive reactivity and vulnerability in individuals with EMSs is consistent with the cognitive-stress diathesis model.

While such research is valuable and has provided a better understanding of schema activation processes, a limitation is that many studies are laboratory based and use subjects who are vulnerable to depression or are already depressed (Scher et al., 2005). As such findings cannot be generalised to

individuals who are not at cognitive risk or outside an artificial setting. Longitudinal research has attempted to overcome this limitation by not using pre-selected individuals and examining them to see if schemas interact with life events to predict depression. While there are only a few such studies, they provide support for the schema activation view. Their main strength is that they demonstrate temporal antecedence of cognitive vulnerability, and examine the impact of natural stressors in individuals lives (Scher et al, 2005). Shirk, et al (1998) for example, focused on the relationship between schema activation and the transition to high school. Findings showed that maladaptive interpersonal schemas assessed before the transition interacted with interpersonal stress, to predict depression during the first term.

This finding is pertinent, as the episodic nature of psoriasis or eczema may serve to trigger EMSs and create adjustment difficulties on a personal and interpersonal level. The chronic nature of such difficulties also suggests that EMSs may make patients vulnerable to relapse. Only one study was found, which explored whether cognitive vulnerability is related to onset, relapse, or recurrence of depression. Segal et al, (1999) examined if cognitive reactivity predicted relapse in a group of formerly depressed patients who had been treated to remission with either CBT or antidepressants. These patients participated in a mood induction task where changes in dysfunctional attitudes were examined in both normal and induced dysphoric moods. They were contacted 4 years later to assess relapse status. Results indicated, that the level of mood-linked cognitive reactivity significantly predicted relapse, with 70% of

participants correctly classified as relapsers or non-relapsers. As such it was concluded, cognitive reactivity, can in fact predict relapse in depression. Measuring levels of distress and cognitive vulnerability in dermatology patients using the YSQ-SF could thus be useful in predicting relapse and in providing appropriate psychological support within hospital settings to those patients that are identified as vulnerable. The research reviewed on schema activation support the idea that EMSs increase risk for future emotional difficulties, and that the various processes studied (e.g., recall, memory and interpretive biases) play a meaningful role in understanding how EMSs create distress. This lends support to the validity of the schema construct as a useful heuristic in understanding the phenomenology of dermatology patients.

4.10. Schema processes

Finally, EMSs remain a core part of self through the process of 'perpetuation'. This involves everything a person does internally and behaviourally to reinforce the schema. Cognitive distortions, self-defeating life-patterns and coping styles are the mechanisms by which this is achieved. Conversely, schema 'healing' involves everything a person does to weaken the schema. These processes can be considered in a schema like 'social isolation' that may develop in a person, who grows up feeling different such as people with great physical beauty or deformity, (Young et al., 2003). This schema may be triggered if altered appearance in skin disease increases the threat of social rejection. Resulting negative thoughts, shame and hiding from others, perpetuate the schema as the person continues to feel excluded and believes more strongly they are different.

Ongoing interpretation of stigmatising experiences as proof of the schemas' validity thus maintains 'social isolation'. Healing in this case would entail learning not to personalise stigmatising events; or to recognise that similarities and differences exist between all people. Behaviourally, this could entail balancing connections with those that share the difference and creating connections of similarity. While therapy assists the healing process, it cannot eradicate schemas as it is not possible to remove the memories or experiences that created them.

4.11 Summary

This chapter has shown the 'schema' construct is a valuable heuristic that explains how the mind uses conscious and unconscious mental frameworks to process information. EMSs can be seen as traits that resist change, and form a core part of self. They create vulnerability in individuals when activated and perpetuate psychological distress through the maladaptive coping styles that are derived from and compensate for each schema. By incorporating, developmental, social, cognitive and biological dimensions as core aspects of self, the schema model provides a robust theoretical framework wherein the psychological functioning of patients with skin disease can be better understood. Having clarified the process of schema activation this investigation can proceed, with Young's Schema Questionnaire, which identifies EMSs in normal and clinical populations. Establishing the reliability of this instrument, in a Greek population is the focus of the next chapter and represents a vital step towards identifying schemas in patients with skin disease, which are assumed to be active.

CHAPTER 5| Reliability of the Greek YSQ-SF

Determining the usefulness of the YSQ-SF in identifying EMSs in dermatology patients is a vital in exploring how psychological processes interact to perpetuate ill-health. This study investigated the reliability of the Greek Young's Schema Questionnaire–Short Form (YSQ-SF) in a cohort of clinical and non-clinical participants. Reliability was assessed by investigating the internal consistency of questionnaire items for each schema in relation to the five schema domains.

5.1 The Young Schema Questionnaire-Short Form (YSQ-SF)

The YSQ-SF is a multidimensional measure of beliefs that identifies EMSs. It has been translated into several languages including French, (Mihaescu et al., 1997) and Dutch (Rijkeboer, 2005). The YSQ-SF developed to improve efficiency of the long-form (YSQ-LF), which has 205-items. A body of research has explored the reliability and validity of the YSQ-SF (Wellbern et al., 2002) and YSQ-LF (Schmidt et al., 1995, Lee et al., 1999) in clinical and non-clinical populations, with successful results (Rijkeboer, 2005). Comparability of the two instruments was examined by Waller et al. (2001) and Stopa et al. (2001). In both studies, scores were significantly correlated and alpha levels on most scales were adequate ($\alpha>0.70$), indicating that psychometric properties of the long and short form are conducive for research and clinical practice. This study aims to investigate the internal consistency of the YSQ-SF as a measure of reliability in a

Greek population. Establishing the reliability of the YSQ-SF is necessary as no previous published works have 1) translated the measure into Greek and 2) no previous studies have examined its psychometric properties. This is especially needed in Greece where there are a limited number of validated instruments available for use. Furthermore, the need for a measure that can identify deeper levels of emotional distress in dermatology patients is vital, as the only routinely used measure in hospitals is the Dermatology Quality of Life Index (Finley & Khan, 1994), which helps doctors ascertain how effective medical treatment is in improving quality of life. Promoting the integration of psychological services in dermatology departments in Greece and equally the UK, thus requires a clinical instrument that can expand more fully on the specific schemas dermatology patients struggle with. This can then guide the nature of psychological interventions provided in adjunct to medical treatment. On a broader theoretical level, reliability of the instrument will also assist in expanding research into EMSs in other medical populations, by identifying the relationship between maladaptive 'schemas of self' and various forms of chronic illness. Authorisation, for the use and translation of the YSQ-SF was provided by Jeff Young.

5.2 Method

5.2.1 Procedure

Syngrou Hospital in Athens is the largest dermatology department in Greece. Following ethical approval questionnaires were distributed by an independent medical professional to consecutive out-patients. To ensure privacy and confidentiality, a room was arranged for participants to fill in the questionnaire. A

cover letter (Appendix 1) outlined the aims of the study and that participation would not influence treatment. Participants signed a consent form and sealed the completed questionnaire in an envelope addressed to the University.

5.2.2 Participants

Questionnaires were distributed between June - December 2004 to a cohort of 215 clinical and non-clinical participants (Table 3). These included over 18 out-patients (n=145) diagnosed as having psoriasis (n=78) or eczema (n=67). The mean age was 40 (SD 14.93) and 37 (SD 12.63) respectively. Non-clinical participants (n=70) had a mean age of 33 (SD 9.49). Overall, there was equal distribution of male (47%) and (53%) female subjects across samples.

5.2.3 Instrument

The YSQ-SF is constructed so that five representative items are listed under each of the 15 schemas. Respondents are asked to rate how true each item is, in terms of how they see themselves, others and the world (Appendix 4). All items are scored on a Likert scale ranging from one to six (1= completely untrue of me, 2 = mostly untrue of me, 3 = slightly more true than untrue of me, 4 = moderately true of me, 5 = mostly true of me and 6 = describes me perfectly). High scores indicate the presence of a schema. In line with a developmental perspective EMSs are divided into 5 developmental domains. The YSQ-SF was translated by a psychiatrist in Greece and back translated by independent bi-lingual translators in the UK according to standard procedures. The novelty of this lies in the fact that while the YSQ-SF has been used world wide, up to now

the instrument was not available for use in Greek populations. Establishing the its reliability thus expands its applicability to a different cultural setting.

5.3 Reliability analysis

When questionnaires make use of Likert scales, calculating and reporting Cronbach's alpha is imperative as this measures the reliability of a psychometric instrument. Cronbach's alpha is not a statistical test but a coefficient of internal consistency that shows how well a set of items (or variables) measure a one-dimensional latent construct. In this study this refers to whether, items on the YSQ-SF reliably measure schemas as defined under each domain. If inter-item correlations are high, items are seen to measure the same underlying construct and the reliability of the questionnaire is considered 'good'. If items are multidimensional however, and do not measure the same construct Cronbach's alpha will usually be low. The coefficient Cronbach's alpha, ranges between 0 and 1, and the closer the coefficient is to 1.0 the greater the internal consistency of items (Gliem & Gliem, 2003). While the English YSQ-SF has established its reliability by virtue of the research conducted in various clinical populations, further proof is still needed to establish its reliability in a Greek dermatology subjects. Prior to considering results of this study, the demographic characteristics of the samples, namely age, gender, marital status, education, religion, age of disease onset and perceived severity are provided in Table 3.

Demographic information	Psoriasis	Eczema	Control
N	78	67	70
Age			
Mean (SD), years	40.05 (14.93)	36.80 (12.63)	36.84 (12.89)
Gender			
Male	48	22	33
Female	30	45	37
Marital status			
Single	25	17	18
Dating/Engaged	12	18	22
Married	38	22	26
Divorced	2	7	2
Other	1	3	2
Education			
Primary school	7	4	3
High school	29	28	18
College	15	15	8
University	26	19	41
None	1	1	0
Religion			
Greek Orthodox	71	64	68
Other	7	3	3
Age of disease onset			
Mean (SD), years	27 (14.23)	16 (12.43)	
Perceived severity of skin disease (1-10 scale)			
Mild >/5	47%	72%	
Moderate to severe <5	53%	28%	

Table 3: Demographics table and samples characteristics

5.4 Results

The reliability of the Greek YSQ-SF was analysed using SPSS 12.0 for Windows. An internal consistency analysis was conducted on the five domains and 15 sub-scales. Inter-item correlations, were calculated separately for each schema.

Early Maladaptive Schemas	Cronbach's alpha
Domain: Disconnection and Rejection	
Emotional deprivation	0.87
Abandonment/instability	0.66
Mistrust/abuse	0.84
Social isolation	0.85
Domain: Impaired autonomy and performance	
Defectiveness/shame	0.92
Failure	0.91
Dependence/incompetence	0.90
Vulnerability to harm and illness	0.88
Domain: Impaired limits	
Entitlement	0.82
Impulse control	0.82
Domain: Other directedness	
Enmeshment	0.86
Subjugation	0.64
Self-sacrifice	0.90
Domain: Overvigilance and inhibition	
Emotional inhibition	0.69
Unrelenting standards	0.77

Table 4: Cronbach's alphas (α) for EMSs in the five schema domains

With respect to schemas domains the reliability analysis revealed that 'impaired autonomy and performance' had the strongest internal consistency as was evident by high alpha scores of schemas in this scale. In the relation to EMSs 12 of the 15 subscales had alpha levels greater than 0.7. Three schemas 'abandonment', 'emotional inhibition' and 'subjugation', narrowly missed this level. The internal consistencies of the subscales are illustrated in Table 4. Overall, Cronbach's alphas for the 15 schemas on the Greek YSQ-SF reached acceptable levels of internal consistency and were high in coherence for the schemas of 'failure', 'dependence/incompetence' and 'defectiveness/shame'.

5.5 Discussion

The YSQ-SF subscales represent stable constructs that should convey temporal stability (Hellinga et al., 2000). The instrument is thus designed to test the idea that individuals have internal cognitive representations that continue to impact adulthood. Results on the reliability of the instrument showed that the Greek YSQ-SF has appropriate and satisfactory levels of internal consistency, which are similar to results reported in previous work (Schmidt et al., 1995; Stopa et al., 2001). Lower alpha scores on EMSs of 'abandonment' 'subjugation' and 'emotional inhibition' indicate greater variance in items representing these scales (Table 4). This reflects a need to further improve the language on these items as cultural differences over interpretation may have rendered these weaker in identifying subjects' conviction in a the schema. The domain with the highest alpha scores was 'impaired autonomy and performance' which entails beliefs of that prevent individuals from differentiating themselves from others (Young et al.,

2003). Overall, however the high internal consistency of the majority of items under each of the 15 schema subscales indicates that the YSQ-SF is reliable tool in assessing cognitive representations in clinical and non-clinical populations.

5.6 Limitations

Certain limitations must be noted when interpreting the current findings. Firstly, Cronbach alpha scores only provide an estimate of internal consistency, thus they do not indicate the stability or consistency of the YSQ-SF over time or in different samples (Clarke & Croft, 1998). Future research on its reliability could provide more accurate estimates, by administering the instrument using a test-retest strategy (Crombie, 1996). Results were also obtained under a specific set of circumstances and within a hospital setting, thus generalising use of the Greek YSQ-SF to other clinical and non-clinical samples must be done with care. Having established that the YSQ-SF is reliable, it is possible to proceed investigating the nature of schema representation in patients with skin disease in adulthood and how these may have formed in early development. Since dermatology patients have been noted to have high levels of psychological morbidity, it is likely that they will differ from healthy controls on the YSQ-SF. If this is so, this could lead to testable hypotheses on the influence of schemas in skin disease. Developmentally, psoriasis and eczema also onset at different ages thus they may pose different challenges in adjustment. The next study provides a perfect context to investigate developmental factors and schema formation in dermatology patients, by using the hierarchical classification of schema domains to investigate what core emotional needs were not met during childhood.

CHAPTER 6 | Group differences in schema domains

Schema domains provide a developmental framework that indicates how EMSs form due to the frustration of core emotional needs in childhood. Investigation of these domains in patients with psoriasis and eczema is aimed at determining, whether difficulties in early development contribute to a poor concept of self. By identifying which, domains are most pertinent to dermatology patients' emotional difficulties in adulthood may be better understood in this population.

6.1 'Universal' developmental needs

The schema model draws from Piaget (1952) theory and states that five 'universal' needs must be met if children are to develop healthily. These include: (1) the need for secure attachments (2) autonomy, competence and a sense of identity; (3) freedom to express valid needs and emotions; (4) spontaneity and play and (5) realistic limits and self-control. While individuals vary, by needing more of one thing than another, a psychologically healthy individual has these needs met in childhood and develops into a person who gets these needs met in adulthood (Young et al., 2003). When these needs are not met, they continue to go unmet in adulthood and create emotional difficulties on a personal and interpersonal level (McGinn & Young, 1996; Wellburn et al., 2002). The five schema domains capture the nature of these difficulties as each domain relates to one broad grouping of needs and discusses how these were blocked in early

life. It is proposed that EMSs learned in childhood remain fixed at an early level of development and when triggered by demanding times in adulthood, the person is unable to adapt to changing life experiences (Freeman & Jackson, 1998). In this respect, Young's schema domains also parallel Erikson's theory on the stages of psychosocial development.

Age	0 to1	1 to 3	3to 6	6 to puberty
Erikson's Stages	Trust vs. Mistrust	Autonomy vs. Shame & Doubt	Initiative vs. Guilt	Industry vs. Inferiority
Schemas	Mistrust Abandonment	Dependence Lack of individuation	Dependence Emotional deprivation Incompetence	Incompetence
⇦	Unlovability/Defectiveness/Badness			⇨

Table 5: Schemas and Eriksonian psychosocial stages of development

Both theories state that the period between infancy and adolescence has a powerful impact on schema formation. According to Erickson children learn to function in the world by resolving challenges. Each stage thus represents a pair of opposing learning experiences (see Table 13). Favourable resolution of a stage occurs when a balance is struck that leans towards the positive. This leads to 'adaptive schemas' where the child's needs are met. Failure to resolve a stage leads to difficulties in resolving further stages, with the consequence that the

person will confront and struggle with the same difficulty, in later life. Piaget and Erikson's theoretical ideas thus form a solid conceptual basis for understanding Young's schema domains and the developmental processes involved in EMSs formation. The five domains are briefly described below.

6.2 Schema domains

I Disconnection and rejection

Individuals with schemas in disconnection and rejection are unable to form secure attachments with others as they hold beliefs that their needs for safety, nurturance, love and belonging will not be met. Whilst growing-up their family environment was typically unstable, abusive, cold, rejecting or isolated. EMSs in this domain include mistrust/abuse, defectiveness/shame, emotional deprivation, abandonment/instability and social isolation/alienation (Young et al., 2003).

II Impaired autonomy and performance

In this domain individuals hold beliefs that interfere with their ability to separate and differentiate from others. In childhood they had parents who overprotected or neglected them. Both extremes in parenting lead to insecure bonding and create problems with autonomy. Parents typically undermined the child's self-confidence and failed to praise achievements outside the home. In adulthood these individuals thus struggle to create their own identities and their own lives. Schemas include failure, enmeshment and vulnerability to harm or illness.

III Impaired limits

Impaired limits, refers to individuals who experience difficulties in accepting the rules and expectations of society because their families of origin were overly permissive or indulgent. Individuals with EMSs in this domain thus lack internal limits on reciprocity or self-discipline. They struggle to respect the rights of others, keep commitments, meet long-term goals and often come across as narcissistic. Schemas include insufficient self-control and entitlement.

IV Other directedness

This domain depicts a strong emphasis on meeting the needs of others to gain approval, maintain connection or avoid retaliation. Individuals with EMSs in this group lack awareness of their needs and anger. As children they were forbidden to follow their inclinations, thus as adults instead of being internally directed they feel insecure in relationships and follow the ideas and desires of others. Typical families modelled conditional acceptance so that a child learnt to retain important aspects of self to get approval. Schemas include 'subjugation' and 'self-sacrifice'.

V Overvigilance and Inhibition

The suppression of impulses and emotions is characteristic of schemas in this domain and include 'emotional inhibition' and 'unrelenting standards'. In such individuals, life feels grim, focused on work and constant performance. A need to meet inner rigid rules on achievement is at often at the expense of happiness, relaxation, close relationships or good health. Their upbringing was typically strict as parents never encouraged play or the pursuit of happiness. Self-control and

self-denial predominates over pleasure, thus as adults these individuals are worriers, who believe their life would fall apart if they failed to stay alert.

DOMAIN	EARLY MALADAPTIVE SCHEMAS
Disconnection and Rejection	• Abandonment/instability • Mistrust/abuse • Emotional deprivation • Defectiveness/shame • Social isolation/alienation
Impaired Autonomy	• Dependence/incompetence • Vulnerability to harm or illness • Enmeshment undeveloped self • Failure
Impaired Limits	• Entitlement/grandiosity • Insufficient self control/self-discipline
Other-directedness	• Subjugation • Self-sacrifice
Overvigilance and inhibition	• Unrelenting standards • Emotional Inhibition

Table 6: Hierarchical classification of domains and EMSs (Appendix 3)

6.3 Schema domains and skin disease

In essence, understanding the domain a person with skin disease struggles with involves 'entering the world of the schema'. Depending on the specific unmet core need, each schema has its own emotions, choice of partners, way of being in a relationship and triggering events (Young, 2002). A person with a schema in

disconnection and rejection for example, *lives in the world of 'abandonment'* or *in the world of 'social isolation'*. The implication is that if 'skin disease' activates a particular schema, emotional distress will not be isolated to disfigurement, but can shape a person's way of 'being', how they relate to others, and what is experienced as stressful. In the domain of impaired autonomy, a person with a 'failure' schema for example, could undergo major stress when employment opportunities seem jeopardised by the visibility of skin disease. Feelings of incompetence may then be coped with, by camouflaging to avoid negative evaluation. Depending on the domain, the meanings linked to psoriasis or eczema will thus vary - but ultimately it is thought that individuals will cope in ways that serve to maintain EMSs, so that core needs continue to go unmet

6.4 Aims and hypotheses

Based on the important influence early development has on adult functioning the aim of this study is to explore if dermatology patients can be differentiated on the basis of schema domains, given the prevalence of psychological morbidity in this group. If the frustration of core needs fuel EMSs formation in dermatology patients, this could partly explain adjustment difficulties in adulthood. The first hypothesis thus states that there will be differences in schema domains between patients with skin disease and healthy controls. The second hypothesis builds on this, and states there will be differences in the schema domains between psoriasis and eczema patients' due to different ages of disease onset, which may have different developmental implications. This has not been investigated in the literature, except for studies on the impact of infantile eczema (Solomon, 1987).

Findings of this study will thus provide new knowledge on how early experiences can shape cognitive development and attachment in patients with skin disease.

6.5 Method

6.5.1 Participants

Respondents comprised of two clinical groups and a group of healthy controls. Patients with psoriasis (n=78) and eczema (n=67) were recruited from the out-patient clinic in Syngrou Hospital. In psoriasis, the mean age was 40 (SD=14.93) and mean age of onset 27 (SD 14.23). In eczema the mean age was 37 (SD 12.63) and mean age of onset 16 (SD 12.43). The control group (n=70) had a mean age of 33 (SD 9.49) and were recruited form residents in the community. All groups were screened by a demographics questionnaire to exclude factors that could influence schema development (Appendix 2). This included early trauma such as the death of a parent, current use of psychotropic medication and past or previous history of psychological therapy. These exclusion criteria were deemed necessary to ensure that any difference in the groups was not related to pathological experiences in childhood or due to the effects of therapy.

6.5.2 Power analysis

A power analysis using DATASIM (Bradley, 1988) was carried out to determine the appropriate sample size that would enable any effects due to treatment to be identified. A minimum treatment effect of 0.5 and a power of 0.8 were decided. The power analysis revealed that a combined sample size of 52 per group or more would be large enough to detect such effects.

6.5.3 Procedure

Questionnaires were distributed to consecutive out-patients. Participants were approached by an independent medical professional who informed them the study, was anonymous and would not affect treatment. Participants signed a consent form and in a quiet designated room filled in the questionnaire. This took twenty minutes to complete. In the control group participants were informed that their responses would be used for comparison purposes.

6.5.4 Instrument

Each of the groups completed the Greek YSQ-SF, a 75-item self-report questionnaire (Young, 1998). All items are scored on a six-point Likert scale where 1= completely untrue of me, to 6 = describes me perfectly. High scores indicate the presence of a schema. In chapter five it was shown that the fifteen subscales had high internal consistency across the five domains.

6.6 Statistical analysis

In this analysis three samples, psoriasis, eczema and controls were compared using univariate ANOVAs a statistical method that identifies differences in means between more than two groups. Scoring of the YSQ-SF involved calculating the mean of item scores under each scale, which was taken as the dependent variable (schema domains). This method of scoring was applied in preference to the informal scoring used in clinical practice, which entails identifying the critical index of responses by the number of high scores on each schema. By experimenting with both methods Waller et al., (2001) showed that a means

approach has greater discriminatory power than the informal method, which masks differences and leads to fewer significant differences between groups. The F-ratio and p-value in ANOVAs indicates whether the main effect of the independent variable "skin disease" is significant. A p-value of $p<0.05$ was taken as an acceptable level of significance. While ANOVAs identify if skin disease results in differences on schema domains between groups, this statistical method compares all values simultaneously and does not indicate 'where' those differences lie. Is it between psoriasis and eczema, psoriasis and controls, or eczema and controls? As such appropriate post-hoc tests are used to identify the specific nature of this difference between groups.

6.7 Results

Dermatology patients and controls were compared across the schema domains Based on means and standard deviations, results showed that on a developmental level patients with skin disease had stronger experiences of 'disconnection and rejection' in early childhood vs. controls. Univariate ANOVA's thus confirmed that the three sample groups were indeed significantly different from one another (see Table 6). Most importantly, results showed that across all the schema domains dermatology patients had higher levels of EMSs. Post-hoc Tukey tests were used to further explore the nature of this difference. Results indicated psoriasis and eczema patients were significantly worse off vs. controls in two key domains 'disconnection and rejection' and 'other directedness' and in the remaining 3 domains 'overvigilance and inhibition', 'impaired autonomy', and 'impaired limits' psoriasis patients, were significantly worse vs. controls.

	Psoriasis [P]		Eczema [E]		Control [C}							
	N=78		N=67		N=70		Total		ANOVA			
DOMAINS	M	(SD)	M	(SD)	M	(SD)	M	(SD)	F ratio	p	Post hoc Tukey	
Disconnection and rejection	52.49	(23.20)	51.48	(27.04)	40.34	(12.86)	48.22	22.42	6.79*	0.00	P vs. E	td = 1.01, p = 0.96
											P vs. C	td =12.14, p = 0.00*
											E vs. C	td =11.13, p = 0.01*
Impaired Autonomy	38.00	(17.74)	34.91	(16.14)	30.71	(13.67)	34.67	16.22	3.83*	0.02	P vs. E	td =3.09, p = 0.48
											P vs. C	td =7.29, p = 0.02*
											E vs. C	td =4.20, p = 0.28
Impaired Limits	26.97	(10.02)	23.39	(8.93)	22.74	(8.91)	24.48	9.48	4.46*	0.01	P vs. E	td =3.59, p = 0.06
											P vs. C	td =4.23, p = 0.02*
											E vs. C	td =0.65 , p= 0.91
Other Directedness	27.00	(10.46)	27.03	(12.03)	21.44	(8.27)	25.20	10.63	6.84*	0.00	P vs. E	td =0.03 , p = 1.00
											P vs. C	td =5.56 , p = 0.00*
											E vs. C	td =5.59 , p = 0.01*
Overvigilance	30.83	(10.96)	27.79	9.64	25.06	(9.28)	28.00	10.27	6.14*	0.00	P vs. E	td =3.04 , p = 0.17
											P vs. C	td =5.78, p = 0.00*
											E vs. C	td =2.73, p = 0.25

Table 7: Means, standard deviations, ANOVA and Tukey results for schema domains

6.8 Discussion

6.8.1 Group differences in schema domains

The first hypothesis of this study namely, that patients with psoriasis and eczema are significantly different from controls across schema domains was confirmed. This finding is new and indicates a very important point, namely that the

obstruction of core needs in childhood is relevant to understanding the interplay of skin disease and emotional difficulties in dermatology patients. This sample scored highly in 'disconnection and rejection', which is concerned with the need for secure attachment. Skin disease in childhood can frustrate such needs if parents struggle with a child that looks 'different'. If insecure attachments develop due to skin disease or analogous family difficulties then the 'feeling' of disconnection will continue to impact personal and interpersonal functioning in adulthood. Consequently as the model predicts, psoriasis in adulthood or the stigma of chronic eczema, will continue to frustrate the personal need for acceptance, love and security. Evidence supporting the 'theme' of disconnection is evident in the dermatology literature, which shows that skin disease impacts on patients' emotional, social, occupational and personal relationships creating insecurity and ample potential for rejection. Findings on the domains are thus unique as they have assisted in isolating and identifying the cognitive variables that may be implicated in the difficulties surrounding skin disease in adulthood.

Psoriasis and eczema patients also scored highly in the domain of 'other directedness', which involves a focus on meeting the needs of others at the expense of one's own (Young et al., 2003). EMSs in this domain occur later in development and are thus 'conditional', which suggests individuals may have learnt to 'compensate' for difficulties by suppressing needs and emotions to gain approval and love. EMSs in this domain could thus serve as coping styles that prevent activation of primary schemas in the domain of disconnection and rejection. The stigma of skin disease however, can jeopardize such coping

because even if an individual suppresses their needs to please others, altered appearance can still lead to discrimination and rejection. The findings on 'other directedness' are also new and unique as they provide insight into how EMSs and skin disease can impact on interpersonal relationships, an area that has received very little attention in the dermatology literature.

6.8.2 A common profile for psoriasis and eczema

It has been suggested that eczema patients, may be prone to developing a distinct personality pattern given the disease onsets in childhood, unlike psoriasis which onsets in adulthood (Buske-Kirschbaum et al., 2001; White et al., 1990). The second hypothesis thus predicted that psoriasis and eczema patients would be significantly different from each other on the schema domains. This hypothesis was not supported, as both dermatology samples were only significantly different from controls. This finding has not been previously reported in the literature, and is very interesting, as it suggests that the age of disease onset, is less relevant in distinguishing the psychological makeup of the two groups. If a distinction does exists, it might be that psoriasis and eczema patients are vulnerable by virtue of which core developmental needs are frustrated in childhood. This conceptualization is the first of a kind that can bring studies on adjustment in psoriasis and eczema closer together, by confirming that psoriasis and eczema patients are more alike on a cognitive level than previously thought. Furthermore, since both diseases are similar in their symptomatology and in the psychosocial consequences they engender, it makes sense that these patients would experience similar difficulties in adulthood. Current research in

psychodermatology has begun to support the notion that the profiles of these two patient groups may not be that different. Using standardized measures Buske-Kirschbaum et al. (2004) investigated personality factors and stress responses in patients with psoriasis and eczema. They found that both groups had significantly higher scores on trait anxiety, and susceptibility to stress vs. controls, in situations characterized by failure, uncertainty and social conflict. Both groups also scored significantly lower on positive self-concept. Eczema patients had a distinct personality profile, but this did not differ from that found in psoriasis. The authors thus concluded there was no 'eczema personality type' but rather a personality pattern linked to chronic inflammatory skin disease. The idea of a personality profile for chronic illness is supported by evidence that shows patients with autoimmune disease and cancer have an almost identical personality profile to that found in eczema and psoriasis (Anderson et al., 1985). The finding that dermatology patients' have EMSs in similar domains, is significant as it lends further support to this notion by suggesting that developmental deficits exert a powerful influence in the formation of self in these patients.

The fact that psoriasis patients were significantly different from controls in all the domains is another new finding and indicates that these patients experienced a wide spectrum of emotional or interpersonal difficulties throughout development. Psoriasis may thus trigger EMSs in these individuals creating distress that makes coping with the condition more difficult. Finally, in many studies an elevated level of anxiety is a noted characteristic of dermatology patients; this is also supported by the findings of this study as the control sample was evidently less distressed.

6.9 Family patterns and EMSs

The assumption embedded in the schema domains is that poor early parenting influences EMS formation, because insecure attachments breed anxiety in the child and this continually hampers development in childhood. Current studies on depression support this notion and show that EMSs and family relationships are causally related. Taylor and Ingram (1999) investigated the claim that children of depressed mothers are more at risk for developing psychological difficulties. They compared information processing in children and adolescent in-patients of depressed mothers (n=40) vs. controls (children of non-depressed mothers, n=46). Results showed that sub-optimal maternal care had a significant influence on development, as primed at-risk children had less positive self-schemas and a negative information processing style. A small sample limits generalization, but these findings show that a poor self concept and dysfunctional processing are core aspects in depression and that the quality of early parental relationships have a continuing influence on mental health.

In a larger sample of undergraduate students (*n* = 194) Harris and Curtin (2004) investigated whether retrospective parenting, EMSs and depression were related. Findings showed that four EMSs i.e. defectiveness, vulnerability to harm/illness, dependence and insufficient self-control, correlated with perceptions of parenting and depression; and EMSs partially mediated this relationship. Since psoriasis and eczema have been identified as risk factors for persistent episodes of depression, a similar mechanism of schema activation may thus operate where psychosocial consequences of the disease trigger EMSs. It is important to note

that the presence of EMSs alone, is not sufficient for the onset of depression, as schemas need to be activated by particular life difficulties. For example, a child might experience constant criticism from a hard disciplinarian father (you are weak, you didn't try hard enough, it's your fault). Their schema might be developing along the lines *"I'm inferior. I'm a weak person. My worth depends on what other people think of me".* Later in life their marriage breaks down, which activates the schema (*It's my fault. I can't handle things; no one wants me*).

These studies raise the question of whether early developmental experiences lead to the altered views of self in patients who suffer with skin disease in adulthood. This cannot be assumed, since one position in the field is that emotional distress in dermatology patients could be a result of the disease, and not due to underlying personality factors. The impact of poor parenting as a significant contributor in EMSs formation however is supported by findings outside the realm of dermatology. For example, Page et al. (2006) examined parental perceptions of their infants and their own abilities as parents over one year, in a non-clinical sample of mothers (n=174). It was hypothesized parenting perceptions and life circumstances would predict interactive behaviour at home. Base-line assessments were conducted in hospital within 36-hours of delivery and follow up assessments at 6 and 12-months. Findings showed that perceptions of children themselves were predicted by parents' perceptions of their own parents, and by lifestyle stress. Only empathic responsiveness in parents predicted the quality of behavioural interactions at home. This supports the schema models view on the influence of early parenting and indicates that

parental care is just as much influenced by cognitions and attachment experiences parents themselves hold from the past. This provides a possible explanation as to why dermatology patients are similar to each other developmentally, as similar parenting experiences may have led to similar emotional difficulties and an increased susceptibility to stress in childhood.

6.10 Limitations

A criticism of this study is that it is not clear, if schemas in dermatology patients contribute to a pre-morbid personality profile that is of etiological significance or if the debilitating effects of chronic skin disease 'reactivate' pre-existing schemas that impact the disease and coping. This is a complex question that is debated in psychodermatology (Koo & Lebwohl, 2001; Picardi et al., 2003). While there is unlikely to be a simple answer to the role of schemas on health, the themes of 'disconnection and rejection' and 'other directedness' provide very valuable clues to the type of emotional and interpersonal issues that cause distress in patients. Disfigurement for example, could trigger distress related to early shame-based incidents associated with rejecting parents (Gilbert, 1998).

A further limitation is that 'early' and 'late' disease onset was not distinguished within each patient group. A broad distinction was evident as the mean age of onset was 16 (adolescence) in eczema and 27 (adulthood) in psoriasis. It may be that individuals whose psoriasis onset in childhood vs. adulthood and vice versa for eczema, are qualitatively different from patients with traditional periods of onset. A lack of stringent classification thus limits the generalization of findings. If

onset was controlled for, comparisons on schema domains could have yielded different results. For example, the literature shows adults whose skin disease manifests at an early age are more susceptible to carrying feelings of stigmatization and low self worth (Fortune et al., 1998a; Perrott, 2000). As such differences between psoriasis patients and eczema patients may have emerged. This limitation can be addressed in future research by matching participants on age of onset and other variables to minimize variance between groups. Since findings confirm the importance of unfulfilled core needs in childhood, investigating specific schemas in each group will be useful in discovering in what way psoriasis and eczema patients are similar or different from each other? The next chapter attempts to address this question.

CHAPTER 7 | YSQ-SF discriminates dermatology patients

Knowledge of factors that contribute to distress in skin disease is essential for supporting psychologists in providing improved care for patients at risk. In this study the discriminative ability of the YSQ-SF is examined in three sample groups, psoriasis, eczema and healthy controls to support such an endeavour. Findings on EMSs in psoriasis and eczema will be particularly useful in identifying how underlying meanings relating to core aspects of self can make some dermatology patients more vulnerable than others.

7.1 Schemas and coping in skin disease

The framework of the schema model provides a new way of conceptualising the emotional struggles patients face whilst coping with skin disease. Earlier findings on domains identified what core needs are not met, but not which schemas are pertinent to dermatology patients. Skin disturbance may activate a 'defectiveness' schema in one person and strengthen the idea of 'being flawed'; leading to social avoidance, but if an 'emotional inhibition' schema is triggered in another person, core difficulties may centre on fear of expressing feelings of 'anger' in close relationships. These differences in meaning express an important point namely, that a bias in information processing directs people to attend to particular experiences, more readily than others. The implication is that patients are not always aware that the emotional distress they attribute to skin disease

may in part be linked to schema processes that they themselves are perpetuating by virtue of how they cope. This view is explained in the schema model, which differentiates between EMSs and coping strategies. Young et al. (2003) writes...'the schema itself contains memories, emotions, bodily sensations and cognitions, but not an individual's behavioural response. Although most coping responses are behavioural, patients also cope through cognitive and emotive strategies. Whether the coping style is manifested through cognition, affect or behaviour it is not a part of the schema'.

The idea that coping responses are reactions to schema activation raises interesting questions on our understanding of adjustment in dermatology patients. Various forms of avoidance are commonly reported in the research literature. In a survey of psoriasis patients, Toms (1997) showed that patients deliberately avoided swimming and communal showers in the summer, few wore short sleeves, shorts or skirts as they feared ridicule, and many felt that people saw them as 'contagious'. Emotional avoidance is evident in patients who minimize their skin disease by contrasting it to more 'serious' medical conditions, like cancer. Studies on body image also show that patient difficulties are mediated by fear so that activities associated with disfigured parts of the body are avoided because they generate anxiety-provoking thoughts and feelings (Newell, 1991). In exploring cognitions in psoriasis patients Richards et al., (2001) found that perceived stigma increased levels of disability and distress. While these various findings describe strategies individuals use to cope with skin disease, it is not clear on a theoretical level what mechanisms drive such forms of coping.

7.2 Evidence for the role of schemas

The application of cognitive behavioural therapy (CBT) in psychodermatology has provided some answers, by showing that a bias in information processing is evident in many distressed patients. The model has proved efficacious in helping dermatology patients' address coping difficulties, primarily through challenging distortions in thinking and altering dysfunctional behaviours. While results from clinical trials comparing the effectiveness of different types of therapies (e.g. person centred vs. CBT in vitiligo patients) are promising (Papadopoulos et al., 1999) they are also somewhat limited as there is little longitudinal research to support the long term maintenance, of coping skills learnt in therapy. Furthermore, some of the available evidence is contradictory.

Fortune et al., (2004) investigated the usefulness of a CBT management program aimed at addressing psoriasis patients' coping strategies and perceptions of their condition i.e. helping patients manage misinterpretations and unhealthy beliefs about the disease and its effects. Whilst the intervention did not set out explicitly to change coping, Leventhal's model predicts that illness perceptions influence the use and selection of coping strategies. Changes in patients coping were thus expected to flow from changes in perceptions of psoriasis. Results showed however that coping strategies were not altered at 6-month follow-up. This finding does not support the self-regulation model, but does provide preliminary support for the role of schema processes. Since EMSs prevent individuals from undergoing corrective experiences, it can be argued that coping responses are

unlikely to alter after CBT treatment as EMSs drive coping styles and in doing so, sustain chronic difficulties.

7.3 Aims and hypotheses

In order to explore whether EMSs influence psychological processing in dermatology patients, this study aims to determine if psoriasis and eczema patients can be differentiated on a schema level. In chapter 6 findings showed that the domain of 'disconnection and rejection' and 'other directedness' were key themes to understanding developmental difficulties in the early environment of these individuals. While this made evident that core emotional needs for 'acceptance' and 'autonomy' were not satisfactorily met in these patients, it is not evident on a cognitive level, how similar or different these patients are from each other in relation to controls. The notion that psoriasis and eczema patients may have a personality profile that is characteristic of individuals with chronic illness, suggests that psoriasis and eczema patients may share traits that increase their vulnerability to emotional distress in adulthood. Building on results from the schema domains, it is thus hypothesised that dermatology patients will be significantly different from controls by endorsing more EMSs on the YSQ-SF.

7.4 Method

7.4.1 Participants

Three groups participated in the study. The clinical groups of psoriasis (n=78) and eczema patients (n=67) were diagnosed by a dermatologist and recruited

from the out-patient unit in Syngrou Hospital. The mean age for psoriasis patients was 40 (SD=14.93), and for eczema 37 (SD 12.63). The mean age of onset for eczema patients was 16 (SD 12.43) and for psoriasis 27 (SD 14.23). The control group was recruited from the local community (n=70) and consisted of healthy volunteers, mean age 33 (SD 9.49). All groups completed a demographic questionnaire to exclude factors that could influence schema functioning.

7.4.2 Procedure

Questionnaires were distributed to consecutive psoriasis and eczema out-patients at the dermatology unit. An independent professional explained, the study was anonymous and would not affect treatment. Participants signed a consent form and filled in the measure which took 20 minutes to complete. Control subjects were given a similar explanation and told their responses would be used for comparison purposes.

7.4.3 Statistical analysis

Participants completed the YSQ-SF a 75-item self report measure (Young, 1998) that consists of 15 EMSs subscales. To identify psoriasis, eczema and controls differed across the subscales of the YSQ-SF multivariate ANOVAs were conducted for comparison purposes. Mulitivariate ANOVAs were deemed appropriate for this study as the technique allows for the assessment of group differences across multiple metric dependent variables (Denscombe, 1998). A significant F-ratio is used to infer differences between group means on the dependent variable; in this case between group membership and EMSs. Post-

hoc Tukey tests calculate a new critical value that can be used to evaluate if differences between any two pairs of means are significant. The critical value in a Tukey test thus involves the mean difference, which must be exceeded to achieve a significant result. This is useful as it indicates which groups are significantly different from each other, on each schema. The current analysis has three advantages: firstly by measuring several dependent variables in a single experiment, there is a better chance of understanding the way they interact and their relevant importance. Secondly, multivariate ANOVAs protect against Type I errors that might occur if multiple ANOVA's were conducted independently; and thirdly, sometimes this method can reveal differences that are not discovered by independent tests (Denscombe, 1998).

7.5 Results

Table 7 shows results obtained on the YSQ-SF. Based on means and standard deviations the three groups differed across schema subscales. As expected, dermatology patients had higher means and less healthy scores vs. controls. Multivariate ANOVAs identified significant patterns of difference on 8 out of 15 subscales ($p<.05$). Post-hoc Tukey tests revealed further significant differences on EMSs and group membership. Firstly, in contrasting the clinical groups vs. controls 3 schemas, 'emotional deprivation', 'mistrust/abuse' and 'self sacrifice' emerged as significant for both psoriasis and eczema. Secondly, in psoriasis significant differences were observed on four further schemas, 'defectiveness', 'social isolation' 'emotional inhibition' and 'vulnerability to harm'. Eczema patients were only significantly different from controls, on the subscale of 'abandonment'.

YSQ SCALES	PSORIASIS N=78 M	(SD)	ECZEMA N=67 M	(SD)	CONTROL N=70 M	(SD)	TOTAL M	(SD)	ANOVA F	p	Post hoc Tukey	
Emotional deprivation	11.26	(6.10)	10.81	(6.32)	8.30	(4.33)	10.15	(5.78)	5.68*	0.00	P vs. E P vs. C E vs. C	td = 0.45, p= 0.88 td = 2.96, p= 0.00* td = 2.51, p= 0.03*
Abandonment	10.46	(5.66)	11.13	(10.2)	8.11	(3.46)	9.91	(7.01)	3.65*	0.03	P vs. E P vs. C E vs. C	td = 0.67, p= 0.83 td = 2.35 , p= 0.10 td = 3.02, p=0.03*
Mistrust/abuse	12.28	(5.19)	11.87	(5.73)	9.61	(4.15)	11.28	(5.17)	5.76*	0.00	P vs. E P vs. C E vs. C	td = 0.42, p= 0.87 td = 2.67, p= 0.00* td = 2.25, p= 0.03*
Social Isolation	10.09	(5.73)	9.73	(5.75)	7.76	(3.20)	9.22	(5.14)	4.43*	0.01	P vs. E P vs. C E vs. C	td = 0.36, p= 0.91 td = 2.33, p= 0.01* td = 1.97, p= 0.60
Defectiveness	8.40	(5.28)	7.94	(4.35)	6.56	(2.91)	7.66	(4.38)	3.54*	0.03	P vs. E P vs. C E vs. C	td = 0.45, p= 0.80 td = 1.84, p= 0.03* td = 1.38, p= 0.15
Failure	9.14	(4.76)	8.76	(4.73)	7.40	(3.79)	8.46	(4.50)	3.04*	0.05		
Dependence/ incompetence	8.49	(4.88)	8.01	(4.19)	7.40	(4.08)	7.99	(4.42)	1.12	0.32		
Vulnerability to harm/ illness	10.47	(5.90)	9.51	(5.61)	7.67	(3.59)	9.26	(5.27)	5.56*	0.00	P vs. E P vs. C E vs. C	td = 0.97, p= 0.50 td = 2.80, p= 0.00* td = 1.84, p= 0.10
Enmeshment	9.90	(5.79)	8.63	(3.89)	8.24	(4.24)	8.96	(4.80)	2.46	0.09		
Subjugation	9.68	(5.52)	10.79	(9.67)	8.18	(4.28)	9.54	(6.84)	2.54	0.08		
Self-sacrifice	17.32	(7.06)	16.24	(6.64)	13.26	(5.42)	15.66	(6.63)	7.76*	0.00	P vs. E P vs. C E vs. C	td = 1.08, p= 0.57 td = 4.06, p= 0.00* td = 2.98, p= 0.02*
Emotional Inhibition	12.67	(6.19)	10.64	(5.54)	9.00	(6.03)	10.84	(6.10)	7.08*	0.00	P vs. E P vs. C E vs. C	td = 2.02, p= 0.10 td = 3.67, p= 0.00* td = 1.64, p= 0.24
Unrelenting Standards	18.17	(7.40)	17.15	(6.41)	16.06	(6.72)	17.16	(6.91)	1.73	0.18		
Entitlement	14.60	(6.10)	12.39	(5.96)	12.46	(5.23)	13.21	(5.85)	3.53*	0.03	P vs. E P vs. C E vs. C	td = 2.21, p= 0.05 td = 2.14, p= 0.06 td = 0.06 , p= 0.99
Insufficient Self-control	12.37	(5.81)	11.00	(4.54)	10.29	(5.31)	11.27	(5.33)	3.01	0.05		

Table 8: Means, standard deviations, multivariate ANOVAs and Tukey scores on EMSs in psoriasis, eczema and controls ($p<0.05$)

On the remaining 7 schemas, 'entitlement', 'impulse control' and 'failure' narrowly missed statistical significance at the .05 level. No group differences were observed on 'unrelenting standards', 'dependence/incompetence', 'enmeshment' and 'subjugation'. The latter 3 schemas suggest a cultural trend of over-involved family ties, which is deemed normal in Greek culture. 'Unrelenting standards' had the highest mean score across groups, which suggest Greeks may hold strong beliefs on perfectionism. Overall, it was of interest that psoriasis patients had a broader range of EMSs vs. eczema patients; and more significantly that the majority of EMSs in dermatology patients fell in the domain of disconnection and rejection. These results support the hypothesis that psoriasis and eczema patients endorse more EMSs on the YSQ-SF vs. healthy controls. Seeing as the schema domains are hierarchically structured in line with child development, the EMSs pertinent to each patient group will be discussed in the same order.

7.6 Discussion

7.6.1 EMSs in 'Disconnection and Rejection'

Early infancy and childhood play a significant role in the formation of EMSs in patients with psoriasis and eczema. Despite the different periods of disease onset - on an emotional level, these adults share a similar experience of 'disapproval', and sense of 'emotional separation from others'. Early rejection is thus a key developmental issue, as all the EMSs in this domain were relevant, two of which were pertinent to both groups. How schemas in this domain may influence the meanings surrounding psoriasis and eczema will be explored.

'Mistrust/abuse' and 'emotional deprivation' were common to both psoriasis and eczema patients. Coping with skin disease in a society where beauty is revered, can activate a schema like 'mistrust abuse' by confirming in patients that in comparison to others who have healthy skin, 'they got the short end of the stick,' and were 'cheated' of a normal life. 'Emotional deprivation' in patients with skin disease creates feelings of being alone or empty and reinforces negative predictions like, there will no one there who will provide understanding, physical affection or guidance in times of need. 'Abandonment' was only relevant in patients with eczema. Emotions linked to this schema include chronic anxiety and depression over perceived/actual loss and anger at people who have left. The EMS can be activated when patients use their disease to avoid relationships, to protect themselves from experiencing what they anticipate as inevitable loss. The schema thus fuels perceptions of unreliability on those available for connection.

'Defectiveness' and 'social isolation' were significant for psoriasis patients. 'Defectiveness' makes individuals feel inferior and perpetuates the belief that they would be unlovable - if defective parts of their self were exposed. Shame is more about whom the person is 'their being', rather than what the person does. Since psoriasis onsets later, it is unlikely the illness contributed to schema formation, but in adulthood, the disease may come to symbolise a defect that must be hidden. Psoriasis in this instance reactivates a latent schema, wherein the child's inherent sense of worth was damaged. As mentioned earlier 'social isolation' refers to individuals who feel likes outsiders to most groups. Stigma and physical limitations of psoriasis can strengthen feelings of exclusion and

alienation from others. If a patient happens to have both a 'defectiveness' and 'social isolation' schema, then the one may reinforce the other.

DOMAIN	EARLY MALADAPTIVE SCHEMAS	CLINICAL GROUP
Disconnection and Rejection	• Abandonment/instability	Eczema
	• Mistrust/abuse	Eczema and psoriasis
	• Emotional deprivation	Eczema and psoriasis
	• Defectiveness/shame	Psoriasis
	• Social isolation/alienation	Psoriasis
Impaired Autonomy	• Dependence/incompetence	N/A
	• Vulnerability to harm or illness	Psoriasis
	• Enmeshment undeveloped self	N/A
	• Failure	N/A
Impaired Limits	• Entitlement/grandiosity	N/A
	• Insufficient self-control/discipline	Psoriasis
Other Directedness	• Subjugation	N/A
	• Self-sacrifice	Eczema and psoriasis
Overvigilance	• Emotional Inhibition	Psoriasis
	• Unrelenting standards	N/A

Table 9: Domains and significant EMSs in psoriasis and eczema

7.6.2 EMSs in 'Impaired Autonomy'

'Vulnerability to harm/illness' was significant in psoriasis patients and refers to a conviction that one is living perpetually in harm's way. This cognitive pattern embodies the exaggerated expectation that regardless of how things are now, everything will eventually deteriorate. Fears become catastrophes based on an assessment of how dangerous the world is and how weak or unprotected the person feels (Hackman, 1998). The schema is evident in patients whose perception of psoriasis compromises their self-worth, health and quality of life. Fortune et al. (1998a) explored patient's beliefs on psoriasis using the Illness Perception Questionnaire. Findings support this schema as 69% strongly agreed psoriasis had a major consequence on their life, 53% felt psoriasis strongly effected how they saw themselves as a person, and women were more likely to believe psoriasis had a severe impact on their lives despite having clinically less severe psoriasis. Such beliefs produce high anxiety and since psoriasis is exacerbated by emotional stress the schema becomes a self-fulfilling prophecy.

7.6.3 EMSs in 'Impaired Limits'

In impaired limits, the schema of 'insufficient self-control' entails difficulties in self-discipline, restraining emotions and impulses. Difficulty in tolerating frustration means that avoiding discomfort, is characteristic of this schema. Psoriasis can evoke frustration and anger by having to adhere to treatment regiments or by having to bear the discomfort of flaking skin. The schema may thus be activated by physical or emotional consequences of the disease. Fried (1995) investigated psychosocial impairment in psoriasis and reported that anxiety, depression and

anger was evident during flares and remissions. This suggests psoriasis patients may experience similar frustrations in other life area that require tolerance.

7.6.4 EMSs in 'Other Directedness'

In this domain, 'self-sacrifice' was significant in eczema and psoriasis patients and involves the tendency to put others needs above ones own in order to maintain connection. Research on interpersonal adjustment attests to this theme, as dermatology patients harbour fears that their altered appearance will lead to rejection from partners' and many avoid emotional or physical intimacy for this reason (Anthis, 2004; Kent & Thompson, 2002). Emotions of fear and anxiety can fuel 'self-sacrifice' behaviour in relationships, because the schema operates to perpetuate behaviours that prevent rejection from occurring.

7.6.5 EMSs in 'Overvigilance and Inhibition'

Finally, the schema of 'emotional inhibition' was significant in psoriasis and relates to an inability to express emotions. In this schema, self-control is valued over intimacy because individuals' fear, if they express difficulties related to psoriasis they will be overcome with shame. Self-disclosure is thus avoided. The significance of this schema is evident in the literature, as it is akin to the concept of alexithymia, which is characterized by reduced symbolic thinking, poor fantasy life and a limited ability to identify and verbally express emotions. These characteristics are believed to be common among patients affected by diseases with a substantial psychosomatic component (Taylor, 1984; Sifneos. 1996). Using the Spielberger Anger Expression Scale and other psychosocial measures Gupta

et al., (1996) studied patients with early onset psoriasis and found these patients exhibited greater psychopathology than late onset patients, and where more prone to suppressing and internalising anger. The authors suggested personality traits linked to ineffective anger resolution, rendered patients vulnerable to stress. Further evidence for 'emotional inhibition' is provided by Picardi et al. (2005) who investigated the role of stressful events, perceived social support, attachment security and alexithymia in triggering exacerbations in psoriasis. In-patients were compared with patients that had skin diseases with a negligible psychosomatic component. Findings showed psoriasis patients had lower social support and higher attachment-related avoidance. The rate of alexithymia in psoriasis was more than twofold vs. comparisons. Although caution must be applied in generalizing findings to out-patients, the authors suggest alexithymia, attachment avoidance and poor social support increases psoriasis exacerbations through impaired emotional regulation. Physiological mechanisms of the immune system were seen to mediate the interplay between stress, personality and psoriasis.

Having explored the significant schemas in each domain, it is evident that EMSs provide a more in-depth perspective of the emotional difficulties that patients with eczema and psoriasis struggle with. In doing so, the schema construct can account for areas of similarity, in relation to developmental needs and individual differences in adjustment. A common trigger that is likely to activate schemas in both patient groups is body image disturbance and how this is processed in relation to self , others and societal norms. The age of disease onset and how socio-cultural factors influence perceptions of self, will be briefly discussed.

7.7 Disease onset and socio-cultural factors

In this study, the mean age of onset in eczema was 16 and over 60% of the sample was female. Adolescence is a critical period for schema formation and social pressure for women to look good from this age onward is noted for creating psychological distress in skin disease (Barankin & DeKoven, 2002). Given that female body dissatisfaction is common in the Western world (Cohn & Adler, 1992) norms over what aspects of self get approval, may activate EMSs in patients with psoriasis and eczema. Evidence for socio-cultural influences on appearance comes from data that shows, in Greece 1 in 5 adolescent girls are at risk for exhibiting disordered attitudes toward body image and food (Ruggiero, 2003). This rise in body image disturbance, has occurred as social demands in Greek culture have changed in recent years, so that excellence in 'body shape and fitness' have replaced old values of moral integrity (Ruggiero, 2003).

As such if parents pressure a child to fit a mould of appearance, having psoriasis or eczema will endanger this goal. Arguably, families in the control group are exposed to the same cultural pressures, but rearing practices in such families', more than likely focus on the needs of the child than those of the parents. The role of the media as an 'external force' is also significant since it supports the notion of 'what is beautiful is good'. In psoriasis the mean age of onset was 27 and over half the sample was male. Skin disease may activate schemas in these individuals, by jeopardising existing sources of social approval and acceptance. Psoriasis may also stigmatise the stereotypical male identity and body image by revealing a physical weakness that is not evident in healthy men.

7.8 Limitations

While this study has illuminated the types of EMSs pertinent to dermatology patients, there is no evidence that the EMSs identified, are active. The inclusion of measures that identify emotional distress in medical populations, like the Center for Epidemiologic Studies-Depression Scale (CES-D) (Radloff, 1977) or the Hospital Anxiety Depression Scale (HADS) (Zigmond & Snaith, 1983) would provide evidence of schema related distress. Furthermore, while dermatology patients had more EMSs than controls on the YSQ-SF, whether this is still the case when they are not distressed is not clear. Comparing levels of dysfunctional schemas during and after episodes of depression or anxiety would provide better insight into how EMSs, create emotional vulnerability (Stopa & Waters, 2005).

Finally, the YSQ-SF describes the content of beliefs regarding self and close relationships. There is little research that simultaneously explores the relationship between the content and process of schema functioning. As such, results can only be used to make informed speculations on how dermatology patients cope with EMSs. Research that has used the COPE (Carver et al, 1989) to identify coping strategies related to depression and self-reported disability in psoriasis, show a weak association between coping and psychological difficulties experienced by patients (Fortune et al., 2002). This may be due to the fact that findings are interpreted in relation to disability, and not in relation to schema content. Young's coping inventories that address schema compensation and schema avoidance could be applied in future research but these still need to be validated.

7.9 Summary

In this study EMSs in psoriasis and eczema were discussed. The YSQ-SF differentiated dermatology patients from controls by showing psoriasis patients exhibited a wider range of schemas than eczema patients; and both groups shared EMSs in the domains of 'disconnection and rejection' and 'other directedness'. The identification of schemas as relevant to dermatology patients indicates that early developmental experiences impact psychological functioning in adulthood and this may also increase susceptibility to skin disease. Literature on attachment shows that family environments that instil a negative view of self in children lead to a spectrum of cognitive vulnerabilities, dysfunctional coping, poor emotional regulation and low competence in various life areas (Wickrama et al., 1997; Richter et al., 1990). Given the significance of the family system and environment in schema formation, investigating the nature of early parental bonding in dermatology patients will be the focus of the next three chapters.

Chapter 8 | Parent-child attachments and skin disease

Early attachments are critical in determining psychological health in childhood. These bonds are predictive as it is thought they establish internal working models that set the stage for future relationships. Children develop a secure sense of self and social competency by virtue of the success or failure they experience when relating to parents and others. This chapter explores factors surrounding secure and insecure attachments and proposes that exploring parental bonding in dermatology patients is vital to understanding EMSs formation.

8.1 Secure and insecure attachments

'Attachment' refers to the enduring affectional bond that develops between an infant and caregiver. The role of the attachment figure in early life is to provide a 'safe and secure base' from which the child can master the environment (Bowlby, 1977; Ainsworth, 1978). Through this bond the child gradually develops an internal model of self and others. What constitutes 'good enough parenting' however depends on the quality of relationship that transpires between child and caregiver. Parental sensitivity and appropriate reactions to a child's needs, will essentially determine if after 12 to18 months, a secure or insecure attachment develops (Lamb, 2002). Research studies on attachment show children who have responsive parenting and are securely attached in infancy, approach problem-solving tasks positively and with more persistence than insecurely

attached children. They report less physical and psychological symptoms; are empathic, and socially competent in relationships with peers and adults. Conversely, if parents respond to a child's needs with rejection and are neither helpful, nor available then insecure attachments arise (Egle et al., 1997). Children subsequently learn to keep-to-themselves and develop patterns of avoidance or aggression. Difficulties in social competence are evident as these children have trouble relating to others, their behaviour is mistrustful, hostile and distant, or overly dependent (Sroufe & Rutter, 1984; DuBois & Felner, 1996). The quality of early attachments is thus significant, as prospective longitudinal studies consistently show that insecure bonds influence later relationships and this has been included in the list of risk-factors for adult psychopathology (Dozier & Lee, 1999). More specifically, insecure bonding has been linked to Axis I and Axis II disorders (Bienvenu, 2001), like depression (Coyne et al, 1998), loneliness (Hazan & Shaver, 1987), low self-esteem (Brennan & Morris, 1997) and personality disorders (Randolf & Dykman, 1998).

8.2 Attachment and skin disease

Psychodermatology recognises that early life experiences have important consequences, given the emotional significance of the skin as a medium of communication between mother and child. Through the mother's contact with the infant's skin, her stroking and tenderness, the infant gradually identifies its boundaries, defines itself and separates from the mother-child dyad of pregnancy. Physical contact is also a primary medium whereby parental attitudes are communicated to the child, whether these are attitudes of love and

acceptance, or rejection and hate (Koblenzer, 1997). Such 'non-verbal dialogue' has been linked to the formation of cognitive 'structures' like body image and self-esteem, which are pertinent in skin disease.

8.3 Psychotoxic diseases of childhood

The role of the family has been widely studied in eczema as the nature of the condition, not only provides an ideal model to explore psychological influences in skin disease, but it elucidates how early bonds impact childhood development. In observing institutionalised mothers and infants in the first year of life, Spitz's (1965) seminal study on the effect of maternal deprivation on infants showed that symptoms of ill-health developed in new-borns when the emotional climate in the mother-child bond was less than good. These he termed 'psychotoxic diseases of childhood'. Infantile eczema was determined by the 'quality of mothering' infants received, whereas infantile depression was induced by the 'quantity' i.e. mother was mostly absent. In this sample 15% of infants developed eczema as opposed to 2-3% in the general population. Spitz stated an inherent predisposition i.e. atopic diathesis, and maternal attachment that did not meet the child's needs, disposed infants to developing eczema. These infants exhibited greater cutaneous excitability vs. controls, displayed difficulties in impulse control, aggression and were socially less well adjusted. Mothers also differed from controls. Their personality was anxious and masked with hostility towards their infants. Notably, they did not like to care for their infants and deprived them of contact. Considering these findings now, it could be that attachment difficulties arose not because mothers were hostile, but because they were depressed. This

is supported by data that shows infant massage improves attachment in mothers with post-natal depression (Onozawa et al., 2001). While Spitz's work provoked thought, it was criticised for ignoring cultural factors in attachment and for not taking socio-economic factors into account. Observations were also of a specific population, thus findings cannot be generalised.

8.4 Parental strain in infantile eczema

Infants with eczema are often irritable, exhibit persistent crying and sleep disturbance, due to discomfort caused by itch-scratch cycle (Pauli-Pott et al., 1999). The child's constant pre-occupation with its skin can stress the family, and create strain, resentment or withdrawal in parents who are trying to cope (Van Moffaert, 1992; Pauli-Pott et al, 1999). Parental bonding may be disrupted if for example, the child senses a mother's aversion when ointments are administered. Some parents reject their troublesome child to shield themselves from feelings of helplessness evoked by demands of the disease (Papadopoulos & Walker, 2003). In these cases, when a parent is not nurturing or responsive, the child will feel 'abandoned' at a time when it desperately needs to be soothed (Howlett, 1999; Park, et al. 2004). Other parents become very anxious, and overprotect their child whilst disregarding the needs of other siblings (Solomon & Gargnon, 1987). 'Protectiveness' may be internalised by the affected child as vital for its emotional survival, which then fosters dependency. Such dynamics negatively influence the mother-child bond, and create obstacles in the development of a secure attachment. Moreover, attachment difficulties may have a negative affect on the progress of eczema (Blomquist & Sakki, 1991; Pauli-Pott et al., 2003). A

parent's 'perceived' severity of their child's eczema has been found to determine the impact it has on the parent (Balkrishnan et al., 2003). Pauli-Pott (1999) explored maternal perceptions of eczema, and found, mothers who perceived their infants as '*clearly affected by the disease,'* saw themselves as depressive and hopeless; mothers' whose infants had '*severe eczema'* saw themselves as more anxious and overprotective (vs. controls). Mothers whose infants had '*less severe'* eczema did not differ from controls. This suggests that if negative interactions between parent and child get locked in a dysfunctional relationship - stress in the family will rise, and this can exacerbate symptoms in a psychosomatic cycle involving the child, the family and disease (Howelett, 1999).

In exploring family structures in eczema, Gil et al. (1987) found that *less severe* symptoms in the child were linked to an independent, organised family structure; and *severe symptoms* to a high religious/moral orientation. It was hypothesised that parenting behaviour in organised families may promote autonomy by supporting a child, to be in charge of treatment. In religious families, an emphasis on protection (e.g. controlling symptoms or moral behaviour) could increase stress and exacerbate eczema. Gil et al. did not consider the role of parental bonding styles in their study, but confirmed that levels of care and protection expressed by parents can influence illness symptomatology in the child. The above research confirms that attachment dynamics are influenced by the characteristics of the child, the characteristics of the parent and that the stress of illness also imposes on this relationship. The consequences of early childhood will inevitably shape a child's cognitive and emotional development.

8.5 A conceptual bridge to schema formation

Even though attachment research confirms that early bonds sow the seeds for later relationships, the theory itself does not provide a complete model of psychopathology. Many authors' suggest however that attachment styles may function as a conceptual bridge linking early relational experiences with schema development (Platts et al., 2002; Manson et al., 2005). This has been explored by Safran (1990) through the notion of 'interpersonal schemas'. These are defined as 'general representations of self other' and are moulded by interactions in the parent and child relationship. Since self-other relationships are a core part of daily life, the quality of interpersonal functioning may be shaped by psychological problems related to EMSs. A study that compared interpersonal schemas of women who were abused in childhood vs. women who were abused and re-victimised in adulthood, found the latter group had more interpersonal problems due to the attachment style they fostered in relationships (Graves, 2004).

Applying this observation to psychodermatology it could be that patients with eczema or psoriasis who have a poor concept of self and an insecure attachment style, may continue to seek unsupportive environments and relationships in adulthood thus creating stress that impacts their physical and psychological health. To explore this notion further it is necessary to establish the nature of insecure attachments patients' with skin disease experience. The findings in chapters 6 and 7 showed EMSs are pertinent in understanding the cognitive profile of dermatology patients. Studying the association between skin disease, parenting and EMSs is the next logical step in understanding the way in which,

attachment styles contribute to EMS formation. Thus far there are no studies in the psychodermatology literature that have attempted to address this question. To explore this further, Parker et al.'s (1979) widely published Parental Bonding Instrument will thus be used. The instrument was translated and back translated into Greek and its reliability is investigated in the next chapter

Chapter 9 | Reliability of the Greek Parental Bonding Instrument

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This study sought to establish the reliability of the Greek Parental Bonding Instrument (PBI). As such two hundred and fifteen questionnaires were analysed in patients with eczema, psoriasis and healthy controls. The internal consistency of items for mother and father figures was conducted on the scales of 'care' and 'overprotection'. This was aimed at determining if the PBI is a useful tool in assessing cognitive representations of recalled parenting in a Greek population.

9.1 Parental bonding instrument

The Parental Bonding Instrument (PBI) identifies parenting behaviours on two dimensions (Parker et al., 1979, Appendix 5). The 'care' subscale assesses emotional warmth and responsiveness (vs. indifference and neglect) and the 'protection' subscale assesses intrusive parental control (vs. support of autonomy). These dimensions can also be understood as extensions of the secure base behaviour of the infant/toddler. Children continue to seek 'care' from their parent when they have been overwhelmed in their exploration of the world. Overprotection on the other hand hampers their ability to explore, learn, and develop their own identities. Parker et al.'s (1979) scales are bipolar, with items that load both negatively and positively. PBI responses rely on recollections of early parenting up to the age of 16, and the validity of the measure is supported by studies that show subject ratings correlate strongly with ratings of parents, siblings and impartial raters (Steiger et al., 1989; Parker et al., 1979). Age, sex

and class have been found to have a minimal effect on scores (Parker, 1983). By administering the PBI to depressed patients and repeating it during remission, 'care' and 'protection' scores have proven stable over time and independent of mood effects (Parker, 1983; Gotlib et al., 1988). Parker (1986) also found a close relationship on the PBI for monozygotic and dizygotic twins, which suggests little variation on the scales can be attributed to genetics.

The majority of research on the PBI has looked for connections between recalled parenting and psychological difficulties, especially depression and to a lesser extent anxiety (Wilborg & Dahl, 1997). Results have been overwhelmingly positive, and show in both clinical and community samples, 'low care and high overprotection', is correlated with psychological symptoms. Thirty-five studies to date have examined the connection between depression and PBI variables (e.g. Shah & Waller, 2000; Enns, et al, 2000; Parker et al, 1997). The majority of these (25) have compared depressed individuals to non-psychiatric controls. All studies show at least some connection between 'care', 'overprotection' and depression. In exploring the strength of the connection between PBI and depression, 'care' has emerged as the strongest predictor, for both or either parent. A plethora of investigations have also shown the PBI has adequate reliability and validity; good internal consistency, and satisfactory re-test reliability (Gerlsman et al., 1990).

The findings from the studies presented thus far on schema domains and EMSs have spurred a need to investigate the nature of early parenting difficulties in this group of patients. This sample of dermatology patients used in this study is

different to those mentioned in the literature by virtue of the fact that they are Greek and suffer with specific skin diseases of psoriasis and eczema. Identifying perceptions of 'care' and 'overprotection' experienced by these patients within the Greek cultural context, will be useful as it will indicate whether 1) EMSs formation is in fact linked to early maternal and paternal bonding experiences, 2) whether the presence of skin disease is significant, and 3) whether the cultural context plays a role in influencing parental behaviours in early development. To begin addressing these issues, and to gain a greater understanding of the relationship between EMSs, parental bonding and skin disease this study aims to first examine the psychometric properties of the PBI. The original version was translated by the author and back translated by independent translators. Confirming reliability of the Greek PBI, also allows for its administration in a different cultural setting.

9.2 Method

9.2.1 Participants

Questionnaires were distributed to out-patients attending the dermatology department of Syngrou Hospital. Participants in the clinical samples comprised of male and female respondents over the age of 18 years that had been formally diagnosed as having psoriasis or eczema. In this sample there were about an equal number of patients with eczema (n=67) and psoriasis (n=78). The mean age for psoriasis patients was 40 (SD 14.93) and 37 for eczema (SD 12.63).

Participants in the healthy control sample (n=70) had a mean age of 33 (SD 9.49) and were recruited from a wide range of local residents in the community.

9.2.2 Procedure

Questionnaires were distributed to consecutive psoriasis and eczema out-patients. Participants were approached by an independent medical professional who informed them on the nature of the study, that it was anonymous and would not affect treatment. Participants signed a consent form and in a designated room filled in the questionnaire. This took approximately 20 minutes to complete. In the control group participants were given a similar explanation but were informed that their responses would be used for comparison purposes.

9.2.3 Instrument

The PBI is a 25-item self-rating questionnaire that measures how adults remember their parents (mother and father separately) during their first 16 years (Parker et al., 1979). Two subscales measure parenting styles as perceived by the child. The 'care' scale (12 items), measures warmth, empathy and emotional support and the 'protection' scale measures overprotection, intrusiveness and control. 'Care' items include statements like 'was affectionate to me' and 'protection' items, statements such as 'tended to baby me'. Respondents rate each parent on a four-point Likert scale where '3'= very like; '2' = moderately like; '1'= moderately unlike and '0'= very unlike. From the two subscales, four parental bonding styles are identified: 'optimal bonding', 'weak bonding', 'affectionate constraint' and 'affectionless control'.

9.3 Reliability analysis

Cronbach's alpha is a coefficient of internal consistency and shows how well a set of items measure a one-dimensional latent construct. This study sought to investigate if PBI items reliably measured 'care' and 'protection' attachment styles for maternal and paternal figures in a Greek population. When inter-item correlations emerge as high, items are said to measure the same underlying construct and reliability is considered adequate. If items are multidimensional, alpha scores will be low indicating that items are not correlated to each other within a dimension. Cronbach's alpha ranges between 0 and 1, and the closer the coefficient is to 1.0 the greater the internal consistency (Gliem & Gliem, 2003

9.4 Results

Data was analysed using SPSS 12.0 for Windows. To determine the internal consistency of the Greek PBI a reliability analysis was conducted on the parental bonding subscales. Cronbach's alpha was calculated separately for each parent on the 'care' and 'protection' scales. A cut-off criterion of 0.7 was used for alpha scores as Nunnally (1978) posits this represents an acceptable level of internal consistency; alpha scores of 0.8 are considered good, but if scores are lower than 0.6 then the reliability of the measure is questionable. The analysis showed that in the Greek PBI, the subscales of 'care' and 'overprotection' for both parents reached alpha levels of above 0.7 as specified. These are illustrated in Table 9.

Parental Bonding Subscales	Parent	Cronbach's alpha
Care Scale	mother	0.84
	father	0.84
Protection Scale	mother	0.74
	father	0.74

Table 10: Cronbach's alphas (α) for parental bonding scales of care & protection

Alpha values for the two bonding subscales were encouraging, and in this sample were particularly high in the 'care' scale for mothers and fathers. Parental bonding scores were also similar, with coefficients of congruence on the 'care' and 'protection' scales for each parent respectively.

9.5 Discussion

In this study a cohort of dermatology patients and healthy controls rated 25 attitudinal and behavioural items in accordance to how they remembered both parents during their first 16 years. In the original paper the split-half reliability for the 'care' scale was 0.88 and 0.74 for 'protection' in a non-clinical sample (Parker, 1983). In this study, alpha scores for mother and father on both scales were also high indicating good internal consistency in the Greek version. Arrindell et al. (1989) translated the PBI into Dutch, and also investigated its relevance in non-English speaking groups. Alpha coefficients across samples (two student samples, a community sample and a group of phobic out-patients) ranged from

0.89 to 0.91 for 'care', and 0.83 to 0.88 for 'protection' suggesting marked homogeneity for the care scale. Greek alpha scores were 0.84 and 0.74 respectively, which also demonstrates greater homogeneity for the 'care' scale.

It is advocated that the PBI is best understood through the interaction of both subscales. Examining either scale independently could lead to erroneous conclusions about quality and parenting style. For example, while common sense suggests that having a high 'care' scores is beneficial, the degree of benefit depends on the protection scores. If high care is coupled with high protection, then 'affectionate constraint' style of parenting results. A child will thus feel smothered by a parent who reportedly, loves them so much that they are not allowed to do anything for themselves (Ainsworth et al., 1978). Waller et al. (2001) reports that attachments of 'affectionless control' (low care, high protection) are typical of patients with eating disorders. Attachment that involves 'high care and low protection' results in optimal parenting. Social competence in children is said to be fostered by an authoritative parenting style which is akin to 'optimal bonding' (Baumrind, 1978). This involves promoting independence by rationally directing a child's activities, exerting firm control when needed and not hemming the child in with restrictions.

9.6 Limitations

A limitation of this study is that subjects reported on childhood memories thus it is impossible to confirm if they experienced such rearing practices (Reti et al., 2002). While establishing 'congruence' between the past and what is reported is

an inherent limitation of retrospective measures. Young et al. (2003) and Parker & Gladstone (1996) view this as less of a limitation. They argue if dissonance between perceived and actual parenting is conceded, a bias toward 'perceived parenting' should be advocated. In other words, a child's memory or perception of events has more influence on development, than the reality of what happened. Despite concerns over the accuracy of self-report data, there is evidence that recall bias is not as great as some fear (Bernstein et al., 1994). Parker (1983) found retrospective ratings of early parental support made by adult children, were corroborated by separate reports from their parents. In reviewing literature on adverse childhood events, Brewin et al. (1993) also concluded that claims on the apparent unreliability of retrospective reports are largely 'exaggerated'.

A further, limitation is that the PBI assesses parenting over an extended period yet collects data at one point in time. The idea that 'care' and 'overprotection' styles remain stable has not been fully tested (Parker, 1989). It is possible that different phases in childhood may induce different parental attitudes and behaviours, which is also dependent on the cultural context of the family. It is worth noting that by defining parenting practices, there is an inherent judgment in the PBI. In labelling the scales the authors refer to a core dimension as 'overprotection' 'vs. 'training'. Instead of labelling the quadrant for 'high care, low overprotection' as 'affectionate permissiveness/independence' it is called 'optimal bonding'. Items are also culturally loaded, pulling for self-determined action on the part of the child. These labels are tied to Western individualist notions of optimal development. Good parents train children to think for themselves and

allow them to do what they want to do, while offering understanding and support they need to develop a free-thinking spirit. The PBI scores also express the Western ideal for outcomes of early attachment. Securely attached infants, like 'optimally bonded' children can independently explore the environment, and return to the caregiver for support and reassurance.

Despite the limitations on recall bias, and cultural applicability of the instrument, results show the Greek PBI has adequate internal consistency and reliably measures cognitive representations of early parenting. It's testing on a Greek population, also represents an effort to increase applicability of the PBI to broader cultures, beyond the English speaking population it was normed on. These advantages allow for further investigation of the links between parental bonding, schema domains and skin disease as suggested in this chapter.

Chapter 10| Parental bonding, schema domains and skin disease

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The Parental Bonding Instrument and Young's Schema Questionnaire were used in this study, to consider the relationship between parental bonding and schema domains in dermatology patients and healthy controls. Attachment to each parent is explored separately, to evaluate the unique influence each parent has on schema formation. How Greek culture may impact and influence parenting behaviour is also considered.

10.1 Culture and parenting practices

The culture, norms and values of any given society are bound to influence parenting behaviour (Peterson, 2000). In most Greek families, child rearing is the mother's responsibility and discipline is left to the father. Greek parents also tend to be over-protective, highly involved in raising their children (Coclami & Bor, 1993; Rose et al., 2003) and display greater behavioural control in comparison to Anglo-Saxon parents (Francis & Papageorgiou, 2004). In German families, physical punishment and conflict, is reported to occur with greater frequency (Nickel & Egle, 2001). Despite cultural differences in child rearing, if parents show affection, encouragement and have clear age-appropriate, boundaries secure attachments form (Enns et al., 2002; Stewart-Brown, 2000). Children generalise such learning and subsequently develop into competent adults that seek socially supportive environments (Caspi & Elder, 1988). The stress of

illness in childhood often challenges parenting behaviour. Coping with eczema, for example, may involve getting a child to cooperate with a time-consuming, uncomfortable task like adhering to a medical regimen (Canetti, 1997). A Greek mother, who struggles to discipline an uncooperative child, may pass this responsibility to the father. A controlling father may then set limits that stress the child, which can exacerbate the disease or lead to difficulties in the father-child bond. How mothers and fathers parent thus has a significant impact on attachment security. This is based on research that shows the father-bond in infants, is not based primarily on the model of the mother-child relationship, but upon the father's representation or model of his own family of origin (Paquette, 2004). As such cultural stereotypes on what parental behaviours are considered appropriate may also impact styles of attachment fostered in childhood.

10.2 Maternal and paternal roles

In the literature there is an abundance of research that highlights the significance of mother-child bond, despite the fact that fathers have an important and independent impact on children's development and well being (Royal College of Paediatrics and Child Health, 2002). Equally, in psychodermatology, while several studies propose that an insensitive, rejecting mother figure and insufficient tactile stimuli are responsible for childhood eczema (Howelett, 1999; Koblenzer & Koblenzer, 1988) some research also shows that severe childhood eczema is not related to the quality of the mother-infant attachment (Daud et al., 1993). A focus on maternal bonds is limited however, in light of the fact that there is no research at all, on the role of father-child attachments in eczema or other

skin diseases in childhood. This trend is very intriguing as independent data from longitudinal studies show that mothers and fathers have a distinct influence on how a child develops its concept of self (Lamb, 1986; Steele, 2002). Mothers tend to provide lessons on emotional regulation; while more social lessons are 'taught' by fathers (Suess et al., 1992; Verschueren & Marcoen, 1999).

In the mother-child bond, children acquire understanding of complex feelings, including the ability to acknowledge distress in others and the capacity to generate flexible coping strategies. The mother bond is also crucial in calming and comforting a child in times of stress (Paquette, 2004). By contrast, the early father-child bond appears to uniquely influence a child's perceived functioning in peer relationships and self-report of difficulties in adolescence (Steele & Steele, 2001). Fathers thus play a more important role in social development, by shaping a child's openness to the world. Paquette, (2004) describes this is as the father-activation relationship, which develops primarily through play. 'Men tend to excite surprise and momentarily destabilize children; they encourage children to take risks, while ensuring their safety. Through this children are permitted to learn to be brave in unfamiliar situations and to stand up for themselves'. This developmental dynamic is only effective in a secure father-child bond; consequently, if eczema symptoms or other child difficulties limit spontaneity and play, the father-child relationship may be particularly affected. The attachment style parents adopt may be more important in understanding child development rather than distinguishing parental roles by gender. Ultimately, it is the

characteristics of a father as a parent vs. as a 'man' that may impact levels of attachment security in the parent child bond (Lamb & Tamis-Lemonda, 2004).

10.3 Parental bonding styles

The PBI dimensions capture the various parenting styles that contribute to secure and insecure forms of attachment. The instrument has two dimensions, care and protection (high vs. low), which give rise to 4 rearing styles that characterise the mother and father-child bond. These are 'affectionate constraint' (high care, high control), 'affectionless control' (low care, high control), 'neglectful parenting' (low care, low control) and 'optimal bonding' (high care, low control).

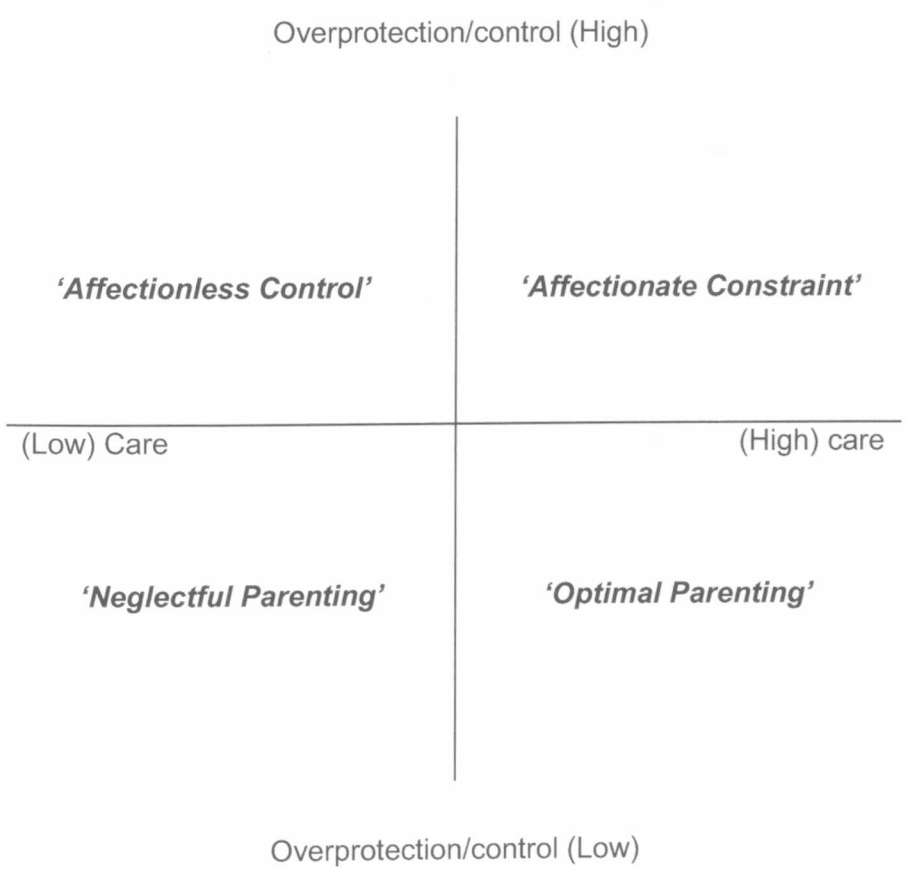

Figure 3: Parental Bonding Instrument - quadrants of parenting styles

Studies on insecure attachment and adult psychopathology using the PBI show that low care, coupled with overprotective parenting (affectionless control) is characteristic of adults with depression (Gotlib et al., 1988; Parker & Hadzi-Pavlovic, 1992), delinquency (Howard, 1981) and drug abuse (Clausen, 1996). The attachment style of 'affectionate constraint' has some specificity to panic disorder (Silove et al., 1991) and 'optimal bonding' is related to successful social adaptation and psychosocial outcomes (Mark, 1994). Many studies also suggest 'low care' is the more important dimension of the two (MacKinnon et al., 1993; Duggan et al., 1998). Insecure bonding has also been linked to EMSs and attachment styles since both organise experience and behaviour in adulthood. In a broad sample of patients attending mental health services in the UK, Mason et al. (2005), reported that 81% had insecure attachment styles and EMSs differed significantly according to attachment style. Individuals with fearful and preoccupied attachments possessed the most EMSs. The authors did not differentiate subjects by diagnosis as this is at odds with the developmental approach underlying attachment and schema theory; however it would have been interesting, to see if results obtained could have elucidated diagnostic categories.

Despite all the plausible links made between attachment theory (chapter 8) and the formation of cognitive schemas, (chapter 4) - there is a no literature on how early parental attachment styles relate to EMSs in medical populations. This is suprising as skin disease and illness linked events are near-perfect triggers for the mobilization of attachment behaviour (Maunder & Hunter, 2001). For example, in many patients the exacerbation of skin disease triggers feelings of

fear, loss, threat, isolation and dependency, which are equally the types of stressors that initiate attachment behaviour. Furthermore, an understanding of schema processes has assisted in clarifying the distinction between attachment behaviours that can be elicited by the stress of skin disease e.g. camouflaging to avoid ridicule and more enduring attachment patterns e.g. avoiding relationships. Recently, research on psychiatric populations has called for greater attention to be placed on the examination of paternal and maternal bonding and schemas, and their impact on current patient functioning. This is based on the fact that since EMSs are related to parental bonding, different experiences with maternal and paternal figures may be of importance in EMSs formation (Harris & Curtin, 2002; Leung, Thomas, & Waller, 2000; Shah & Waller, 2000). On a contextual level, the absence of psychodermatology as a discipline, in Greece means dermatology lacks a base upon which to build research that can explore such issues. As a consequence there is no psychological literature on Greek adult patients with chronic skin disease, which makes the contribution of the studies in this thesis not only novel but also vital for the promotion of psychodermatology as an important area of dermatological practice.

10.4 Aims and hypotheses

Based on the findings from the previous studies, this study aims to address a gap in the literature by investigating maternal and paternal bonding in psoriasis and eczema patients in relation to Young's schema domains. This is guided by findings in Chapter 6 where EMSs emerged as relevant in the psychological profile of patients indicating dermatology patients have less healthy parenting

experiences than individuals without skin disease. It is hypothesized firstly, that dermatology patients will be more insecurely attached as depicted by the PBI than controls across schema domains and secondly, that father-child attachment in patients with skin disease will differ in the domain of disconnection and rejection from mother-child bonding. This second hypothesis specifically aims to expand knowledge on father bonding in skin disease since there is no literature on the subject and this is based on two guiding assumptions. Firstly, since fathers are shown to influence social competence in children, their parenting style may be relevant as 'fear of negative evaluation', interpersonal difficulties and social stigma are sensitive areas for patients with skin disease in adulthood. Secondly, in the patriarchical Greek family system the father is often ascribed the role of a distant, controlling authoritarian figure (vs. mothers who are more nurturing), and this parenting style is akin to attachment behaviours that lead to EMSs formation in the domain of disconnection and rejection.

10.5 Method

10.5.1 Participants

Respondents comprised of two clinical groups of dermatology patients and one group of healthy controls. Patients formally diagnosed with psoriasis (n=78) and eczema (n=67) were recruited from the dermatology out-patient unit. The mean age for psoriasis patients was 40 (SD 14.93) and 37 (SD 12.63)in eczema. The mean age of onset for eczema was 16 (SD 12.43) and for psoriasis patients 27 (SD 14.23). The control group (n=70) had a mean age of 33 (SD 9.49) and participants were recruited form the local community. Groups were screened by a

demographics questionnaire to exclude factors that could influence schema formation. This included early trauma such as the death of a parent, psychotropic medication and past history of psychological therapy.

10.5.2 Procedure

Questionnaires were distributed to consecutive out-patients by an independent medical professional who informed them on the nature of the study. It was emphasised that participation was anonymous and would not affect treatment. Participants signed a consent form and filled in the measures, which took about twenty minutes to complete. The control group was recruited from the community and were told their responses would be used for comparison purposes.

10.5.3 Instruments

Each group completed the YSQ-SF, a 75-item self report questionnaire that measures 15 early maladaptive schemas across five developmental domains (Young, 1998). All items are scored on a six-point Likert scale where 1 = completely untrue of me, to 6 = describes me perfectly. High scores indicate the presence of a schema. Participants also completed the PBI (Parker et al., 1979), a 25-item measure that rates how adults recall their mother and father during their first 16 years. Two sub-scales measure parenting styles; the 'care' dimension measures warmth, empathy and emotional support (12 items) and the 'protection' measures overprotection, control and intrusiveness (13 items). Respondents rate each parent on a four-point Likert scale where '3'= very like; 'to

'0'= very unlike. From the subscales, four bonding styles are identified -'optimal bonding', 'weak bonding', 'affectionate constraint' and 'affectionless control'.

10.6 Statistical analysis

To examine the association between skin disease and parental bonding, Pearson chi-square was used to investigate the strength of association between the two variables. Requirements for this test include having over 20 observations and samples of approximately the same size. These conditions were met and a significant association in the analysis indicated the data warranted further analysis. A two-way ANOVA was deemed suitable for this. This is an extension of the one-way analysis of variance and compares the means of samples that are classified in two ways i.e. there are two independent variables. These variables (parenting styles & schema domains) are called factors, and the idea is that the factors affect the dependent variable (skin disease). Each factor has 2 or more levels and the degrees of freedom for each, is 1 less than the number of levels.

A two-way Anova can thus indicate how and mother and father bonding influence schema development in patients with psoriasis and eczema. A significant F-ratio for one independent variable indicates a main effect, but since two independent variables are considered simultaneously, a two-way ANOVA also reports if the interaction between the IVs is significant. If a significant main effect or interaction is found, then it can be concluded that a significant difference exists somewhere amongst the levels of IVs. The next step is to isolate exactly, where significant differences lie for mother and father bonding. Since there are 4 types of parental

bonding styles (levels of IV), significant F-values for each parent are examined with post-hoc Tukey tests. This statistical method has been described previously. In the results section, the main effects for maternal and paternal bonding are described. However, when there is a significant interaction in a two-way ANOVA the most complete description of the results, is told by the interaction.

10.7 Results

Pearson Chi-Square indicated a significant association between mother bonding and participant group status ($\chi^2 = 15.73$, df = 6, p = 0.02), Similarly, there was a significant association between father bonding ($\chi^2 = 17.43$, df = 6, p = 0.01) at $p < 0.05$ and group status. To investigate the substantive nature of this association a two-way ANOVA was carried out for maternal and paternal bonding. The association between the significant schema domains and maternal bonding styles in patients with skin disease and controls are depicted in Table 10. The analogous results for father bonding are depicted in Table 12 and 13.

10.7.1 Mother bonding and schema domains

Significant main effects for maternal bonding were observed in four out of the five domains. Post-hoc Tukey comparisons were thus conducted to investigate, which maternal styles were relevant. A significant main effect in the domain of 'disconnection and rejection' indicated that two maternal bonding styles were harmful. Participants who had 'affectionless control' or 'neglectful bonding' 'from their mothers felt significantly more disconnected than those who received optimal parenting and had their core needs met. A significant main effect was

also observed in the domain of 'impaired autonomy'. Post-hoc tests showed that in contrast to optimal care, maternal 'affectionless control' once again impaired a persons' ability to be independent. These two domains had the strongest association to maternal bonding out of the four that emerged as significant.

In the domain of 'impaired limits', the maternal 'affectionless control' impaired a persons ability to exercise reciprocity and self discipline, compared to individuals who had optimal care; and in 'other directedness', individuals who had maternal 'affectionless control' or 'neglectful bonding', felt more powerless to meet their needs vs. those who had optimal care. There were no main effects in the domain of 'overvigilance and inhibition'. Overall, in relation to the domains no interactions on maternal bonding and skin disease were observed. The main effects indicate however that sub-optimal maternal care is relevant in understanding what core needs are not met in childhood, and the subsequent impact this has on psychological development. In particular, a mother who is rejecting and controlling perpetuates insecure bonding by hampering the child's need for gaining acceptance, connection with others and developing autonomy. These difficulties continue into adulthood and impact mental health and the nature of interpersonal relationships fostered with others. The findings on maternal bonding are not new but are consistent with existent findings in the literature that indicate 'affectionless control' is linked to mental health difficulties in the mother such as depression, and that similar mental health difficulties are observed in the off spring of such mothers in adulthood (Gotlib et al., 1988; McGinn et al. 2005).

Mother Bonding						
Schema DOMAINS	**ANOVA**		**df**	**p**	**Parenting STYLES**	**Post-hoc Tukey**
Disconnection and Rejection	**F-ratio**	7.55*	3	0.00	NP vs. OP NP vs. AL NP vs. AT OP vs. AL OP vs. AT AL vs. AT	td =12.06, p = 0.04* td = 5.01, p = 0.70 td = 1.91, p = 0.99 td = 17.07, p = 0.00* td = 10.15, p = 0.26 td = 6.91, p = 0.61
	F-interaction	1.60	6	0.15		
Impaired Autonomy	**F-ratio**	7.12*	3	0.00	NP vs. OP NP vs. AL NP vs. AT OP vs. AL OP vs. AT AL vs. AT	td = 8.04, p = 0.08 td = 4.43, p = 0.57 td = 4.10, p = 0.83 td = 12.48, p = 0.00* td = 3.94, p = 0.78 td = 8.54, p = 0.18
	F-interaction	0.83	6	0.55		
Impaired Limits	**F-ratio**	4.31*	3	0.01	NP vs. OP NP vs. AL NP vs. AT OP vs. AL OP vs. AT AL vs. AT	td = 4.57, p = 0.10 td = 1.37, p = 0.91 td = 2.73, p = 0.77 td = 5.94, p = 0.00* td = 1.84, p = 0.88 td = 4.10, p = 0.36
	F-interaction	0.44	6	0.85		
Other Directedness	**F-ratio**	4.41*	3	0.01	NP vs. OP NP vs. AL NP vs. AT OP vs. AL OP vs. AT AL vs. AT	td = 6.07, p = 0.04* td = 0.49, p = 1.00 td = 3.46, p = 0.70 td = 6.57, p = 0.00* td = 2.61, p = 0.78 td = 3.95, p = 0.49
	F-interaction	0.30	6	0.94		
Overvigilance and Inhibition	**F-ratio**	0.76	3	0.52		
	F-interaction	0.24	6	0.96		

Table 11: Two way ANOVA results for main effects & interactions between mother bonding styles and schema domains

10.7.2 Father bonding and schema domains

A two-way ANOVA for fathers also indicated a significant main effect in the domain of 'disconnection and rejection'. Post-hoc Tukey tests showed that participants who experienced all forms of insecure father bonding i.e. neglectful bonding, affectionless control and affectionate constraint felt more rejected as adults. In this domain an interaction of father bonding with skin disease was observed. More specifically, psoriasis patients with 'affectionless control' and eczema patients' with 'affectionless control' or 'affectionate constraint' father bonding were more disconnected than those who had optimal care. Further univariate ANOVAs on group status and father bonding showed a significant difference for the parenting style of 'affectionless control' in both psoriasis and eczema. Post-hoc tests indicated eczema patients felt more disconnected than controls. Table 13, shows the two-way ANOVA results for the four other domains.

In the domain of 'impaired autonomy' a significant main effect followed by post-hoc tests indicated that persons who experienced 'neglectful' or 'affectionless control' father bonding, were more impaired in their ability to be independent vs. those with optimal care. In the domain of 'impaired limits' and the domain of 'other directedness' significant main effects were observed in both. Respective post-hoc tests showed that 'affectionless control' father bonding influenced a persons ability to set appropriate limits and capacity to meet their needs. No interactions were observed in these domains.

Father Bonding (1)

Schema DOMAIN	ANOVA		df	p	Parenting STYLES	Post-hoc Tukey Comparisons
Disconnection & Rejection	F-ratio	10.58*	3	0.00	NP vs. OP	td = 12.17, p = 0.05*
					NP vs. AL	td = 8.27, p = 0.29
					NP vs. AT	td = 1.57, p = 0.99
					OP vs. AL	td = 20.44, p = 0.00*
					OP vs. AT	td = 13.74, p = 0.01*
					AL vs. AT	td = 6.70, p = 0.46
	F-interaction	2.22	6	0.04	GROUPS	Psoriasis (P) / Eczema (E) / Control (C)

F-ratio (P)	df (P)	p (P)	F-ratio (E)	df (E)	p (E)	F-ratio (C)	df (C)	p (C)
2.87	3	0.04*	7.06	3	0.00*	2.57	3	0.06

	Post-hoc Tukey (P)	Post-hoc Tukey (E)
NP vs. OP	td = 10.94, p = 0.70	td = 13.00, p = 0.48
NP vs. AL	td = 7.39, p = 0.86	td = 22.10, p = 0.11
NP vs. AT	td = 5.57, p = 0.97	td = 16.03, p = 0.47
OP vs. AL	td = 18.33, p = 0.03*	td = 35.10, p = 0.00*
OP vs. AT	td = 5.37, p = 0.95	td = 29.03, p = 0.02*
AL vs. AT	td = 12.96, p = 0.51	td = 6.07, p = 0.94

Parenting STYLES	F-ratio	df	p	GROUPS	Post-hoc Tukey
Neglectful Parenting (NP)	0.12	2	0.89		
Optimal Parenting (OP)	0.68	2	0.51		
Affectionless Control (AL)	5.70	2	0.01*	P vs. E	td = 12.63, p= 0.22
				P vs. C	td = 16.63, p= 0.06
				E vs. C	td = 29.26, p= 0.00*
Affectionate Constraint (AT)	2.82	2	0.80		

Table 12 Two way ANOVA results for main effects and Interactions between father bonding styles and eczema, psoriasis and controls in the domain of disconnection and rejection

Father Bonding (2)

Schema DOMAIN	ANOVA		df	p	Parenting STYLES	Post-hoc Tukey Comparisons
Impaired Autonomy	F-ratio	9.31*	3	0.00	NP vs. OP	td = 4.93, p = 0.50
					NP vs. AL	td = 9.97, p = 0.03*
					NP vs. AT	td = 2.69, p = 0.92
					OP vs. AL	td = 14.90, p = 0.00*
					OP vs. AT	td = 7.62, p = 0.12
					AL vs. AT	td = 7.28, p = 0.15
	F-interaction	1.10	6	0.39		
Impaired Limits	F-ratio	5.75*	3	0.00	NP vs. OP	td = 4.14, p = 0.19
					NP vs. AL	td = 2.81, p = 0.53
					NP vs. AT	td = 2.25, p = 0.80
					OP vs. AL	td = 6.96, p = 0.00*
					OP vs. AT	td = 1.89, p = 0.79
					AL vs. AT	td = 5.06, p = 0.06
	F-interaction	0.28	6	0.95		
Other Directedness	F-ratio	7.84*	3	0.00	NP vs. OP	td = 5.74, p = 0.05
					NP vs. AL	td = 2.80, p = 0.60
					NP vs. AT	td = 0.71, p = 0.99
					OP vs. AL	td = 8.53, p = 0.00*
					OP vs. AT	td = 5.03, p = 0.10
					AL vs. AT	td = 3.50, p = 0.38
	F-interaction	1.16	6	0.33		
Overvigilance and Inhibition	F-ratio	2.66	3	0.05		
	F-interaction	0.86	6	0.52		

Table 13 Two way ANOVA results for main effects and interactions between father bonding styles and domains of impaired autonomy, impaired limits, other directedness and overvigilance and inhibition

10.8 Discussion

Overall, the results obtained on parental bonding confirm the first hypothesis that dermatology patients are more insecurely attached vs. controls as depicted by the PBI across schema domains. The second hypothesis that father-child attachments in patients with skin disease will differ from maternal attachments in the domain of disconnection and rejection was also confirmed, and indicates that early father bonding has a significant influence in the formation of EMSs in dermatology patients and especially so, in patients with eczema.

10.8.1 Maternal influences on schema development

The family is a place where children either acquire skills to face life difficulties or it can be a source of stress where the ground for future difficulties is set (Parrott, 1993; Pearlin & Turner, 1987). For most parents providing optimal care is a challenge and especially so, if this entails coping with a child's chronic illness. The results of this study confirm that overall dermatology patients experience less healthy parenting in the course of their development. With respect to mother bonding, sub-optimal care was evident through the attachment styles of maternal 'affectionless control' and 'neglectful' bonding. This confirms mother-bonding is related to themes of 'disconnection and rejection' and 'impaired autonomy' in the schema domains. These findings are consistent with research that shows insecure maternal bonding predicts psychopathology in adult life. Since there was no interaction with skin disease, results do not replicate Spitz's early findings and recent research that claims there is an association between eczema and the maternal deprivation in early childhood. A point of interest in relation to 'neglectful

bonding' is that a mothers' child rearing history i.e. perceptions of her own parents' child rearing practices has been identified as a risk factor for child neglect or abuse (Hemenway, et al, 1994). Lesnik-Oberstien et al. (1995) compared emotionally abusive mothers and non-abusive mothers on the PBI and found that abusive mothers reported relationships with both parents as less caring. It thus seems that on a general level, childhood stress sets up intergenerational cycles, wherein sub-optimal care in one generation may perpetuate insecure attachments and distress in the next.

10.8.2 Paternal influences on schema development

As the second hypothesis predicted father-child bonding emerged as particularly important in the psychological development of dermatology patients. This is a new and interesting finding. The interaction in the domain of 'disconnection and rejection' shows fathers of eczema and psoriasis patients who were controlling and interfering in childhood influenced EMS formation. In adulthood skin disease and its consequences trigger great distress in these individuals due to powerful feelings of deprivation or rejection that EMSs in this domain evoke. The stigma of skin disease may be heightened by deficits in social competence, wherein the child experienced ongoing negative interactions with parents, peers and others in their early environment. On cultural level, the perceptions Greek dermatology patients have of parental figures fits with the stereotype of a controlling father, but surprisingly not of a nurturing mother. In comparing these results to related fields, a similar finding on father bonding was observed in patients with eating disorders. Meyer & Gillings (2004) examined if EMSs mediated the relationship between

father bonding and bulimia. Results showed 'mistrust/abuse' partially mediated the relationship between paternal 'overprotection' (affectionless control) and severity of bulimic attitudes. This is significant as 'overprotective father bonding' and the schema of 'mistrust/abuse' in the domain of disconnection and rejection, were also significant in dermatology patients. Furthermore, this paternal attachment style often evokes feelings of anger and hostility in a child, two emotions that have also been implicated in the genesis and maintenance, of eating disorders and skin disease. Parallel findings in these two fields very interestingly suggest that poor father-bonding may influence the development of body image, both as an internal and social construct of self. The fact that eating disorders primarily affect women and that higher levels of distress are often observed in female patients with skin disease, is of interest when considering, how fathers may influence their daughters' psychological development.

10.9 Limitations

A limitation of this study is that trends of maternal and paternal attachment where only explored across groups. It is not evident from the results, if 'overprotection' by fathers' or 'poor care by mothers' is significantly different in relation to the gender of participants. It may be that female and male perceptions of parenting behaviour differ. Differences in perceptions may stem from the fact that what girls understand as 'caring and interest', boys may see as 'controlling and intrusive'. Furthermore, in Greek patriarchical families it may be easier for a father to express affection to a child of the opposite sex, if it is taboo to do the same with a child of the same sex e.g. between father and son in case the son becomes a

'sissy'. Analysing results by gender would provide insight into EMS development and how this impacts core needs, like autonomy and independence. While many factors impact attachment security, including psychosocial circumstances in the family, the strong relationship between insecure parental bonding and schema domains links early experiences, with the activation of EMSs in later life.

CHAPTER 11 | Discussion of main research findings

Exploring knowledge on the role of early maladaptive schemas and parental attachment in adult dermatology patients was aimed at expanding theoretical concepts in psychodermatology. This was achieved through a series of studies that progressively investigated the relationship between skin disease, EMSs and parental bonding in childhood.

11.1 Hypotheses

Two main hypotheses were made at the start of this thesis. The first predicted that EMSs contribute to the difficulties patients with psoriasis and eczema endure, and that the presence of EMSs across domains would distinguish dermatology patients from individuals who do not have skin disease. Results confirmed this hypothesis, as significant differences emerged on schema level representation between individuals with skin disease and healthy controls. The fact that psoriasis and eczema patients scored highly in the domains of 'disconnection and rejection' and 'other-directedness,' indicates these are key developmental themes, in the formation of EMSs in these individuals.

The second hypothesis predicted that sub-optimal parenting in early life contributes to the development of early maladaptive schemas and that father boding would have a differential impact vs. mother bonding in patients with skin disease. Findings revealed significant differences between groups on early attachment to parental figures. Poor parental bonding was related to schema

formation. More specifically, in mother bonding this was depicted by low care through the attachment styles of 'affectionless control' and 'neglectful parenting'. In fathers, all forms of sub-optimal care were significant. An interaction effect showed that fathers who were less caring and more controlling towards their children predicted EMSs formation in the domain of 'disconnection and rejection' for psoriasis, and even more so for eczema patients. While participants in the control group may have experienced some unhealthy parenting in early life and subsequently developed EMSs, these are not activated by skin disease. It is concluded that psoriasis and eczema have the potential to activate early maladaptive schemas in adulthood. These findings are important as they indicate EMSs are relevant in understanding the nature of underlying psychopathology and developmental difficulties in a medical population. Furthermore, the results are the first of a kind to provide support for the use of schema theory in psychodermatology. The significance of these two findings in relation to the current literature and clinical practice, are expanded in this chapter.

11.2 Early maladaptive schemas in patients with skin disease

11.2.1 A developmental perspective

In psychodermatology, a move towards considering developmental factors as precursors to the difficulties observed in dermatology patients, may be vital in unlocking mechanisms that influence coping and adjustment. Presumably, patients that adjust well to skin disease are not individuals who do not have any negative experiences but perhaps, cognitively and developmentally they are

adults who are more resilient, as they can adaptively meet their needs in spite of life's difficulties. In this study two developmental domains emerged as pertinent to dermatology patients. The first and earliest of the five, 'disconnection and rejection,' corresponds to Erikson' stage of 'trust vs. mistrust'. Unhealthy resolution of this stage leads to EMSs like 'abandonment' or 'mistrust/abuse'. These schemas create vulnerability in the self by lowering self-esteem and heightening fear of rejection. The second domain, 'other directedness,' corresponds to unhealthy resolution of the stage 'initiative vs. guilt'. In this stage, formation of 'self-sacrifice' or 'subjugation' schemas create vulnerability by impacting how well a person can meet their needs. Healthy resolution would entail, learning to 'trust in oneself and others', and 'being confident of ones identity and personal resources'. Each domain is discussed further, but it suffices to say that patients with EMSs that lack such developmental resources could struggle more in coping with skin disease in adulthood.

11.2.2 Security and the need to feel loved

The relevance of 'disconnection and rejection' in psoriasis and eczema, indicates these individuals experienced emotional or physical mistreatment in childhood. Families in this domain are unstable, abusive and rejecting thus children grow up with the belief that their needs for safety and nurturance will not be met. While many factors promote such family dynamics, the onset of disease could affect a child's temperament and elicit unhealthy parenting. In eczema, rejection may occur if a parent struggles with the disease or if religious beliefs lead to eczema being construed as punishment for past sins (Papadopoulos & Bor, 1999).

In psoriasis patients, rejection may have occurred due to factors other than the disease, such as ongoing parental strife. In adulthood these patients are vulnerable to experiencing emotional difficulties because EMSs in this domain ensure that their need to feel secure, accepted and loved is never fulfilled. As such they tend to recall incidents of rejection and expect negative responses from others, especially if they believe that their skin disease is stigmatizing (Kent, 1999). By biasing information processing, EMSs continue creating difficulties in forming satisfying attachments. Going against an active schema by trying to get the need for nurturance and acceptance met, is often too disruptive to the core organization of self (Young et al, 2003). Instead coping styles such as avoidance, maintenance or compensation minimise distress to a degree but simultaneously, create adjustment difficulties like those described earlier. The core emotional need for meaningful connection, and fear of rejection due to skin disease, thus appear relevant in understanding the anguish that dermatology patients endure.

11.2.3 Pleasing others and the need for approval

Dermatology patients also scored highly in the domain of 'other-directedness', which involves an excessive focus on meeting the needs of others to gain approval, maintain connection and avoid retaliation. This leads to a poor sense of self, characterised by poor awareness of personal needs. In families of origin, parents model conditional acceptance and typically, the child has to retain important aspects of 'self' to get approval. The onset of eczema can fuel EMS formation as a child's altered appearance jeopardises parental status and can trigger disapproval in the family. Sensing parental displeasure over 'appearance',

the child may then strive to excel in approved areas like sport or academia to get recognition. In this instance, suppressing needs and emotions activates the schema, while the need to gain approval maintains it. This striving may persist into adulthood and influence work dynamics and personal relationships.

Support for this in skin disease, is suggested by Leary et al. (1998) who report that anxiety in dermatology patients is mediated by the level of self belief individuals' have in their ability to manage impressions they make on others. In clinical practice individuals with EMSs in 'other directedness' commonly present with somatic complaints, e.g. headaches, pain and fatigue (Young et al., 2003). Identification of this domain as relevant to skin disease thus confirms Young's observation on psychosomatic elements in EMSs. Studies on somatisation also show that individuals', who suppress their emotions, primarily communicate and experience somatic not psychological distress, and thus seek help for those symptoms (Lipowski, 1988). Possibly, for some patients' psoriasis and eczema provides a means of bringing attention to themselves, without asking directly and without conscious awareness. In this sense, the disease may have a functional role by granting permission to receive care and decrease care for others.

11.3 A common profile of EMS in psoriasis and eczema

Exploration of developmental obstacles in dermatology patients has revealed a new and more complex perspective regarding the meanings surrounding skin disease and how patients with specific schemas cope. It is noteworthy that all of

the EMSs in the domain of 'disconnection and rejection' were significant for dermatology patients relative to controls (see Table 14).

DOMAIN	EARLY MALADAPTIVE SCHEMAS	CLINICAL GROUP
Disconnection and Rejection (DR)	• Abandonment/instability	Eczema
	• Mistrust/abuse	Eczema and psoriasis
	• Emotional deprivation	Eczema and psoriasis
	• Defectiveness/shame	Psoriasis
	• Social isolation/alienation	Psoriasis
Other directedness (OR)	• Subjugation	N/A
	• Self-sacrifice	Eczema and psoriasis

Table 14: Domains of DR, OD and common EMSs in psoriasis & eczema

More specifically, three schemas were 'shared' by psoriasis and eczema patients. These include 'mistrust/abuse' and 'emotional deprivation' in the domain of disconnection and rejection, and 'self-sacrifice' in the domain of other directedness (Table 14). Since EMSs formation was addressed earlier, schema processes will be used to explain how these common schemas may influence patient functioning.

11.3.1 Mistrust/abuse (DR)

Individuals with a mistrust/abuse schema are guarded and suspicious. The schema promotes expectations that others will intentionally lie, abuse, humiliate or reject them in some way (Young et al., 2003). This schema can influence the

meaning of psoriasis or eczema by fuelling anxiety and distrust of others. Mistrust may extend to the medical profession, who may be seen to be 'fooling' the patient with treatments that don't work. Negative social reactions to altered appearance, may also confirm in some patients that people are intentionally, hurtful and rejecting (Jacoby, 1994). Even if the skin disease is only visible to the patient, it can maintain feelings of low self esteem and unattractiveness. When activated, the schema propels individuals to avoid intimacy, to not share inner thoughts and feelings or get close to others. In the literature, this theme is evident as many psoriasis and eczema patients, both single and married experience sexual difficulties (Gupta & Gupta, 1997). In some individuals, if childhood abuse contributed to the formation of a 'mistrust /abuse' schema, then skin disease may further exacerbate difficulties linked to physical or sexual intimacy. Adjustment difficulties are fuelled because, instead of learning to manage eczema or psoriasis within trusting relationships, these individuals constantly anticipate betrayal, which reinforces avoidant behaviour. Over time, mistrust leads to further loss of intimacy and this makes coping with the impact of skin disease a very lonely and shaming experience (Gilbert & Miles, 2002).

Kent & Keohane (2001) explored adjustment in psoriasis and found exposure to negative social events increased avoidance and vigilance, which supports the current finding, however this was unrelated to patients' self-esteem. This seems surprising as low self-esteem is linked to adjustment difficulties in disfigurement (Kent, 1999; Porter & Beuf, 1991). Quality-of-life was most affected in patients with visible psoriasis and those with a high 'fear of negative evaluation'. Crocker

and Major (1989) suggest that respondents protected their sense of self, despite rejecting experiences by using healthy attributions. While this may be so, the activation of EMSs in this domain will emphasize rejection, but 'mistrust/abuse' may not influence 'self esteem,' because the schema has an interpersonal focus. Identifying the chronicity of difficulties could be a better indicator of whether individuals are responding 'healthily', or if schema processes are perpetuating mistrust of others, which is maintained through socially avoidant behaviour.

11.3.2 Emotional deprivation (DR)

Psoriasis and eczema patients that struggle with an 'emotional deprivation' schema, expect they will not get enough attention, support or affection from others. As such they feel deprived, misunderstood and alone in the world. This schema promotes deprivation of nurturance, empathy and protection (Young et al., 2003). In the literature many psoriasis and eczema patients claim, people make conscious efforts not to touch them (Gupta et al., 1998). This deprivation of touch is not based on 'oversensitivity', as data confirms an avoidant reaction to disfigurement is a culturally sanctioned phenomenon (Bull & Rumsey, 1988). The impact of withdrawal on individuals with 'emotional deprivation' however, is very painful and reinforces a lack of empathy in others. Arguably, stigmatising reactions may occur more with strangers than people a patient knows well. The impact of this schema however, is supported by findings that show romantic and social relationships become particularly strained under the effects of skin disease (Ginsburg & Link, 1989; Lannigan & Coterill, 1989; Anthis, 2004). This may occur because schema activation prevents individuals from asking partners and

friends to meet their needs. Patients do not expect emotional support, they do not ask for it and consequently they usually do not get it (Young & Behary, 1998). If 'avoidance' is used to cope with the schema, the person will feel helpless at expressing their needs for love or comfort; if 'overcompensation' is used, then the person may act like they have no needs at all. In the end, deprivation of empathy and protection is the common outcome. This contrasts to research that shows social support ameliorates the impact of skin disease (Picardi et al., 2005). Embracing sympathetic attitudes of friends and family, or being part of self-help groups for psoriasis or eczema is valuable, as these networks assist in fulfilling emotional and social needs. Unfortunately, in Greece such national resources are not available but in countries where they are, they can remedy feelings of hopelessness and helplessness, which are strong predictors of perceived stigma and equally, core emotions generated by the schema of emotional deprivation (Lu et al., 2003; Koo & Yeung, 2002).

11.3.4 Self-sacrifice (OD)

Patients with psoriasis or eczema, who have a 'self-sacrifice' schema focus excessively on meeting the needs of others. A highly empathic temperament often promotes self-sacrifice, to prevent others from experiencing pain, to do what is as right or maintain connection with individuals that are seen as needy. This stance of giving to others is voluntary and experienced as a virtue (Young et al., 2003). The cost of 'always giving' however is that over time, it breeds anger, resentment and leads to 'emotional deprivation' because the persons own needs are never met. Interestingly, emotional difficulties like anger, emotional conflict

and hostility are noted as precipitating factors in both psoriasis and eczema (Lyketsos, 1985; Koblenzer, 1997). Lerda & Angelini (2004) have also reported that eczema patients are overly anxious and ineffective in handling anger vs. controls, which is suggestive of schema activation. The strongest maintaining factor in patients that have a 'self-sacrifice' schema, is 'guilt' that the person feels if they put themselves first or if they get angry. This guilt is ameliorated through more self-sacrifice and anger simply gets buried.

A culturally interesting interpretation, of 'self-sacrifice' also needs mentioning. In Greece, the highest cultural value is that of '*philotimo*', which refers to the 'love of honour' and this supports self-sacrifice as a virtue. In the individual, this represents a deep-seated inner awareness that motivates the good a person does. This is more than just an admired trait in Greeks, but a behavioural code of conduct. The expectation is that all members of society will first act in the interest of the greater good (Georgas, 1998). Unfortunately, neither the word, nor the idea has any English equivalent. The fact however, that dermatology patients were significantly different from controls on this schema suggests that when cultural altruism becomes extreme and breeds resentment in some individuals, it can negatively impact physical and psychological health.

Overall, the three schemas discussed, namely 'mistrust/abuse', 'emotional deprivation' and 'self-sacrifice' provide new and deeper insight into the psychological difficulties experienced by psoriasis and eczema in patients. From the literature described in earlier chapters, it appears there are two pathways by

which EMSs interrelate with skin disease. Firstly, in childhood eczema can contribute to EMSs formation through the impact illness has on parenting. Secondly, since psoriasis does not onset in childhood, it is the consequences of the disease that may reactivate latent schemas. The outcome of both these pathways is the same, unfulfilled needs of nurturance, acceptance and safety in childhood reactivate EMSs and impact adjustment in adulthood.

Having discussed which schemas are common to these patient groups, the specific schemas relevant to psoriasis and eczema will be considered next. Although these schemas are discussed separately, it is very likely that different schemas are linked to each other, within one individual. This study could not investigate such an association and can thus only report on how individual schemas may function in skin disease. The finding that 'emotional deprivation' and 'self-sacrifice' schemas occurred in both patient groups does suggest a link however, as these schemas share a similar content and may activate each other.

11.4 Schemas in psoriasis

'Defectiveness/shame' and 'social isolation' (DR)

Overall, patients with psoriasis had the widest range of EMSs indicating that developmental difficulties through childhood and adolescence play a crucial role. In the domain of disconnection and rejection two further schemas, 'defectiveness' and 'social isolation' were significant. 'Defectiveness' generates shame as individuals believe they are inherently flawed; thus simply having psoriasis can

validate this schema. The schema impacts adjustment by making patients feel self-conscious, insecure, and creates fear that others will see their defects. During schema activation cognitive distortions may include 'personalizing' peoples stares or 'jumping to conclusions' they will be rejected (Kent & Thompson., 2003). 'Dermatological shame' i.e. embarrassment over appearance, can be specific to psoriasis, or generalised in a schematic way to the self (Kellet, 2002). In relationships both forms of shame deteriorate emotional and physical intimacy (McKenna & Stern, 1997). The 'social isolation' schema, leads patients to believe they are different because of their disease, and thus not part of most groups. Aspects of self that are usually affected include body image and self-esteem (Cox, 2002). Since avoidance is a core coping style of this schema, patients choose a life wherein they engage in solitary activities. Depending on the severity of the schema (vs. severity of disease), individuals may form some relationships but on the whole will still feel separate to the wider world.

Vulnerability to harm and illness (IA)

The chronicity of psoriasis can activate the schema of 'vulnerability to harm/illness' by spreading fear and catastrophic beliefs. Unpredictability over health and lengthy medical treatments', increase feelings of vulnerability and may spur reassurance seeking from medical professionals. Anxiety is a core emotion and may range from low level dread to full blown panic. A longitudinal study exploring illness perceptions in psoriasis found that a 'strong illness identity' was linked with more visits to out-patient clinics and worse outcomes on physical, social and mental health (Scharloo et al., 1998). This finding coupled with the fact

that anxiety exacerbates psoriasis provides support for the meaning generated by the schema. An account given from a psoriasis patient with this schema shows the levels of vigilance and fear that some patients endure:

'The first thing I do when I wake is to check my body to see if the patches have changed. I know the exact shape and size of every patch, and if I notice a new one, then I feel sick to the stomach. Its so hard, because I don't know what to expect; last year I could wear short skirts, this year I cant because the patches on my legs are so ugly; who knows, what I'll have to wear next year to hide them'.

Insufficient self-control/self-discipline (IL)

An inability to restrain emotions or impulses characterises the schema of 'insufficient self control', which leads to an inability to persist with routine, avoidance of discomfort, disorganisation and the intense expression of emotion (Young et al., 2003). While literature on adjustment shows emotional expression is beneficial as it encourages acceptance of losses related to chronic illness; venting and 'outward aggression', is more akin to this schema. In psoriasis this may be depicted by a constant pre-occupation with unbearable aspects of the condition (Matussek et al., 1985; Hill & Kennedy, 2002). Physical symptoms, such as pruritus, the persistence of flaking lesions or the need for ongoing treatment can thus activate the schema. It has been noted that heavy drinking and smoking are common lifestyle habits in psoriasis patients despite the fact that both addictions, exacerbate the disease (Morse et al., 1985). Schema theory would view these behaviours as avoidant coping strategies, generated by the

schema to assist the individual in blocking emotions or physical discomfort associated with the disease.

Emotional inhibition (OI)

The last schema relevant to psoriasis is 'emotional inhibition', which develops when a child is shamed for spontaneously displaying emotion. Typically these adults value self-control over intimacy. In relationships, they suppress displays of warmth and restrain aggression based on the belief that expressing emotions will lead to loss of control. Fear of humiliation thus strengthens the resolve to remain guarded. Such individuals may not appear anxious over having psoriasis, but their coping style is very avoidant (Furnham et al., 2003). Evidence for this schema was linked earlier, to alexithymia. Biological findings provide further support, as research shows that individuals', who unconsciously inhibit negative thoughts and feelings, are at increased risk of impaired immune functioning and a range of health problems (Shea et al., 1993). The harmful effects of 'emotional inhibition' is also evident when contrasted to data that shows patients who seek social support, express emotions and engage in active coping are less anxious, less depressed and prescribed less treatment (Scharloo et al., 1998).

11.5 Schemas in eczema

Abandonment/instability (DR)

'Abandonment' was the only other significant schema in eczema, which supports the notion that skin disease can disrupt parent-child bonding. In childhood

prolonged separation from a parent provokes a consistent set of reactions starting with protesting and crying, which then leads to withdrawal from social interaction (Main, 1996). The infant learns to constantly monitor the environment to assess accessibility of caretaking figures and when alarmed, will cry for, or flee to these individuals for support. The child thus vacillates between exploration, and retreat to the protection of the attachment figure (Hazan & Shaver., 1990). Adults with an 'abandonment' schema thus become emotionally distressed when they expect to lose people close to them i.e. others will desert them, get sick and die or suddenly disappear. Consequently, they remain alert for any sign that someone is about to leave their lives (Young et al., 2003). In intimate relationships, the most powerful triggers include threat of separation or divorce. Fear of losing a partner due to skin disease can activate the schema and evoke heightened displays of distress over eczema, to elicit a nurturing response from the partner (i.e. surrendering). Individual's who overcompensate will minimize displays of distress, to prevent rejection. Nonetheless, when coping with the disease fuels anxiety, conflict, or communication difficulties in a relationship then the threat of separation and abandonment is amplified.

In summary, the findings on EMSs in psoriasis and eczema patients show that by directing perceptions and behaviour, schema processes can create meanings that shape the experience of chronic skin disease. The finding that age of onset is less relevant, and that unmet developmental needs in childhood unite these patient groups, is equally intriguing. Although the findings on EMSs and schema domains are preliminary and require further research, they are novel and

exemplify the first attempt to gain understanding of cognitive and developmental variables that perpetuate long term distress in dermatology patients. Furthermore, by isolating these variables it has been possible to link literature on adjustment to findings on a broad range of EMSs. This association observed is complimentary, which indicates that the schema model can provide a new theoretical conceptualisation of the mechanisms that create and maintain distress in dermatology patients. The main findings on parental attachment and how this impacts EMSs formation lend further weight to these findings and is considered next in relation to the second hypothesis.

11.6 Parental bonding and emotional regulation

The way in which early parent-child bonds, continue to affect adult life is vital in schema and attachment theory because views on attachment security have changed over time. Early theorists viewed the 'secure base' from a behavioural perspective referring to the caregiver as the one to whom a child visibly turned to for protection. This view was limited in its application to adults, until it was realized a 'secure base' is not only *an external figure* but also a representation of security within the individual psyche. Apart from reaching out to others, adults have an 'inner working model' of schemas to regulate emotions (Holmes, 2001). In acknowledging these cognitive variables, attachment research has assigned increasing importance to the effects of parental bonding on emotional regulation, thus bringing schema and attachment theory closer together (Waller & Scheidt, 2006). The second main hypothesis of this study thus predicted that sub-optimal parenting in early life contributes to the development of early maladaptive

schemas; and that father boding has a differential impact vs. mother bonding in patients with skin disease. The first part of the hypothesis which predicts a relationship between poor parental care and EMS (that foster poor emotional regulation) was confirmed and is supported by research in the field. This shows that insecurely attached children experience difficulties in regulating and expressing distress in situations they feel upset, because as Young predicts they have learnt that their needs will not be met (Lutkenhaus et al, 1985). Adult studies equally show that insecure attachments are linked to alexithymia (Waller & Scheidt, 2006; Troisi et al., 2001) and defensive forms of emotional expression (Dozier & Kobak, 1992; Fraley et al., 2000). The cross sectional nature of this research limits generalisation, however the finding that dermatology patients are more insecurely attached vs. controls is new and suggests that when core needs are not met, secondary attachment strategies may develop through EMSs, to amplify or play down the expression of emotional suffering and attachment needs. The link between insecure attachment in childhood and EMSs is very significant in understanding psoriasis and eczema, as emotional distress in these patients may not only precipitate the onset or exacerbation of disease but the presence of EMS ensures that emotional regulation remains impaired thus creating difficulties in adjustment on a personal and interpersonal level.

11.7 Maternal and paternal bonding in skin disease

The second part of the hypothesis namely that maternal and paternal bonding has a differential influence on EMSs formation in dermatology patients - showed that differences in attachment styles does impact childhood development in

patients with psoriasis and eczema. The interaction between father bonding and skin disease is particularly significant as it provides a new perspective on the nature of schema formation in Greek dermatology patients. The influence of maternal and paternal attachment styles is discussed below.

11.7.1 Maternal attachment

A secure mother-child bond requires a healthy mother, who promotes optimal development by providing conditions that allow a child to grow into an adult who can process emotional experiences without using avoidant or defensive strategies. Maternal care that lacks such resources breeds poor attachment security. In this study, insecure maternal bonding was portrayed primarily by the attachment style of 'affectionless control', which was significant in four schema domains. The strongest influence was in 'disconnection and rejection' together with 'neglectful bonding'. Mothers' with an 'affectionless control' have been described as harsh, overprotective and neither caring nor emotionally available toward their children. In considering the meaning of this finding, it is suggested, that maternal depression may explain this attachment style. Several studies show for example, that mothers who are depressed display 'affectionless-control' parenting towards their off-spring compared to non-depressed mothers (Goodman et al., 1994; Miller et al., 1999). This attachment style has also been linked to elevated risk for anxiety and depression (Mackinnon et al., 1993; Gerlsman et al., 1994; Canneti, 1997), indicating that children who are insecurely attached to their mothers become vulnerable by developing EMSs that create emotional difficulties in adulthood. Shah and Waller (2000) explored this

hypothesis in clinical sample by studying the relationship between perceived parenting and adult depression as measured by the YSQ, PBI and BDI. Similar to EMSs identified in dermatology patients, schemas of 'defectiveness', 'self-sacrifice,' and 'insufficient self-control' differentiated depressives from controls. In the depressed group, high maternal-control and low father-care was significant. EMS like 'vulnerability to harm' mediated this relationship indicating that poor parenting increased susceptibility to depression. This concurs with research that shows parents rated high on control are more likely to have depressed children (Gotlib et al., 1988; Weisman et al., 1997; McGinn, 2005).

In the psychodermatology literature, evidence that mothers of children with eczema are more depressive, and overprotective in comparison to mothers with healthy children (Pauli-Pott et al., 1999), supports the attachment styles identified in this study. Literature on parenting experienced by patients with psoriasis is not available thus current findings cannot be compared for this group. Although no interactions on maternal bonding and skin disease were observed, a rejecting mother will still have a significant impact on a child's development and self-concept. For example, through repeated interactions with the mother, a child may form negative thinking patterns regarding self and others. This may lead to poor interpersonal skills and sensitivity to negative experiences (Cummings & Davies, 1994; Hauenstein, 2003). Feelings of helplessness evoked by this attachment style may be transferred into adulthood so that skin disease, increases the risk of depression. While maternal bonding is significant in EMS formation, in this study poor father bonding had a more powerful impact on patients with skin disease.

11.8 Paternal attachment

It is only in the past decade that the vital role fathers' play in facilitating child development has been documented. Research has shown that fathers who are involved, nurturing and supportive have children that thrive cognitively, socially and emotionally (Biller & Lopez Kimpton, 1997; Dubowitz et al., 2001). Unfortunately not all fathers have a positive influence on their child's development. Findings on psoriasis and eczema have shown for the first time that individuals who experienced all forms of sub-optimal care from their fathers - 'affectionless control' in particular, felt more disconnected and prone to rejection as adults. The interaction of father bonding and skin disease in the domain of 'disconnection and rejection' further suggests that attachment difficulties in these patient groups, started very early in development. How sub-optimal father bonding may manifest in psoriasis and eczema is discussed below.

11.8.1 Psoriasis and father bonding

Fathers with an 'affectionless control' attachment style tend get involved with their child based on their own needs and not that of the child's. Bancroft & Silverman (2002) note that maltreating fathers tend to take interest in their child at their convenience or when an opportunity for public recognition of their fathering is available. Through this avoidant style of relating fathers thus alternate between periods of intense superficial interest and neglect. Picardi et al., (2005) found a strong link between attachment-related avoidance and exacerbation of psoriasis. The authors suggest several ways in which insecure bonding can influence affect the course of psoriasis. Insecure attachment can affect emotional

regulation by increasing perceived stress; it can affect the intensity of the physiological stress response thus impacting psoriasis, and it can govern the success of social support in buffering stress. The impact of insecure attachment on the concept of self is also supported by longitudinal studies that report a negative self-concept in psoriasis patients, regardless of the current state of their skin (McKenna & Stern, 1997). Depression, suicide and suicidal ideation is also common in this patient group and this is also linked to 'affectionless control' parenting (Martin & Waite, 1994). Another account of the interaction of EMSs and father bonding in psoriasis is that patients may have been depressed as children, because fathers were overprotective. Depressed adults tend to rate their parents as more protective (Lloyd & Miller, 1997) thus a negative cognitive bias may have thus influenced scoring on the PBI. While some authors make a strong case for mood bias on psychometric testing (Lewinsohn & Rosenbaum, 1987) others have found no evidence for this (Parker, 1989; Gotlib et al., 1988).

11.8.2 Eczema and father bonding

In eczema, 'affectionless control' and 'affectionate constraint' father bonding strongly predicted schema development in this domain. Both attachment styles amplify vulnerability in a child but 'affectionless control', had the strongest influence once again. This indicates as studies already suggest that the absence of care from a father is more harmful than overprotection. Perhaps such fathers cope with their child's eczema by being 'distant' and leave the nurturing to the mother. Other fathers may show greater control to protect a child they perceive as weak. Staab et al., (2000) explored the impact childhood eczema had on the

family, and found that both parents' quality-of-life was heavily impaired. Being the main carer, mothers suffered the most, but fathers had more problems in accepting the disease and less confidence in medical treatment. In dealing with chronic illness, it may be that fathers prone to anxiety respond to the child with an 'affectionate constraint' style and fathers prone to depression with 'affectionless control'. In this latter case, eczema could exemplify a child's unconscious attempt to elicit nurturance from a father that is perceived as rejecting and remote. Some authors report a noticeable amount of separations in families with childhood eczema (Stewart & Thomas, 1995). In this study, eczema patients had the highest rate of divorce. This is interesting as the loss that accompanies separation confirms EMSs in the domain of disconnection and rejection.

Schema research has recently started to explore the differential impact of mother and father bonding on EMSs development and provides support for the new findings on dermatology patients. Blisset et al., (2006) explored the relationship between EMSs and current parental attachments in a non-clinical sample. Findings showed that schemas that significantly predicted attachment clustered in 'disconnection and rejection' and that abandonment, mistrust/abuse, emotional deprivation and social isolation predicted the quality of father bonding. Negative representations of current relationship functioning with parents provided further support, for the notion that EMSs are associated with family experiences of detachment, rejection, abuse and unpredictability. A limitation is that the sample consisted only of young women, and thus findings cannot be generalised to men who may perceive their fathers differently. A strength of the study, is that the

findings support the hypothesis that maternal and paternal attachment have a differential impact on schema formation. With regards to the assumption made earlier that father-bonding may influence social development in dermatology patients - studies on parenting that have included mothers and fathers show that parent gender does impact children's socialization, but the findings have been mixed. For example, Parker (1979) reported that only maternal bonding predicted participants' depression and anxiety ratings. In contrast, Parker (1981) found that participants with anxiety disorder remembered both their mothers and fathers as having an 'affectionless control' parenting style, which concurs with the findings on parental attachments in dermatology patients. While the consistency of associations between maternal and paternal bonding, and adult distress has yet to be documented the interaction of father bonding, and skin disease provides new data to the field and suggests, this area will benefit from further research.

11.9 Cultural influences on parenting

Having considered the two main hypotheses it is imperative to acknowledge that parent-child relationships do not exist in a vacuum. In any given society the family system is bound by accepted parenting practices and socio-cultural influences. Thus, examination of parenting variables is not possible outside the context of the culture parents are embedded in, and this relationship must be held in mind when considering parenting literature and the results of this study. To explore this notion further, cultural influences on secure base behaviour is discussed in order to gain greater understanding of factors that influence attachment and EMS formation in patients with skin disease in a different culture.

11.9.1 Differences in secure base behaviour

As seen in chapter 10, Western researchers see the parent as a secure base for the child's independent exploration, which ultimately represents a Western cultural ideal (Hazan & Shaver, 1990). Other cultures see this exploration as less healthy, and nurture dependence, seeing connection to the family as a primary goal, and success in the larger world as part of a process bringing honour to one's family. Greek parents drawn from the metropolis of Athens are seen to represent 'distal parenting'; a rearing style that promotes autonomy in children through face-to-face contact and object play. This fosters formation of an 'independent self' that is adaptive in Western urban, middle-class families and is often modelled strongly by the father (Keller et al., 2004).

In comparison 'proximal parenting' in non-Western communities emphasizes body contact and stimulation. Such parenting supports the development of an 'interdependent self', through the use of body contact and interactional warmth, which support the child's acceptance of norms, family values and obedience (MacDonald, 1992). Each of these parenting practices can be seen as valid cultural interpretations of secure base behaviours, and each lead to a different nurturing in the parent-child bond. Evidence for this is provided by Rothbaum et al., (2000) who explored differences in infant secure base behaviour in the US and Japan, to explain parenting differences. Japanese babies were shown to engage in far less exploration than US babies. They were more oriented to their mothers, who took on an educative stance by communicating and exploring with the child. Secure base behaviour in Japan was thus related to dependency vs.

independent exploration, and served to educate a child on socially accepted behaviours. Findings like these raise questions over the cross-cultural relevancy of attachment theory - given that as the theory stands, it is core to Western parent-child relationships, despite the fact that universal developmental goals are solved differently in various cultures (Greenfield et al., 2003). Caution is thus needed when discussing attachment across cultures. It may be more helpful to think of secure base behaviour in global terms - as an infant's sense of safety needed to adapt to the outside world.

The effect of culture on parenting is depicted by Van Ijzendoorn (1995) who conducted a meta-analytic review of studies, where the attachment styles of parents were compared to the attachment styles of their children. Findings revealed that parental attachment styles explained 22-35% of the variance in children's attachment styles, showing a strong pattern of intergenerational transmission. This is important for schema theory, as patterns of insecure attachment as observed in this study with dermatology patients, may only be linked to EMSs formation in Western cultures. It can be argued that schemas in patients with psoriasis and eczema from non-Western cultures may be very different given differences in attachment and the importance placed on developing an interdependent sense of self. Equally the meaning surrounding skin disease may be very different in these populations. A diagrammatic representation of the interaction between parenting and socio-cultural influences is provided in Figure 4 (Reebye et al., 2004).

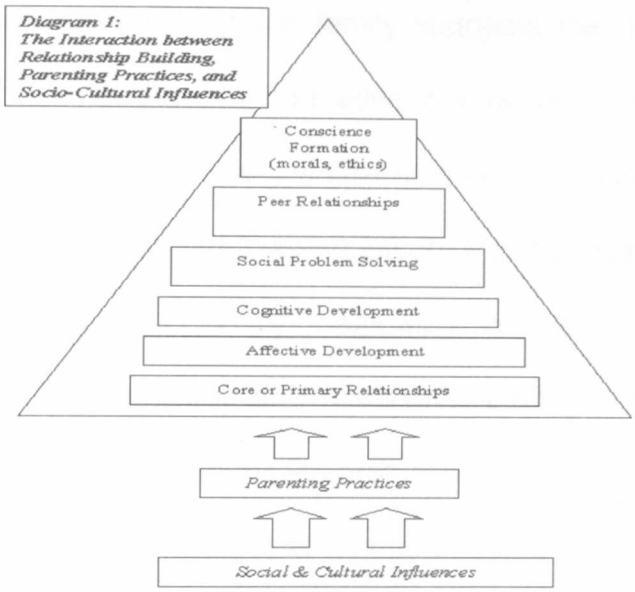

Figure 4: Interplay of parenting and socio-cultural influences

This diagram summarises an important point, namely that parental bonds are the *building block* from which a child develops maturity in affective and cognitive development; social problem solving, peer relations and consciousness formation. Cultural influences, impact this complex system and differences in child rearing will ultimately define, what constitutes 'good enough' parenting.

11.9.2 Culture and father bonding

Cross-culturally there is huge variation in the nature of father-child interactions (Engel & Breaux, 1994). In general the Western father which typifies the average Greek father - is not often seen as a socially active, available and nurturing parent. Instead social forces emphasise his economic contribution to the family unit, which means work responsibilities disconnect him at least temporarily from child rearing (Silverstein & Auerbach, 2001). The trend of de-emphasizing a

father's emotional involvement in the family suggests the attachment style of 'affectionless control' may have a normative cultural element. In recent years however, changing family structures, where mothers are increasingly balancing career and family has challenged this perception. Maridaki-Kassiotaki, (2000) for example, found Greek fathers in urban areas were more involved in child-centred activities vs. those in rural areas and many attributed psychological stress to childrearing responsibilities. Changes in parental roles from one generation to the next may thus also impact the type of attachment fathers have with their children.

How culture impacts parenting also influences interpretation of the current findings on attachment. The control sample had fewer schemas than the clinical groups, indicating these individuals experienced 'optimal bonding' and have a healthy self-concept. Even if the control group did receive some sub-optimal care these negative experiences were not sufficiently pervasive. Parenting experienced by dermatology patients, however hampered the development of an 'independent' self as indicated by the presence of EMSs. This cannot be attributed solely to skin disease, as psoriasis and eczema have different periods of onset. If illness or life difficulties in Greek families fosters dependency among members to increase coping - then the pressure placed on parent-child attachments, may be more harmful than in 'proximal' families were interdependence is encouraged. Given that the PBI taps into independent ideals of parenting it can be argued that, the observed relationship on father bonding, EMSs and skin disease is only be true for Western families, and that individuals within interdependent families may have a very different view of their parents.

11.9.3 Greek parenting and chronic illness

In relation to chronic illness, while there are no studies exploring how Greek families cope with skin disease per se, there is some evidence that diabetes has a disruptive effect. A qualitative study of 30 Greek families with a child diagnosed with chronic diabetes type-1 and facing difficulties with metabolic control reported that presence of the disease and demands of treatment was linked with certain family dynamics. These included enmeshed relationships, ambiguous roles and rules, hierarchy break down, coalition between mother and child, 'infantilization' of the child and interestingly an absence of father involvement. Healthy siblings were assigned parental roles and these families presented with signs of social isolation (Tsamparli & Kounenou, 2004). Many of these difficulties predict schema development as identified in this study, and also provide support for the role of fathers in perpetuating distress. In considering such family disruption and why the interaction of father bonding and skin disease emerged as relevant in Greek patients, the cultural concept of 'honour and shame' in Mediterranean families provides some further insight on the meaning illness in Greek families.

11.9.4 Honour and shame in Mediterranean families

Honour in the Mediterranean society is the way a person sees himself and the way a society regards him. *'It is his estimation of his own worth, his claim to pride'* (Pitt-Rivers, 1977). While certain virtues like honesty, integrity, loyalty and other moral qualities are common to both sexes, the concept of honour and shame has largely to do with a person's gender and consequently his or her position in society and the family (Malina & Neyrey, 1991). The honour of a man

and of a woman implies different modes of conduct (Pitt-Rivers 1977). In the Mediterranean culture a man's honour depends on his authority over his household, his position as a husband and father, his strength in public dealings and his boldness. A man of honour possesses nobility, must be competent with regard to various problems and must know how to solve them (Campbell, 1964). A man loses honour when he fails in some, or all the factors upon which his honour depends. Thus, if a man shows weakness of character, cowardice, shyness or is unable to provide for his family, his status of honour is questioned (Gilmore, 1990). Acceptance of humiliation from others, failure to defend his reputation and those of others, also result in loss of honour. The concept of honour and shame provides an interesting cultural perspective on factors that can influence attachment in Greek families. Having a child with eczema can be shaming for a Greek father that has to present a child, whose appearance stands out from normal children. Even if he attempts to 'control' or 'solve' the situation by taking the child to the best doctors, the lack of cure in eczema will create feelings of helplessness, as the father confronts the reality that he is unable to solve his child's problem. On a social level, any illness in a family and knowledge of this to others (extended family and friends) is viewed as stigmatising in Greek culture, as it encourages people to gossip and point the family out as having 'a problem' thus casting a shadow over the sense of pride a father can take over his family.

On a cultural level, perhaps 'affectionless control' denotes an attachment style where a fathers' honour is jeopardised by the shame of a sick child. By being distant the father may be acting out a form of self preservation, wherein he

upholds a sense of dignity by disengaging from the problem and others. To this day, psoriasis and eczema still carry strong myths of leprosy and contagion in Greece, thus patients and families that suffer with the problem become isolated, and do not discuss or share difficulties around the disease to prevent being shamed. This is driven by the fact 'honour and shame' is instilled in children, from early life, and particularly so by fathers. When this cultural expectation, combines with life difficulties it may activate EMSs in vulnerable individuals. For example, in life event like divorce in a patient with eczema, as mentioned earlier - creates stigma that impacts the person, the family, and how a father may view the honour and health of his children. Cultural hypotheses can also be made on maternal 'affectionless control' and 'neglect' in patients with skin disease. A Greek mother loses her honour and is seen of *'light virtue',* when she does not act in accordance with behaviours that uphold her honour. For example, if a woman does not sustain her family properly (because she may be depressed), is 'lax' as a housewife, fails in her duties as a mother, or neglects her household, she is at a risk of losing her honour. Loss of 'honour' can evoke conflict in a patriarchical family and jeopardise child development by fostering insecure attachments.

11.10 Summary

This chapter has discussed the hypotheses and main findings on schema domains, EMSs and parental bonding which emerged as pertinent to the psychological functioning of psoriasis and eczema patients. These findings are all new and significantly contribute to expanding knowledge in the field of psychodermatology. The findings on specific schemas in Greek dermatology

patients' were considered in relation to each patient group and also in relation to the idea that these patients may share a common profile. This was expanded further by considering deficits in early development and emotional regulation that are seen to contribute to schema formation and schema activation processes. How EMSs are shaped by early attachments with mother and father figures was also discussed in relation to the finding that parents have a differential impact on a child's development and EMSs formation. The importance of poor father bonding in patients with skin disease was highlighted. In considering how cultural factors impact the meaning of chronic illness, the concept of 'honour and shame' which is embedded in Mediterranean families and the Greek psyche was discussed with reference to its influence on father bonding. The final chapter of this thesis, 'summary and conclusions', returns to the scientist practitioner model that guides the profession of counselling psychology. This frame of reference encourages reflection over the nature of research, the meaning of helping and emphasizes a developing link between research and practice in guiding a clinician's work. As such the main limitations of this study are discussed and the clinical implications of the findings are explored in more detail.

Chapter 12 | Summary and conclusion

12.1 Broadening the scope of the clinicians gaze

The field of psychodermatology emerged out of the need to develop a more comprehensive approach to understanding the complex and equally fascinating relationship between the psyche and the soma. In its evolution Walker (2005) writes that psychodermatology has become as much an ethos, as it is a discipline; it involves professional, clinical and research-oriented awareness, and acceptance of the broad and very personal psychological and social implications of skin disease. The studies described in this thesis were constructed under this philosophy, and on the biopsychosocial framework whose biggest contribution was transforming the way illness, suffering and healing are now viewed.

The schema model was incorporated to investigate idiosyncratic meanings that trigger emotional distress in patients with eczema and psoriasis, using EMSs as its main focus of investigation. Through this, new insight has been gained into the concept of self in dermatology patients and, how specific EMSs are implicated both developmentally and cognitively in shaping adjustment. The role of attachment experiences also confirmed that parental bonding is related to EMS formation as the model predicts, and that sub-optimal paternal care predicts emotional distress in Greek patients, which is also a new and interesting finding. The model is thus relevant to psychodermatology, as the schema construct is social-cognitive in nature and includes hypotheses on biological processes involved in the development and maintenance of psychological difficulties. The

frame of the biopsychosocial model also helped conceptualise the relationship between psyche and soma, and was useful in interpreting the interaction between psychological and physiological correlates in skin disease. As such an attempt was made throughout this thesis to emphasize the reciprocal relationship between schemas, early life and disease status. Exploration of socio-cultural influences on attachment further expanded meanings that shape concepts of self in Greek dermatology patients. In using both models as a conceptual framework, the impact of psoriasis and eczema was understood as a multilevel phenomenon.

The findings of this study on dermatology patients, have also informed the theoretical models used. Results indicate that individual differences exist in how individuals respond to psoriasis and eczema. The biomedical model struggled to explain these differences due to its linear approach to understanding illness. Within the biopsychosocial model it is now possible to consider that EMSs may influence the physiological expression of skin disease by modulating levels of stress during schema activation (Mazzeti et al., 1994; Young et al., 2003). In this sense, the cognitive representation of self is inextricably linked with the physical self. The schema model has also provided a snapshot of patients' current psychological functioning (and future vulnerabilities), which has important implications for helping. Confirmation that EMSs are pertinent to dermatology patients suggests that maladaptive views of self, may mediate the relationship between disease and distress in adulthood. The call for health psychology models to pay more attention to concepts of self in understanding perceptions of health and illness is thus confirmed. Differences between controls and clinical

samples on schemas (Chapters 6 & 7) and parental attachment (Chapter 10) show that 1) the activation of EMSs influence how individuals' think, feel, act and relate to others and 2) that the quality of early parental bonds impact mental health in adulthood. Overall, the findings have enhanced knowledge in psychodermatology through the recognition that skin disease is not a discrete problem but impacts and is impacted by many aspects of self. In this respect the biopsychosocial and schema frameworks have neatly captured and shown that the subjective experience of psoriasis and eczema is broader than the physical manifestation of disease. What is less evident in the psychodermatological literature is that the interaction of skin disease and EMSs can lead individuals to inadvertently recreate in adulthood the conditions that in childhood were most harmful to them.

12.2 Toward a schema theory of illness

Research and clinical interest on the efficacy of schema theory in addressing chronic psychological disorders in adulthood is rapidly increasing. Its application to psychodermatology is new and offers several advantages to existing illness-representation models. Firstly, the model is holistic, person-centred and considers individual functioning on a developmental time frame, across life areas. This makes the theory integrative in its approach and capable of elucidating personal and interpersonal meanings in the experience of skin disease. By providing a clear theoretical framework on EMS content and processes, it provides researchers with distinct constructs to measure, which can only improve the validity and efficacy of the theory over time. Conceptually, the schema model

also provides scope for (re)considering findings on adjustment using constructs that explain the maintenance of chronic distress.

In a similar effort by linking EMSs and coping, psychological interventions that promote healthy adjustment can be developed to buffer the experience of illness. Research in psychodermatology has shown CBT compliments medical treatment and is effective in helping patients cope with skin disease. This thesis advocates the need to tailor CBT protocols in dermatology, to address 'meanings regarding self' from a schema-focused perspective. In doing so an opportunity is created in therapy, to engage with motivational forces that individuals may or may not be aware of i.e. 'the unconscious consciousness, trapped inside the patient' (Yalom, 1992). This will assist in addressing maladaptive interactional processes that render individuals vulnerable to chronic difficulties. In so far that these interactions have a biological basis is of interest, and provides scope for further research into the biological underpinnings of schema formation in skin disease. Developmental factors in schema formation also create the necessity for prevention measures and the development of interventions that address the needs of children and adolescents with skin disease.

Whilst the application of the schema model to psychodermatology opens up a path of exciting clinical and research endeavours, certain difficulties must be mentioned. Firstly, in the same way that models' of health and illness were faulted earlier for having little to say about the self, the schema model can be faulted for having little to say about health and illness. While it is recognised that

somatic symptoms are linked to certain schemas, illness is presented only as an 'aside' to core schemas. This may reflect the lack of research on early maladaptive schemas and ill-health. Researchers thus need to continue examining schemas in medical populations in order to gain a clearer understanding of psychobiological processes involved in illness. Clinicians also need to be sensitive when using the model; for many patients in medical settings, their illness and coping with its consequences, is their central reality which may feel removed from experiences in childhood. Engaging and keeping dermatology patients in counselling, may thus require attention to illness issues, prior to considering how adjustment difficulties may link to their deep seated schemas.

Finally, while the schema model has accumulated an impressive amount of research on its applicability and usefulness across disorders, these findings including the results of this thesis can only be interpreted in a meaningful way if the YSQ-SF measures the same constructs, across different populations. This means that EMSs need to be one-dimensional constructs and that the multi-dimensional structure of the YSQ-SF is invariant across samples. Results on the instrument thus far indicate that it has promising psychometric properties; can reliably distinguish clinical from non-clinical samples (Rijkeboer, 2005), and is sensitive to therapeutic change by showing reduced belief in EMSs through the course of therapy. The accumulation of evidence, however is based primarily on samples drawn from psychiatric populations in Western cultures. More research is thus needed, to establish whether the schema model can be applied towards developing a cross-cultural schema theory of illness. There is also a need for

further investigation on whether schema activation contributes to the onset and exacerbation of disease. The findings of this thesis represent a first step towards answering such questions, by showing the YSQ-SF is in fact a valuable research tool that can be readily applied to a dermatological population.

12.3 Research limitations

Having considered the theoretical usefulness of the schema model in skin disease it is also necessary to outline the various limitations that impact the findings and to explore future avenues of research. Limitations pertaining to the individual studies were presented and discussed in each chapter. As such an overview of the main limitations inherent to counselling research will be outlined.

12.3.1 Design and correlational data

The cross-sectional design of the study, wherein measures where taken at one point in time within a specific population makes it is difficult to draw conclusions on causality and the direction of relationships between the variables examined. While the results lend support to Young's schema model and are in accordance with findings on parenting and adult psychopathology, definitive causal associations cannot be concluded. This is because the data is correlational and it cannot be assumed that EMSs directly impact on the manifestation of skin disease or that EMS are directly responsible for the psychological consequences observed in patients. The results however, support the value of the schema framework in understanding core meaning structures and how EMSs formation can spur distress in dermatology patients. Predicting what specific triggers, or

events, activate EMSs in each patient is difficult when using psychometric tools alone. This research can thus be enhanced by qualitative interviews that could assist in developing idiosyncratic schema profiles or by eliciting themes that create difficulties in adjustment. A broader issue also highlighted by this investigation, is the centrality of adopting a life course perspective (Shaw et al., 2004), when studying social and psychological determinants of health

12.3.2 Sampling procedures

A POWER analysis indicated a minimum sample size of 52 was sufficient to show significant effects. With regards to participants, selection bias may have influenced the results. In the clinical groups this limitation was overcome by using consecutive out-patients; but as these patients were recruited in a hospital under the supervision of medical professionals it may have influenced their motivation to participate in the study. For example, 'self sacrifice' may have made it difficult for some psoriasis or eczema patients, to say no to filling-in the questionnaire. Unavoidably, the control group had different testing conditions as they had to be individuals in the community without major health problems. This introduced a further bias to sampling but was necessary for comparison purposes. The study was conducted in Athens using a Greek urban population at a University hospital, which precluded many possible candidates from taking part, again exposing the data to bias. Given the limited amount of psychological research on Greek dermatology patients however, the current findings provide a basis for future research wherein comparisons can be made with other patients groups, such as patients attending private clinics or public hospitals in rural areas.

12.3.3 Translation of measures

The translated versions of the PBI and YSQ-SF were piloted and adequate reliability for both instruments was demonstrated for the Greek population. It should be noted however, that while a high values for Cronbach's alpha indicate good internal consistency of items in a scale it does not mean that the scale is unidimensional. Factor analysis is a more rigorous method to determine the dimensionality of a scale but was beyond the scope of this study and should thus be investigated by future researchers. With regards to YSQ-SF, some participants may have found it difficult to complete the questionnaire due to difficulties in understanding the language on certain items. 'Non responders', for example, partially filled out the questionnaire or returned it blank. This may have not necessarily reflected a lack of motivation to participate, but literacy difficulties, since the YSQ-SF requires a certain level of education to complete.

For example, due to a lack of dermatological services in rural areas it is common, to see middle aged and elderly patients with very basic education travelling from rural outskirts or the Greek islands to be seen at the 'best hospital' in Athens. The difference in education levels is evident in the demographic information as the control group was more educated than the clinical groups (almost 60% had attended university). In the clinical samples up to 40% had reached high school and about 10% primary school level. Simplifying the language of the Greek YSQ-SF could make the instrument more user-friendly. This criticism also applies to the English version and may have led to the recent revision of the measure. Responses on the instruments may have also been influenced by cultural factors,

namely the meaning of participating in a 'psychological' study. This refers to 'how comfortable' patients with psoriasis and eczema felt in disclosing information about their lives that was not directly linked to their disease. Time permitting such meanings could have been investigated through semi-structured interviews as mentioned, to supplement responses in the questionnaires.

12.3.4 Measures of emotional distress

In this study the YSQ-SF showed that dermatology patients were more distressed vs. controls by virtue of the number of schemas they endorsed. It was thus assumed based on the literature on schema activation that EMSs in this population are active, and that some individuals are more conscious of them than others. The inclusion of a depression measure, such as the Beck Depression Inventory or those measure mentioned in chapter 7, would have provided further support for this claim, by linking emotional distress to schema activation in skin disease. In spite of this, by emotional regulation to attachment difficulties it was possible to discuss the how EMSs create vulnerability in psoriasis and eczema through the schema domains, which encapsulate the developmental difficulties individuals faced when their schemas were formed.

12.3.5 Gender effects

Due to restrictions on the amount of data that could be presented, findings were not analysed in terms of gender. Approximately equal amounts of male and female subjects in all samples prevented an obvious biasing of data. Analyzing differences within groups and not just between groups could have provided a

richer understanding of the interaction between variables. For example, it could have been investigated, whether on the PBI, female participants rated their relationships to each parent differently to male participants. Data on depression shows that daughters of mothers with a history of depression, report high levels of maternal 'affectionless control' and low self-esteem. When examined ten years later, these daughters were at increased risk of developing major depression. These associations were not present among sons (Miller et al., 1999). Since women are generally more distressed by skin and hair disorders than men (Cash & Pruzinsky, 2002), gender effects may have influenced scoring on the YSQ-SF.

Further research is needed to explore if gender mediates the psychological impact of skin disease. In today's society where female beauty is highly valued, women may be more vulnerable in suffering from the stigma of disfigurement (Kleinman, 1988). In the past decade however, men have become more physically and psychologically conscious of having a skin condition, which has narrowed the divide. Gender differences are not evident in adjustment of burn victims, thus these claims remain speculative (Brown et al., 1988). On cultural level due to the lifestyle in Greece, increases emphasis on appearance has led to a norm of attaining a 'perfect body image' to become an increasingly important. How individuals in the community differ in their perceptions of body image in comparison to dermatology patients would be an interesting question to explore.

Overall, with regards to the limitations described and their impact on this research - attempts were made to minimise their effects. Due to the inherent

restrictions of quantitative research however, it is only feasible to limit such effects as much as possible, and to cautiously interpret data in light of these.

12.4 Future research

In broadening the framework of helping in psychodermatology, the schema model recognizes the past has a powerful and continuing influence over the present. Consequently a client's developmental history and view of self are central to understanding the meanings surrounding skin disease. A model that incorporates the formation, activation and maintenance of schemas allows for more complex formulations of client difficulties. What seems clear from the findings is that childhood adversity is a potent source of meaning and can explain reactions to stressors in adulthood. Future research could include the following:

12.4.1 Schema focused CBT

On a clinical level and as a consequence of the current research, a fascinating avenue for future work would entail developing a counselling protocol with a schema component. This could be compared to traditional CBT and tested by means of an intervention study across different groups of dermatology patients. This fits with the scientist practitioner paradigm of counselling psychology that encourages the linking of theory to practice. Since the YQS-SF is sensitive to schema healing, administering the measure pre-and-post therapy would allow for schema change to be monitored over time. By comparing schema focused and traditional CBT protocols more effective treatments can be created, based on what aspects of treatment are useful in helping clients cope in the long term.

Whilst the clinical applicability of the model remains to be seen, the model provides an innovative way of conceptualising care. Experience in my own practice has shown it to be extremely useful in guiding interventions that facilitate change (schema healing) and adjustment to psychosocial consequences of skin disease. Clients also find the concepts of the schema model helpful as it provides a different language and perspective to talk about their distress.

12.4.2 Parental depression in attachment security

Distressed caregivers influence many aspects of the childrearing environment and there is ample evidence in the literature that connects parental distress to sub-optimal care. Future research, could thus explore the contribution of the extended family and school environment on emerging attachment security in patients with psoriasis and eczema, when one or both parents have mental health difficulties. This could be interesting because studies suggest that there is no single source of resilience or vulnerability, and that most peoples' coping capacities lie somewhere in between. Such information could be used clinically to promote schema healing, by helping clients recognise how they developed healthy schemas through relationships that did meet their needs.

12.4.3 Lifespan development

Schema theory stipulates that EMSs form in childhood and adolescence and elaborate in adulthood. Although negative childhood experiences can result in adult psychopathology longitudinal studies are also needed, to establish the validity of this hypothesis within the schema framework. EMSs seem to convey

temporal stability, which is a prerequisite in measuring stable characteristics, but even so, there is no concrete evidence that EMSs exist across the lifespan. The findings of this research suggest that EMSs do have an ongoing influence. To investigate this notion further, psychologists in Holland are currently conducting research directed at developing two short schema questionnaires for children and adolescents (Rijkeboer et al., 2004). In doing so it is hoped clues will be found into 'what type' of EMSs can be identified in individuals that are still developing.

'It is more important to know what sort of person has a disease,

than to know what sort of disease a person has'

Hippocrates

13.1 Improving collaboration in dermatological practice

Doctors often underestimate the degree of psychological and social morbidity caused by skin disease (Stankler, 1981). Those who adopt the biopsychosocial model however, when treating dermatology patients are rewarded with improved therapeutic alliances and grateful patients who experience improved quality of life (Barankin & De Koven, 2002). Given that psoriasis and eczema recur throughout patients' lives, it may be more important to help patients cope with the disfiguring and social consequences of the disease. In Greece, the idea of psychologists working in collaboration with doctors and offering counselling to patients is still a new. In some respects 'a mind-body' split has dominated medical settings and equally the thinking of patients. Currently, if psychological referrals are made, they are for 'severe cases' that need psychiatric assessment or psychotropic medication. Changing the ethos of care in a different cultural environment will require, educating dermatologist on the psychological implications of skin disease and finding non-threatening ways to inform patients on the value of psychological care. Fortunately, the image of psychology has improved in recent years via the media, which has normalized seeking help 'outside the family'. Furthermore, in

conducting this study there was much interest from patients, which suggests there is a need for individuals to be given the opportunity to talk about the difficulties they face whilst coping with their condition.

There is great scope for developing psychodermatological research in Greece, but this can only be achieved if collaborative relationships are advanced through the establishment of psychological services in dermatology departments. Making links evident and a normal part of patient care can promote this process. Invariably, the support of dermatologists themselves and government funding is essential. Conducting clinical seminars to disseminate psychological knowledge and the implications on patient care can also promote open discussion. This requires psychologists in the field to take interest in dermatology conferences and to be informed of developments surrounding treatment. Such knowledge leads to advanced accurate empathy, improves therapeutic formulations and promotes a biopsychosocial approach to care. In psoriasis and eczema, preliminary studies suggest that adjunctive psychological therapies are effective in the clinical management of the disease. Fortune et al. (2002) examined if a 6-week multidisciplinary management approach could improve the clinical severity of psoriasis and the psychological distress and disability the disease engenders. Results showed that in comparison to standard treatment, psoriasis patients who opted for the multidisciplinary care improved significantly on all variables at 6-weeks and 6-months follow up. Similar models of practice can be very helpful if implemented in developing countries like Greece.

13.2 Schema therapy in dermatology

The schema model does not provide a comprehensive theory of psychopathology but a working theory that integrates and guides clinical interventions. The model remains respectful to the concept of 'self' and the notion that each person has a unique way of seeing the world. By recognising that most humans have 'some unmet core need', it also accepts that 'vulnerability' and 'resilience' is an inherent part of the human condition. The course of schema therapy will thus be briefly discussed and 'limited reparenting', is highlighted as an important component of therapeutic change.

The process of helping

Schema therapy is divided into two phases: assessment and change. In the assessment phase, presenting problems relating to the experience of skin disease are linked to the life and history of the client, and relevant EMSs and coping patterns are identified. This involves gradually generating a set of working hypotheses on the biological, psychological and social components of the client's difficulties using multiple assessment strategies including the YSQ-SF and other self-monitoring assignments. Once EMSs are identified the therapist explores how the client characteristically maintains, avoids or compensates for their schemas on a personal and interpersonal level. A crucial component of the assessment process includes the activation of primary schemas. This is achieved by asking the client to image early childhood scenes, with their mother, and then father in order to trigger schemas emotionally (Young, 2002). The aim of such

experiential work is to gather information and to assist the client in creating links between current problems and related childhood experiences.

As the alliance develops and before change is initiated, education on the schema model enables the client to understand their schemas intellectually and to experience them emotionally. At end of this phase, a schema conceptualization developed jointly by therapist and client, and a treatment plan is put in to action. This formulation is likely to reflect that person's idiosyncratic view of eczema or psoriasis and its impact on their quality of life. While it is useful to conceptualise the assessment and change phases as distinct processes, clinical practice shows that in fact, they often overlap and the one always informs the other.

In the change phase the therapist blends cognitive, experiential, behavioural and interpersonal strategies in a flexible manner, depending on the needs of the client. The aim of this phase is to modify relevant schemas by altering the distorted view of self and of others. The curative component of the therapist-client relationship is also an essential aspect of the change process. Throughout the course of schema therapy, the treatment plan concentrates on interventions that promote schema healing. The case formulation is the lynch pin of this therapeutic effort, but remains hypothetical and requires updating in light of evidence emerging from working with the client. Waller (2005, personal communication) points out that in the assessment phase, many patients can only focus on part of the formulation at any one time, it may be more the task of the therapist to keep the broad picture in mind in the early stages, by sharing relevant aspects of the

conceptualization in a 'user-friendly' manner and at the appropriate time. In the change phase, the focus may entail working on a specific schema that the client agrees interferes with how they cope with psoriasis or eczema. The excerpt below provides an overview of schema work with a female client that coped with chronic skin disease since adolescence:

'Anna is a middle aged housewife who suffers with psoriasis. Her two core schemas are self-sacrifice and emotional deprivation. These impacted on her ability to meet her needs, as she often 'did everything for her husband and two teenage sons' without asking for things in return. To be 'a good wife and mother', she believed was her role in the family. When distressed the client found it difficult to express anger, in fear she would damage her marriage or children in some way; or that they would land up hating her. In terms of her skin condition, the client admitted that she got respite when her psoriasis flared and could no longer do certain chores. Following identification of her schemas, imagery of distressing events in her childhood revealed that Anna had controlling parents that expected her - being the eldest, to take care of her siblings and to focus on the needs of the family. In doing so the client strived to gain their love and approval, but nothing she ever did was good enough. Anna chose to work on her self-sacrifice schema. In the change phase, the focus was on developing skills on a cognitive and behavioural level that would help meet her needs. This included assertiveness training and learning to express anger without feeling guilty or fearing an impending catastrophe. In image the client was assisted to express her anger and needs to each parent, and was encouraged to use the therapeutic

alliance as a nurturing base. This learning was transposed into her everyday life so that she sacrificed less for loved ones and let them take more responsibility for meeting their own needs. Following this work Anna was ready to work on her primary schema of emotional deprivation. The client's psoriasis exacerbated when she was stressed, but her remission periods lengthened. As time passed the meaning of psoriasis also changed and at the end of counselling the client viewed her condition as a door that had opened her psychological freedom'

Limited reparenting

A central tenant in the application of the schema model is that the therapeutic relationship is a tool to be used within therapy, as a mediator of change. This is achieved by creating a 'secure base' for the client through 'limited reparenting'. The findings of this research on EMSs and parental bonding highlight the centrality of this notion in skin disease. In clinical work, the focus of the schema model is congruent with the philosophy of counselling psychology that stresses the phenomenology of the client distress, the emotional meaning of events and significance of subjective and inter-subjective experiences. In the same way that counselling psychology views the alliance as a vehicle for change, the schema model also places greater emphasis on the bond between therapist and client.

The process of limited reparenting is most valuable for clients with EMSs in the domain of 'disconnection and rejection' and would thus be useful in the therapeutic experience of patients' with psoriasis and eczema. For example, if the parents of a client with psoriasis were very critical (as exemplified in Anna's background) then the therapist tries to be available and as accepting as possible.

The therapist may also make a point of praising the client and recasting events in a positive light. If parents were withholding, the therapist tries to be as nurturing as possible. By promoting a therapeutic atmosphere wherein core needs can be met, issues relating to skin disease such as altered appearance or social functioning, can be addressed in a broader and more self-enhancing way. No attempt is made at any stage to re-enact the parent or regress the patient to a state of childlike dependency. The therapist only offers an approximation of the missed emotional experience, while respecting the ethical boundaries of the therapeutic alliance (Cecero & Young, 2001). The clinical process discussed above demonstrates how schema theory can be linked to dermatological practice to increase understanding of client difficulties and improve patient care

11.7 Concluding thoughts

My journey through this doctoral thesis and its clinical components has helped me realise that fundamentally the transformation of meanings lies at the core of helping. A good therapeutic relationship between therapist and client provides the context for such change. Helping clients recognise that they have the ability to transform the meanings they attach to their symptoms, relationships and life problems is possibly the most simple, but most powerful insight that can occur through therapy. The schema model in my view makes this process transparent and provides the tools that make it achievable. Inevitably, the experience of doing this research has also transformed some of my own meanings. On a broad level I am aware that at the end of this journey, another one begins but I hope to build on the learning that I have gained. During quiet moments, I have also thought of

various stories in my life and about how my own schemas have impacted my interpretations. I wondered how I have changed these stories to better fit the outcome that I sought. I asked myself the same questions with regards to my understanding of clients and considered how my own schemas could interfere or may have hampered the process of helping. This level of reflection is a perquisite in my own development and an essential component of 'being' a counselling psychologist. A moment of contentment was the inner recognition that both the clinical and research experiences embedded in this journey have strengthened my conviction and hope in applying the schema model in the future. To be inspired at this stage of my career feels like having a gift that is mine - but equally there to be shared by helping clients transform the meanings in their lives.

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Appendices

Appendix 1: Cover letter and consent form (Greek/English)

ΠΡΟΣΚΛΗΣΗ ΓΙΑ ΣΥΜΜΕΤΟΧΗ ΣΕ ΜΙΑ ΕΡΕΥΝΑ

Καλείστε να πάρετε μέρος σε μία έρευνα η οποία σκοπεύει να διερευνήσει τη σχέση ανάμεσα στις δερματολογικές ασθένειες και ορισμένους ψυχολογικούς παράγοντες. Προτού αποφασίσετε να λάβετε μέρος είναι σημαντικό να κατανοήσετε που αποσκοπεί. Παρακαλώ να διαβάσετε τις παρακάτω πληροφορίες προσεκτικά.

Πολλοί άνθρωποι πάσχουν από δερματολογικές ασθένειες. Παρόλα αυτά ο τρόπος αντιμετώπισης κάθε ασθένειας διαφέρει από άτομο σε άτομο. Οι πληροφορίες που θα μας δώσετε, θα βοηθήσουν στην κατανόηση των διαφορετικών τρόπων αντιμετώπισης δερματολογικών ασθενειών. Σε ορισμένες περιπτώσεις χρειάζεται να κάνουμε συγκρίσεις για να καταλήξουμε στον καλύτερο τρόπο θεραπείας για τον κάθε ασθενή. Για να επιτευχθεί αυτό συχνά γίνεται ομαδοποίηση, των ασθενών ανάλογα με την δερματολογική τους ασθένεια έτσι ώστε να κατανοηθούν οι εμπειρίες τους, και οι σκέψεις τους συνολικά.

Με λίγα λεπτά από τον χρόνο σας, μπορείτε να συμπληρώσετε τα ερωτηματολόγια τα οποία ζητούν τα ακόλουθα: 1) γενικές πληροφορίες για τον εαυτό σας, 2) τις δικές σας απόψεις για τον εαυτό σας και τις σχέσεις σας με τους γονείς σας. Επισημαίνω, ότι τα ερωτηματολόγια δεν επικεντρώνονται στην δερματολογική σας ασθένεια αλλά στους τρόπους σκέψεις σας, στους τρόπους αντιμετώπισής σας και στις σχέσεων σας. Στην περίπτωση που ενώ τα συμπληρώνετε - έχετε κάποιες απορίες, απαντήστε όπως εσείς το κατανοείτε, καθώς δεν υπάρχουν λάθος ή σωστές απαντήσεις. Επίσης είναι σημαντικό να μην ξοδέψετε πολύ χρόνο για να απαντήσετε στις ερωτήσεις. Αν παρόλα αυτά, έχετε κάποια δυσκολία να απαντήσετε - θα σας πρότεινα να απαντήστε με βάση την πρώτη σκέψη, που έρχεται στο μυαλό σας για αυτήν την ερώτηση.

Η συμμετοχή σας στην έρευνα είναι εντελώς εθελοντική. Εάν αποφασίσετε να πάρετε μέρος, κρατήσετε αυτό το χαρτί και υπογράψτε τη φόρμα συγκατάθεσης (Βλέπε επόμενη σελίδα). Ακόμη και αν λάβετε μέρος μπορείτε να σταματήσετε οποιαδήποτε στιγμή. Σε οποιαδήποτε περίπτωση, η απόφαση σας δεν θα επηρεάσει την περίθαλψή σας.

Όλες οι πληροφορίες που θα συλλεχθούν θα παραμείνουν ανώνυμες, καθώς σε κανένα από τα ερωτηματολόγια δεν χρειάζεται να γράψετε το όνομά σας. Επίσης καμία από τις πληροφορίες δεν θα δοθεί στο γιατρό σας, αν και θα γνωρίζει για την συμμετοχή σας. Για ακόμη μια φορά, θυμηθείτε ότι η έρευνα είναι <u>εμπιστευτική</u> και οι πληροφορίες που θα μας παρέχετε θα συμβάλουν σημαντικά στην κατανόηση της σχέσεις ανάμεσα στις δερματολογικές ασθένειες και στους ψυχολογικούς παράγοντες - προκειμένου να αναπτυχθούν νέοι τρόποι αντιμετώπισης τους.

Θα ήθελα να σας ευχαριστήσω για τον χρόνο σας και τη συνεργασίας σας.

Με εκτίμηση,

Λίτσα Άνθη
Συμβουλευτική Ψυχολόγος

ΕΓΓΡΑΦΗ ΦΟΡΜΑ ΣΥΓΚΑΤΑΘΕΣΗΣ

Έχω κατανοήσει το σκοπό της έρευνας και έχω κρατήσει το σχετικό ενημερωτικό φυλλάδιο.

Δίνω ελεύθερα την συγκατάθεση μου για συμμετοχή σ'αυτή την έρευνα. Κανένας δεν μου άσκησε οποιαδήποτε πίεση. Γνωρίζω ότι μπορώ να διακόψω την συμμετοχή μου ανά πάσα στιγμή. Γνωρίζω ότι εάν δεν λάβω μέρος στην έρευνα, θα μπορώ να συνεχίσω τη θεραπεία μου κανονικά.

Υπογραφή Ασθενούς/Εθελοντή _____

Ημερομηνία _____

LONDON GUILDHALL
UNIVERSITY

INVITATION TO PARTICIPATE IN A RESEARCH STUDY

You are invited to take part in a research study that aims to investigate the relationship between skin disease and various psychological variables. Before you decide whether you would like to participate in it is important that you comprehend what this investigation involves. Please read the following instructions carefully.

Many people suffer from skin diseases. In the face of of this reality, coping with illness differs from person to person. The information that you provide will assist in the understanding of the different ways of adjusting to skin disease. In some instances it is necessary make comparisons in order to facilitate the best form of treatment for every patient. For this to be achieved patients are sometimes grouped according to their dermatological condition so that their experiences and thoughts can be better understood as a whole.

With a few moments of your time, you could complete the questionnaires that ask you for the following: 1) general information about yourself, 2) your perceptions of yourself and your relationships with your parents. I reiterate the questionnaires do not focus on your skin disease but on your ways of thinking, ways of coping and on your relationships. If whilst completing the questionnaires – you have some questions over the items, answer in terms of how you understand the question as there are no right or wrong answers. In addition it is important not to spend too much answering the questions. If after all these considerations you still experience some difficulty in answering – I would suggest that you answer on the basis of the first thought that came to mind for that question.

Your participation in this study is completely voluntary. If you decide to take part, keep this information sheet and sign the consent form.(See next page).Even if you take part, you can stop at any time. In any event, your decision will not influence your treatment.

All the information collected will remain anonymous, and on no questionnaire is it necessary to write your name. In addition none of the information will be given to your doctor, even though they are aware of your participation. Once again, remember that the study is <u>confidential</u> and the information you provide will contribute greatly in the understanding of skin disease and psychological variables – so that new ways of care can be developed.

Thank you for your time and your collaboration.

Yours sincerely

Litsa Anthis
Counselling Psychologist

CONSENT FORM

I have understood the aim of this research study and I have kept the information leaflet.

I freely give my consent in the participation of this study. Nobody has exercised any form of pressure over me. I know that I can end my participation at any moment. I understand that if I don't take part in the research study, I will be able to continue my treatment as usual.

Signature of patient/volunteer _____

Date _____

Appendix 2: Demographics questionnaire (Greek/English)

ΔΗΜΟΓΡΑΦΙΚΟ ΕΡΩΤΗΜΑΤΟΛΟΓΙΟ

Παρακαλώ είναι σημαντικό να απαντήσετε σε όλες τις ερωτήσεις. Οι πληροφορίες που θα συλλεχθούν **είναι εμπιστευτικές και απόρρητες**. Απαντήστε κάθε ερώτηση βάζοντας ένα √ στην απάντηση που σας ταιριάζει καλύτερα ή γράφοντας τις πληροφορίες που ζητιούνται.

1) Ποιά είναι η ηλικία σας; _____

2) Ποιό είναι το φύλο σας; Άνδρας ☐ Γυναίκα ☐

3) Ποιά είναι η οικογενειακή σας κατάσταση;

Άγαμος	☐	Παντρεμένος/η	☐
Έχω φίλο/η	☐	Χωρισμένος/η	☐
Αρραβωνιασμένος/η	☐	Άλλο_____	

4)Έχετε παιδιά; Ναι ☐ Όχι ☐ Αν ναι, πόσα παιδιά έχετε _____

5) Ποιά είναι η θρησκεία σας;_____

6) Πόσο θρησκευόμενη/ος πιστεύετε ότι είστε (Βάλτε σε κύκλο τον αριθμό που πιστευτέ ότι σας εκφράζει καλύτερα);

1 2 3 4 5 6 7

(πάρα πολύ πιστή/ος) **(καθόλου πιστή/ος)**

7) Ποιό είναι το εκπαιδευτικό σας επίπεδο;_____

8) Ποιό είναι το τωρινό σας επάγγελμα;_____

9) Ζούσα και με τους δυο μου γονείς μέχρι την ηλικία των _____ χρόνων

10) Ο πατέρας μου ζει ακόμα: Ναι ☐ Όχι ☐ : Ο πατέρας μου πέθανε όταν ήμουν _ χρονών

11) Η μητέρα μου ζει ακόμα: Ναι ☐ Όχι ☐ : Η μητέρα μου πέθανε όταν ήμουν __ χρονών

12) Η γονείς μου χώρισαν όταν ήμουν _____ χρονών

12.1)Έζησα με το πατέρα ☐ την μητέρα ☐ από την ηλικία των __ , μέχρι ___ χρονών

13) Ζούσα με συγγενείς άλλους από τους γονείς μου ☐ από την ηλικία των _μέχρι _ χρονών

14) Ποια είναι κατά περίπου το οικογενειακό σας εισόδημα:

1) 0-1.000.000δρχ/ 0-2.934 Ευρώ ☐
2) 1.001.000-2.000.000δρχ/ 2.934-5.869 Ευρώ ☐
3) 2.001.000-3.000.000δρχ/ 5.869-8.804 Ευρώ ☐
4) 3.001.000-4.000.000δρχ/8.804-11.738 Ευρώ ☐
5) 4.001.000-5.000.000δρχ/11.738-14.673 Ευρώ ☐
6) 5.001.000-6.000.000δρχ/14.673-17.608 Ευρώ ☐
7) 6.001.000-7.000.000δρχ/17.608-20.542 Ευρώ ☐
8) 7.001.000δρχ/ και πάνω 20.542 Ευρώ ☐

15) Πάσχετε από κάποια από τις παρακάτω δερματολογικές ασθένειες;

Ψωρίαση ☐ Έκζημα ☐ Άλλο_____ Όχι ☐

(15.1) **Τη ηλικία είχατε όταν πρωτοεμφανίστηκε η δερματολογική σας ασθένεια;**_____

(15.2) **Στην παρακάτω κλίμακα παρακαλώ, βάλτε ένα Χ ανάμεσα στο 0 και 10 σύμφωνα με το πόσο σοβαρή αντιλαμβάνεστε ότι είναι η δερματολογική σας ασθένεια;**

0 1 2 3 4 5 6 7 8 9 10
ελαφριά μέτρια σοβαρή

(15.3) **Σήμερα παίρνετε κάποια φάρμακα για τη δερματολογική σας ασθένεια;**

Ναι ☐ Όχι ☐

(15.4) **Παλαιότερα παίρνατε φάρμακα για τη δερματολογική σας ασθένεια;**

Ναι ☐ Όχι ☐

16) Πάσχετε από κάποια άλλη ασθένεια;

Ναι ☐ Όχι ☐ Αν ναι, καθορίστε_____

17) Χρησιμοποιήσατε φάρμακα για κατάθλιψη ή άγχος;

Ναι ☐ Όχι ☐

18) Κάνατε ψυχοθεραπεία ή είχατε λάβει ψυχολογική υποστήριξη;

Ναι ☐ Όχι ☐ Αν ναι, καθορίστε πότε και πόσο καιρό___

Σας ευχαριστώ πολύ για το χρόνο σας!

DEMOGRAPHICS QUESTIONNAIRE

Please note that it is important that you answer all the questions. The information that will be collected is **completely confidential**. Answer each question by placing a √ by the answer that suits you best or by writing down the information that is being asked.

1) What is your age?

2) What is your gender? Male ☐ Female ☐

3) What is your family status?

Single ☐ Married ☐
I have a girlfriend/boyfriend ☐ Divorced ☐
Engaged ☐ Other _____

4) Do you have children? Yes ☐ No ☐ If yes, how many _____

5) What is your religion? _____

6) How religious are you? (Circle a number that you believe best represents you)

1 2 3 4 5 6 7
(very religious) (not at all religious)

7) What is your education level? _____

8) What is your current occupation? _____

9) I lived with both my parents until the age of _____ years

10) My father is still alive: Yes☐ No ☐ : **My father died when I was _____ years**

11) My mother is still alive: Yes☐ No ☐ : **My mother died when I was _____ years**

12) My parents got divorced when I was _____ years

12.1) I lived with my father ☐ my mother ☐ from the age of ____years to _____years

13) I lived with relatives other than my parents' ☐ from the age of ____years to _____ years

14) What is your average family income?

1) 0-1.000.000 drachmas / 0 – 2.934 Euro ☐
2) 1.001.000 - 2.000.000 drachma / 2.934 - 5.869 Euro ☐
3) 2.001.000 - 3.000.000 drachma / 5.869 - 8.804 Euro ☐
4) 3.001.000 - 4.000.000 drachma / 8.804 - 11.738 Euro ☐
5) 4.001.000 - 5.000.000 drachma / 11.738 - 14.673 Euro ☐
6) 5.001.000 - 6.000.000 drachma / 14.673 - 17.608 Euro ☐
7) 6.001.000 - 7.000.000 drachma / 17.608 - 20.542 Euro ☐
8) 7.001.000 drachma - and higher 20.542 Euro ☐

15) Do you suffer from any of these skin conditions?

Psoriasis ☐ Eczema ☐ Other_____ No ☐

15.1) **At what age did your skin disease onset?** _____

15.2) **On the scale below pleas place and X between 0 and 10 in accordance with how severe you perceive your skin disease to be:**

_____

0 1 2 3 4 5 6 7 8 9 10

mild moderate severe

15.3) **Do you currently take any medication for your skin condition?**

Yes ☐ No☐

15.4) **Have you taken medication for your skin condition in the past?**

Yes ☐ No☐

16) Do you suffer from any other illness?

Yes ☐ No☐ If yes, please specify _____

17) Are you under medication for depression or anxiety?

Yes ☐ No☐

18) Are you undergoing psychotherapy or have you participated in psychological therapy?

Yes ☐ No☐ If yes, specify when and for how long _____

Thank you very much, for your time!

Appendix 3: Full listing of schemas and domains

DISCONNECTION & REJECTION

(Expectation that one's needs for security, safety, stability, nurturance, empathy, sharing of feelings, acceptance and respect will not be met in a predictable manner. Typical family of origin is detached, cold, rejecting, withholding, lonely, explosive, unpredictable or abusive.)

1. ABANDONMENT / INSTABILITY (AB)
The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable (e.g. angry outbursts), unreliable or erratically present; because they will die imminently; or because they will abandon the patient in favour of someone better.

2. MISTRUST / ABUSE (MA)
The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or 'getting the short end of the stick'.

3. EMOTIONAL DEPRIVATION (ED)
Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are:

A. **Deprivation of Nurturance**: Absence of attention, affection, warmth or companionship.
B. **Deprivation of Empathy**: Absence of understanding, listening, self disclosure or mutual sharing of feelings from others
C. **Deprivation of Protection**: Absence of strength, direction or guidance from others.

4. DEFECTIVENESS / SHAME (DS)
the feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involve hypersensitivity to criticism, rejection and blame; self-consciousness', comparisons and insecurity around others; or a sense of shame regarding ones perceived flaws. These flaws may be **private** (e.g. selfishness, angry impulses, unacceptable sexual desires) or **public** (e.g. undesirable physical appearance and social awkwardness)

5. SOCIAL ISOLATION / ALIENTATION (SI)
The feeling that one is isolated from the rest of the world, different from other people, ans/or not part of any group or community.

IMPAIRED AUTONOMY & PERFORMACE

(Expectations about oneself and the environment that interfere with one's perceived ability to separate survive, function independently or perform successfully. Typical family of origin is enmeshed undermining of a child's confidence, overprotective or failing to reinforce the child for performing competently outside the family.)

6. DEPENDENCE /INCOMPETENCE (DI)
Belief that one is unable to handle ones everyday *responsibilities* in a competent manner, without considerable help from others (e.g. take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions.) Often presents as helplessness.

7. VULNERABILITY TO HARM OR ILLNESS (VH)
Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: a) medical catastrophes, b) emotional catastrophes e.g. going crazy, c) external catastrophes e.g. elevators collapsing, victimised by criminals, airplane crashes, earthquakes.

8. ENMESHMENT / UNDEVELOPED SELF (EM)
Excessive emotional involvement and closeness with one or more significant others (often parents) at the expense of full individuation or normal social development. Often involves the belief that at least on e of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by or fused with others OR insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction or in extreme cases questioning ones existence.

9. FAILURE (FA)
The belief that one has failed will inevitably fail or is fundamentally inadequate relative to one's peers in area of achievement (school, career, sports etc.). Often involves beliefs that on is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.

IMPAIRED LIMITS

(Deficiency in internal limits, responsibility of others, or long term goals; orientation. Leads to difficulty in respecting the rights of others, cooperating with others, making commitments or setting and meeting realistic goals. Typical family of origin is characterised by permissiveness, overindulgence, lack of direction or a sense of superiority – rather that appropriate confrontation, discipline, and limits in relation to taking responsibility, cooperating in a reciprocal manner and setting goals., In some cases, a child may not have been pushed to tolerate normal levels of discomfort, or may not have been given adequate supervisor, direction or guidance).

10. ENTITILEMENT / GRANDIOSITY (ET)
The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interaction. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider is reasonable, or the cost to others; OR an exaggerated focus on superiority (e.g. being among the most successful, famous, wealthy) - in order to achieve *power* or *control* (not primarily for attention or approval). Sometimes includes excessive competitiveness toward or domination of others; asserting ones power, forcing one point of view, or controlling the behaviour of others in line with one own desires - without empathy or concern for others needs or feelings.

11. INSUFFICIENT SELF CONTROL / SELF-DISCIPLINE (IS)
Pervasive difficulty or refusal to exercise sufficient control and frustration tolerance to achieve ones personal goals or to restrain the excessive expression of one emotions and impulses. In its milder form the patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion at the expense of personal fulfilment, commitment or integrity.

OTHER-DIRECTEDNESS

(An excessive focus on the desires, feelings and responses of others at the expense of ones own needs – in order to again love an approval maintain ones sense of connection or avoid retaliation. Usually involves suppression and lack of awareness regarding ones own anger and natural inclinations. Typical family of origin is based on conditional acceptance: children must suppress important aspects of themselves in order to gain love, attention and approval. In many such families the parents emotional needs and desires –or social acceptance and status –are valued more than the unique needs and feelings of the child.)

12. SUBJUGATION (SB)
Excessive surrendering of control to others because one feels *coerced* – usually to avoid anger, retaliation, or abandonment. The two major forms of subjugation are:

A. **Subjugation of Needs**: Suppression of one s preferences decisions and desires.
B. **Subjugation of Emotions**: Suppression of emotional expression, especially anger.

Usually involves a perception that one's desires, opinions and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g. passive-aggressive behaviour, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, 'acting out' and substance abuse.)

13. SELF-SACRIFICE (SS)
Excessive focus on *voluntarily* meeting the needs of others in daily situations, at the expense of ones own gratification. The most common reasons are: to prevent causing pain to others. To avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one own needs are not being adequately met and to resentment of those who a re taken care of. (Overlaps with co-dependency).

14. APPROVAL SEEKING /RECOGNITION SEEKING
Excessive emphasis on gaining approval, recognition or attention from other people or fitting in at the expense of developing a secure and true sense of self. Ones sense of self-esteem is dependent primarily on the reaction of others rather than on one's own natural inclinations. Sometimes includes and overemphasis on status appearance, social acceptance, money or achievement - as a means of gaining approval, admiration or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying or hypersensitivity to rejection.

OVERVIGILANCE & INHIBITION

(Excessive emphasis on suppressing one spontaneous feelings, impulses and choices or on meeting rigid, internalised rules and expectations about performance and ethical behaviour - often at the expense of happiness, self expression, relaxation , close relationships or health. Typical family of origin is grim, demanding and sometimes punitive: Performance, duty, perfectionism, following rules or hiding emotions and avoiding mistakes predominate over pleasure, joy and relaxation. There is usually an undercurrent of pessimism and worry –that things could fall apart if one fails to be vigilant and careful at all time.)

15. NEGATIVITY / PESSIMISM (NP)
A pervasive lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes betrayal, things that could go wrong etc.) while minimising or neglecting the positive and optimistic aspects. Usually includes an exaggerated expectation in a wide range of work, financial or interpersonal situations - that things

will eventually go seriously wrong, or that aspects of ones life that seem to be going well will ultimately fall apart. Usually involves an inordinate fear of making mistakes that might lead to financial collapse, loss, humiliation, or being trapped in a bad situation, because potential negative outcomes are exaggerated, these patients are frequently characterised by chronic worry, vigilance, complaining or indecision.)

16. EMOTIONAL INHIBITION (EI)
The excessive inhibition of spontaneous action, feeling or communication—usually to avoid disapproval by others, feelings of shame, or losing control of one impulses. The most common areas of inhibition involve: a) inhibition of anger and aggression, b) inhibition of positive impulses (e.g. joy, affection, sexual excitement, play) c) difficulty expressing *vulnerability* or *communicating* freely about ones needs etc or d) excessive emphasis on rationality while disregarding emotions.

17. UNRELENTING STANDARDS / HYPERCRITICALNESS (US)
The underlying belief that one must strive to meet very high internalised standards of behaviour and performance usually to avoid criticism. Typically results in feelings of pressure or difficulty in slowing down; and in hypercriticalness toward onself and others. Must involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment or satisfying relationships. Unrelenting standards typically present as a) perfectionism, inordinate attention to detail or an underestimate of how good one's own performance is relative to the norm; b) rigid rules and 'shoulds' in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts or c) preoccupation with time and efficiency so that more can be accomplished.

18. PUNITIVENESS
The belief that people should be harshly punished for making mistakes. Involves the tendency to be angry, intolerant, punitive and impatient with those people (including oneself) who do not meet ones expectations and standards. Usually includes difficulty forgiving mistakes in oneself and others, because of a reluctance to consider extenuating circumstances, allow for human imperfection or empathise with feelings.

Appendix 4: Young Schema Questionnaire - Short Form (Greek/English)

Schema Questionnaire- S1

ΟΔΗΓΙΕΣ

Οι παρακάτω προτάσεις είναι προτάσεις που θα μπορούσε κάποιος να χρησιμοποιήσει για να περιγράψει τον εαυτό του. Παρακαλώ, διαβάστε την κάθε πρόταση και αποφασίστε το πόσο καλά σας περιγράφει. Αν για κάποια πρόταση δεν είστε σίγουρος/η, βασίστε την απάντησή σας σε αυτό που νιώθετε συναισθηματικά, και όχι σε αυτό που νομίζετε ότι ισχύει. Επιλέξατε την υψηλότερη βαθμολογία από το 1 έως το 6 που σας περιγράφει και γράψτε την στον χώρο μπροστά από την πρόταση.

ΒΑΘΜΟΛΟΓΙΑ

1= Δεν ισχύει καθόλου για μένα	4= Ισχύει μέτρια για μένα
2= Δεν ισχύει σε μεγάλο βαθμό για μένα	5= Ισχύει σε μεγάλο βαθμό για μένα
3= Μάλλον ισχύει, παρά δεν ισχύει	6= Με περιγράφει με τον καλύτερο τρόπο

1 ____ Τον περισσότερο καιρό δεν είχα και δεν έχω κάποιον να με καθοδηγεί, να μοιράζεται τον εαυτό του μαζί μου ή να νοιάζεται πραγματικά για οτιδήποτε μου συμβαίνει.

2 ____ Κατά κανόνα δεν υπήρχαν και δεν υπάρχουν άνθρωποι να μου δώσουν ζεστασιά, υποστήριξη και τρυφερότητα.

3 ____ Στο μεγαλύτερο μέρος της ζωής μου δεν έχω νιώσει ότι αποτελώ κάτι ξεχωριστό για κάποιον.

4 ____ Κατά κανόνα δεν είχα και δεν έχω κάποιον που να με ακούει πραγματικά, να με καταλαβαίνει, ή να συντονίζεται στις πραγματικές μου ανάγκες και συναισθήματα

5 ____ Σπάνια υπήρχε ή υπάρχει ένας δυνατός άνθρωπος για να μου δώσει σωστές συμβουλές ή
ed κατευθύνσεις όταν δεν είμαι σίγουρος/η για το τι να κάνω.

6 ____ Βρίσκω ότι προσκολλώμαι σε ανθρώπους που είναι κοντά μου επειδή φοβάμαι ότι θα με εγκαταλείψουν.

7 ____ Χρειάζομαι τους άλλους τόσο πολύ που ανησυχώ ότι θα τους χάσω.

8 ____ Ανησυχώ ότι οι άνθρωποι που αισθάνομαι κοντά τους θα με εγκαταλείψουν ή θα με παρατήσουν.

9 ____ Όταν νιώθω ότι κάποιος για τον οποίον νοιάζομαι αρχίζει να αποτραβιέται από μένα, με πιάνει απόγνωση.

10 ____ Μερικές φορές ανησυχώ τόσο πολύ ότι οι άνθρωποι θα με εγκαταλείψουν, ώστε να τους σπρώχνω μακριά μου.
ab

11 ____ Νιώθω ότι οι άνθρωποι θα με εκμεταλλευτούν.

12 ____ Νιώθω ότι δεν μπορώ να μην αμύνομαι μπροστά σε άλλους, ειδάλλως θα με πληγώσουν σκόπιμα.

13 ____ Είναι μόνο θέμα χρόνου πριν κάποιος με προδώσει.

14 ____ Είμαι αρκετά καχύποπτος/η ως προς τα κίνητρα των άλλων ανθρώπων.

15 ____ Είμαι συνήθως σε επιφυλακή ως προς τα απώτερα κίνητρα των ανθρώπων.
ma

16 ____ Δεν ταιριάζω με τίποτα και με κανέναν.

17 ____ Είμαι ουσιαστικά διαφορετικός/η από τους άλλους ανθρώπους.

18 ____ Δεν ανήκω πουθενά. Είμαι μοναχικός/ή.

ΒΑΘΜΟΛΟΓΙΑ:

1= Δεν ισχύει καθόλου για μένα	4= Ισχύει μέτρια για μένα
2= Δεν ισχύει σε μεγάλο βαθμό για μένα	5= Ισχύει σε μεγάλο βαθμό για μένα
3= Μάλλον ισχύει, παρά δεν ισχύει	6= Με περιγράφει με τον καλύτερο τρόπο

19 ____ Νιώθω αποξενωμένος (απόμακρος) από τους άλλους ανθρώπους.

20 ____ Αισθάνομαι πάντα στο περιθώριο κάθε παρέας.
si

21 ____ Κανείς άνδρας/καμία γυναίκα που επιθυμώ δεν θα μπορούσε να με αγαπήσει αν έβλεπε τα ελαττώματά μου.

22 ____ Κανείς που επιθυμώ δεν θα ήθελε να μείνει κοντά μου να γνώριζε τον πραγματικό μου εαυτό.

23 ____ Δεν αξίζω την αγάπη, την προσοχή και την εκτίμηση των άλλων.

24 ____ Νιώθω ότι δεν μπορώ να αγαπηθώ.

25 ____ Είμαι τόσο απαράδεκτος/η σε πολύ βασικά πράγματα ώστε να αποκαλύψω τον εαυτό μου στους άλλους.
ds

26 ____ Σχεδόν τίποτα από ότι κάνω στη δουλειά (ή το σχολείο) δεν είναι τόσο καλό όσο μπορούν να το κάνουν οι άλλοι.

27 ____ Είμαι ανεπαρκής σε ότι αφορά επιτεύγματα.

28 ____ Οι περισσότεροι άνθρωποι είναι πιο ικανοί από ότι εγώ σε θέματα δουλειάς και επιτευγμάτων.

29 ____ Δεν έχω τόσο ταλέντο, όσο έχουν οι περισσότεροι στη δουλειά τους.

30 ____ Δεν είμαι τόσο έξυπνος/η όσο οι περισσότεροι άνθρωποι στην δουλειά τους (ή το σχολείο).
fa

31 ____ Δεν αισθάνομαι ικανός/ή να τα καταφέρω μόνος/η μου στην καθημερινή μου ζωή.

32 ____ Σκέφτομαι ότι είμαι ένα εξαρτημένο άτομο σε ότι αφορά την καθημερινή μου λειτουργικότητα.

33 ____ Μου λείπει η κοινή λογική.

34 ____ Η κρίση μου δεν είναι για να την εμπιστεύεται κανείς στις καθημερινές καταστάσεις.

35 ____ Δεν αισθάνομαι σίγουρος/η για την ικανότητά μου να λύνω καθημερινά προβλήματα που προκύπτουν.
di

36 ____ Δεν μπορώ να ξεφύγω από την αίσθηση ότι κάτι κακό πρόκειται να συμβεί.

37 ____ Νιώθω ότι μια καταστροφή (φυσική, εγκληματική, οικονομική ή ιατρική) θα μπορούσε να προκύψει ξαφνικά κάθε στιγμή.

38 ____ Ανησυχώ ότι θα μου επιτεθούν.

39 ____ Ανησυχώ ότι θα χάσω όλα μου τα χρήματα και θα γίνω άπορος/η.

40 ____ Ανησυχώ ότι θα αναπτύξω μια σοβαρή ασθένεια, ακόμη κι όταν ο γιατρός δεν έχει διαγνώσει
vh τίποτε σημαντικό.

41 ____ Δεν έχω μπορέσει να αποχωριστώ από το γονιό/τους γονείς μου, με τον τρόπο που φαίνεται να το κάνουν τα άλλα άτομα της ηλικίας μου.

ΒΑΘΜΟΛΟΓΙΑ

1= Δεν ισχύει καθόλου για μένα	4= Ισχύει μέτρια για μένα
2= Δεν ισχύει σε μεγάλο βαθμό για μένα	5= Ισχύει σε μεγάλο βαθμό για μένα
3= Μάλλον ισχύει, παρά δεν ισχύει	6= Με περιγράφει με τον καλύτερο τρόπο

42 ____ Ο γονιός/Οι γονείς μου κι εγώ έχουμε την τάση να μπλεκόμαστε ο ένας στη ζωή και τα προβλήματα του άλλου.

43 ____ Είναι πολύ δύσκολο στους γονείς μου κι εμένα να κρατήσουμε κρυφές ο ένας από τον άλλον πολύ προσωπικές λεπτομέρειες, χωρίς να νιώσουμε προδομένοι ή ένοχοι.

44 ____ Αισθάνομαι συχνά σαν ο γονιός/οι γονείς μου να ζουν μέσα από μένα, ότι δεν έχω μια δική μου ζωή.

45 ____ Συχνά αισθάνομαι ότι δεν έχω μια ξεχωριστή ταυτότητα από τους γονείς μου ή τον/την σύντροφό μου.
em

46 ____ Νομίζω κάνω αυτό που θέλω, πάω γυρεύοντας για μπελάδες.

47 ____ Αισθάνομαι ότι δεν έχω άλλη επιλογή από το να ενδίδω στις επιθυμίες των άλλων, ειδάλλως θα μου το ανταποδώσουν ή θα με απορρίψουν με κάποιο τρόπο.

48 ____ Στις σχέσεις μου αφήνω τον άλλο να έχει το πάνω χέρι.

49 ____ Αφήνω πάντα τους άλλους να παίρνουν αποφάσεις για μένα, έτσι ώστε να μην ξέρω πραγματικά τι θέλω για μένα.

50 ____ Έχω μεγάλη δυσκολία να απαιτώ να γίνονται σεβαστά τα δικαιώματά μου και να παίρνονται
sb υπόψη τα συναισθήματά μου.

51 ____ Τελικά είμαι εγώ αυτός/ή που καταλήγει να φροντίζει τους ανθρώπους που είναι κοντά.

52 ____ Είμαι ένα καλό άτομο επειδή σκέφτομαι τους άλλους περισσότερο από τον εαυτό μου.

53 ____ Είμαι τόσο απασχολημένος/η κάνοντας πράγματα για τους ανθρώπους που νοιάζομαι, που έχω λίγο χρόνο για τον εαυτό μου.

54 ____ Είμαι πάντα αυτός/ή που ακούει τα προβλήματα των άλλων.

55 ____ Οι άλλοι με βλέπουν σαν τον άνθρωπο που κάνει πάρα πολλά για τους άλλους και όχι αρκετά
ss για τον εαυτό του.

56 ____ Είμαι τόσο συγκρατημένος/η ώστε δεν δείχνω θετικά συναισθήματα προς τους άλλους (π.χ. τρυφερότητα, να δείξω ότι νοιάζομαι.

57 ____ Βρίσκω άβολο το να εκφράζω τα συναισθήματά μου προς τους άλλους.

58 ____ Μου είναι δύσκολο να είμαι εγκάρδιος/α και αυθόρμητος/η.

59 ____ Ελέγχω τον εαυτό μου τόσο πολύ που οι άλλοι νομίζουν ότι δεν έχω αισθήματα.

60 ____ Οι άλλοι με βλέπουν σαν συναισθηματικά τεντωμένο/η.
ei

61 ____ Πρέπει να είμαι ο καλύτερος/η στα περισσότερα πράγματα που κάνω. Δεν δέχομαι να είμαι δεύτερος/η.

62 ____ Προσπαθώ να καταφέρνω ότι καλύτερο. Δεν αρκούμαι στο «αρκετά καλό».

63 ____ Πρέπει να ανταποκρίνομαι ικανοποιητικά σε όλες μου τις ευθύνες.

64 ____ Νιώθω να πιέζομαι συνεχώς να πετυχαίνω και να ολοκληρώνω πράγματα.

ΒΑΘΜΟΛΟΓΙΑ:

1= Δεν ισχύει καθόλου για μένα	4= Ισχύει μέτρια για μένα.
2= Δεν ισχύει σε μεγάλο βαθμό για μένα	5= Ισχύει σε μεγάλο βαθμό για μένα
3= Μάλλον ισχύει, παρά δεν ισχύει.	6= Με περιγράφει με τον καλύτερο τρόπο

65 ____ Δεν μπορώ να χαλαρώνω εύκολα ή να βρίσκω δικαιολογίες για τα λάθη μου.
us

66 ____ Μου είναι ιδιαίτερα δύσκολο να δεχθώ το «όχι» για απάντηση όποτε θέλω κάτι από τους άλλους.

67 ____ Είμαι ξεχωριστός/ή και δεν θα έπρεπε να δέχομαι πολλούς από τους περιορισμούς που ισχύουν για τους άλλους.

68 ____ Απεχθάνομαι το να με περιορίζουν ή να με εμποδίζουν να κάνω αυτό που θέλω.

69 ____ Νιώθω ότι δεν θα έπρεπε να ακολουθώ τους συνήθεις κανόνες και συμβάσεις που ακολουθούν οι άλλοι.

70 ____ Αισθάνομαι ότι αυτά που έχω να προσφέρω είναι μεγαλύτερης αξίας από τις εισφορές των άλλων.
et

71 ____ Δεν φαίνεται να μπορώ να επιβάλω στον εαυτό μου να ολοκληρώσει συνηθισμένες ή βαρετές δουλειές.

72 ____ Αν δεν μπορώ να καταφέρω έναν στόχο, απογοητεύομαι εύκολα και τα παρατάω.

73 ____ Μου είναι πολύ δύσκολο να θυσιάσω την άμεση ικανοποίηση με σκοπό την επίτευξη ενός μακροπρόθεσμου στόχου.

74 ____ Δεν μπορώ να πιέσω τον εαυτό μου να κάνει πράγματα που δεν τα ευχαριστιέμαι, ακόμη κι όταν γνωρίζω ότι είναι για το καλό μου.

75 ____ Σπάνια μόνο καταφέρνω να είμαι συνεπής στις αποφάσεις μου.
is

Y S Q – S1

Developed by Jeffrey Young Ph.D

Name:_____ Date:_____

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

RATING SCALE:

1= Completely untrue for me
2= Mostly untrue for me
3= Slightly more true than untrue
4= Moderately true for me
5= Mostly true for me
6= Describes me perfectly

1. _____ Most of the time, I haven't had someone to nurture me, share him/herself with me, or care deeply about everything that happens to me.

2. _____ In general, people have not been there to give me warmth, holding, and affection.

3. _____ For much of my life, I haven't felt that I am special to someone.

4. _____ For the most part, I have not had someone who really listens to me, understands me, or is tuned into my true needs and feelings.

5. _____ I have rarely had a strong person to give me sound advice or direction when I 'm not sure what to do.

*ed

6. _____ I find myself clinging to people I'm close to because I'm afraid they'll leave me.

7. _____ I need other people so much that I worry about losing them.

8. _____ I worry that people I feel close to will leave me or abandon me.

9. _____ When I feel someone I care for pulling away from me, I get desperate.

10. _____ Sometimes I am so worried about people leaving me that I drive them away.

*ab

11. _____ I feel that people will take advantage of me.

12. _____ I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me.

13. _____ It is only a matter of time before someone betrays me.

14. _____ I am quite suspicious of other people's motives.

15. _____ I'm usually on the lookout for people's ulterior motives.

*ma

16. _____ I don't fit in.

17. _____ I'm fundamentally different from other people.

18. _____ I don't belong; I'm a loner.

19. _____ I feel alienated from other people.

20. _____ I always feel on the outside of groups.

*si

21. _____ No man/woman I desire could love me one he/she saw my defects.

22. _____ No one I desire would want to stay close to me if he/she knew the real me.

23. _____ I'm unworthy of the love, attention, and respect of others.

24. _____ I feel that I'm not lovable.

25. _____ I am too unacceptable in very basic ways to reveal myself to other people.

*ds
26. _____ Almost nothing I do at work (or school) is as good as other people can do.

27. _____ I'm incompetent when it comes to achievement.

28. _____ Most other people are more capable than I am in areas of work and achievement.

29. _____ I'm not as talented as most people are at their work.

30. _____ I'm not as intelligent as most people when it comes to work (or school).

*fa
31. _____ I do not feel capable of getting on my own in everyday life.

32. _____ I think of myself as a dependent person, when it comes to everyday functioning.

33. _____ I lack common sense.

34. _____ My judgement cannot be relied upon in everyday situations.

35. _____ I don't feel confident about my ability to solve everyday problems that come up.

*di
36. _____ I can't seem to escape the feeling that something bad is about to happen.

37. _____ I feel that a disaster (natural, criminal, financial, or medical) could strike at any moment.

38. _____ I worry about being attacked.

39. _____ I worry that I'll lose all my money and become destitute.

40. _____ I worry that I'm developing a serious illness, even though nothing serious has been diagnosed by a physician.

*vh
41. _____ I have not been able to separate myself from my parent(s), the way other people my age seem to.

42. _____ My parent(s) and I tend to be overinvolved in each other's lives and problems.

43. _____ It is very difficult for my parent(s) and me to keep intimate details from each other, without feeling betrayed or guilty.

44. _____ I often feel as if my parent(s) are living through me—I don't have a life of my own.

45. _____ I often feel that I do not have a separate identity from my parents or partner.

*em
46. _____ I think if I do what I want, I'm only asking for trouble.

47. _____ I feel that I have no choice but to give in to other people's wishes, or else they will retaliate or reject me in some way.

48. _____ In relationships, I let the other person have the upper hand.

49. _____ I've always let others make choices for me, so I really don't know what I want for myself.

50. _____ I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account.

*sb

51. _____ I'm the one who usually ends up taking care of other people I'm close to.

52. _____ I am a good person because I think of others more than of myself.

53. _____ I'm so busy doing for the people that I care about that I have little time for myself.

54. _____ I've always been the one who listens to everyone else's problems.

55. _____ Other people see me as doing too much for others and not enough for myself.

*ss

56. _____ I am too self-conscious to show positive feelings to others (e.g. affection, showing I care)

57. _____ I find it embarrassing to express my feelings to others.

58. _____ I find it hard to be warm and spontaneous.

59. _____ I control myself so much that people think I am unemotional.

60. _____ People see me as uptight emotionally.

*ei

61. _____ I must be the best at most of what I do; I can't accept second best.

62. _____ I try to do my best; I can't settle for 'good enough'

63. _____ I must meet all my responsibilities.

64. _____ I feel there is constant pressure for me to achieve and get things done.

65. _____ I can't let myself off the hook easily or make excuses for my mistakes.

*us

66. _____ I have a lot of trouble accepting 'no' for an answer when I want something from other people.

67. _____ I'm special and shouldn't have to accept many of the restrictions placed on other people.

68. _____ I hate to be constrained or kept from doing what I want.

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

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

*et

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

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

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

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

75. _____ I have really been able to stick to my resolutions.

*is

Appendix 5: Parental Bonding Instrument (Greek/English)

PBI

Το παρακάτω ερωτηματολόγιο περιγράφει διάφορες στάσεις και συμπεριφορές των γονέων. Για να το συμπληρώσετε παρακαλούμε προσπαθήστε να θυμηθείτε πως ήταν η συμπεριφορά **της Μητέρα σας** και **του Πατέρας σας** απέναντί σας, για τα 16 πρώτα χρόνια της ζωής σας και βάλτε ένα √ στο κατάλληλο κουτάκι δίπλα σε κάθε ερώτηση για κάθε έναν από τους γονείς σας.

		Πολύ πιθανό	**Μέτρια πιθανό**	**Μέτρια απίθανο**	**Πολύ απίθανο**
1. Μου μιλούσε με εγκάρδια και φιλική φωνή	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
2. Δεν με βοήθησε τόσο όσο χρειαζόμουν	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
3.Με άφηνε να κάνω τα πράγματα που μου άρεσαν	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
4. Φαινόταν συναισθηματικά ψυχρή προς εμένα	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
5. Φαινόταν να κατανοεί τα προβλήματα και τις ανησυχίες μου	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
6. Ήταν στοργική σε μένα	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
7. Της άρεσε να παίρνω τις δικές μου αποφάσεις	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
8. Δεν ήθελε να μεγαλώσω	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
9. Προσπαθούσε να ελέγχει οτιδήποτε έκανα	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
10. Παραβίαζε την ιδιωτική μου ζωή	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
11. Απολάμβανε να συζητά τα πράγματα μαζί μου	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
12. Συχνά μου χαμογελούσε	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
13. Έτεινε να με κανακεύει	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
14. Φαινόταν να μην καταλαβαίνει τι χρειαζόμουν ή ήθελα	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
15. Με άφηνε να αποφασίζω μόνος/η μου για τα δικά μου	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
16. Με έκανε να αισθάνομαι ότι δεν ήμουν επιθυμητός/η	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
17. Με έκανε να αισθάνομαι καλύτερα όταν ήμουν αναστατωμένος/η	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐

		Πολύ πιθανό	Μέτρια πιθανό	Μέτρια απίθανο	Πολύ απίθανο
18. Δεν μιλούσε μαζί μου πάρα πολύ	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
19. Προσπάθησε να με κάνει να εξαρτώμαι από αυτήν	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
20. Ένιωθα ότι δεν θα μπορούσα να φροντίσω τον εαυτό μου χωρίς αυτήν	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
21. Μου έδωσε τόση ελευθερία όση χρειαζόμουν	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
22. Με άφηνε βγαίνω έξω όσο συχνά ήθελα	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
23. Ήταν υπερπροστατευτική απέναντι μου	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
24. Δεν με επαινούσε	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐
25. Με άφηνε να ντύνομαι με όποιον τρόπο με ευχαριστούσε	Μητέρα	☐	☐	☐	☐
	Πατέρας	☐	☐	☐	☐

Developed by G. Parker, H. Tupling & L.B. Brown

Σας ευχαριστώ πολύ για το χρόνο σας!

PBI

This questionnaire lists various attitudes and behaviours of parents. As you remember your **Mother** and **Father** in your first 16 years, would you place a tick √ in the most appropriate brackets next to each question.

		Very like	Moderately like	Moderately unlike	Very unlike
1. Spoke to me with a warm friendly voice	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
2. Did not help me as much as I needed	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
3.Let me do those things I liked doing	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
4.Seemed emotionally cold to me	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
5. Appeared to understand my problems and worries	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
6. Was affectionate to me	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
7. Liked me to make my own decisions	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
8. Did not want me to grow up	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
9. Tried to control everything I did	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
10. Invaded my privacy	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
11. Enjoyed talking things over with me	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
12. Frequently smiled at me	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
13. Tended to baby me	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
14. Did not seem to understand what I needed or wanted	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
15. Let me decide things for myself	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
16. Made me feel I wasn't wanted	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
17. Could make me feel better when I was upset	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐

		Very like	Moderately like	Moderately like	Very unlike
18. Did not talk with me very much	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
19. Tried to make me dependent on her/him	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
20. Felt I could not look after myself unless she/he was around	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
21. Gave me as much freedom as I wanted	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
22. Let me go out as often as I wanted	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
23. Was overprotective of me	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
24. Did not praise me	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐
25. Let me dress in any way I pleased	Mother	☐	☐	☐	☐
	Father	☐	☐	☐	☐

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Thank you very much for your time.