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Early Maladaptive Schemas in Substance Use Patients and their Intimate Partners: A Preliminary Investigation

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Abstract

Recent research has documented that substance users have a number of early maladaptive schemas that may underlie their substance use and that treatment that addresses these schemas may result in improved outcomes. Research has also shown that intimate partners of substance users have a number of mental and physical health problems, although no known research has examined the early maladaptive schemas of these relationship partners. The current study examined the early maladaptive schemas of substance use treatment patients and their intimate partners ($N = 80$). Findings showed that both patients and intimate partners had a number of problematic early maladaptive schemas; that patients scored significantly higher than their intimate partners on a few early maladaptive schemas; and that patient and intimate partner schemas may be interrelated. Implications of these findings for treatment and future research are discussed.

Keywords

Substance use; alcohol; drugs; early maladaptive schemas; treatment

It is well documented that substance use is a prevalent and devastating problem throughout the world. In an effort to improve treatment of individuals with substance use disorders, research has begun to focus on co-occurring mental health problems that may be relevant to treatment[1], including personality characteristics[2]. In particular, researchers have proposed that early maladaptive schemas may be especially relevant to individuals with substance use disorders, and that a dual-focus on substance use and schemas may produce more efficacious treatment outcomes[3]. Indeed, empirical investigations have shown that early maladaptive schemas are prevalent among individuals with substance use disorders, and that treatment of these schemas may help to reduce substance use[2]. However, to our knowledge, no known research has examined the early maladaptive schemas of intimate partners of individuals with substance use disorders, a group known to have increased mental health and medical problems relative to the general population[4]. Thus, the current study aimed to investigate the early maladaptive schemas of patients at a substance use treatment facility and their intimate partners.

Early Maladaptive Schemas

According to Beck[5], schemas are cognitive structures that are used for screening, coding, and interpreting information in one's environment. Because it is believed that schemas first develop during childhood[6], schemas set the stage for how individuals process experiences

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and stimuli throughout their lives. Early maladaptive schemas are believed to develop through deleterious and traumatic experiences during childhood, particularly experiences that involve one's family of origin[2, 3, 7]. These schemas often generate a high level of negative affect and self-defeating consequences, and they may interfere with meeting needs for connection, autonomy, and self-expression[6]. All early schemas, whether maladaptive or not, are thought to be pervasive and enduring, and are reinforced and elaborated upon during adolescence and adulthood, rendering them highly resistant to change[2]. According to Young and colleagues[6], early maladaptive schemas can be triggered by everyday events and moods, particularly events and moods that can cause emotional distress. In turn, this emotional distress and schema activation can cause dysfunctional interactions with other people[6].

Young and colleagues[6] described 18 maladaptive schemas, which can be grouped into 5 different domains (see Young et al[6], for an in-depth discussion of each schema). These five domains include themes pertaining to over-vigilance and inhibition, disconnection and rejection, other directedness, impaired autonomy and performance, and impaired limits. In response to these maladaptive schemas, individuals are theorized to develop a number of different coping skills to help reduce the negative outcomes associated with these schemas. However, these coping styles are generally highly dysfunctional and maladaptive, and often involve avoidance behavior, including the use of substances[3, 7].

Substance Use and Early Maladaptive Schemas

Young and colleagues[6, 7] have postulated that early maladaptive schemas and the dysfunctional coping skills they produce may often underlie substance use disorders. On the basis of this assumption, Ball[3] proposed the relevance of early maladaptive schemas to the treatment of substance use. Research has shown that treatment of substance use has better outcomes when treatment also focuses heavily on their maladaptive personality characteristics[8–10]. In addition, research suggests that personality disorders are overrepresented in substance use patients and early maladaptive schemas are highly related to personality disorders[3, 6]. Thus, Ball[3] developed Dual Focus Schema Therapy (DFST) for the treatment of substance use and early maladaptive schemas. DFST combines schema therapy and relapse prevention[3], and initial results suggest promising outcomes with this approach[2]. Because of Ball's research, clinicians and researchers have become increasingly interested in the relation between early maladaptive schemas and substance use.

Recently a few studies have investigated early maladaptive schemas among substance users. Brotchie and colleagues[11] compared individuals seeking treatment for alcohol abuse, opiate abuse, and combined alcohol and opiate abuse with a non-clinical sample of non-substance users on their early maladaptive schemas. With the exception of four schemas that were not significantly different between the clinical and non-clinical groups (failure, self-sacrifice, unrelenting standards, and entitlement), the clinical group had more maladaptive schemas than the non-clinical group. In addition, individuals who abused both alcohol and opiates had higher emotional inhibition beliefs than individuals abusing only one substance. In addition, Roper, Dickson, Tinwell, Booth, and McGuire[12] showed that individuals with alcohol dependence had more maladaptive schemas than a non-clinical, non-alcohol dependent group. Thus, early maladaptive schemas appear to pose problems for substance use patients, suggesting that a focus on these schemas may produce better treatment outcomes.

Mental Health of Substance Users' Intimate Partners

Recent research has examined the mental health functioning of substance use patients' family members. For instance, family members of substance use patients, including intimate partners, often have elevated rates of depression, substance use disorders, traumatic

experiences, and medical conditions (e.g., asthma, diabetes) when compared to family members of non-substance users[13]. Knowledge of intimate partner functioning is important because researchers have recently advocated for substance use treatment to also include a focus on family members, as they can be influential in the change process and/or also have their own problems that need clinical attention[14]. In addition, treating family members individually or conjointly with patients may help to exact the influence that family members can have on the course of substance use and recovery[14].

To our knowledge, no known studies have examined early maladaptive schemas among substance use patients' intimate partners. Knowing the early maladaptive schemas among intimate partners of substance use patients is important for several reasons. First, it brings attention to the personal struggles that intimate partners may be experiencing and provides a direction for intervention. Second, it acknowledges that these personal struggles are enduring characteristics of the individual and may not be amenable to quick change. Third, identifying the early maladaptive schemas of intimate partners and substance use patients would provide researchers and clinicians information on enduring characteristics of both dyad members, which could provide direction for family-level interventions aimed at reducing substance use.

Current Study

The current study examined the early maladaptive schemas of substance use treatment patients and their intimate partners. This study has the potential to inform clinicians and researchers on the mental health functioning of intimate partners of substance use patients and the dyadic interventions that may be most effective at reducing substance use. Due to the lack of research in this area, no specific hypotheses were made regarding intimate partners' schemas. However, it was expected that substance use intimate partners would endorse a variety of early maladaptive schemas and would have fewer problematic scores on early maladaptive schemas than their substance using intimate partners.

Method

Procedures and Participants

Pre-existing patient records from the Adult Residential Program (ARP), an inpatient substance use treatment facility located in the Southeastern United States were reviewed for the current study. All procedures were approved by the Institutional Review Board (IRB). The ARP program is an a 30 day treatment program that is guided by the 12-step model and only admits patients into the facility who have a primary substance use disorder diagnosis and are approximately 25 years of age or older. In addition to the traditional 12-step model, the ARP focuses heavily on patient's early maladaptive schemas and offers family-level interventions, including family therapy.

As part of the initial intake assessment upon admission to the treatment facility, patients complete a number of self-report measures and semi-structured interviews, including the Young Schema Questionnaire – Long Form, Third Edition (YSQ-L3[15]), which is discussed in more detail below. In addition, DSM-IV-TR[16] diagnoses are made through consultation with a Ph.D. Licensed Psychologist, a Psychiatrist, and substance use counselors.

As part of the treatment, approximately 3–5 family therapy sessions are conducted with patients' intimate partners, parents, siblings, children, or friends, depending on the unique needs of each patient and the willingness of family members to participate in therapy. For the current study, the charts of patients were reviewed to determine whether they had an intimate partner who completed the YSQ as part of family therapy.

Patient records were searched from January 2008 to September 2010 to determine whether family members who participated in family therapy also completed the YSQ. This resulted in a total of 40 dyads ($N = 80$), patients and partners, who both completed the YSQ. No demographic information was obtained from family members and, thus, is not reported. The majority of patients were male (90%), all were heterosexual, 77.5% were married, and 22.5% were dating. For the patients ($n = 40$) the mean age was 39.2 ($SD = 8.7$), the mean length in months of their relationship with their intimate partner was 99.3 ($SD = 96.3$), 85% lived with their intimate partner prior to treatment, 12.5% lived alone prior to treatment, and 2.5% lived with their parents, and 39 patients reported being non-Hispanic Caucasian (one patient did not report their ethnicity).

For the 40 patients, the primary diagnose derived from their charts were as follows: 42.5% had a primary diagnosis of alcohol dependence, 32.5% opioid dependence, 7.5% cocaine dependence, 7.5% cannabis dependence, 5% polysubstance dependence, 2.5% alcohol abuse, and 2.5% cannabis abuse. Twenty-six patients (65%) also had a secondary substance use diagnosis, which included 11.5% sedative, hypnotic, or anxiolytic dependence, 7.7% cannabis dependence, 7.7% alcohol abuse, 7.7% nicotine dependence, 7.7% cannabis abuse, 3.8% alcohol dependence, 3.8% opioid dependence, 3.8% cocaine dependence, 3.8% other (or unknown) substance dependence, and 3.8% cocaine abuse.

Measures

Demographics—Upon admission to the treatment facility, patients are asked a number of demographic questions, including their age, gender, race/ethnicity, relationship status, number of months involved in an intimate relationship, and housing status prior to entering treatment.

Early Maladaptive Schemas—Patients and intimate partners completed the Young Schema Questionnaire – Long Form, Third Edition (YSQ-L3[15]). The YSQ-L3 is a 232-item self-report measure that examines 18 early maladaptive schemas. Respondents are asked to indicate how much each item describes themselves on a six point scale (*1 = completely untrue of me; 6 = describes me perfectly*). Scores of 4 or greater on each item are indicative that that particular schema may be relevant to the individual. The 18 early maladaptive schemas subscales, and possible score ranges for each, are: emotional deprivation (the belief that one's emotional support needs will not be met by others; 0–54), abandonment (the belief that others will be unavailable or unreliable in their support and connection; 0–102), mistrust/abuse (the belief that others will hurt, take advantage, abuse, and manipulate; 0–102), social isolation (a feeling that one if isolated from the world and other people; 0–60), defectiveness (a feeling that one is bad, defective, or inferior; 0–90), failure (the belief that one is, or will be, a failure in important life areas; 0–54), dependence (the belief that one cannot handle everyday responsibilities without the help of others; 0–90), vulnerability (fear that catastrophic events will occur and there is nothing that can be done to prevent it; 0–72), enmeshment (being excessively emotionally involved/connected with important people; 0–66), subjugation (always surrendering control to others due to the belief that one is coerced; 0–60), self-sacrifice (having to meet the needs of other people at the expense of oneself; 0–102), emotional inhibition (inhibition of important emotions, thoughts, and communications; 0–54), unrelenting standards (the belief that one must attain very high internalized standards of behavior; 0–96), entitlement (the belief that one is superior to other people and deserves special privileges; 0–66), insufficient self-control (difficulty in exercising self-control and distress tolerance or in restraining excessive emotional expression; 0–90), approval-seeking (an intense emphasis on achieving the attention, approval, and recognition of other people; 0–84), negativity/pessimism (a pervasive focus on the negative aspects of life; 0–66), and punitiveness (the belief that people should be punished harshly for their mistakes; 0–90)[6, 15].

Each early maladaptive schema can be divided into scores that reflect low, medium, high, or very high schema endorsement. Scores falling into the *high* and *very high* range indicate that an individual likely has that particular schema; scores of *medium* are indicative that an individual may have that particular schema and should be given attention; and scores of *low* indicate that an individual likely does not have that particular schema[15]. The YSQ has demonstrated good reliability and validity[17].

Results

Correlations between patient schemas and intimate partner schemas are presented in Table 1. Results showed that all 18 patient schemas were positively and significantly associated with the emotional deprivation schema of intimate partners. A similar pattern emerged for patient schemas and the abandonment schema of intimate partners, with 13 of the 18 schemas being positively and significantly associated with intimate partner abandonment schema. A pattern appeared to emerge where a number of patient schemas were positively associated with intimate partner schemas that fall in the domain of disconnection and rejection.

Table 2 presents means and standard deviations among patient and intimate partner schemas. Since the majority of schema domains were positively skewed, Mann-Whitney U tests were used to examine the differences between patients and intimate partners on mean schema levels (e.g., skewness of greater than 1.5). The Mann-Whitney U is a nonparametric test that is essentially equivalent to the standard *t*-test but does not assume a normal distribution of the data. Effect sizes (*d*) were also calculated by comparing the mean scores of patients and intimate partners, divided by their pooled standard deviations[18]. Cohen[18] suggested that a small effect size is equal to a *d* of .20, a medium effect size is equal to a *d* of .50, and a large effect size is equal to a *d* of .80.

Patients scored significantly higher on defectiveness ($U = 594$, $Z = 2.383$, $p < .05$, $d = .67$), failure ($U = 624$, $Z = 2.368$, $p < .05$, $d = .42$), dependence ($U = 601$, $Z = 2.183$, $p < .05$, $d = .48$), vulnerability ($U = 579$, $Z = 2.492$, $p < .05$, $d = .56$), and insufficient self-control ($U = 349$, $Z = 4.450$, $p < .001$, $d = 1.13$) relative to their intimate partners. There was a trend for patients to score higher on approval-seeking ($U = 614$, $Z = 1.858$, $p < .07$, $d = .38$) than their partners. Intimate partners scored significantly higher than patients on self-sacrifice ($U = 434$, $Z = 3.524$, $p < .001$, $d = .74$).

Table 3 presents the clinical interpretations of the early maladaptive schemas for patients and intimate partners. Schemas rated as *high* and *very high* are considered to be core features of the individual, with those endorsed as *medium* warranting further investigation and *low* generally not being a cause for concern[15]. Unrelenting standards was rated high or very high for 50% of patients, representing their most highly endorsed schema. Other high/very high schemas for patients were insufficient self-control (42.5%), self-sacrifice (40%), punitiveness (35%), and emotional inhibition (27.5%). For intimate partners, self-sacrifice was rated high or very high for 80% of the sample. Other high/very high schemas for intimate partners were unrelenting standards (60%), punitiveness (32.5%), mistrust/abuse (27.5%), emotional inhibition (22.5%), and abandonment (20%).

Discussion

The purpose of the present study was to examine the early maladaptive schemas of substance use treatment patients and their intimate partners, how they are associated with each other, and whether patients and intimate partners had similar or different schemas. This is the first known study to examine these enduring characteristics among intimate partners of substance use patients. Findings showed that while patients scored significantly higher on a

number of schemas, there was considerable similarity among patients and intimate partners on a number of schemas.

Findings from the correlation analyses showed an interesting pattern of results where the majority of patient schemas were positively associated with intimate partner schemas that fall under the domain of disconnection and rejection. In fact, all 18 patient schemas were positively and significantly associated with the emotional deprivation schema of intimate partners. Although the cross-sectional nature of the current study precludes determination of the causal relationship among these variables, theoretically it is likely that the emotional deprivation schema of intimate partners developed during childhood[6] and was present prior to forming a relationship with their substance using partner. If this is indeed true, results of the present study indicate that individuals with the emotional deprivation schema may choose partners who will be unable to provide them with the emotional support they desire, such as substance abusers, further perpetuating their schema. Consistent with this idea, it is possible that patient schemas are interfering with their ability to provide the emotional support their intimate partners' desire. Patients may be less emotionally available to their partners due to their substance use, leading to an increased feeling and belief among intimate partners that they are being deprived of the emotional support and connection they wish for. This finding is likely further exacerbated by the fact that patients were in a residential treatment center and therefore may not have been as available to provide support and connection. It cannot be ruled out, however, that the emotional deprivation schema of intimate partners contributes to increases in all of the patient schemas. Future research that uses longitudinal investigations will help to elucidate the causal direction among these schemas.

Results also showed that the schema most often endorsed by intimate partners was self-sacrifice. Consistent with schema theory and the notion that schemas develop during early childhood[6], it is possible that individuals who are high on self-sacrifice are attracted to individuals who will foster their self-sacrificing behaviors, such as individuals who abuse substances. In addition, substance users may be more attracted to individuals who are high on self-sacrifice because it may potentially make it easier for them to consume substances. The self-sacrificing behaviors of intimate partners may actually represent a more pervasive form of enabling behaviors that support the use of substances that are characterized by a lack of consequences and care taking, which family members of substance users often engage in[19].

It is also possible that one potential reason for the finding that intimate partners scored quite high on self-sacrifice is that partners may feel like they are sacrificing and providing a lot of support due to the patient being in residential treatment, which likely involves taking on more responsibility (e.g., more household responsibilities, financial, childcare, etc.). Although the YSQ-L3 is designed to examine relatively stable features of the individual, and theory suggests that schemas are relatively stable and enduring characteristics, research has shown that situational factors, such as mood, can influence reporting on this measure[20]. Thus, it is possible that the situational factor of a partner being in residential treatment influenced reports on the YSQ-L3 and, particularly, self-sacrifice. Longitudinal research will help to clarify the interrelationships among patient and intimate partner schemas.

The finding that patients scored higher than their intimate partners on defectiveness, failure, dependence, vulnerability, and insufficient self-control could be an indication that these schemas are particularly likely to be associated with problematic substance use. For instance, it is possible that patients used substances to help cope with and/or avoid their feelings of being bad, unwanted, and inferior (defectiveness), of having failed or being inadequate (failure), that they are unable to effectively handle everyday responsibilities

(dependence), that they cannot prevent harm or catastrophes will happen (vulnerability), and having low frustration tolerance and inability to contain one's emotions and impulses (insufficient self-control). This finding is consistent with previous research that has shown that substance use patients scored higher on these schemas than a non-clinical control group[12] and the belief that substance use may be one way individuals attempt to cope with their maladaptive schemas[7]. If patients are using substances to cope with their maladaptive schemas, then it is possible that substance use is reinforcing their maladaptive schemas, rendering them even more resistant to change. It should be noted that this conclusion is preliminary until research examines the substance use of intimate partners to determine whether they are consuming substances at lower, similar, or greater levels than patients and how their substance use may be related to their schemas.

It is interesting to note that there were large differences between intimate partners and patients on self-sacrifice (with intimate partners scoring higher) and insufficient self-control (with patients scoring higher). Because insufficient self-control can be conceptualized as a lack of control over one's behavior and ability to control impulses, it is possible that a number of intimate partners are attempting to "balance out" their partner's impulsive behaviors, taking on additional responsibilities themselves (i.e., self-sacrifice). Although this is speculative until additional research replicates and extends the findings of the current study, the fact that patients and intimate partners identify with these very different schemas has potentially important implications for family-level interventions. Knowing the dynamics of the couple and how their schemas may be related to each other may help focus attention toward the behaviors that are in need of most attention and the most change during the course of treatment.

Implications for Individual and Couples Therapy

Although preliminary, the results from the current study suggest that couples therapy with substance use patients, and individual therapy for intimate partners of substance use patients, should take into consideration the early maladaptive schemas of intimate partners and how they may interact with that of their partners. In conjunction with other studies, results from the current study indicate that therapists should take into consideration the possibility that the substance use patient is not the only individual with mental health problems in need of attention. It is well documented that intimate partners of substance users have a number of mental and physical health problems that are of clinical significance[13], and this is the first known study to demonstrate that they also may have enduring characteristics that may also need to become the focus of attention. These findings suggest that therapists who work with intimate partners of substance users should take into consideration that a number of these individuals may have both Axis-I diagnoses and health issues that need attention[13], as well as enduring characteristics (e.g., early maladaptive schemas, Axis-II personality disorders) that may contribute to a number of their current personal and relationship difficulties.

A number of existing treatments include both the primary substance user and intimate partner in treatment (e.g., Behavioral Couples Therapy[21]), with research documenting positive outcomes[22, 23]. Findings from the current study indicate that treatment providers could consider how the enduring characteristics of patients and intimate partners may impact treatment and the dynamics of the couple. This, in turn, could provide better insight into the treatment techniques that could be implemented and the features of both the individual and couple that may need more attention. Techniques outlined by Ball[3] in his dual-focused schema therapy and schema therapy in general[6] could be modified and used in family therapy sessions to better aid therapists in targeting early maladaptive schemas.

Limitations

When interpreting the findings from the current study a number of limitations should be considered. First, the cross-sectional nature of the current study poses a number of limitations. It is unknown whether patient and intimate partner schemas were similar or different prior to their relationships forming and whether the relationship has had an impact on schemas. Longitudinal research is needed to disentangle these possibilities. It is also possible that social desirability affected the results of the current study. That is, it is possible that patients and intimate partners underreported the undesirable aspects associated with many of the early maladaptive schemas. Conversely, it is possible that one reason that self-sacrifice was so highly endorsed is that some may view the behaviors associated with this schema as desirable or as necessitated by their partners' substance use. Future research should control for social desirability when investigating schemas in this population. The relatively small sample size of the current study also poses a limitation. Larger samples would allow for the examination of whether schemas vary depending on primary substance use disorder, as some research suggests that schemas may vary depending on the type of substance used[11]. The generalizability of the current study is also limited due to the fact that the entire sample of patients was non-Hispanic Caucasian, primarily male, and attending a residential substance use treatment program.

In addition, the lack of demographic information for intimate partners is problematic. Although this was a limitation of the chart records that were reviewed for the current study, it is unknown whether any demographic information for intimate partners affected the results of the current study. Future research should gather intimate partner demographic information and determine whether this information has any bearing on early maladaptive schemas. In addition, no information on the alcohol and drug use of intimate partners was collected. Knowing whether intimate partners also consume alcohol and/or drugs will provide a researchers and clinicians with an idea of whether intimate partners may also be using alcohol and/or drugs to cope with their maladaptive schemas.

In summary, the current study is the first to investigate early maladaptive schemas among substance use patients' intimate partners and whether their schemas are similar or different to that of their substance using partner. Although preliminary, findings from the current study showed that while substance use patients scored significantly higher on a number of schemas, intimate partners also scored high on a number of schema dimensions and scored even higher than patients on self-sacrifice. These findings indicate that early maladaptive schemas may be a relevant treatment target for intimate partners of substance use patients and a focus on patient and intimate partner schemas during family therapy may be beneficial for reducing substance use. Continued research on the early maladaptive schemas of substance users and their intimate partners is needed.

References

1. Rounsaville BJ, Kranzier HR, Ball S, Tennen H, Poling J, Triffleman E. Personality disorders in substance abusers: Relation to substance abuse. J Nerv Ment Dis. 1998; 186:87–95. [PubMed: 9484308]
2. Ball, SA. Cognitive-behavioural and schema-based models for the treatment of substance use disorders. In: Riso, LP.; du Toit, PL.; Siein, DJ.; Young, JE., editors. Cognitive schemas and core beliefs in psychological problems: A scientist practitioner guide. Washington, DC: American Psychological Association; 2007.
3. Ball SA. Manualized treatment for substance abusers with personality disorders: Dual focus schema therapy. Addict Behav. 1998; 23:883–891. [PubMed: 9801723]

4. Copello A, Templeton L, Krishnan M, Orford J, Velleman R. A treatment package to improve primary care services for the relatives of people with alcohol and drug problems. Addict Res. 2000; 8:471–84.
5. Beck, AT. Depression: Clinical, experimental, and theoretical aspects. London: Staples Press; 1967.
6. Young, JE.; Klosko, J.; Weishaar, ME. Schema therapy: A practitioner's guide. New York: Guilford Press; 2003.
7. Young, JE. Cognitive therapy for personality disorders: A schema focused approach. Sarasota, FL: Professional Resource Exchange; 1994.
8. Alterman A, Cacciola J. The antisocial personality disorder diagnosis in substance abusers: Problems and issues. J Nerv Ment Dis. 1991; 179:401–409. [PubMed: 1869868]
9. Messina N, Farabee D, Rawson R. Treatment responsivity of cocaine-dependent patients with antisocial personality disorder to cognitive-behavioral and contingency management interventions. J Consult Clin Psychol. 2003; 71:320–329. [PubMed: 12699026]
10. Nace EP, Saxon JJ, Shore N. Borderline personality disorder and alcoholism treatment: A one-year follow-up study. J Stud Alcohol. 1986; 47:196–200. [PubMed: 3724153]
11. Brotchie J, Meyer C, Copello A, Kidney R, Waller G. Cognitive representations in alcohol and opiate abuse: The role of core beliefs. Br J Clin Psychol. 2004; 43:337–342. [PubMed: 15333236]
12. Roper L, Dickson JM, Tinwell C, Booth PG, McGuire J. Maladaptive cognitive schemas in alcohol dependence: Changes associated with a brief residential abstinence program. Cognit Ther Res. 2010; 34:207–215.
13. Ray GT, Martens JR, Weisner C. Family members of people with alcohol or drug dependence; Health problems and medical costs compared to family members of people with diabetes and asthma. Addiction. 2009; 104:203–214. [PubMed: 19149814]
14. Copello A, Templeton L, Orford J, Velleman R, Patel A, Moore L, MacLeod J, Godfrey C. The relative efficacy of two levels of a primary care intervention for family members affected by the addiction problem of a close relative: A randomized trial. Addiction. 2009; 104:49–58. [PubMed: 19133888]
15. Young, JE.; Brown, G. Young schema questionnaire. Sarasota, FL: Professional Resource Exchange; 2003.
16. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4. Washington, DC: Author; 2001. rev
17. Oei TPS, Baranoff J. Young schema questionnaire: Review of psychometric and measurement issues. Am J Psychol. 2007; 59:78–86.
18. Cohen, J. Statistical power analysis for the behavioral sciences. 2. Hillsdale, NJ: Erlbaum; 1988.
19. Rotunda RJ, West L, O'Farrell TJ. Enabling behavior in a clinical sample of alcohol-dependent clients and their partners. J Subst Abuse Treat. 2004; 26:269–276. [PubMed: 15182891]
20. Stopa L, Waters A. The effect of mood on responses to the young schema questionnaire: Short form. Psychology and Psychotherapy: Theory, Research and Practice. 2005; 78:45–57.
21. O'Farrell, TJ.; Fals-Stewart, W. Behavioral couples therapy for alcoholism and drug abuse. New York, NY: Guilford; 2006.
22. O'Farrell, TJ.; Fals-Stewart, W. Family-involved alcoholism treatment: An update. In: Galanter, M., editor. Recent developments in alcoholism, volume 15: Services research in the era of managed care. New York: Plenum; 2001. p. 329-356.
23. O'Farrell TJ, Murphy CM, Stephan SH, Fals-Stewart W, Murphy M. Partner violence before and after couples-based alcoholism treatment for male alcoholic patients: The role of treatment involvement and abstinence. J Consult Clin Psychol. 2004; 72:202–217. [PubMed: 15065955]

Table 1

Correlations between patient and intimate partner schemas.

	EDi	ABi	MAi	SIi	DEFi	FAi	DEPi	VUi	ENMi	SUBi	SSi	EIi	USi	ENi	ISCi	APSi	NPi	PUNi
EDp	.95***	.58***	.59***	.61***	.30	.35*	.17	.57***	.10	.52***	.39*	.32*	.39*	.09	−.07	.19	.47**	.26
ABp	.74***	.64***	.44**	.53***	.08	.24	.11	.24	−.08	.34*	.25	.23	.23	.14	−.18	.02	.14	.11
MAp	.54***	.45**	.34*	.37*	.12	.07	.06	.06	−.14	.23	.22	.09	.16	.14	−.09	−.00	−.05	−.05
SIp	.65***	.56***	.36*	.54***	.16	.38*	.26	.15	−.04	.30*	.26	.32*	.26	.28	−.01	.17	.10	.25
DEFp	.66***	.69***	.40**	.68***	.27	.42**	.41**	.25	.08	.40**	.26	.33*	.24	.29	−.05	.21	.14	.13
FAp	.67***	.55***	.29	.62***	.26	.46**	.35*	.24	.01	.38*	.25	.33*	.16	.23	−.11	.21	.15	.14
DEPp	.59***	.50**	.40*	.48**	.18	.26	.09	.15	−.02	.33*	.26	.24	.26	.24	−.08	.17	.10	.11
VUp	.47**	.49**	.29	.54***	.08	.34*	.24	.15	.04	.35*	.28	.35*	.14	.29	−.06	.21	−.00	−.02
ENMp	.33*	.20	.17	.21	.10	.36*	.21	.14	−.02	.09	.03	.23	.14	.05	−.04	.08	.10	.19
SUBp	.58***	.42**	.25	.40**	.22	.32*	.19	.11	−.12	.20	.11	.13	.09	.10	−.22	.03	.02	.00
SSp	.59***	.32*	.42**	.51**	.54***	.22	.31*	.22	.19	.36*	.21	.45**	.40*	.49**	.12	.07	.08	.22
EIp	.31*	.26	.19	.25	−.02	.09	.10	−.01	−.14	.03	.12	.12	.13	.17	−.06	−.13	−.15	−.08
USp	.46**	.10	.13	.26	−.04	−.08	−.14	.08	−.02	.02	.15	.14	.25	.09	−.12	−.25	−.01	−.03
ENp	.38*	.28	.23	.28	.03	.26	.17	−.03	−.04	.09	.08	.33*	.07	.17	−.00	.03	−.10	.01
ISCp	.46**	.39*	.22	.34*	.05	.32*	.20	.09	−.11	.11	.05	.11	.06	.04	−.13	.08	.02	−.12
APSp	.46**	.45**	.25	.39*	.15	.27	.26	.04	.05	.17	.15	.25	.19	.31*	−.06	.10	−.03	.07
NPp	.52***	.38*	.21	.47**	.10	.28	.15	.27	−.02	.31*	.13	.24	.15	.14	−.20	.02	.09	.04
PUNp	.32*	.11	.23	.25	.07	−.16	−.02	.07	.06	.11	.28	.14	.39*	.39*	.08	−.12	−.09	.05

*$p < .05$,

**$p < .01$,

***$p < .001$

Note: Vertical row and "p" represents patients; horizontal row and "i" represents intimate partners. ED = emotional deprivation; AB = abandonment; MA = mistrust/abuse; SI = social isolation; DEF = defectiveness; FA = failure; DEP = dependence; VU = vulnerability; ENM = enmeshment; SUB = subjugation; SS = self-sacrifice; EI = emotional inhibition; US = unrelenting standards; EN = entitlement; US = unrelenting standards; ISC = insufficient self-control; APS = approval seeking; NP = negativity/pessimism; PUN = punitivness.

Table 2

Mean differences between patients and intimate partners on early maladaptive schemas.

Schema	Patient *M* (*SD*)	Partner *M* (*SD*)	*d*
Emotional Deprivation	9.6 (15.2)	6.2 (11.0)	.22
Abandonment	13.9 (20.7)	10.6 (15.4)	.18
Mistrust/Abuse	13.8 (21.0)	19.2 (25.7)	.23
Social Isolation	6.5 (11.8)	3.4 (6.2)	.32
Defectiveness	10.5 (18.0)*	1.7 (3.8)	.67
Failure	6.2 (13.8)*	1.7 (5.8)	.42
Dependence	9.9 (18.0)*	3.2 (7.5)	.48
Vulnerability	9.7 (15.8)*	2.8 (6.6)	.56
Enmeshment	7.9 (13.8)	6.1 (10.7)	.14
Subjugation	8.2 (14.7)	9.2 (14.1)	.06
Self-Sacrifice	27.5 (26.1)	46.8 (25.5)**	.74
Emotion Inhibition	10.1 (11.0)	7.1 (9.1)	.29
Unrelenting Standards	26.4 (19.6)	31.8 (22.3)	.25
Entitlement	10.2 (14.1)	4.8 (7.8)	.47
Insufficient Self-Control	27.0 (25.9)**	5.3 (8.0)	1.13
Approval-Seeking	16.4 (20.1)	9.3 (16.2)	.38
Negativity/Pessimism	12.8 (18.1)	8.3 (14.7)	.27
Punitiveness	21.7 (20.7)	17.3 (18.5)	.22

* $p < .05$,

** $p < .001$

Table 3

Differences between patients and intimate partners on schema interpretations.

Schema	Patient (%)	Partner (%)
Emotional Deprivation		
Low	65.0	75.0
Medium	15.0	12.5
High	5.0	5.0
Very High	15.0	7.5
Abandonment		
Low	62.5	75.0
Medium	17.5	5.0
High	10.0	12.5
Very High	10.0	7.5
Mistrust/Abuse		
Low	65.0	60.0
Medium	15.0	12.5
High	7.5	7.5
Very High	12.5	20.0
Social Isolation		
Low	77.5	87.5
Medium	10.0	7.5
High	5.0	5.0
Very High	7.5	0
Defectiveness		
Low	72.5	97.5
Medium	7.5	2.5
High	15.0	0
Very High	5.0	0
Failure		
Low	80.0	92.5
Medium	10.0	2.5
High	2.5	5.0
Very High	7.5	0
Dependence		
Low	80.0	95.0
Medium	7.5	2.5
High	5.0	2.5
Very High	7.5	0
Vulnerability		
Low	70.0	85.0
Medium	10.0	10.0
High	10.0	5.0

Schema	Patient (%)	Partner (%)
Very High	10.0	0
Enmeshment		
Low	72.5	80.0
Medium	12.5	2.5
High	5.0	15.0
Very High	10.0	2.5
Subjugation		
Low	72.5	65.0
Medium	12.5	17.5
High	7.5	5.0
Very High	7.5	12.5
Self-Sacrifice		
Low	32.5	12.5
Medium	27.5	7.5
High	20.0	25.0
Very High	20.0	55.0
Emotional Inhibition		
Low	57.5	70.0
Medium	15.0	7.5
High	22.5	22.5
Very High	5.0	0
Unrelenting Standards		
Low	27.5	22.5
Medium	22.5	17.5
High	27.5	27.5
Very High	22.5	32.5
Entitlement		
Low	60.0	82.5
Medium	17.5	12.5
High	12.5	2.5
Very High	10.0	2.5
Insufficient Self-Control		
Low	37.5	82.5
Medium	20.0	10.0
High	12.5	7.5
Very High	30.0	0
Approval-Seeking		
Low	50.0	80.0
Medium	27.5	5.0
High	7.5	7.5
Very High	15.0	7.5
Negativity/Pessimism		

Schema	Patient (%)	Partner (%)
Low	62.5	72.5
Medium	12.5	12.5
High	12.5	5.0
Very High	12.5	10.0
Punitiveness		
Low	42.5	57.5
Medium	22.5	10.0
High	12.5	17.5
Very High	22.5	15.0