Relationship between early maladaptive schemas, flexibility of action with suicide ideation among patients with mood disorders of Ahvaz city

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Abstract

The aim of this study was to determine the relationship between early maladaptive schemas, flexibility of action with suicide ideation in patients with mood disorders. The number of participants was 127 people who were selected by simple random sampling. The research design was correlational. Measuring tools included Young Schema Questionnaire Short Form (1990), Conner-Davidson Resilience Scale (2003) and Beck Scale of Suicide Ideation (1991). Data were analyzed using Pearson correlation coefficient and multiple regression analysis. Results showed that there is a significant positive correlation between early maladaptive schemas in the areas of communication failure and rejection, autonomy and impaired function, constraints hampered with suicide ideation. In addition, there is a significant negative correlation between flexibility of action and suicide ideation. Regression analysis also showed that there is a multiple relation between early maladaptive schemas in the areas of communication failure and rejection, autonomy and impaired function, hampered constraints, and flexibility of action with suicide ideation.

Keywords: early maladaptive schemas, flexibility of action, suicidal ideation, mood disorders.
Introduction

Mood is an emotional air that is stable and penetrating experienced in an inner way and affects one's behavior and perception of the world. Mood may be normal, elevated or depressed. People typically experience a range of emotional states and their set of emotional manifestations is equally broad and large, they also feel that they can more or less control their mood and emotional states. Mood disorders are a group of clinical disorders characterized by the lost sense of mastery and the person takes enormous suffering. In patients who have an elevated mood (that is in mania), expansiveness, flight of ideas, insomnia, increased self-confidence and megalomaniac thoughts. In patients who have depressed mood (i.e. depression), there is loss of energy and passion, feeling guilty, difficulties with concentration, loss of appetite, and thoughts of death or suicide. Other signs and symptoms of mood disorders include changes in activity level, cognitive abilities, speech, and vegetative functions (such as sleep, sexual activity, and other biological disciplines). These changes usually lead to impaired interpersonal, social and occupational functions in the patient.(Kaplan & Sadoc, 2007, translation by Farzin Rezaei, 2006).

Today, rapid social changes, lifestyle changes and complexities of modern life threat health, hygiene, and safety. Life problems increase human vulnerability (Kotler, 2003), which is why people often suffer from anxiety, depression, unreasonable resentment or incompetence in dealing with the problems of life (Palmer, 2001).

Some people's lifestyle is based on self-destruction or benefit from dysfunctional and abnormal ways of confrontation (such as suicide), suicide as a behavior is a death that is committed by the individual himself (Ivey, 2000).

According to Shnaidman (2002) "Suicide is the conscious act of self-harm, which can be seen as a multi-dimensional problem in a human in need and for his designated problem this is thought to be the best solution." Based on the definition by National Institute of Mental Health America (2005), Suicide is a deliberate attempt to end life by the person himself someone and this attempt may become action, or just stay as a feeling in the person like desire to commit suicide and suicide ideation (Yontef & Jacobs, 2005). In the field of etiology of suicide, several factors including cognitive-psychological factors, physical illness, mental illness such as depression, economic factors such as unemployment, economic problems, being fired from work, bankruptcy and loss of social status and emotional causes such as failure in love, the loss of loved one, death or serious illness of a relative, family conflicts and disturbances. The most obvious warning in committing suicide is direct expressing of the desire. Studies show that almost two-thirds of those who commit suicide have already announced their intention, shared it with others, and threatened to do so. So one of the successful ways of suicide prevention is attention to the expression of the idea by others, help solving their problems and help them to see a psychologist or psychiatrist (Shnaidman, 2002).

Today, psychological studies have proven that the existence of psychiatric disorders, especially mood disorders, may be the most powerful risk factor for suicide. Almost 95 percent of patients who have attempted suicide or committed suicide have a form of mental illness.
Depressive disorder, 80%; schizophrenia, 10%; and dementia, 5% include the cases. The risk of suicide in psychiatric patients is 3 to 12 times higher than it is in non-patients. The degree of risk also depends on age, sex, diagnosis, and outpatient or inpatient status of the patient (Kaplan & Sadoc, 2003).

The phenomenon of suicide, as a mental health problem, in the world as a problem of increasing nature has received special importance. Every year, about a million people lose their lives due to suicide, and twenty million people attempt suicide (Bertolote, et al., 2002). In such circumstances, not only society loses its comprehensive productive forces but also because of illness, disability, and psychosocial damage caused by this problem, it has to pay high maintenance costs for years to take special care. On the other hand, suicide damages the mental health of family members of the victims. It leaves negative impact on social life and the possibility of its occurrence in a family environment and society increases. The whole range of suicide behavior is from ideation of suicide, threatening suicide to complete suicide (Shaffer & Pefeffer, 2001).

Although there is no exact, statistics of the incidence of suicide in Iran, according to studies, suicide rate in Iran is similar to other countries (Jamshidzadeh, 2003; quoted Akbari Zardkhaneh, Jafari, Dolatshahi, Mamaqanieh, 2009).

Based on the initial descriptions of psychopathology by Beck, each mental disorder has universal thinking-habitual patterns and schemata that specify the type of vulnerability related to that disorder (Leahy, 2008).

Schemata development often goes back to childhood. According to Yang (1999), some people develop early maladaptive schemas due to negative childhood experiences that affect the way of thinking, feeling and behavior in the following intimate relationships and other aspects of their lives. Yang believes that schema is created because of unfulfilled essential emotional needs in the childhood that include secure attachment to others, autonomy, competence and identity, freedom to express needs and healthy emotions, spontaneity and fun, real limits and self-restraint (Yang et al., translation by Hamidpour and Andouz, 2007).

Schemes are divided into five classes according to five needs of the child, cuts and rejection, autonomy and impaired performance, limitations disrupted, others orientation, over-vigilance and prevention (Yang, translation by Sahebi and Hamidpour, 2005).

Early maladaptive schemas are deep and pervasive patterns or themes that are formed in childhood or adolescence and continued in adulthood, and are related to the person relationship with themselves and others and are highly inefficient. In the formation of schemas, the inherent mood interacts with early maladaptive communication experiences (Young, Klosko & Weishaar, 2003) and more specifically, these schemas change into maladaptive schemas if basic psychological and global needs of the individual are not met. Yang, Kloso and Weishaar (2003) believe that the mood of the child plays an important role in the development of schemas because an unusually severe mood makes parents involved in a relationship that not so favorable. Schema should be considered as Trait - Like that is stable over time (Weishaar and Beck, 2006).
In fact, it seems that the schemes can show high stability over a period of 2.5 to 5-years (Rizzo, Fram, et al., 2006) or maintain their stability even beyond depressive symptoms over a period of 9 years (Wang, Halvorsen, Icesmn and Waterloo, 2010). Studies show that early maladaptive schemas are related to some disorders more than others, however, it seems that early maladaptive schema is a general vulnerability and connected to a wide range of psychiatric disorders (Hoyi and Honart, 2007; Rizzo, Medaks and Santourli, 2007; Reeves and Taylor, 2007; Prnio-Gavia, Castiel Ho, Golhadou and Konha, 2006).

In a study, Dil, Power, Kane, Michael Stewart and Murray (2010) examined the role of parental attachment bond and early maladaptive schemas in suicidal behavior. The findings of this study emphasized the complexity of suicidal behavior and factors related to suicidal behavior. Although assumption cannot be based on causality, the findings show the importance of not only internal relations and early experiences of attachment bond with parents but also prominent schemas associated with suicidal behavior.

Flexibility of action is one of the factors that has helped the person in dealing with and compatibility with difficult and tense states in life and save people from pathological disorders and difficulties in lives (Rater, 1985).

Flexibility of action as defined as the confidence of the person in his abilities to overcome the stress, having coping skills, self-esteem, emotional stability and personal characteristics that increase social support from others. This structure is one of the factors that prevent psychological problems among young people and save them from developing psychological effects of problematic events. Pinquart (2008) has defined the flexibility of action as a process, ability, or the outcome of successful adaptation with threatening conditions. In other words, flexibility of action is positive adjustment in response to adverse conditions (Samani, Jafari and Sahragard, 2007). Hamill (2002) defined flexibility of action as merit of people in the face of events that are as significantly catastrophic. Sharknas (2002) believes that people are born with inherent flexibility of action, and by breeding characteristics such as the ability to problem-solving, critical and creative thinking, planning and accepting help from others maintain flexibility in action. Connor and Davidson (2003) considered some elements of flexibility of action as including competence, personal integrity, tolerance, negative emotions, control (ability to control and manage situations) and their spirituality. Numerous studies show that flexibility of action is an important factor in a number of action groups considered at risk like children and young people and have an important mediating role in the pathogenesis of many psychiatric disorders (Mylant, Cuares, Meehan, 2002; Lee and Cranford, 2008). The researchers came to the conclusion that patients who have attempted suicide received significantly lower scores on the flexibility of action compared with patients who never attempted suicide. These researchers have also expressed that low flexibility of action is linked to the occurrence of suicidal-like thoughts and behaviors (Roy, Sarchiapone, Carli, 2007).

Kordestani, Pourhossein et al. (2013) investigated the relationship between depression, anxiety, flexibility of action, stress and mental health and suicide ideation in students of Tehran University. The results showed that the relationship between suicide ideation with flexibility of action was negative and significant. Moreover, anxiety, depression, mental health and stress were positively correlated with suicide ideation. Based on regression analysis, depression had the
largest share in anticipation of suicide ideation and then anxiety, mental health, flexibility of action and stress were placed in this prediction. These variables together explained 21% of variance in suicide ideation. The results of this study suggest that understanding the psychological and mental health problems such as anxiety and depression, and other factors such as flexibility of action and stress as important variables in understanding suicide and thinking about it plays an important role.

In a study, Nasri Shenouda and Ezat Basha (2014) examined the bilateral relationship between suicide ideation and flexibility of action, social support and social stress among university students. The sample in this study consisted of 293 male and female Egyptian students (24-18 years). The results of this study showed that there is a significant difference between women and men in social pressure, flexibility of action and social support. However, there was no significant difference in scores of men and women in suicide ideation. The results also showed that suicide ideation and social stress were positively correlated in men and women. In addition, there is a negative correlation between suicide ideation and flexibility of action and social protection of men and women.

In a study, McLaren and Elissa (2009) examined the ability of the implementation of three models of flexibility of action in anticipation of suicide ideation due to depression (risk factor) and social support and a sense of belonging (protective factors). A sample 99 male Australian farmers completed questionnaires of depression, suicidal thoughts, social support and a sense of belonging. High level of a sense of belonging was compensating in high levels of depression and as community support, sense of belonging and generally protective factors increase, suicide ideation through depression is reduced. Although the findings are limited due to the small sample size and reliance on self-report measures, they suggests that increased social support and a sense of belonging are beneficial for mental health of farmers.

Karami, Zakii, Alikhani and Mohammadi (2012) investigated the relationship between the Eysenck Personality features and flexibility of action with attitudes to suicide among girl students. Results showed that personality traits of neuroticism and psychotic mental attitude have a positive and significant correlation with suicide, but extroversion had a negative correlation with suicide attitudes. In addition, the results showed that flexibility of action is negatively correlated with attitudes to suicide.

Sudani, Valizadeh, Alavi and hekmat (2010) examined the simple multiple relationship between flexibility in action and life expectancy with suicide of prisoners with AIDS in Khuzestan. The results of data analysis showed that there is a significant relationship between the suicidal act with flexibility of action and life expectancy of prisoners suffering from AIDS (P<0.01). Multiple regression analysis also showed that flexibility of action and life expectancy, in total, explained 47% of criterion variable that is suicide.

Bayrami, Iqibli and Gholizdeh (2012) conducted a study on 200 students of Tabriz University of Medical Sciences, they found that suicide has a positive and significant relationship with neuroticism and has a negative relationship with extraversion and flexibility of action. Since suicide is often preventable, the most important issue is better forecasts and early intervention. On the other hand, a high risk of suicide in psychiatric patients, especially those with mood disorders compared with other people, identifying risk factors and predictors of suicide risk can
bring about recognizing and the prognosis for mental health professionals and probable grounds for health planning and preventive action. According to the concepts discussed, by collecting data on psychological variables: initial maladaptive schema, flexibility of action and suicide ideation in relation to patients with mood disorders, the present study seek to answers the quality of the relationship between these psychological variables, understand, and explain the relationships between them. This fundamental research question was, is there a simple multiple relationship between early maladaptive schema areas (lack of communication and rejection, autonomy and impaired function, hampered restrictions, others orientation, over-vigilance and prevention) and flexibility of action with suicidal ideation in patients with mood disorders in Ahvaz?

Research design, population and methods of sampling
The research design was correlational. The study population included all patients referring with mood disorders in Ahvaz in 2015. First, the complete list of referred people to Golestan hospital and Naft Ahvaz, which announced their readiness to participate in this study and were diagnosed with mood disorder by psychiatric diagnosis, including 205 patients, was determined and then 127 subjects were prepared and randomly selected according to Morgan table.

Measuring tool
In this study, in order to measure the variables the following tools were used:

Young Schema Questionnaire Short Form (YSQ-SF)
Young developed YSQ-SF in 1990, this 205-unit questionnaire is extremely time-consuming and therefore its use is associated with problems (Lee et al., 1991; quoted in Calvete et al., 2005). For ease of use, Young and Brown drafted the short form of the questionnaire in 1994 (Calvete et al., 2005; Kesirou et al., 2004). This questionnaire has 75 questions and is designed to measure 15 cognitive maladaptive schemas. Many studies support the reliability of YSQ-SF. In the study by Welborn et al (2002), all 15 subscales of Schema Questionnaire-Short Form have sufficient to very good internal consistency. Cronbach's alpha was calculated for all schemes from 76% to 93% (Welborn et al., 2002). The results of another study by Calvete and colleagues (2005) to investigate internal consistency of YSQ-SF was, in general, stated the acceptable reliability of Cronbach's alpha coefficient for the 15 schemas between 61% to 85% which is significant (Calvete et al., 2005).

In Iran, YSQ-SF is normalized by Fatehizadeh and the Abbasian in 2003 at the University of Isfahan. Its reliability is calculated as 0.94 using Cronbach's alpha that is significant (Fatehizadeh and Abbasian, 2005; quoted in Barazandeh, 2005). Factor analysis results of Wellburn et al (2002) strongly support the internal structure of the questionnaire. In this study, the relationship between subscales of schemes questionnaire was measured with symptoms of anxiety, depression and paranoia and the results supported the construct validity of the questionnaire indicating that cognitive schemas are strongly associated with pathological symptoms.

In their study, Fatehizadeh and the Abbasian (2003) studied the concurrent validity of the questionnaire by correlation Schema test with Irrational Beliefs Test (IBT), and the correlation obtained was 0.36 and meaningful. In addition, face validity of the questionnaire was approved by 12 University of Isfahan (Fatehizadeh and Abbasian, 2003; quoted in Barazandeh, 2005).
Each item of YSQ-SF is scored on a 6-point Likert scale from "completely wrong" to "completely right." 1. Completely wrong, 2. Almost wrong, 3. more right than wrong, 4. slightly right, 5. almost right, 6. completely right. If a person in two sentences from five sentences for each schema, chooses option 5 or 6, that scheme is likely to be etched in his mind.

In the present study to determine the reliability of early maladaptive schema questionnaire, Cronbach's alpha was used that was 0.95 for the whole questionnaire indicating good reliability coefficients of the questionnaire.

**Conner-Davidson Resilience Scale (CD-RISC)**

This scale has 25 items with 5 options (never, rarely, sometimes, often and always) that Mohammadi (2005) adapted it for use in Iran, by using Cronbach's alpha, he obtained coefficient reliability of scale as 89% and obtained the validity of the scale with correlation coefficient method from 41% to 64% for each item and the total score of the category. Michelle Choi (2004) conducted a study to evaluate the Russian psychometric scale of flexibility of action, it included the translated version of both variable the flexibility scale measures (the personal and individual acceptance and life), but its modified form for a twelve-item scale was used. This two-factor structure included nine individual competence and three items of individual's acceptance and life, he analyzed the obtained information from a longitudinal study of 224 women belonging to the former Soviet Union and offered the final analysis (internal consistency) as 88 %. Concurrent validity of the scale was confirmed with correlating it with family tenacity index (R=0.25, P=0.01) and perceived stress scale (R=0.418, P<0.01).

Heieman, Lee and Kurry (2003) tested the reliability and validity of the flexibility of action scale translated into Spanish. To this end, 315 women who were Mexican and had participated in a larger study were considered as the sample due to ease. From among them, the information of 147 women who had command over Spanish-language reading and writing was used in the analysis. English form of the scale included 25 general scales, 17 related to personal capacity and eight cases in connection with his acceptance of life and self and after removing two of the questions, the scale became 23 questions. The reliability (internal consistency) of the scale using Cronbach's alpha was estimated as 93% that was acceptable for 23-item scale as well as its sub-scales. Scale validity was shown with significant positive correlation between functional flexibility of action and life satisfaction (R=0.35, P<0.01) and a negative correlation was found between flexibility of action and symptoms of depression (R=-0.29, P=0.01). This analysis confirmed the appropriateness of 23 questions form and the Spanish scale of flexibility of action and its sub-scales in relation to low-income Mexican women living in America.

As mentioned, this scale has 25 items 5 options (never, rarely, sometimes, often and always). Each section will be assessed on a 5-point scale (0-4) and the total score is from 0 to 100 where high scores indicate that the person has more flexibility of action.

In the present study, to determine the reliability of the questionnaire of flexibility of action, Cronbach's alpha was used that was 0.92 for the entire questionnaire, which indicates that the reliability coefficients of the questionnaire is desirable.
Beck Scale of Suicide Ideation (BSSI)
BSSI is a self-evaluation tool with 19 questions. This questionnaire is developed by Beck and Steer (1991), in order to detect and measure the intensity of attitudes, behaviors and is planning to commit suicide. Beck Scale for Suicidal Ideation is one of the several comprehensive tool for assessing the severity of suicidal ideation and the only tool to assess active and inactive suicidal tendencies. The scale is based on three point score from 0 to 2, where the overall score of the person is calculated based on the sum of the scores from 0 to 38. The questions of the scale assess points such as a death wish, active and inactive desire to commit suicide, the frequency of suicidal thoughts, feelings of self-control, barriers, suicide and attempted suicide willingness and there are five screening question in Beck's questionnaire. If the subject's answers in these five questions indicate active or inactive suicidal tendencies, then the subjects should also continue next 14 questions. The average time to complete the questionnaire is 10 minutes. In Beck's scale, for identifying suicidal thoughts, a special form is designed and based on the contents of the questions, the risk of suicide can be determined as follows: (0-5) having suicidal thoughts, (6-19) in preparation for suicide, (20-38) intend to commit suicide. Beck Scale for Suicidal Ideation has had high correlation with standardized clinical depression tests, and scale of suicide ideation (SSI). Beck Scale for Suicidal Ideation domain correlation coefficient with standardized tests for depression and suicidal tendencies were from 90% for patients admitted to 94% for clinic patients. In addition, this scale was correlated with the question of suicide in Beck's depression from 58% to 69%. In addition, it was correlated with Beck's hopelessness scale and Beck depression Inventory from 64% to 75%. In the present study, Cronbach's alpha was used to determine the reliability of suicide ideation that was 0.95 for the whole questionnaire, which shows the desirable reliability of the questionnaire.

Research findings
A) Descriptive findings
The findings of this study including descriptive statistical parameters such as mean, standard deviation and the number of sample subjects for all variables studied in this study are presented in Table 1.

Table 1: Mean and standard deviation of the scores of the subjects in the research variables

<table>
<thead>
<tr>
<th>Statistical indicators</th>
<th>Variable</th>
<th>Mean</th>
<th>Standard deviation</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early maladaptive schemas in communication failure and rejection</td>
<td>8.28</td>
<td>5.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impaired autonomy and impaired performance schema domain</td>
<td>5.26</td>
<td>4.76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schema for hampered restrictions</td>
<td>3.72</td>
<td>2.88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schema for others orientation</td>
<td>3.60</td>
<td>2.49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schema for over-vigilance</td>
<td>3.75</td>
<td>2.54</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
As can be seen in Table 1, in early maladaptive schema (EMS) variable in the field of communication failure and rejection, mean and standard deviation are, respectively, 8.28 and 5.52, in EMS variable in the autonomy and impaired performance, 5.26 and 4.76, in EMS variable in hampered constraints is 3.72 and 2.88, in EMS variable for others orientation 3.60 and 2.49, in EMS variable for over-vigilance and prevention, 3.75 and 2.54, in flexibility of action, 73.20 and 17.91 and in suicide ideation variables, mean and standard deviation are, respectively, 11.48 and 9.76.

B) Findings related to research hypotheses

This study includes the following hypotheses each of which along with the results of the analysis is presented in this section.

First hypothesis: there is a relationship between early maladaptive schemas in the field of communication failure and rejection and suicide ideation in patients with mood disorders.

The second hypothesis: there is a relationship between early maladaptive schemas in the area of autonomy and impaired performance and suicide ideation in patients with mood disorders.

The third hypothesis: there is a relationship between early maladaptive schemas in the area of hampered restrictions and suicide ideation in patients with mood disorders.

Fourth hypothesis: there is a relationship between early maladaptive schemas in the area of others orientation and suicide ideation in patients with mood disorders.

Fifth hypothesis: there is a relationship between early maladaptive schemas in the area of over-vigilance and suicide ideation in patients with mood disorders.

**Table 2: The simple correlation coefficient between early maladaptive schemas and suicide ideation patients with mood disorders**

<table>
<thead>
<tr>
<th>Criterion Variable</th>
<th>Statistical Indicator</th>
<th>Correlation (r)</th>
<th>Level Significance (p)</th>
<th>Number The sample (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schemas for communication failure and rejection</td>
<td>0.39</td>
<td>0.0001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schemas for autonomous areas</td>
<td>0.37</td>
<td>0.0001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schemas for hampered restrictions</td>
<td>0.22</td>
<td>0.013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schemas for others orientation</td>
<td>0.12</td>
<td>0.174</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schema for over-vigilance</td>
<td>0.12</td>
<td>0.163</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As shown in Table 2, there is a significant positive correlation between early maladaptive schemas and lack of communication and rejection of the patients with mood disorders and suicide ideation (p=0.0001 and r=0.39). Thus, the first hypothesis is confirmed. In other words, as...
early maladaptive schemas increases in the area of communication and the rejection of patients with mood disorders suicidal ideation increases. Moreover, there is a significant positive correlation between early maladaptive schemas in autonomy and impaired function of the patients with mood disorders and suicide ideation (p=0.0001 and r=0.37). Thus, the second hypothesis is confirmed. In other words, as early maladaptive schemas in autonomy and impaired function areas increases in patients with mood disorders, suicidal ideation increases.

There is a significant positive correlation between early maladaptive schemas in hampered restrictions of the patients with mood disorders and suicide ideation (p=0.013 and r=0.22). Thus, the third hypothesis is confirmed. In other words, as early maladaptive schemas in hampered restrictions areas increases in patients with mood disorders, suicidal ideation increases.

There is no relationship between early maladaptive schemas in others orientation area with suicide ideation in patients with mood disorders (p=0.174 and r=0.12). Thus, the fifth hypothesis cannot be confirmed. There is no relationship between early maladaptive schemas in over-vigilance area with suicide ideation in patients with mood disorders (p=0.163 and r=0.12). Thus, the fourth hypothesis cannot be confirmed.

Sixth hypothesis: there is a relationship between flexibility of action and suicide ideation in patients with mood disorders.

Table 3: Correlation coefficient between flexibility of action and suicide ideation in patients with mood disorders

<table>
<thead>
<tr>
<th>Criterion Variable</th>
<th>Statistical Indicator</th>
<th>Correlation (r)</th>
<th>Level Significance (p)</th>
<th>Number The sample (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide ideation</td>
<td>Flexibility of action</td>
<td>-0.56</td>
<td>0.0001</td>
<td>127</td>
</tr>
</tbody>
</table>

As can be seen in Table 3, there is a significant negative correlation between flexibility of action and suicide ideation among patients with mood disorders (p=0.0001 and r=-0.56). Thus, the sixth hypothesis is confirmed. In other words, with an increase in flexibility of action of the patients with mood disorders, suicide ideation decreases.

Seventh hypothesis: there a simple multiple relationship between are early maladaptive schema (lack of communication and rejection, autonomy and impaired function, hampered restrictions, others orientation, over-vigilance and prevention) and flexibility of action with suicidal ideation in patients with mood disorders.
Table 4: multiple correlation coefficient of predictor variables (schema fields of early flexibility of action) with suicide ideation in patients with mood disorders using the simultaneous and stage levels

<table>
<thead>
<tr>
<th>Method</th>
<th>Predictor variables</th>
<th>R</th>
<th>R²</th>
<th>F</th>
<th>p=</th>
<th>β</th>
<th>t</th>
<th>p=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry</td>
<td>Lack of communication and rejection</td>
<td>0.61</td>
<td>0.37</td>
<td>7.71</td>
<td>0.0001</td>
<td>0.01</td>
<td>0.095</td>
<td>0.924</td>
</tr>
<tr>
<td></td>
<td>Autonomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.21</td>
<td>1.48</td>
<td>0.140</td>
</tr>
<tr>
<td></td>
<td>Various restrictions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.01</td>
<td>0.088</td>
<td>0.930</td>
</tr>
<tr>
<td></td>
<td>Others orientation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-0.18</td>
<td>-1.62</td>
<td>0.107</td>
</tr>
<tr>
<td></td>
<td>Vigilance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.06</td>
<td>0.581</td>
<td>0.562</td>
</tr>
<tr>
<td></td>
<td>Flexibility of action</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-0.49</td>
<td>-5.12</td>
<td>0.0001</td>
</tr>
<tr>
<td>Stage</td>
<td>Flexibility of action</td>
<td>0.56</td>
<td>0.31</td>
<td>5.058</td>
<td>0.0001</td>
<td>-0.56</td>
<td>-7.61</td>
<td>0.0001</td>
</tr>
</tbody>
</table>

As presented in Table 4, regression of the prediction of suicide ideation patients with mood disorders from the variables of early maladaptive schema domains (lack of communication and rejection, autonomy and impaired function, hampered restrictions, others orientation, over-vigilance and prevention), flexibility of action is significant (p<0.0001 and F=7.71). Thus, the seventh hypothesis is confirmed. Variable flexibility of action with beta coefficient of 0.49 can significantly predict the suicide ideation of the patients with mood disorders negatively. In addition, the value of $R^2$ indicates that 37% of the variance of suicide ideation of the patients with mood disorders is explained by the above-mentioned variables. The results of stepwise regression analysis have showed that the variable of flexibility of action is predictive of suicide ideation of functional patients with mood disorders.

**Discussion and conclusion**

As shown in Table 2, there is a significant positive correlation between early maladaptive schemas and lack of communication and rejection of the patients with mood disorders and suicide ideation (p=0.0001 and r=0.39). Thus, the first hypothesis is confirmed. In other words, early maladaptive schemas increase in the area of communication and the rejection of patients with mood disorders suicidal ideation increases. This finding is consistent with research by Dill and colleagues (2010), in explanation of these findings it can be said that based on the views of Durkheim (1900; quoted Sotoudeh, 2005) in four kinds of suicide (self induced, altruistic, anomic and fatalistic), the level of social cohesion...
and the relationship between individuals and the society is very weak and disturbed, existing studies suggest that mood disorders, especially depression, is the most common detection of suicide (Hahusseau, 2011). In fact, patients with mood disorders suffer from high levels of emotional disturbance. Disorders like depression and mania awaken a range of negative emotions such as low energy, irritability, sadness, lethargy, loneliness, feelings of failure and frustration, and a feeling of emptiness, one of whose inevitable consequences is the weakening of social solidarity that is associated with having suicidal thoughts (Yang et al., 1995).

On the other hand, the early maladaptive schema in the field of communication failure and rejection in abandonment/instability phase (in the form of insecurity and mistrust for support and connecting with others), in mistrust/misbehave (as distrust towards bad intentions of the others in the communication), in the emotional deprivation (for deprivation of affection, deprivation of empathy and lack of social support), in defect/shame aspect (as excessive sensitivity to criticism, blame, rejection), in the social isolation/alienation aspect (as feeling of belonging to a community) in patients with mood disorders as a distorted cognitive falsification of real life, cause further weakening of social cohesion and due to the continuity character of schemas (Yang et al., 1995) and lead to impairment in social relationships and intensifying the isolation and having suicidal thoughts, so it is accepted that in the present study between early maladaptive schemas in the field of communication and the rejection of patients with mood disorders have been significant and positive with suicide ideation.

The second hypothesis: As shown in Table 2, there is a significant positive correlation between early maladaptive schemas in autonomy and impaired function of the patients with mood disorders and suicide ideation (p=0.0001 and r=0.37). Thus, the second hypothesis is confirmed. In other words, as early maladaptive schemas in autonomy and impaired function areas increases in patients with mood disorders, suicidal ideation increases. This finding fits with research by Dill et al (2010), in explaining the findings, it can be said that by considering psychoanalytic approach and vision of Karel Gostave Yong (1945; quoted Zolfaghari, 2011), which states that in the triple scope of suicide (ideators, suicide attempters and performers) the person's relationship with the reality seems to be disturbed and the roots of this disorder is in the proper understanding of the facts, rooted in childhood and the formation of the main nuclei of his character. This has been shown in many studies, and many suicidal thoughts and tendencies refer to unsolved problems related to childhood (Loki, 2005). In this regard, early maladaptive schemes in the sphere of autonomy and impaired performance, aspects of dependence / incompetence, vulnerability to harm or illness and not change/caught by failure all lead to cognitive falsification of the patient of confrontation with realities of all life problems that lead to psychosocial growth, and while having mood disorder and severe negative swings, in the study population in the present study, it can be accepted that a significant positive correlation was observed in early maladaptive schemas in areas of autonomy and impaired performance with patients' suicide ideation with mood disorders.

The second hypothesis: As shown in Table 2, there is a significant positive correlation between early maladaptive schemas in hampered restrictions of the patients with mood disorders and suicide ideation (p=0.013 and r=0.22). Thus, the third hypothesis is confirmed. In other words, as early maladaptive schemas in hampered restrictions areas increases in patients with mood disorders, suicidal ideation increases.
This finding is consistent with research by Dill et al (2010), in explaining the findings, it can be said based on cognitive approach to suicide by Ellice (1989; translated by Firoz Bakht, 2004), which states that the root cause of suicidal thoughts and suicide attempts is the irrational beliefs that the person has in life, beliefs such as megalomania, emotional irresponsibility, tend to blame, excessive concern and deep attachment to others all of which cause thought rumination and negative emotional attacks such as extreme anxiety, anger and depression in the person. In the studies by Ijan (2010) in clinical population with mood disorders, it was shown that nearly all patients have irrational beliefs that are the core of all suicide ideation.

As Yang et al. (1995) showed in meta-analysis that there is a strong relationship between early maladaptive schemas and the formation of irrational beliefs, it seems that irrational beliefs towards realistic constraints and self-control in lack of satisfying needs lead to the formation of early maladaptive disorder in hampered restrictions in terms of aspects of deserve/ magnanimity (in form of feeling superiority), and insufficient restraint and self-discipline (in form of disablement in appropriate restraint, insufficient tolerance to achieve goals and personal impulse control) that cause having cognitive distortions of reality and irrational beliefs in the face of real life. This issue not only strengthens emotional swings such as depression, anger and impulsivity and reinforcing mood disorder and severe negative emotional swings, in the population studied in this research, but also causes more suicidal thoughts, so it is acceptable that a positive relationship was observed between early maladaptive schemas in hampered restrictions with suicide ideation in patients with mood disorders.

The fourth hypothesis: As shown in Table 2, there is no significant positive relationship between early maladaptive schemas in the others orientation area with suicide ideation of patients with mood disorders (p=0.12 and r=0.174). The fourth hypothesis is not confirmed. This finding is consistent with research by Dill and colleagues (2010). In explaining the findings, it can be said that with reference to New psychoanalysis and Hornay views (1965; quoted Biabangard, 2004), which states that suicide is the result of a lack of dependence on others and also failure to take appropriate emotional response from others.

According to Hornay, from among the three main characters neurotic that is seal demand militants and isolation-oriented, seal demand characters seeks to gain too much support from others has too much dependence on others and has sickness-like devotion and is the least susceptible to psychological damage such as alcoholism, drug addiction, mood disorders, depression, and suicidal ideation.

On the other hand, failure to fulfill the needs freely and reliable feelings in childhood causes extreme focus on individual needs, desires and feelings of others, so that their needs are ignored, resulting in the formation of his early maladaptive schemas in other areas for orientation in compliance aspects (extreme relinquish of self-control to others to avoid extreme anger, frustration or revenge). Devotion (excessive sensitivity to the suffering of others, prevention of harm to others and avoiding the guilt feeling due to selfishness) has a great closeness to the seal demand character in Hornay's view. In this definition, excessive dependence on others causes undermining of accountability, independence, self-reliance and activation of the person's rumination.

It appears that, this is along with levels of communication and social support that leads to solidarity with others, but aggressive negative emotion such as depression and mania of the
studied patients with mood disorder in this study causes isolation as well and weakens the effect of solidarity with others, so it is plausible that no relationship was found between the early maladaptive schemas in others orientation aspect with suicide ideation of patients with mood disorders (significant relationship was not observed).

Fifth hypothesis: As shown in Table 2, there is no relationship between early maladaptive schemas in others orientation area with suicide ideation in patients with mood disorders (p=0.163 and r=0.12). Thus, the fifth hypothesis cannot be confirmed. This finding is consistent with research by Dill et al (2010).

In explaining these findings, it can be said that early maladaptive schemas in the field of over-vigilance and preventing in terms of emotional inhibition (inhibition of anger and aggression, positive shocks, difficulty in expressing vulnerability or communicate freely, extreme emphasis on rationality without considering emotions), and in the field unrelenting standards / extreme fault seeking (extreme and negative perfectionism) lead to unrealistic perceptions and cause severe mood swings and lead to cognitive distortions of reality. This was expected to have a positive correlation with suicide ideation, but early maladaptive schemas in the field of over-vigilance and prevention, semantic peculiarity with defense mechanisms of repression, sublimation and reaction formation, especially in the dry rationality, is devoid of excitement with psychoanalytic perspective (Yasaii, 2010). That the person applies them so that by distortion or denial of the fact, he leads to reduce anxiety and coping with negative emotions and temporarily preserve the balance and maintain the integrity of the character to find real solutions This point somewhat moderates the power of early maladaptive schemas in the field of over-vigilance and prevention in the occurrence of suicidal thoughts affected by mood disorders in patients with mood disorders, Therefore, it is plausible to accept that no significant positive correlation was found between early maladaptive schemas in the field of over-vigilance and retention of suicide ideation in patients with mood disorders (no significant relationship was observed).

Sixth hypothesis: As can be seen in Table 3, there is a significant negative correlation between flexibility of action and suicide ideation among patients with mood disorders (p=0.0001 and r=-0.56). Thus, the sixth hypothesis is confirmed. In other words, with an increase in flexibility of action of the patients with mood disorders, suicide ideation decreases. This finding is consistent with research findings of Kurdistani Pourhossein et al (2013), Karami and colleagues (2012), Sudani and colleagues (2010), Beirami and colleagues (2012), Nasri Shounudeh and Ezat Basha (2014) and McLarna and Chalysa (2009).

In explaining this finding, it can be said that flexibility of action is the process of suitable adaptation of the person in the face of suffering and psychological trauma from any source that significantly causes psychological stress, and people with high levels of flexibility of action have high resilience, coercive opposition, mood and feelings positive. Such a person can resist stress, anxiety and the factors that caused the creation of many psychological problems will show strength and overcome them (Kaplan and Sadoc, 2003; translated by PourAfkari, 2003). On the other hand, although several studies have shown that flexibility of action is poor in patients with affective disorder (Roy, 2010), but through increasing the levels of positive emotions, it can strengthen effective coping skills and gaining social solidarity from the others and successful coping with negative experiences and negative emotions, physical symptoms of mood disorders and depression and thus suicide ideation as a method of coping does not develop. Thus, in the
present, the existing of a significant negative relationship between flexibility of action and suicide ideation among patients with mood disorders is justified.

The seventh hypothesis: as presented in Table 4, regression of the prediction of suicide ideation patients with mood disorders from the variables of early maladaptive schema domains (lack of communication and rejection, autonomy and impaired function, hampered restrictions, others orientation, over-vigilance and prevention), flexibility of action is significant (p<0.0001 and F=7.71). Thus, the seventh hypothesis is confirmed. Variable flexibility of action with beta coefficient of 0.49 can significantly predict the suicide ideation of the patients with mood disorders in a negative way. In addition, the value of R² indicates that 37% of the variance of suicide ideation of the patients with mood disorders is explained by the above-mentioned variables. The results of stepwise regression analysis have showed that the variable of flexibility of action is predictive of suicide ideation of functional patients with mood disorders.

In explaining this, it can be said that lack of emotional support plays an important role in estimating suicide risk Granbam (2010) as the existence of formal and informal social support is an important conservation role, social isolation and living alone are important risks for patients with mood disorders. Due to flexibility of action, as a personal skill in overcoming emotional crisis conditions in these patients, emotional distress is reduced, and it is effective in finding the adaptability strength to overcome difficulties and to comply with the conditions and mood disorder syndrome, and in the present study, it has the ability to predict suicide ideation in patients with mood disorders in a negative way.
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