AN EXPLORATION OF THE RELATIONSHIP BETWEEN
CHILDHOOD SEXUAL ABUSE, CAREGIVER SUPPORT,
AND MALADAPTIVE COGNITIVE SCHEMA AMONG
INCARCERATED WOMEN

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ABSTRACT

Although childhood sexual abuse (CSA) is considered a widespread problem in the United States that often has lasting implications for the survivors, there has been a paucity of theory driven research that has investigated the impact of CSA on individuals’ Early Maladaptive Schemas (EMS). The current research investigated the impact of “severe” CSA on the development of EMS, the impact of parental caregiver Care and Overprotection during childhood on EMS, and the interaction of CSA and primary caregiver Care and Overprotection on EMS in a sample of incarcerated women (N=161). It was hypothesized that women who experienced CSA would evidence more severe EMS than women who did not experience CSA. A MANOVA provided partial support for this hypothesis. It was additionally hypothesized that women who experienced low primary caregiver Care would evidence more severe EMS than women who experienced high primary caregiver Care. A MANOVA provided full support for this hypothesis. It was further hypothesized that women who experienced high primary caregiver Overprotection would evidence more severe EMS than women who experienced low primary caregiver Overprotection. A MANOVA provided partial support for this hypothesis. However, a MANOVA failed to evidence an interaction between CSA and primary caregiver Care and Overprotection on EMS. Although CSA was related to the development of EMS, primary caregiver Care and Overprotect during childhood appeared to be a more critical variable in terms of EMS. The current research findings
were consistent with previous research which supported a correlation between CSA and features of Borderline Personality Disorder. The findings additionally underscore the importance of primary care giver relationships during childhood on subsequent psychological adjustment.
DEDICATION

This dissertation is dedicated to the survivors of childhood sexual abuse and all of the children in need of love and validation.
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CHAPTER I
INTRODUCTION

Childhood sexual abuse (CSA) is considered a widespread problem in the United States that often has lasting implications for the survivors (e.g., Beitchman, Zucker, Hood, daCosta, Akman, & Cassavia, 1992; Finkelhor, 1990). Researchers have investigated the etiology, epidemiology, and the short and long-term sequelae of CSA in depth. However, there has been a paucity of theory driven research that has investigated the impact of CSA on individuals’ beliefs about themselves and the world around them. Core belief systems, also called cognitive schemas, may be positive or negative and develop during an individual’s formative years. It has been assumed that maladaptive cognitive schemas develop following childhood trauma and are responsible for a person’s subsequent dysfunctions (e.g., Briere & Runtz, 1993). But, to date, research has failed to explore the various underlying early maladaptive schema (EMS) that may develop as a result of CSA in a systematic, theory driven manner.

It is important to understand the cognitive link between the traumatic event and subsequent psychological distress in order to help provide efficacious treatment for the survivors of CSA. The link may not be a simple one, as the presence or absence of other variables may affect the degree to which maladaptive schema development follows the occurrence of CSA. Social support has been found to be a particularly robust protective variable across many areas of research (Cohen & Hoberman, 1983; Thoitis, 1985).
Research has indicated that one of the most important variables related to the
development of short-term and the long-term sequelae of CSA is family support (Conte & Shurmann, 1987; Fromuth, 1986; Hyman, Gold & Cott, 2003; Wyatt & Mickey, 1988). In the case of childhood trauma such as CSA, parental/caregiver support would seem to be the most salient form of social support. Thus, a thorough understanding of the impact of parental/caregiver support on EMS is needed. Such research may help inform practice and assist clinicians in developing more efficacious treatment plans for both child and adult survivors of CSA. Through understanding the maladaptive schema that may occur following trauma and the potentially moderating impact of caregiver support on the schema, clinicians may be able to operationalize treatment modalities to address and ameliorate the maladaptive schema in the adult survivors. For child survivors, the treatment modalities may include early interventions facilitating the supportive involvement of caregivers immediately following the trauma.

This chapter will provide a definition of CSA and discuss the prevalence of CSA in the United States in depth. Chapter one will also highlight hallmark literature related to the empirically supported sequelae of CSA, cognitive schemas, and the impact of family support. This discussion will provide the foundation for a more in-depth review of relevant variables in Chapter 2 and the presentation of general research questions designed to add to this promising area of research with implications for both theory and practice.

Definition of CSA

The operational definition of CSA has varied greatly and has been a serious impediment to the systematic study and research of CSA. The frequently vague definition
of CSA is a critical challenge (Brand, 2003; Glod, 1993; Rind, Tromovich, & Bauserman, 1998) that has resulted in research inconsistencies. As a result, one must be cautioned in interpreting the statistics involving CSA. Definitions of CSA have included “forced, tricked, or manipulated contact with a child by an older person (generally five or more years older) for the purpose of the sexual gratification of the older person” (Conte, 1995, p.402). CSA has also been defined as “any sexual experience ranging from invitation to do a sexual act to intercourse, that occurs before age 18, with a relative, with someone at least 5 years older than she, or with someone who forces her to engage in the sexual act regardless of age difference” (Downs, 1993, p.332). Variations in definitions are problematic because an emotional response to a proposition to engage in a sexual act or to being exposed to genitalia is likely to be very different from actually being touched or penetrated. Operationalizing these drastically different experiences as the same variable may result in research that either underestimates or overestimates the impact of CSA.

The present research follows that of a prominent scholar in the field (Finkelhor, 1984) in defining CSA as any sexual activity or proposition experienced by an individual under the age of 17 with an individual at least 5 years older. If threat of force or use of force occurred, the experience is defined as CSA regardless of the age of the perpetrator. To allow more specificity in conclusions, this umbrella definition can be broken down into three operationally defined levels of CSA severity, as will be detailed in subsequent chapters. It should be noted that the definition of CSA is a culturally defined construct that may vary across cultures and time. The present definition is consistent with the most current legal statutes in the United States.
Prevalence of CSA

The following studies investigating the prevalence of CSA in the United States were the most widely cited empirical studies in the literature, included the largest and most comprehensive samples, and provided the clearest definitions of CSA. General prevalence findings are described below, as are gender and racial/ethnic findings where available.

In 1990, Finkelhor, Hotaling, Lewis, and Smith conducted the only national study investigating the prevalence of CSA. The Los Angeles Times Survey Research Organization recruited 2,626 men and women, ages 18 and over, from residential telephone numbers throughout the United States (Finkelhor et al., 1990). Twenty-seven percent of women and 16% of men reported that they had experienced some form of sexual abuse prior to the age of 18. The term sexual abuse included exposure to sexualized behaviors, fondling, attempted intercourse, and actual intercourse. The median age of abuse for girls was 9.6 years of age, and the median age for abuse for boys was 9.9 years of age. This study found that among those who had experienced sexual abuse, boys were more likely to have been abused by strangers than girls, 40% versus 21% respectively. Girls were more likely than boys to have been abused by family members, 29% versus 11% respectively. Six percent of the girls had been abused by a father or step-father. Males were the more common perpetrators of abuse with 83% of the boys and 98% of the girls. Most perpetrators were at least 10 years older than their victims. Sixty-two percent of the male survivors interviewed and 49% of female survivors interviewed had experienced actual or attempted intercourse. Force was used in the abuse
with 15% of the boys and 19% of the girls. Eight percent of the males and 11% of the females reported that the abuse lasted longer than a year.

In 1992, Saunders and colleagues investigated the prevalence of CSA with a sample of 2,004 adult women living in South Carolina. CSA was defined as unwanted sexual experiences that occurred before the age of 18 and involved the use or threat of force. Rape was indicated if the mouth, anus or genitalia of the child was penetrated. Contact not involving penetration was defined as molestation, and experiences without physical contact were defined as non-contact abuse. Thirty-three percent of the sample reported the occurrence of an unwanted sexual experience that included rape, molestation, and/or non-physical contact abuse.

In a study by Wyatt (1985) and a follow-up study by Wyatt, Burns, Solis, and Vargas (1999), CSA was defined as the solicitation to engage in sexual behaviors, exhibitionism, fondling, and anal, vaginal, and oral penetration with an individual who was either at least 5 years older than the survivor or who used coercion. Within this broad definition, Wyatt also distinguished the severity of abuse. In the 1985 study, 248 European American and African American women were interviewed via phone. Sixty-two percent of the participants reported that they had experienced CSA as defined by the authors. CSA, excluding solicitation and unwanted kissing, was reported by 54% percent of the African American and 65% of the European American women. In the follow up study, Wyatt and colleagues interviewed a community sample of 338 European American and African American women. They found that 34% of the sample as a whole reported that they had experienced CSA before the age of 18. No significant differences were found in the prevalence of CSA between ethnic groups in either study.
Russel (1986) also found no significant difference in the overall prevalence of CSA between racial/ethnic groups, although incest did appear to occur more frequently among Latinas than among African Americans, Asian Americans, and European Americans. Finkelhor (1986) also reported that socioeconomic status did not appear to impact the prevalence of CSA.

Despite epidemiological efforts such as the above, the actual prevalence of CSA remains unclear. Other research investigating the occurrence of CSA provides estimates as low as 6.8% (Seigel, Sorenson, Golding, Burnam, & Stein, 1987) to as high as 62% (Wyatt, 1985) in the samples investigated. Definitional variation and related measurement discrepancies, as noted above, may account for some of the rate variation. The varying rates may also be attributed in part to the self-report nature of most studies. Respondents may vary in their willingness to disclose abuse in relation to the specific methodology used. In addition, estimates of the prevalence of CSA derived from self-report survey results are likely to be discrepant from those derived from formally reported cases (Finkelhor, 1994). For example, Finkelhor, Hotaling, Lewis, and Smith (1990) found that 42% of males and 33% of females interviewed had never disclosed the child sexual abuse prior to the interview. Despite these inconsistencies, it is apparent that CSA is a pervasive form of violence in the United States (Finkelhor et al., 1990; Meichenbaum, 1995).

CSA and Psychological Dysfunction

Exhaustive research has demonstrated the correlation between CSA and short term and long term psychological dysfunction. Briefly, the short-term correlates of CSA include sexualized behaviors such as excessive or public masturbation, requesting sexual
stimulation from children and adults, and age inappropriate sexual knowledge (Beitcham et al., 1991, Browne & Finkelhor, 1986). Additional short-term correlates to CSA include Post Traumatic Stress Disorder (PTSD) and related symptoms such as nightmares, intrusive thoughts, anxiety, and fears (Beitcham et al., 1991; Browne & Finkelhor, 1986). Regressive behaviors such as enuresis, encopresis, tantrums, whining, truancy, self-injurious behaviors (Beitcham et al., 1991; Browne & Finkelhor, 1986), and school problems (Adams-Tucker, 1981; Peter, 1976) were also found to be related to an experience of CSA.


There have been inconsistent findings with regard to racial/ethnocultural differences in the long term sequela of CSA. Russell (1986) and Wyatt (1985) reported that African
Americans experienced longer lasting effects of CSA than their European American counterparts. In contrast, Locke (1995) reported that African American women consistently reported fewer short-term and long-term symptoms of psychological distress following the occurrence of CSA than European American women. Rabon (1994) found no significant difference with regard to later psychological adjustment between racial/ethnic groups reporting a history of CSA. Mennen (1995) also found a lack of pervasive differences between Latina American, Asian American, European American, and African American girls and adolescents reporting CSA.

In his 2001 dissertation, Eisenhower hypothesized that African Americans would have more parental support and higher levels of resilience than European Americans, and that European Americans would report a higher level of severity of abuse than African Americans. He based these hypotheses on the strong kinship bonds and religious orientation characteristic of African American families, as well as a pattern of overcoming direct and indirect racism and discrimination. While Eisenhower found that social support from parents did mediate the relation between CSA and long term distress in survivors of CSA, he did not ultimately find support for his hypotheses that African Americans would have more parental support and higher levels of resilience than European Americans, or that European Americans would report more severe abuse.

Psychological Dysfunction and Cognitive Schemas

Cognitive distortions, as an aspect of the “deeper” maladaptive schema construct, are misassumptions that people make about themselves, others, the environment, and the future based on childhood experiences (Briere & Runtz, 1993). These assumptions can include such things as an overestimation of the danger in the world and an
underestimation of one’s self-worth. Researchers and clinicians have long theorized that
there is a connection between maladaptive cognitions developing from a traumatic event
and subsequent psychological dysfunction. This contention has been put forth in relation
to disorders such as depression (e.g., Browne & Finkelhor, 1986), anxiety (e.g., Bagley &
Ramsey, 1986; Briere & Runtz, 1993; Runzt, 1987), and interpersonal difficulties (e.g.,
Horowitz, 1991). Briere and Runtz, for example, cited Beck and Emery’s 1985 model of
anxiety disorders and highlighted the cognitive aspects of abuse-related anxiety that lead
to ongoing perceptions of threat or danger.

Researchers investigating the maladaptive cognitions of survivors of CSA have found
correlations between CSA and feelings of guilt, low self-esteem, locus of control, self–
blame, and attributions of positive and negative events (Burt & Katz, 1987; Gazan &
CSA is associated with abuse-related negative thoughts and beliefs that, in turn, are
related to subsequent depressive symptoms. He investigated the cognitive themes of self-
blame and self-denigration with adult survivors of CSA using the Belief Inventory
(Pearlman, 1996) and demonstrated that cognitive therapy remediated the impact of
sexual trauma by reducing Belief Inventory scores. Gold (1986) investigated attributions
of positive and negative events and found that adult survivors of CSA were more likely to
attribute negative events to internal factors such as their character and their behavior,
while positive events were attributed to external factors. According to Gold and others,
cognitive distortions such as these may mediate the relation between CSA and the
negative symptomatology evident among adult survivors (Gold, 1986; Jehu, 1989, Runtz,
1991). The research related to CSA and self-esteem produced more conflicting results,
with some studies finding a negative correlation between self-esteem and CSA and others finding no relationship (Briere & Runtz, 1990b; Fromuth, 1986; Runtz, 1987; Sillman, 1993; Sorenti-Little, Bagley, & Robertson, 1984).

Despite the presence of some conflicting results, the aforementioned studies as a whole provide support for the argument that CSA may be broadly correlated with cognitive distortions, and that the presence of specific dysfunctional schemas may possibly be a “missing link” between the occurrence of CSA and the aforementioned associated psychological difficulties. Theorists have stressed the importance of understanding childhood traumas and the impact such trauma has on the child’s subsequent social and interpersonal development (Cichetti & Toth, 1995; Jackson et al., 1990). The assumption is often made, implicitly or explicitly, that the impact occurs through schema development. Unfortunately, the relevant research appeared to be conducted in an incomplete or piece meal fashion. Although cognitive distortions are conceptually related to maladaptive schema, the research related to cognitive distortions has not been investigated in a theory driven, systematic manner and has not specifically identified maladaptive schemas.

According to Beck (1967):

A schema is a [cognitive] structure for screening, coding, and evaluating the stimuli that impinge on the organism…On the basis of the matrix of schemas, the individual is able to orient himself in relation to time and space and to categorize and interpret experience in a meaningful way (p.282).

Horowitz (1991) expressed similar ideas from an interpersonal psychodynamic perspective. He explained:
A person’s schema is an organized meaning or knowledge structure, an overall gestalt of self or of another person. Within the schema are the traits, roles, attributes, and characteristics of the person. Complex person schemas, such as role-relationship models, might include not only the roles, characteristics, and traits of self and other, but a schematic script of the potential transactions and communications of emotions between them (p.491).

In summation, schemas serve as templates for perceptions of later experiences and provide an implicit manner in which a person views him or herself (Young, 1994).

Due to children’s lack of experience in the world, they often lack pre-existing or adequate schemas with which to process traumatic events in a healthy manner (Horowitz, 1991). The intense emotions that may be experienced during and following incidents of CSA, combined with simplistic conceptualizations of the traumatic event(s), may result in children’s maladaptive interpretation of the events in terms of their own responsibility for the abuse and their self-worth following the abuse (Cichetti & Toth, 1995).

Theorists hypothesize that once a child has experienced a traumatic event:

The event appears to be inscribed in a special form of memory that tends to be unusually vivid. As a result, the traumatic event tends to persist in the mind not only in the form of these memories, but in schemas in which the self is perceived as vulnerable to recurrent traumatic experiences. (Horowitz, 1991, p.494)

The “traumatic schema” that developed after an overwhelming life event during childhood may be triggered later in life (p.494).

Cognitive theorist Jeffery Young developed a new approach to treating a variety of mental health problems, including affective disorders and personality disorders, by focusing specifically on the development of dysfunctional schema that emerge during childhood. Young (1990) theorized that individuals who experienced trauma or neglect during their early formative years may develop Early Maladaptive Schema (EMS). He
defined EMS as the “extremely stable and enduring themes that are developed during childhood, are elaborated throughout an individual’s lifetime, and are dysfunctional to a significant degree” (p. 9). Young identified five overarching EMS: (a) Disconnection and Rejection, (b) Impaired Autonomy and Performance, (c) Impaired Limits, (d) Other Directedness, and (e) Overvigilance and Inhibition. These overarching EMS are theoretically related to a number of Axis I and Axis II disorders (Loper, 2003). As part of his theory and treatment development, Young developed the Young Schema Inventory, a novel way to operationalize maladaptive schemas. The Young Schema Inventory (YSQ-L; Young & Brown, 1990) was designed to identify whether an individual was presenting with one or more EMS.

The development of Young’s theory and the YSQ-L opens the door to a more systematic and theoretical study of the relationship between noxious or traumatic events and schema, schema and emotional distress, and schema and significant mental health disorders. The first and most basic of these links, between CSA and EMS, is a primary focus of the present research.

**CSA, Schemas and Moderating/Mediating Variables**

Many survivors of CSA are able to cope with traumatic life events and function in a healthy manner later in life (Farber & England, 1997; Herman, Russel, & Trocki, 1986). In fact, it appears that one-third of all child victims of sexual abuse experience no short-term or long-term psychological difficulties (Kendall-Tackett, Williams, & Finkelhor, 1993). Despite extensive research investigating the correlation between CSA and various psychological disturbances, it is still unclear why some victims of CSA have dysfunction following the traumatic event and some do not. Recent research has attempted to sort
through the factors that contribute to either resiliency or distress following traumatic events such as CSA by investigating mediating and moderating variables (Coffey, Leitenberg, Henning, Turner, & Bennet, 1996; Hyman, Gold, & Cott, 2003; Runtz & Schallow, 1997). A mediating variable accounts, in whole or significant part, for the correlation between the predictor variable and the outcome variable (Baron & Kenny, 1986). Mediating variables have included parental support, severity of trauma, relationship to the offender, age of onset of abuse, and internalized beliefs such as the appraisal of the abuse (Bagley & Young, 1990; Beitchman et al, 1992; Briere & Runtz, 1987; Brown & Finkelhor, 1986; Coffey, Leitneberg, Henning, Turner & Bennet, 1996; Eisenhower, 2001; Fromuth, 1986; Hazzard, Celano, Gould, Lawry & Webb, 1995; Williams, 1993; Wyatt & Newcomb, 1990). Wyatt and Newcomb (1990) reported that, “Child sexual victimization is viewed as a major stressor, from which other psychological, sexual, and relationship problems can emanate depending on the influence of various mediating processes” (p.758). However, there are concerns that some of the aforementioned “mediating” variables are actually more conceptually viable as moderating variables.

A moderator variable is a “qualitative or quantitative variable that affects the direction and/or strength of the relationship between an independent or predictor variable and dependent or criterion variable” (Baron & Kenny, 1986, p.1174). Limited research has investigated variables that moderate the relationship between CSA and the long-term sequelae of CSA. Those examined have included the duration of the CSA (Wyatt & Newcomb, 1990), the relationship of the perpetrator to the survivor of abuse (Wyatt & Newcomb, 1990), the use of force or threat (Friedrich, Urquiza, & Beilke, 1986), whether
penetration occurred (Morrow, 1991), and the reaction and support or lack thereof from the non-offending caregiver (Conte & Shurmann, 1987; Fromuth, 1986; Hyman, Gold, & Cott, 2003; Wyatt & Mickey, 1988). Additional moderating variables have included family dynamics (Edwards & Alexander, 1992; Yama, Tovey, & Fargas; 1993).

Although these studies addressed important variables and generally had supportive results, they only examined moderation as it related to psychological outcomes. Researchers did not consider the potential moderating impact that variables like these might have on the development of dysfunctional cognitions or EMS, which are often presumed to underlie, or mediate, the relation between CSA and subsequent outcomes. Thus, there is a need to further investigate the factors that might buffer the impact of childhood trauma or, in other words, to better understand how to assist a child in building resilience in the face of trauma (Werner & Smith, 1982). At present, research has not sufficiently examined how some variables might moderate the relation between the traumatic event and the development of EMS.

**Family/Caregiver Support**

Thoitis (1986) defined social support as assistance given to individuals who are coping with stressful events. It is theorized that the presence of social support acts as a “buffer” during and following traumatic events, helps individuals more effectively cope with high levels of stress, and serves as protection from developing psychological symptomatology and maladaptive coping strategies (Cohen & Willis, 1995). Tremblay et al. (1999) postulated that “the buffering effect operates by intervening between the stressful event and the victim’s reaction by influencing the cognitive evaluation of the experience, thereby reducing or eliminating the victim’s reaction.” (in Hyman, Gold, &
Cott, 2003. p.99). The “buffering” hypothesis asserts that social support “protects one from pathogenic effects of high levels of life stress” (Hyman et al., 2003, p.99). These authors explained that the “buffering qualities of social support are cognitively mediated, e.g., support operates by affecting one’s interpretation of the stressor.” (p.99). The cognitive analysis is concerned with the individual’s perception of interpersonal support, as opposed to its actual availability. Researchers have hypothesized that following CSA, perceived parental or caregiver support will influence a child’s perception of the traumatic event and him/herself as related to the traumatic event (Cohen & Will, 1985; Cohen & Hoberman, 1983).

There is evidence that family environment, in general, impacts psychological adjustment later in life, absent early childhood trauma (Finkelhor, 1993; Fromuth, 1986; Goodman et al., 1992; Hazzard et al., 1995; Kendall-Tackett, Williams, & Everson, Hunter, & Runyan, 1991). Fromuth (1986) explored the relation between CSA and later psychological distress in a sample of female college students. A statistically significant negative correlation was found between reported CSA and later psychological adjustment; however, the author questioned whether the psychological adjustment was confounded by family dysfunction. When parental supportiveness was controlled, the statistically significant relation between CSA and psychological turmoil was significantly reduced. This study suggests that psychological turmoil may be largely due to the confounding of CSA with family environment, rather than CSA per se. Peters (1988) found, on the other hand, that the relation between CSA and depression was significant even after controlling for the influence of maternal warmth following disclosure of CSA.
The conflicting results of these studies could be due in some part to the researchers’ methodological choice to control family related variables rather than examine them as variables of interest in their own right. Controlling family variables cannot sufficiently address the question of whether the relations between CSA and subsequent psychological outcomes might differ between survivors with more and less healthy early family environments.

As noted in a previous section, numerous variables have been theorized and shown to impact the relationship between CSA and the development of emotional distress. The present study will focus on the potential effect of primary caregiver support, as perceived in general and throughout childhood, on EMS. This variable is seen as having high importance for several reasons. First, to summarize previous arguments, social support has been found to be an important resiliency variable in general (Cohen & Hoberman, 1983; Thoitis, 1985) and in relation to the link between CSA and psychological outcomes (Conte & Shurmann, 1987; Fromuth, 1986; Hyman et al., 2003; Wyatt & Mickey, 1988). Second, primary caregiver support would seem to be the most salient form of social support for children. Finally, if this variable has applied significance, therapists may be able to positively impact the way in which caregivers respond to a child who has been sexually abused. In theory, this could prevent the development of EMS and subsequent psychological dysfunction.

Sampling Considerations

The long-term sequelae of CSA have been researched extensively with non-forensic clinical samples and college samples, possibly due to their convenience. This is problematic because unique characteristics of the college and clinical populations may
impact the research findings and implications. For example, Jumper’s (1995) meta-
analysis suggested that “adult survivors of child sexual abuse among student populations
may experience fewer difficulties with psychological adjustment than do former child
sexual abuse victims among community and clinical populations” (p. 722). Researchers
have attributed the fewer psychological difficulties of the college samples to their
generally higher IQs and social economic status (Schetky, 1988), and possibly to parents
with more emotional and financial resources to support their child following disclosure.

Research involving non-college student and forensic populations has been relatively
neglected. Arguably, these populations include members who may be likely to benefit
from such research and the implications that this research may have on treatment. As a
result, a forensic population was chosen for the purpose of this research. Specifically,
icarcerated women were identified as the population of interest. Ample research
indicates that women in this population frequently have a history of CSA (e.g., Brown,
Miller, & Maguin, 1999; Heney & Kristiansen, 1998; Lake, 1993; Maeve, 2000; United
States Bureau of Justice Statistics, April 1999), and recent research suggests high levels
of early maladaptive schema (Loper, 2003). Exploring linkages between the two would
be of theoretical interest and could potentially yield valuable clinical implications. High
rates of both Axis I and II disorders are found in this population (e.g., Loper, 2003;
United States Bureau of Justice Statistics, April 1999), and clinicians are in need of
effective models for the conceptualization and treatment of these women’s distress (e.g.,

Confounding variables of many kinds are inherent in CSA research. The most
important of these may be that CSA may co-occur with the experience of physical and
emotional abuse. Although emotional abuse and physical abuse will not be specifically measured or controlled in this research, the impact of such abuse will be factored into the analysis to a degree through measures of caregiver support or the lack thereof. If CSA is linked to EMS as hypothesized, the nature of the sample would also lend some support to the argument that the link reflects specific effects of CSA rather than childhood adversity generally. Problematic childhoods of one kind or another are pervasive among women in the judicial system (e.g. Brown, Miller, & Maguin, 1999; Heney & Kristiansen, 1998; Lake, 1993; Maeve, 2000; United States Bureau of Justice Statistics, April 1999), making it less likely that they would be associated with the group who had experienced CSA. Nonetheless, if this preliminary investigation does find support for the theorized relation between CSA and EMS, with or without moderation by caregiver support, subsequent research will be needed to directly assess the roles of the myriad of variables that potentially could confound that relationship.

Summation

CSA is a prevalent problem in the United States. It is associated with short and long-term psychological dysfunction. Theoretical and some empirical evidence support the assertion that EMS may underlie the CSA-psychological dysfunction correlation. Although empirical research has identified cognitive distortions, such as guilt, low self-esteem, and self-blame as correlates of CSA, literature to date is limited in both quality and quantity. A systematic, theory driven approach to the study of CSA-related schema is needed. In addition, theoretical and empirical evidence supports the speculation that the CSA-psychological dysfunction link may be moderated by perceptions of primary caregiver support during childhood.
In short, this study seeks to empirically illuminate the cognitive “missing link” in the largely theoretical childhood sexual abuse-maladaptive schema-psychological dysfunction formula and to do so with attention to the role of a primary resiliency variable, social support. Finally, this study samples a population with high rates of childhood sexual abuse, maladaptive schema, and psychological dysfunction, and one in great need of effective mental health services.
CHAPTER II
REVIEW OF THE LITERATURE

Extensive research has documented a correlation between childhood sexual abuse (CSA) and a variety of long term psychological dysfunctions, but such research has insufficiently investigated the underlying thought processes that theoretically contribute to the subsequent psychological dysfunction. This dissertation intends to expand the body of research related to CSA by exploring the association between CSA and cognitive schema.

It is hypothesized, as introduced in Chapter One, that childhood sexual abuse may be associated with the development of Early Maladaptive Schema (EMS), and that social support throughout childhood from the primary childhood caregiver may be related to the development of EMS. Before delving further into this hypothesis, it is important to identify how theorists have conceptualized how traumatic events impact an individual’s thought processes and long term psychological functioning. As a result, Chapter 2 will first discuss how theorists, such as Beck, Young, and Finkelhor, theorized how childhood trauma impacts individuals’ core beliefs about themselves and their environments, which in turn accounts for their varying responses to traumatic events. This chapter will then discuss research that has employed these theories, briefly discuss the empirically derived correlates of CSA and subsequent psychological distress. Lastly, the role of social
support and its impact of the relation between CSA and psychological distress will be discussed in depth.

Although this dissertation will focus on the impact of traumatic events from a cognitive perspective, the assertion that early traumatic events negatively impact an individual’s ability to function adaptively as adults is not novel. Before Beck’s Cognitive Theory, psychodynamic theorists hypothesized that childhood traumas create unconsciousness conflicts that impact character development (Horowitz, 1991). In 1960, Aaron Beck, the father of Cognitive Therapy (CT), challenged the traditional psychodynamic approaches to conceptualizing, assessing, and treating mental health disorders. In contrast with the psychodynamic therapists of his time, Beck theorized that one’s thoughts, beliefs, and perceptions shape one’s emotional responses to the environment, and that repetitive themes in free association and dreams may be attributed to an underlying schema versus unconscious conflicts.

Beck (1967) defined a schema as a cognitive “structure for screening, coding, and evaluating the stimuli that impinge on the organism…On the basis of the matrix of schemas, the individual is able to orient himself in relation to time, space and to categorize and interpret existence in a meaningful way” (Beck, 1967, p.282). Segal (1988) added that schemas are “organized elements of past reactions and experience that form a relatively cohesive and persistent body of knowledge capable of guiding subsequent perceptions and appraisals” (Segal, 1988, p. 147). In other words, according to cognitive theorists, individuals experiencing psychological distress, neurosis, or pathology have schemas that reflect misconceptions, distorted beliefs and attitudes, unrealistic goals and expectations about themselves and their environment (Beck, 1967).
Such distorted thoughts have been described as a “loop of bad background music” that constantly play in the lives of depressed or otherwise emotionally distressed individuals (Simon, Cecilia & Caopuzzi, 2002).

In 1981, Millon eloquently shared his interpretation of how traumatic events impact schema from a CT approach. He theorized the following:

Significant experiences of early life may never recur again, but their effects remain and leave their mark...they are registered as memories, a permanent trace and an embedded internal stimulus...Once registered, the effects of the past are indelible, incessant and inescapable...The residuals of the past do more than passively contribute their share to the present...they guide, shape or distort the character of current events. Not only are they ever present, then, but they operate insidiously to transform new stimulus experiences in line with the past. (p. 101)

In other words, childhood traumas may impact the way in which individuals perceive themselves as they interact with their environment later in life.

The goal of CT is to bring these underlying belief systems, or schemas, to the awareness of clients, help them understand the effects of these schemas, and then assist them in modifying these underlying perceptions of themselves and the world. Through the collaboration of the therapist and the client, the client begins to identify and manage the maladaptive automatic thoughts.

Young’s Schema Focused Theory

Researchers have established the efficacy of CT and Cognitive Behavioral Therapy (CBT) in the treatment of depression (Craighead, Craighead, & Ilardi, 1998), Generalized Anxiety Disorder (Barlow, Esler, & Vitali, 1998), Obsessive Compulsive Disorder (Franklin & Foa, 1998), personality disorders (Crits-Christoph, 1998), eating disorders (Wilson & Fairburn, 1998), and substance abuse (Finney & Moos, 1998). As research
established the efficacy of CT, the theory itself also evolved. Like Beck, Jeffrey Young, a CT theorist and practitioner, focused on the importance of identifying and treating the core underlying schema that “emerge from repeated filtering of adverse life events through dysfunctional automatic thoughts,” particularly when working with individuals who have experienced traumatic events during their formative years (Loper, p. 253, 2003). Young’s clinically derived Schema Focused Therapy refined the concept of schemas by identifying specific dysfunctional schemas, which he called Early Maladaptive Schemas (EMS). Young defined EMS as the “extremely stable and enduring themes that are developed during childhood, are elaborated throughout an individual’s lifetime, and are dysfunctional to a significant degree” (Young, 1999, p. 9). Consistent with Beck’s definition of schema, EMS are broad pervasive themes that develop in the deepest level of cognition and serve as templates for perceptions of later experiences and provide an implicit manner in which a person views herself/himself (Young, 1994; Young, 1999). EMS are capable of generating high levels of depression and anxiety with the potential of the person causing harm to self or to others. EMS are also capable of interfering with individuals’ ability to meet their core needs of autonomy, connection, and self-expression.

According to Young (1999), EMS are defined by the following characteristics. First, EMS are unconditional beliefs or feelings about oneself in relationship to the environment. The EMS are assumed, implicit, and do not consider other alternatives. For example, “I am failure. Anything I attempt to do will become a failure. The play was failure, and I am a failure.” Second, EMS are “self-perpetuating,” reinforcing, and circular in nature. As a result, EMS are difficult to refute or change. EMS become the
core self-concept and core perception of the environment. If the schema is challenged or refuted, individuals will distort contradictory information to maintain the validity of the schema. In other words, they process information in a manner that reconfirms a belief system. For example, a woman does not reciprocate a man’s advances. He therefore believes, “I am unlovable,” versus other plausible explanations. Third, EMS are dysfunctional by definition and contribute to emotional distress, dysfunctional relationships, and maladaptive coping styles. Fourth, EMS are activated by events. For example, a recent job loss would activate the schema, “I am a failure.” Fifth, EMS are linked to affect. Depressive symptoms and anxiety alone may trigger an EMS.

Young (1999) stated that EMS result from an interplay between a child’s innate temperament, including predispositions for depression and anxiety, and the dysfunctional experiences a child has with a parent, a sibling, or their peers during his/her formative years. The development of EMS, according to Young, may be a result of a “pattern of everyday noxious experiences,” as opposed to a single traumatic event (p.11). EMS may be triggered by everyday events that are relevant to the underlying schema. However, Young also recognized the importance of taking into account an individual’s temperament and genetic predisposition to depression, anxiety, and other affective states in determining the potential causes of the underlying schema. For example, a child may be shy by nature, and therefore be more prone to develop a social isolation schema. Nevertheless, regardless of whether EMS develop as a result of a child’s temperament, a single traumatic experience, a series of “noxious” experiences, or some combination thereof, EMS are deeply entrenched patterns of self-perpetuating themes that are extremely difficult to change.
Young’s theory (1999) identified five overarching schematic domains and, within these domains, 18 underlying schemas. The five overarching domains are: (1.) Disconnection and Rejection, (2.) Impaired Autonomy and Performance, (3.) Impaired Limits, (4.) Other Directedness, and (5.) Overvigilance and Inhibition.

The Disconnection and Rejection domain refers to the belief that an individual’s basic needs for safety, nurturance, and love will not be met (Young, 1999). It is also related to the individual’s belief that she/he is inherently unworthy, defective, and likely to be abused, humiliated, or abandoned. Within this domain is the belief that significant others will abandon or fail to support or protect the individual. Such individuals may also report feeling isolated and alienated. In contrast with disconnection and rejection, connection is related to the ability to establish a stable, enduring, trusting relationship with another person. This includes a sense of belonging or fitting in to society and with peers and family, the ability to establish emotional intimacy, and the ability to accept and feel worthy of love, acceptance, and respect. To establish connectedness, children need to be raised in a stable and dependable environment that provides them with love, nurturance, and understanding. Homes with excessive fighting, substance abuse, chronic mental illness, neglect, and abuse were theorized to be unable to provide the child with a stable, healthy environment. According to Young, children raised in such unhealthy environments were theorized to be prone to develop an EMS within the domain of Disconnection and Rejection. Within the Disconnection and Rejection domain are the following individual EMS (Young, 1999):
- Abandonment and Instability is the perception of instability or unreliability with regard to the physical support and protection of others.
- Mistrust and Abuse is the expectation that others will intentionally hurt, abuse, or manipulate you.
- Emotional Deprivation is the belief that emotional support needs will not be adequately met by others. The deprivation is related to the absence of nurturance or attention and warmth, the absence of empathy, and the absence of protection or guidance from others.
- Defectiveness or shame is the feeling that one is inferior, bad, unlovable, or unwanted. Such individuals may be particularly sensitive to criticism and may be very self-conscious.
- Social isolation and alienation is the belief that one is different from others.

The Impaired Autonomy and Performance domain relates to an individual’s over-connection, dependency and enmeshment with others. Individuals with impaired autonomy often present with an inability to act independently, as they feel incompetent to handle life’s responsibilities without the support and approval of others. Individuals experiencing impaired autonomy and performance express a vulnerability to harm or illness. They experience an exaggerated fear that imminent catastrophe will strike. The catastrophe may be medical, emotional, or related to external experiences. These exaggerated fears and dependency are related to an undeveloped sense of self. Such individuals present with excessive
emotional involvement with others at the expense of full individuation. They may report feeling empty, directionless, inept, and stupid, particularly when they are not receiving active support from their parents, friends or romantic partners. Within the Impaired Autonomy and Performance domain, also referred to as the Overconnection domain, are the following specific EMS (Young, 1999):

- Dependence and Incompetence is the “belief that one is unable to handle one’s everyday responsibilities in a competent manner, without considerable help from others” (p.13).
- Vulnerability to Harm or Illness is the irrational and exaggerated fear that an “imminent catastrophe” will occur at any moment.
- The Enmeshment and Underdeveloped Self schema is the excessive emotional connection or involvement with others at the expense of individuation. Feelings of emptiness and lack of direction commonly occur with this schema.
- Failure is the perception that inevitably one will not succeed in any important area of life.

The Impaired Limits domain is related to problems controlling impulses and a weakened sense of responsibility for others. Individuals with impaired limits present with a sense of entitlement, grandiosity, and a lack of empathy for others. Such individuals express the belief that they are superior or more important than others and are therefore not bound to reciprocity. Individuals presenting with impaired limits are likely to dominate or assert their power over others. They may attempt to control others in order to meet their own needs. The Impaired limits domain is also associated with impulsivity and
poor self-control. This lack of self-control may be related to a desperate attempt to avoid pain, discomfort, memories or responsibility at the expense of personal fulfillment. Substance abuse and other means of dissociating from pain may be common with individuals presenting with this EMS. Within the Impaired Limits domain are the following specific EMS (Young, 1999):

- **Entitlement and Grandiosity** is 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” (p. 14). This schema may also include the need to dominate others by asserting one’s power over others.

- **Insufficient Self-Control and Self-Discipline** is the inability of an individual to exercise sufficient self-control over one’s emotions and impulses.

The Other-Directedness domain relates to an exaggerated focus on the needs or desires of others at the expense of one’s own needs. Individuals presenting with features of the Other-Directedness domain subjugate or surrender control of their own values, beliefs, needs and desires to avoid negative feedback from others. Such negative feedback may be in the form of anger, retaliation and abandonment. Other-Directed individuals are preoccupied with gaining the approval, attention and admiration of others. These individuals sacrifice their own needs to avoid feelings of guilt related to feeling selfish. Other-Directed individuals are overly sensitive to the feelings of others, and feel uncomfortable with others’ pain or disapproval (Young, 1999). Within the Other-Directedness domain are the following specific EMS (Young, 1999):
• Subjugation is the surrendering of control to others with the purpose of avoiding conflicts and abandonment. This can be the subjugation of needs and emotions.

• Self-sacrifice is the voluntary sacrifice of one’s needs at the expense of personal gratification to avoid feelings of guilt and to protect others from pain.

• Approval Seeking and Recognition Seeking is the preoccupation with gaining approval and attention from others at the expense of developing a genuine sense of self.

Lastly, individuals presenting with features of Overvigilance and Inhibition suppress their impulses or the expression of their feelings at the expense of self-fulfillment. Such individuals have rigid rules and expectations for their behavior, and they may be very punitive with themselves if they fall short of their internal standards. Individuals with features of this domain present with a pervasive focus on the negative aspects of life such as pain, death and guilt. Despite this pessimism, such individuals often suppress feelings of anger, vulnerability and even happiness. Their unrelenting standards for perfection are not limited to themselves as they tend to harshly judge others for making mistakes, and they are often described as intolerant, impatient, and unforgiving of others. Within the Overvigilance and Inhibition Domain, are the following specific EMS (Young, 1999):

• Negativity and Pessimism is the persistent and pervasive focus on the negative aspects of life.
- Emotional Inhibition is the failure to express spontaneous opinions and feelings out of fear of being criticized or rejected.
- Unrelenting Standards and Hyper-criticalness is related to the very high internalized standards one sets for her/himself. These standards present as perfectionism and a preoccupation with rigid rules.
- Punitiveness is “the belief that people should be harshly punished for making mistakes.” Such individuals have a tendency to be intolerant and unforgiving (p.14).

In summation, Young’s Schema Focused Theory conceptualizes that the impact of traumatic events and “everyday noxious experiences” during an individual’s formative years, and in combination with temperament, may result in the development of aforementioned EMS, which Young identified in the five broad overarching domains and the eighteen specific EMS within these domains. Although this theory does account for varying schematic development based on the context of the experience and the innate temperament and disposition of the individual, Young’s theory does not specifically consider the impact of specific “types” of traumatic events, such as CSA.

A prominent theorist in the area of childhood sexual abuse, David Finkelhor, did focus specifically on the varying responses an individual may have following varying incident(s) of CSA. Although Finkelhor does not specifically use CT language, it has been argued (Vig, 1997) that his Traumagenic Dynamic Model (TDM; Finkelhor, 1988) is compatible with CT and Young’s Schema Focused Therapy. After reviewing Finkelhor’s TDM, this dissertation will integrate the TDM and Young’s Schema Focused
Theory with the intent of hypothesizing which EMS domains may be most salient with survivors of CSA.

Finkelhor’s Traumagenic Dynamic Model

Similarly to CT theorists, Finkelhor argued that CSA may alter the child’s self-concept, worldview and ability to regulate emotions (1988). The thoughts and feelings generated by the CSA theoretically impact child development and may set the foundation for both short and long-term psychological maladjustment. Finkelhor recognized that trauma, and the impact of traumatic events on a child, is a very complicated process, and as a result, acknowledged that it is difficult to predict a child’s reaction to CSA. Nevertheless, he proposed that CSA may impact children in four basic ways. The first way is betrayal, or the realization that a trusted person hurt them or failed to protect them. The second is the experience of feelings of powerlessness. The third is a feeling of being stigmatized by the abuse. The fourth issue is traumatic sexualization or the exposure to sexual experiences that are outside of appropriate developmental experience. A child may experience emotional distress connected with one, some, or all of the trauma producing dynamics. So, for example, a child may feel both stigmatized and betrayed as a result of the same traumatic event.

Finkelhor (1988) theorized that the varying impact of the sexual trauma occurs because “these dynamics differentially affect the children’s cognitive and emotional orientation to the world, and create a trauma by distorting the children’s self-concept, worldview and affective capacities” (p. 17). In addition, the trauma producing dynamics may receive different emphases based on the context of the abuse. For example, if the
child is abused by a father figure, the betrayal dynamic may be more pronounced than if the abuse was perpetrated by a stranger.

Finkelhor (1988) postulated that each of the trauma producing dynamics may produce different symptomatology. Betrayal is the disruption of trust and occurs when the child realizes that the perpetrator, a once trusted person, manipulated or used them. Feelings of betrayal can also occur when a once trusted person failed to protect them from abuse or chose the perpetrator of the abuse over them. Betrayal is theorized to result in feelings of grief, dependency, anger and mistrust, which may result in greater vulnerability to re-victimization and problems with intimacy.

Children may experience a sense of powerlessness, particularly when the perpetrator of abuse uses force or threats. During such an event, the child feels deprived of power, control or influence over events. Powerlessness is thought to increase feelings of anxiety and prompts the need to control many aspects of life. In addition, children may over-identify with the perpetrator of abuse and/or develop a tendency to see oneself in the role of victim. Powerlessness is also theoretically linked to somatic complaints, depression, dissociation, phobias, and sexual aggression (Finklehor, 1988).

Stigmatization is theorized to relate to feelings of guilt, shame, worthlessness, lowered self-esteem, and a sense of being different from others (Finkelhor, 1988). It refers to the belief that one is defective or bad, thereby producing such feelings and beliefs. These negative beliefs and feelings stem from the experience of CSA and may be reinforced by the child’s social environment, particularly if the child was blamed for the abuse. This low self-esteem and feeling of shame may theoretically contribute to drug or alcohol use, isolation, conduct problems, and parasuicidal and suicidal behaviors.
Traumatic sexualization is theorized to increase the salience of sexual issues and may result in gender identity confusion, precocious or indiscriminate sexual activity or preoccupation, or sexual dysfunction or aversion. “Sexualization refers to the process by which the child’s sexuality, including feelings and attitudes, is formed in a developmentally inappropriate and dysfunctional fashion, as a result of the sexual abuse. The child should develop genital maturity in his adolescence, and his/her sexual identity forms during these years” (Vig, 1997, p. 18).

Finkelhor’s CSA specific TDM does flesh out pathways by which experiences of CSA might lead to the development of 4 of the 5 EMS domains, as laid out in Young’s more general theory. First, it seems that Finkelhor’s CSA related betrayal and stigmatization dynamics map onto Young’s Disconnection and Rejection EMS domain. Overlapping components of these two theoretical constructs are a lack of trust in caregivers and a belief that the world is not a safe or secure place, as well as a sense of being defective and unworthy of love and respect.

Finkelhor’s CSA related construct of powerlessness also overlaps conceptually with Young’s Impaired Autonomy and Performance EMS domain. Individuals presenting with behaviors consistent with this EMS domain may have difficulty acting independently or handling life’s responsibilities without the constant support and approval of others. Similarly, Finkelhor’s theory of powerlessness argues that some survivors of abuse feel that they are powerless to control or influence events in their life. Chronic anxiety and feelings of inadequacy may persist due to the constant fear that catastrophe could strike and the individual would be unable to manage such crisis. Although the overlap between these concepts is not perfect, these concepts both relate to the loss of control the
individual felt during the sexual assault which then carried over to feeling a loss of control, powerlessness, or inefficaciousness later in life.

Finkelhor’s TDM traumatic sexualization or the exposure to sexual experiences at an inappropriate developmental stage is related to an individual’s difficulty managing sexual impulses. It also appears that this age inappropriate sexualization overlaps with Young’s Impaired Limits EMS domain. The Impaired Limits domain is related to problems controlling impulses, delaying gratification, and respecting the rights and feelings of others. Although Young’s EMS relates to impulse control issues with broader behaviors, it is conceptually consistent with Finkelhor’s model of impaired limit setting with sexual impulses following an episode(s) of sexual abuse. On a broad level, the failure to delay or inhibit sexual impulses may also relate to a desperate attempt to avoid pain or a sense of entitlement to certain pleasures as a result of the victimization.

Finklehor’s traumatic sexualization also relates to sexual dysfunction and aversion, which appears to overlap with Young’s Overvigilance and Inhibition EMS domain. The Overvigilance and Inhibition domain broadly relates to the suppression of impulses (including sexual impulses) or the expression of feelings, at the expense of self-fulfillment. The Overvigilance and Inhibition domain may further relate to Finkelhor’s powerlessness construct. The overvigilance and inhibition is arguably a response to a feeling of powerlessness. Empirical research that has suggested that some adult survivors of CSA report sexual dysfunction, specifically an aversion to sexual intimacy (Briere & Runtz, 1993; Gold, 1986), also argues for attention to these constructs in the current research.
Symptoms of Post Traumatic Stress Disorder (PTSD) have also been found to correlate to the short and long term sequelae of CSA (Craine, Henson, Colliver, & MacLean, 1988; Donaldson & Gardner, 1985; Goodwin, 1984). Hallmark symptoms of PTSD are intrusive thoughts, flashbacks, nightmares, anxiety, and the avoidance of stimuli that trigger memories of the traumatic event (American Psychiatric Association, 1994). According to Briere and Runtz (1993), many adult survivors of CSA report experiencing intrusive thoughts and intrusive sensory memories, which were reportedly triggered by sexual intimacy and which may account for sexual aversion. This PTSD related sexual aversion, as discussed above, is compatible with Finklehor’s theories of traumatic sexualization and powerless. PTSD is within the spectrum of an anxiety disorder. Anxiety that is a result of a traumatic event is argued to overlap with Finkelhor’s constructs of stigmatization, powerlessness, and traumatic sexualization, and Young’s Impaired Autonomy domain, Overvigilance and Inhibition domain, and Disconnection and Rejection domain.

Although it is clear that a one-to-one correspondence does not hold at this point in theory development between the varying contexts of CSA and related dynamics, as laid out by Finkelhor’s TDM and Young’s EMS domains, the conceptual overlap is nonetheless striking. Although highly CSA-context-specific hypotheses (e.g. specific schematic sequelae for a child sexually propositioned by an acquaintance or for a child forcibly raped by a relative) could not be forwarded in relation to Young’s EMS at this time, the general relevance of four of Young’s five EMS domains to CSA survivors is clear. This observation would seem to point to a highly promising initial direction for
research attempting to identify the cognitive “missing link” widely presumed to underlie the connection between CSA and adult dysfunction.

In contrast to Young’s EMS domains of Disconnection and Rejection, Impaired Autonomy and Performance, Impaired Limits, and Overvigilance and Inhibition, Young’s EMS domain of Other Directedness does not have a clear overlap with any of Finkelhor’s concepts. This lack of theoretical correspondence is accompanied by a lack of empirical evidence necessitating the investigation of this EMS with survivors of CSA. Although it could be argued that Other Directedness, or the subjugation of one’s needs for the needs or approval of others, is related to low self-esteem or the dependence on others for support, these concepts are more clearly addressed in a manner keeping with Finkelhor’s concepts in the Disconnection and Rejection domain and the Impaired Autonomy and Performance domain. In addition, results described below suggest that the Other Directed domain may be a weakly defined domain even independent of lack of correspondence to Finkelhor’s TDM. Thus, incorporating this schema domain into a CSA related study would not at this time appear productive on either theoretical or empirical grounds.

Table 2.1
EMS Domains and Finkelhor’s TDM

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<thead>
<tr>
<th>EMS Domains</th>
<th>Finkelhor’s TDM</th>
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<tr>
<td>Disconnection and Rejection</td>
<td>Betrayal and Stigmatization</td>
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<tr>
<td>Impaired Autonomy and Performance</td>
<td>Powerlessness</td>
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<tr>
<td>Impaired Limits</td>
<td>Traumatic sexualization</td>
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<tr>
<td>Overvigilance and Inhibition</td>
<td>Powerlessness and Traumatic sexualization</td>
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The Young Schema Questionnaire

In 1994, Young developed an inventory to assess the occurrence of the EMS, the Young Schema Questionnaire, Long Form (YSQ-L). The YSQ-L was composed of 205 questions which were designed to assess the then 16 specific negative core beliefs, or EMS. The validation of this instrument provided support for Young’s clinically derived Schema Theory (Lee, Taylor, & Dunn, 1999; Schmidt, Joiner, Young, & Telch, 1995).

Due to its length, the YSQ-L was found to be difficult to use in some settings. As a result, in 1998, Young and his colleague Brown revised the YSQ-L for brevity, resulting in the development of the 75 item Young Schema Questionnaire-Short Form (YSQ-S). Young chose the questions from the YSQ-L that demonstrated the strongest factor loadings (Schmidt et al., 1995). Waller and colleagues (2001) reported that the psychometric properties of the YSQ-S were similar to the YSQ-L. Stopa, Thorne, Waters and Preston (2001) argued that although the YSQ-L may be more useful in a clinical setting to pick up “subtle nuances” with clients, the YSQ-S was more useful in the research setting “because the selection of items that loaded most highly onto the different factors should have minimized the amount of ‘noise’ in the measurement instrument in comparison with the long version” (p.269).

Internal reliability for the YSQ-S subscales has ranged from .71 to .93, with a mean alpha of .83 (Glasser, Campbell, Calhoun, Bates, & Petrocelli, 2002). The factor structure of the EMS domains utilized in the YSQ-S has been supported through a principle components analysis (PCA) (Lee, Taylor, & Dunn, 1999). Refer to Chapter 3 for an in depth discussion of the psychometric properties of this inventory.
Schemas and Related Cognitive Distortions and CSA

Research beyond that of YSQ scale development has investigated the construct of EMS and the related concept, interpersonal schema. That research is reviewed in this section. First, studies of the EMS construct in general are discussed. The majority of research investigating this construct has explored the association between EMS and personality disorders. A related study that sought to identify an association between interpersonal schema and personality disorders is also addressed. Next, the broad research that has investigated the association between cognitive distortions and subsequent psychological distress and adaptive functioning with adult survivors of CSA is discussed. Lastly, research investigating the association between cognitive distortions and the occurrence of CSA, including the sole study investigating EMS and CSA with regard to the age of onset of abuse, is reviewed. Young’s Schema Focused Theory, a relatively new theory, has begun to generate research in areas of eating disorders, personality disorders, and the adjustment of incarcerated women.

Meyer and Gillings (2003) employed the YSQ-S in their study exploring whether the relation between parental bonding and bulimic psychopathology is mediated by the core beliefs of mistrust and abuse as defined by the YSQ-S. The participants were 61 undergraduate college women with a mean age of 20. The authors did not report race and ethnicity. The authors explained that family dysfunction was repeatedly cited as a contributing factor in not only the development, but the progression of the eating disorder. In order to more fully understand the dynamic between parental bonding, Bulimia Nervosa, and core beliefs, the authors administered the Parent Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979), the YSQ-S, and the Bulimic
Investigatory Test, Edinburgh (BITE; Henderson & Freeman, 1987) to another sample that was composed of 102 female undergraduate college students, with a mean age of 19.4. Race and ethnicity was again not reported. A perception of poor bonding, specifically, high paternal over protection, was associated with individuals diagnosed with Bulimia Nervosa. Overprotection as defined by the PBI is not a positive attribute, rather overprotection is related to dominance and control. The results of a regression analysis suggested that the EMS of mistrust/abuse was a partial mediator in the correlation between paternal overprotection and the severity of bulimic attitudes. The authors theorized that specific core beliefs may develop as a result of overprotective parenting styles, which in turn may contribute to the development of bulimic attitudes. In summation, this study supported the theory that core beliefs are one important link between parental bonding and bulimia.

EMS, Alternative Schemas, and Personality Disorders

The majority of the literature on EMS sought to understand the association between EMS and personality disorders. In 2001, Meyer, Leung, Feary and Mann, investigated the mediating role of Borderline Personality Disorder in the correlation between EMS and bulimic symptomatology in a sample of female college students. The authors failed to report demographic information that included race or ethnicity. The researchers administered the YSQ-S, the BITE, and the Borderline Syndrome Index (BSI; Conte, Plutchik, Karasu & Jerret, 1980) to 61 undergraduate students. Significant correlations between Borderline Personality Disorder as measured by the BSI and eating disorders as measured by the BITE, and EMS as measured by the YSQ-S and Borderline Personality Disorder as measured by the BSI were identified. High levels of bulimic symptoms were
associated with unhealthy core beliefs as determined by responses on the YSQ, and “borderline symptoms were found to be a perfect mediator in the relationship between defectiveness/shame beliefs and bulimic symptomatology” (p. 438).

These researchers hypothesized that personality disorders occur as a result of maladaptive core beliefs about the world. More specifically, they postulated that “shame and the belief that one is inherently flawed will lead to the development of a general sense of social insecurity (abandonment, isolation) and subsequent compensatory behaviors (e.g. impulsiveness dependency), which frequently are collectively described as borderline symptoms” (p. 439). As a result of their findings, Meyer and his colleagues stressed the importance of using Schema Focused Therapy with clients diagnosed with eating disorders to help modify the underlying belief system.

Petrocelli, Glaser, Calhoun and Campbell (2001) investigated the correlation between Young’s five overarching EMS domains and personality disorder scales employing the Millon Clinical Multi-Axial Inventory-Second Edition (MCMI-II; Millon, 1987) and the Cognitive Schema Questionnaire-Short Form (CSQ-SF; Young, 1994) with the intent of clarifying the role of cognitive schemas in personality disorders. The sample was composed of 93 women and 36 men, with a mean age of 28.83 years (SD=7.79, range=18-50), who were participating in outpatient mental health services at a university training center. The authors failed to provide additional demographic information. According to Pertrocelli and his colleagues, Millon theorized that personality disorders were associated with a cognitive style and object representations. The authors stated, Cognitive styles are defined as the content of and the manner in which perceptions, interpretations, and conclusions about the self and the world are formed. Object relations are defined as those memories and attitudes,
largely influenced by significant experiences from the past, that continued to serve as a set of dispositions that mediate the perceptions and reactions to life’s ongoing events (p. 546).

Petrocelli and his colleagues investigated “clusters” of personality disorders and found that individuals who scored high on the MCMI-II’s dependent, histrionic, and self-defeating scales scored moderately high on the abandonment, instability, emotional deprivation, insufficient self-control, self-sacrificing, and unrelenting standards schemas measured by the YSQ-L. Individuals who endorsed items on the MCMI-II suggesting a tendency toward avoidant, anti-social, passive-aggressive, self-defeating, and borderline personality disorders also scored high on the YSQ-L abandonment/instability, emotional deprivation, social isolation, and unrelenting standards schemas. Individuals endorsing items suggestive of histrionic, narcissistic, aggressive/passive aggressive personality characteristics and scoring low in dependent personality disorder and compulsive personality disorder endorsed items on the YSQ-L suggesting moderate schemas related to abandonment, emotional deprivation, self-sacrificing, and unrelenting standards. Subjects who demonstrated high avoidant and dependent personality characteristics, and low narcissistic and aggressive personality features, had moderate scores on abandonment, emotional deprivation, self-sacrificing, and unrelenting standards schemas and were likely to perceive themselves as unworthy by focusing on past, present, and future themes of inferiority. In summation, cluster analysis and discriminant analysis demonstrated that the five overarching domains of EMS “accounted for considerable degree of variance among five empirically derived personality disorder subtypes” (p.556), specifically 76.8% of the variance. The study additionally demonstrated that the absence of EMS was correlated with the absence of personality disorders, which provided
support for the theory that cognitive schemas played important roles in the development and the maintenance of Axis II disorders.

In his dissertation, Emes (1996) explored the relation between personal schemas as measured by the Young Schema Questionnaire-Long Form (YSQ-L; Young, 1994), interpersonal schemas as measured by the Social Cognition and Objects Relations Scale (Westen, Lohr, Silk, Gold, & Keiber, 1990), and Axis II Cluster B personality disorders as measured by the MCMI-II. The psychological inventories were administered to a sample of 80 psychiatric inpatients who were diagnosed with an array of personality disorders. The results of this research suggested that individuals diagnosed with Cluster B Personality Disorders, such as Borderline Personality Disorder, Antisocial Personality Disorder, Histrionic Personality Disorder, and Narcissistic Personality Disorder, endorsed items on the YSQ-L, and the Social Cognition and Object Relations Scale, suggesting that they believed themselves to be more likely to lose control in emotional situations and were more likely to believe that they would be abandoned by significant others when compared to individuals diagnosed with Cluster A and Cluster C Personality Disorders. In addition, Emes reported that individuals diagnosed with Cluster B Personality Disorders appeared less emotionally invested in mature relationships. Lastly, and consistent with Young’s theory, Emes postulated that affect may play a role in the development and maintenance of schemas.

Loper (2003) investigated the relation between schemas, personality disorders, and behavioral maladjustment with a sample of incarcerated women. The author argued that the sample of incarcerated women was an ideal population to investigate due to the high occurrence of Axis I and Axis II disorders and a history of child abuse and neglect. The
sample was composed of 116 women between the ages of 19-58. Fifty-three percent of the sample was African American, 40% was European American, and 8% endorsed other minority status. The subjects were convicted of crimes that varied from robbery to assault and their sentences varied in length. The subjects were administered the Early Maladaptive Schema Questionnaire-Research (EMSQ-R; Ball & Young, 1999), the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II; First, Spitzer, Gibbons & Williams, 1995), and the Brief Symptom Inventory (BSI; Derogatis, 1993). The EMSQ-R was a version of the YSQ-S that was modified for subjects functioning in a lower reading level. The sentence structure of each item of the EMSQ-R was linguistically simpler than items on the YSQ-S. This research had significant methodological problems related to the researcher’s use of the EMSQ-R because the researcher failed to validate this altered instrument. Nevertheless, there was some support for the following findings.

Multivariate regression suggested that beliefs related to Impaired Limits received the strongest level of endorsement, followed by beliefs of Disconnection and Rejection, and then Impaired Autonomy and Performance. It was reported that subjects endorsing items on the impaired limits domain presented with a sense of entitlement, poor impulse control, and a lack of concern for others. The Impaired Limits domain was correlated with screening scores on the SCID-II for Antisocial Personality Disorder, Borderline Personality Disorder, Histrionic Personality Disorder, and Narcissistic Personality Disorder. This domain was also associated with hostility, institutional misconduct, self-reported violence, and victimization. The Disconnection/Rejection domain was associated with a wide array of self-reported mental health diagnoses and emotional
distress. However, this domain did not differentiate between mental health diagnoses. The Impaired Autonomy domain was significantly correlated with Dependent Personality Disorder. Borderline Personality Disorder was related to both the Disconnection/Rejection domain and the Impaired Limits domain. That the Impaired Limits domain was the most highly endorsed domain with this population of incarcerated women is not surprising because the Impaired Limits domain is associated with antisocial and violent behavior. However, Loper argued that this research underscored the importance of understanding the core belief system of incarcerated individuals with the hope of reducing recidivism rates. According to Loper, mental health treatment should also address issues of abandonment and mistrust that have been theoretically linked with depression and anxiety.

A related study by Soygut, Nelson, and Safran (2001) explored the correlation between interpersonal schemas as measured by the Interpersonal Schema Questionaire (ISQ; Hill & Safran, 1994) and personality characteristics as measured by the MCMI-II within the framework of Safran’s Cognitive-Interpersonal Theory. Although this study did not specifically investigate EMS, this article is reviewed because the interpersonal schema construct overlaps with the EMS construct. Safran’s theory addresses cognitive schema within the interpersonal context. According to the theory:

The interpersonal schema is initially abstracted on the basis of interactions with attachment figures, permitting the individual to predict interactions in a way that increases the probability of maintaining relatedness with these figures. In theory, an interpersonal schema contains information of the form: “if I do x, others do y” (Hill & Safran, 1994, p.367).

This theory postulates that most maladjusted individuals are likely to exert strong interpersonal control in many social dynamics because of their belief that they are
able to influence other people’s behaviors through their rigid interpersonal interactions.

Soygut and colleagues recruited 92 subjects who were diagnosed with either depression or anxiety and who were participating in Cognitive Therapy in an outpatient treatment facility. The sample was composed of 40 men and 52 women, with a mean age of 35.09. The researchers reported the subjects’ marital status, but failed to report other demographic information such as race and/or ethnicity. The sample was administered the ISQ and the MCMI-II. The researchers found a correlation between some interpersonal schema and personality characteristics. More specifically, the interpersonal schema related to control was negatively correlated with Histrionic Personality Disorder. An affiliative interpersonal schema was negatively correlated with Schizotypal Personality Disorder. A complimentary interpersonal schema was positively associated with Antisocial Personality Disorder. The authors theorized that individuals diagnosed with Schizotypal Personality Disorder were not likely to anticipate friendly responses from others even when approached in a friendly manner, and individuals diagnosed with Antisocial Personality Disorder were more likely to expect a friendly response because they could act in an affiliative manner when it suited their needs. Preliminary evidence suggested that specific interpersonal schemas were related to specific personality disorders.

In summation, empirical efforts to date have supported the connection between cognitive schemas and personality disorders. Arguably these findings were not surprising considering the connection between fixed behavioral, cognitive, and emotional patterns presented by individuals diagnosed with personality disorders and the underlying schema
that was presumed to support these patterns. Nonetheless, the correlation between EMS and personality disorders is salient to the purposes of this study because of the strong association between personality disorders, most specifically Borderline Personality Disorder, and a history of CSA (e.g., Briere, 1989).

CSA and Borderline Personality Disorder

In 1989, Briere broadly examined the connection between CSA and personality disorders, specifically Borderline Personality Disorder, in a review of the related literature. Briere described Borderline Personality Disorder as a pervasive pattern of instability of self-image, interpersonal relationships and mood, beginning by early adulthood and presenting in a variety of contexts. Briere commented that this pattern appeared to be present in a significant number of survivors of CSA. For example, research has suggested that women with a history of CSA are 2 to 5 times more likely to be diagnosed with Borderline Personality Disorder than women without such a history. Briere theorized that the experience of prolonged CSA can be so threatening that the abused child would become preoccupied with self-protection and survival, rather than focused on the developmental task of building self-awareness and early identity development.

In 1993, Briere and Runtz further theorized that the personality of the childhood victim of sexual abuse was shaped by the adaptation to victimization, rather than healthy development. As a result of this adaptation to victimization, maladaptive cognitive and behavioral patterns develop in adulthood. Research has suggested that these maladaptive perceptual and behavioral problems present in a variety of emotional problems and mental health diagnoses, including somatic complaints, cognitive distortions, mood
dysregulation, and relational problems (Briere, 1989). Cognitive disturbances and distortions such as low self-esteem, guilt, and self-blame were identified as pervasive themes with child and adult survivors of CSA. Lastly, feelings of isolation and stigmatization were frequently reported to have persisted into adulthood and appeared to be more pronounced with incest survivors (Briere & Runtz, 1993; Browne & Finkelhor, 1986). It therefore follows that survivors of CSA will evidence EMS consistent with the aforementioned symptomatology.

CSA and Cognitive Distortions

Research has investigated the impact of CSA on the development of personality disorders, cognitive distortions regarding self-concept and perception of others, and patterns of interpersonal interactions. The following articles presented theories related to the long term sequelae of CSA specifically addressing the impact of CSA on cognitions and core beliefs. Although the following research did not specifically mention EMS or schema, the concepts of cognitive distortions and EMS overlap.

In their review of the literature, Briere and Runtz (1993) identified the following long-term sequelae of CSA: cognitive distortions, altered emotionality, disturbed relatedness, avoidance, and impaired self-reference. Cognitive distortions were assumptions that people made about themselves, others, their environment, and future based on childhood experiences. Assumptions may include an overestimation of the danger in the world, underestimation of self-worth, a sense of helplessness, and an inherent belief that one deserved the abuse. Briere and Runtz theorized that cognitive distortions evolved from several sources, including the psychological reaction to trauma, stigmatization, and the victim’s attempt to make sense of the traumatic experiences.
Briere and Runtz cited a number of studies that provided support for the hypothesis that CSA is associated with feelings of guilt, low self-esteem, and self-blame (Burt & Katz, 1987, Gold, 1986; Jehu, 1989; Jehu, Gazan & Klassen, 1984/1985).

With regard to altered emotionality, Briere and Rutz’s (1993) review of the literature indicated that depressive symptoms and generalized anxiety commonly co-occur with individuals who report a history of CSA. The authors cited Browne and Finkelhor’s (1986) assertion that depressive symptoms are the most commonly reported mental health complaint among adults molested as children in the clinical literature. Jehu (1989) attributed these depressive symptoms to a variety of abuse-related negative thoughts and beliefs, such as self-denigration, self-blame, and guilt. Briere and Runtz (1993) additionally cited empirical literature that found a correlation between reports of CSA and anxiety in adult survivors (Bagley & Ramsey, 1986; Briere & Runtz, 1988).

Briere and Runtz (1993), using Beck and Emery’s Model of Anxiety, theorized that anxiety is attributable to cognitive distortions, conditioned responses, and somatic symptoms of anxiety. This Model of Anxiety Disorders highlights the cognitive aspects of abuse-related anxiety, which typically involve (a) hypervigilance (b) preoccupation with control, and (c) the misinterpretation of neutral or positive interpersonal stimuli as evidence of threat or danger. However, the literature cited only provided theoretical arguments with regard to the impact of the underlying cognitions on affect.

Briere and Runtz (1993) also indicated that clinicians have noted that adult survivors of CSA have difficulty relating “to an internal representation or model of self” (Alexander, 1992; Coutois, 1988, McCann & Pearlman, 1990; Putman, 1990).

According to the researchers, identity development theoretically evolves in the context of
early childhood experiences, including an individual’s attachment to primary caregivers and the individual’s internalization of others’ expectations or perceptions of him or herself (Putman, 1990). Early childhood neglect, abuse, or nurturance is hypothesized to impact the development of “self,” or the ability to access the sense of self. The authors also discussed issues related to self-concept, which include identity confusion, boundary issues, feeling of emptiness, and difficulty regulating emotions. However, few studies have explored these concepts in depth due to a paucity of psychological inventories designed to measure them.

Briere and Runtz (1993) also reported the impact of CSA on subsequent interpersonal relationships. Research suggests that some victims of CSA not only have difficulty relating to themselves, but also have difficulty relating to others in an adaptive manner. “Adults molested early in life may have problems understanding or relating to others independent of their own experiences or needs or, on the other hand, may not be able to perceive or experience their own internal states independent of the reactions or demands of others” (p.323). For instance, adult survivors of CSA, in contrast to those who did not experience CSA, report having fewer friends, feeling less bonded with the non-offending parent, and feeling less satisfaction with sexual relationships (Gold, 1986). Other associated features include poor social adjustment, feelings of isolation (Harter, Alexander, & Neimeyer, 1988), fear and distrust of others (Briere & Runtz, 1987), and difficulty forming and maintaining intimate relationships (Courtois, 1988; Herman, 1981; Jehu, 1989). It was theorized that individuals who had experienced a series of traumatic life experiences may have difficulty perceiving relationships as stable and supportive (McFarlane, Norman, Streiner, & Roy, 1983). Briere and Runtz speculated
“that adults victimized as children may see themselves as unworthy of relationships with people they consider good or healthy, and that some victims may attempt to gain mastery over the abuse by recreating it in the form of involvement in poor or abusive relationships” (p.317). This is consistent with empirical research indicating that long term sequelae of CSA include an increased risk of sexual assault in adulthood (Fromuth, 1986; Polusny & Follette, 1995). For example, women with history of CSA are 2.4 to 3.5 times more likely to be assaulted in adulthood than women without history of CSA (Cloitre, Cohen, & Scarvalone, 2002).

Cognitive attributions have also been a focus of the empirical literature supporting the association between maladaptive cognitive variables and CSA. An attribution is a cognitive process whereby the individual infers the causes of certain situations from internal and external sources (Hamilton, Grubb, Acorn, Trolier & Carpenter, 1990). Janoff-Bulman (1979) found an association between an individual’s ability to cope after a traumatic event and an individual’s attribution of responsibility for the assault. Gold (1986) found evidence that suggested that adult survivors of CSA are more likely than others to attribute negative events to internal and stable factors, including their character and their behavior, while attributing good events to external factors. Gold and other researchers have reported that the cognitive attributions mediate the negative symptomatology evident among adult survivors of child sexual abuse (Gold, 1986; Jehu, 1989; Runtz, 1991). In other words, survivors who attributed CSA to internal factors reported more severe psychological distress.

Eisenhower (2001) investigated how mediating variables impact the long-term life adjustment of European American and African American adult women survivors of CSA.
Eisenhower’s dissertation reported that negative self-attributions, such as self-blame, and perceived parental support mediated healthy versus dysfunctional life adjustment. Eisenhower found a correlation between the negative self-attributions, self-blame and negative self-regard and depressive symptoms, lower self-esteem, and symptoms of Post Traumatic Stress Disorder. Eisenhower concluded that treatment should focus on improving the relationship with the child and the non-offending parent. Treatment should further address the survivors’ negative self-attributions such as self-blame and negative self regard.

**CSA and EMS**

Three empirical studies have specifically investigated the relation between the occurrence of CSA and schema in adult survivors. However, none of these studies specifically investigated Young’s theory of EMS. In her 1997 dissertation, Vig used the YSQ-L to find support for Finkelhor’s Traumagenic Dynamic Model (TDM) and the potentially varying responses a survivor may have based on her/his age at the time of the sexual abuse. Vig additionally sought to understand the implication of the age of onset of the abuse on long term symptomatology. Vig theorized that children who experienced sexual abuse earlier in life would present with more somatic and self-destructive behaviors in adulthood. Using Piaget’s model of Cognitive Development, Vig theorized that when trauma occurs at an earlier age, the developmental functioning may be disrupted not only at the developmental stage that the abuse occurred, but also disrupted at later stages of development. In other words, the developmental milestones could not be achieved as a result of the traumatic event, which in turn impaired the child’s ability to successfully complete latter developmental stages. Vig reported that:
People who were abused at earlier ages, when their defense mechanisms were less developed, seem to be prone to present with higher levels of dissociative, depressive, somatic symptoms, self-destructive behaviors, and interpersonal sensitivity. A survivor who was abused later in life may have developed more defenses, resulting in relatively greater resilience to the above symptomatology (p. 73).

Although some prior research provided support for Vig’s hypothesis (Meiselman, 1987), other studies reported that the age of onset did not have a significant impact on the long term emotional distress often reported by survivors of CSA (Browne & Finkelhor, 1986).

Vig’s (1997) findings from her sample of 61 female adult CSA survivors did support her hypotheses that age of onset was related to somatic complaints, dissociative symptoms, and self-harm attempts. The age of the participants ranged from 22-65 years with a mean age of 41.15 years (SD=9.92). Specifically, survivors who had experienced abuse at a younger age reported more severe symptoms. However, Vig’s hypotheses asserting that survivors who had experienced sexual abuse at a younger age would be more likely to report experiencing depressive symptoms, sexual dysfunctions and interpersonal sensitivity were not supported.

More central to current purposes, Vig (1997) further investigated whether the age of onset of CSA was associated with specific cognitive distortions or beliefs that were derived from Finkelhor’s TDM. Vig used the YSQ-L to define and measure Finkelhor’s TDM concepts of betrayal, stigmatization, sexualization, and powerlessness. Contrary to expectations, the findings indicated that the age of onset was not associated with the development of a specific cognitive distortion. Vig did not clarify her justification for using each individual EMS to extrapolate to Finkelhor’s TMD versus looking at the broader overarching thematic schemas, which map onto clusters of TMD constructs. It
could be argued that the use of the individual maladaptive schemas was too fine grained an approach. This might be especially the case when looking for differential effects by age within a group of individuals who had all experienced CSA.

The lack of a comparable group of individuals who had not experienced CSA was a significant limitation of this study. In effect, the link between CSA and maladaptive cognitions, as operationalized by the YSQ-L, was assumed, not tested. Confirming that this theorized link exists, that CSA survivors do have more maladaptive schemas than those who have not experienced CSA, would seem to be a critical foundational step before attempting to examine differences in cognitions within CSA survivors. Additionally, while age of abuse is a theoretically relevant variable, severity of abuse is also theoretically relevant and may more powerfully differentiate the cognitive outcomes of survivors.

As previously reported, there is little research utilizing the YSQ in studies of CSA. However, related studies have considered concepts similar to schemas such as cognitive appraisals and core beliefs. Research investigating cognitive appraisals, while not employing Young’s precise language, has considered issues related to schemas and supports the assertion that core beliefs and the way individuals perceive themselves and their environment impact their ability to function in an adaptive manner. The following research considered the impact of CSA on cognitive appraisals and core beliefs.

Ponce, Williams, and Allen (2004) investigated the experience of maltreatment as a child, including but not limited to CSA, and the subsequent acceptance of violence in adult intimate relationships. The subjects were 315 women and 118 men who were enrolled in an introduction to psychology course at a large Northeast university. Eighty-
six percent of the sample was European American, 1.4% was African American, 3.5% was Hispanic American, 3.4% was Asian American, and the remainder of the sample endorsed “other” as a racial category. Cognitive distortions were explored as potential mediators of the hypothesized relationships. The researchers used the Constructivist Self Development Theory (McCann & Pearlman, 1990) to explain the hypothesized correlation between childhood mistreatment and the tendency to accept violence in adult relationships, and the mediating effect of distorted cognitive schemas. According to Constructivist Self Development Theory, traumatic experiences can “produce negative, over-generalized ‘disrupted’ schemas that fractionate personal identity, damage emotional and interpersonal life outside of the traumatic environment, and interfere with the ability to meet central psychological needs” (Ponce et al., 2004, p. 98). According to this theory, the trauma disrupts the concepts of self and others related to issues of safety, trust, esteem, control, and intimacy. “When schema are cohesive and adaptive, individuals are thought to develop coping strategies that promote resiliency despite experiencing trauma, abuse, or childhood maltreatment. However, when schemas are disrupted, distorted, or maladaptive, individuals become vulnerable to negative psychological and behavioral outcomes” (p.99). These maladaptive schema can result in difficulties in interpersonal relationships and increase the likelihood of attracting and remaining in violent relationships.

Ponce and his colleagues (2004) administered the Attitudes towards Aggression Scale (Herzberger & Reuckert, 1995), Child Abuse and Trauma Scale (Sanders & Becker-Lausen, 1995), the TSI Belief Scale (Pearlman, 1996), and a Social Desirability Scale (Crowne & Marlow, 1960). The TSI Belief Scale consists of 80 items rated on a
Likert scale that measure the following five cognitive schemas: safety, trust, esteem, control, and intimacy. According to Ponce and his colleagues, this scale, based on Constructivist Self Development Theory, has been found to discriminate between individuals who experienced trauma and individuals who did not, and between survivors of CSA and other types of trauma (McCann & Pearlman, 1990).

After finding a significant correlation between the acceptance of violence in adult relationships and childhood maltreatment, Ponce et al. (2004) then tested the mediating effect of distorted cognitive schemas by employing a multiple regression analysis. The analysis suggested that distorted schema do mediate the impact of maltreatment as a child and subsequent acceptance of violence in both men and women. The results of the study suggested that individuals with a history of childhood maltreatment had a more disturbed cognitive schema than individuals without a history of childhood maltreatment, and that individuals with a more disturbed schema were more likely to be involved in violent relationships. The authors asserted that when children accepted blame for their abuse, and the offending adults reinforced the blame felt by the children, such children were more likely to accept violence in adult relationships as a result of the negative beliefs about themselves.

In a related study, Cloitre, Cohen, and Scarvalone (2002) proposed that the revictimization of adult survivors of CSA is related to the individual’s attachment process, which has been distorted by the occurrence of CSA. Using the Interpersonal Schema Theory, a cognitively based model of attachment to childhood caregivers, the researchers sought to gain a greater understanding of the relation between CSA and subsequent revictimization. Cloitre and colleagues hypothesized that some survivors of
CSA develop interpersonal schemas that “reflect the learned contingency that to be interpersonal engaged means to be abused, and that abuse is a way to be connected” (p. 92). “For example, a young woman from an abusive family who has developed the understanding that interpersonal relatedness is contingent on sexual behavior may offer or allow sex as a way of emotionally connecting to others irrespective of her interests in sex or the lack thereof” (p. 93). The authors proposed that the organizing interpersonal schema of female survivors of childhood trauma are “cognitive tendencies” that are negative in content and rigid in application.

Using a sample of 69 women who were sexually victimized in childhood, in both childhood and adulthood, and women who were never victimized, the authors found support that the interpersonal schema “reflected the expectation that current relationships are similar to the parental relationships of their abusive childhood” (p.106). The authors’ findings supported their “analysis of revictimization as a consequence of a general principle of cognitive and interpersonal functioning rather than as a pathological behavior associated with abuse survivors” (p. 106). Specifically, their analyses yielded the following results. The interpersonal schema of women who were revictimized in adulthood were found to be more negatively distorted than the never victimized group. Women who were only victimized as children presented with a negatively distorted schema that was less severe than women who were victimized in childhood and adulthood, but more distorted than women who never experienced abuse. In other words, women who were only abused in childhood expected less negative behaviors in interpersonal relationships than re-victimized women, and expected less positive behaviors than women who never experienced abuse. Cloitre et al.’s study did have
limitations, as the sample was limited to white, middle-class, and well-educated women. Consistent with Young’s theory, the authors proposed that interpersonal schemas are modifiable through counseling.

In summation, research has identified a variety of short and long-term sequela of CSA that include depressive symptoms, anxiety, symptoms of PTSD, sexual dysfunction, dysfunctional interpersonal relationships, and an underdeveloped self-concept. These emotional and behavioral problems have been primarily theoretically associated with cognitive distortions, such as attributions. Adult survivors of CSA were found to generally attribute positive events to external variables and negative events such as CSA to internal variables such as character (Gold, 1986; Jehu, 1989; Runtz; 1991). In looking specifically at schema and closely related constructs, Ponce et al. (2004) provided empirical support for the contention that CSA is associated with cognitive schema related to safety, trust, esteem, control, and intimacy, which in turn relate a pattern of involvement in violent relationships. Cloitre and colleagues (2002) also found empirical support for the contention that interpersonal schema are associated with re-victimization in adulthood. Although these studies did not specifically follow Young’s EMS, they do provide support for the hypothesis that CSA will be associated with EMS in adult survivors. As can be seen, research has only recently sought to understand the connection between CSA and core cognitions and cognitive structures. Understanding these core beliefs or schema may be critical to providing efficacious treatment to both child and adult survivors of abuse. Therefore, this study will inform practice and assist clinicians and clients in identifying and refuting the maladaptive cognitions.
Moderators and Mediators of Abuse

Research suggested that many survivors of CSA experience short and long-term psychological distress; however, other survivors of CSA were able to adjust and function in an adaptive manner following the sexual abuse (Farber & England, 1997; Herman, Russel & Trocki, 1986). Many sexually abused children were asymptomatic. According to the findings from Beitcham, Zucker, Hood, DaCosta, and Akman’s (1991) meta-analysis, as many as 30-50% of sexually abused children were found to be symptom free or may not have manifested emotional or behavioral symptoms several weeks to months following the episode of sexual abuse. Rind, Tomovich, and Bauserman’s (1998) meta-analysis of a college sample with subjects who were sexually abused during childhood or adolescence reported that CSA impacted men and women differently, and that the “lasting negative effects are not prevalent” with this population (p.37). The authors further asserted that “when negative effects occur, they are often temporary, implying that they are frequently intense” (p.37). Although Rind et al.’s meta-analysis acknowledged that college students who reported CSA were, “on average, slightly less well adjusted than college students without such a history” (p.22), the authors asserted that this poorer adjustment may be attributed to the family environment or other confounds, as opposed to CSA. In summation, Rind and his colleagues reported that “CSA does not cause intense harm on a pervasive basis regardless of gender in the college population” (p. 46). This controversial conclusion points to the need for further study of both the independent and joint effects of CSA and family variables and for study of populations functioning less well than college students.
As briefly discussed in Chapter One, the variations in response to sexual trauma(s) may be related to the researcher’s definition of CSA, but the varying responses may also be attributed to moderating and mediating variables. Several variables have been identified as moderators of CSA and appear to impact psychological adjustment following the trauma. Such moderating variables have included the duration of the CSA (Wyatt & Newcomb, 1990), the relationship of the perpetrator to the survivor of abuse (Wyatt & Newcomb, 1990), the use of force or threat (Friedrich, Urquiza, & Beilke, 1986), whether penetration occurred (Morrow, 1991), and the reaction and support, or lack there of, from the non-offending caregiver (Conte & Shurmann, 1987; Fromuth, 1986; Hyman, Gold, & Cott, 2003; Wyatt & Mickey, 1988). Additional moderating variables have included family dynamics (Edwards & Alexander, 1992; Yama, Tovey, & Fargas; 1993).

Mediating variables include the child’s appraisal or perception of the traumatic event. For example, researchers have explored how a child’s appraisal of an incident impacts her/his emotional reaction to the event and the subsequent experience of emotional distress (Cole & Putman, 1992; Gold, 1986; Jehu, 1989; Peterson, Schwartz, & Seligman, 1981; Runtz, 1991). Research findings suggested that the impact of the abuse may be mediated by the extent the child perceives the experience as threatening or frightening. (Cole & Putman, 1992; Peterson et al, 1981). Many studies have explored the variables that impact the psychological adjustment of survivors of CSA as both moderating and mediating variables.

Researchers have also explored the impact that specific elements of the CSA have on emotional distress. Such specific elements have included the following: the use of force,
duration of the abuse, age of onset of the abuse, the relationship of the perpetrator to the child, and whether or not penetration occurred. For example, abuse involving penetration is associated with increased emotional distress with children (Morrow, 1991). The use of force or psychological coercion was also associated with increased childhood symptomatology (Friedrich, Urquiza, & Beilke, 1986). Psychological coercion may include threats to kill the child, his/her parents, or pet, as well as threats the child may be separated from his/her family if he/she discloses the episode(s) of abuse.

The current research will investigate the impact of perceived primary caregiver support on the development of EMS with female survivors of CSA. Although research has suggested that the aforementioned variables may have an impact on the development of EMS, this research will focus on the specific impact of social support. This is in part because of the breadth of research across areas that find social support to be an important aspect of resiliency. It is also because counseling interventions following trauma may improve the quality of social support, and, therefore, hopefully improve the child’s prognosis. Such things as the relationship the child had with the perpetrator of abuse, the use of force, and the occurrence of penetration, on the other hand, are outside the control and influence of mental health professionals. Since one goal of this study is to directly inform practice, the variable of social support was chosen because it can be influenced through counseling intervention.

Social Support and the Effects of CSA

Family support was found to be both a mediating variable (Conte & Schurman, 1987; Fromuth, 1986; Wyatt & Mickey, 1988) and a moderating variable with regard to the short and long term sequelae of CSA. Spaccarelli (1994) commented that, “Although
child sexual abuse is a serious stressor with pervasive negative effects, some individual and/or environmental resources may operate as protective factors against the development of subsequent behavioral problems” (p. 241). It follows that emotional neglect, or the failure of the non-abusing parent or other care givers to provide emotional support may impact the child’s development and stress reactions (Briere, 1989).

Many researchers have understood the impact of the parental support in relation to the Stress Buffering Hypothesis (Cohen & Hoberman, 1983; Hyman et al., 2003; Thoitis, 1985). According to this hypothesis, social support acts as a “buffer” to high levels of emotional distress and may protect the individual from developing maladaptive coping behaviors (Cohen & Wills, 1985). Hyman and colleagues (2003) defined social support as the “assistance provided to individuals who are coping with stressful events” (p. 295). Tremblay, Herbert, and Piche (1999) postulated that social support’s “buffering” effect intervened between the stressful event and the victim’s reaction and/or perception of the event by influencing the way the individual perceived and evaluated the stressful event.

Cohen and Hoberman (1983) provided preliminary empirical support for the Stress Buffering hypothesis with a sample of college students. They found that both the “perceived availability of social support and the number of positive events moderated the relationship between negative life stress and depression and physical symptomatology” (p. 99). The authors speculated that this buffering effect appeared to have both a moderating and mediating impact on level of distress, as the support may have impacted one’s interpretation of the stressor. Cohen and Hoberman found that an individual’s current perception of social support at the time of the traumatic event offered a unique
contribution to the buffering equation and was related to a decrease in reported depressive symptoms.

In Hyman et al. (2003), social support was found to attenuate or buffer the development and severity of PTSD symptoms in female survivors of CSA between the ages of 17 and 55. Hyman et al.’s sample was 82.4% European American, 6.3% African American, 6.3% Hispanic American, .06% Asian American, .06% Native American, 1.9% multiracial, and 1.9% endorsed “other.” The authors reported that social support bolstered self-esteem and was critical in buffering the development of PTSD. (The time of abuse, duration, and cognitive evaluation of the abuse were also identified as factors that were related to severity of PTSD.) Hyman and colleagues theorized that social support that positively impacted self-esteem buffered the development and severity of PTSD because such social support counteracted feelings of self-blame associated with the abuse. The authors added that feeling valued “may challenge the development of negative core beliefs about self-worth and foster healthier adjustment” (p. 298).

Additional empirical research supported the hypothesis that social support is related to psychological distress in childhood victims of sexual abuse (Coffey, Leitenberg, Henning, Turner, & Bennet, 1996; Feiring, Taska, & Lewis, 1998; Spaccarelli & Kim, 1995; Tremblay, Hebert, & Piche, 1999). Tremblay and colleagues’ retrospective study (1999) reported that children who felt supported by their parents presented with greater self-worth and less behavioral problems. Support from peers did not appear to impact these variables. Feiring et al. (1998) reported that parental support was related to higher self esteem and lower rates of depression in a sample of children and adolescents who had experienced sexual abuse. Spaccarelli and Kim (1995) reported that girls who
received parental support reported higher levels of social competence, fewer symptoms of PTSD and other clinical symptoms, and expressed a less negative view of the abuse following the occurrence of CSA. Coffey and colleagues (1996) found a correlation between feelings of shame related to the occurrence of sexual abuse and self-worth. However, girls who received support from a caregiver reported feeling higher self-worth. It was theorized that social support may counteract feelings of shame by conveying a message that the survivor of the abuse has value.

In a sample of well-adjusted female survivors of sexual abuse, Valentine and Feinauer (1993) identified emotional support as a factor that contributed to the survivor’s resilience following sexual abuse. Adjustment was defined by the ability of the survivor to maintain healthy relationships and stable employment. Runtz and Shallow (1997) found that 55% of the variance in psychological adjustment was accounted for by social support immediately following the incident(s) of CSA in a sample of college students who reported experiencing childhood sexual and physical abuse. Wind and Silvern (1994) found that unsupportive parenting mediated the association between CSA and depression and CSA and low self-esteem in adulthood.

Research has also found that varying sources of social support may have a differing impact on the long term sequelae of the CSA. Feiring et al. (1988) investigated the impact of different sources of social support on psychological distress in a sample of 154 children and adolescents. The authors failed to provide detailed demographic information about their sample. The authors stressed the importance of identifying developmental issues as they related to understanding the function of social support. Research findings suggested that adolescents, as compared to children, generally perceived that they
received less support from parents and other relatives and were more likely to view peers as a source of emotional support. However, support provided by parents was related to less psychological distress, while peer support was related to increased emotional difficulties. It was theorized that parental support may buffer victims from developing emotional distress specifically related to self-blame and self-esteem because survivors supported by parents may feel less stigmatized and less isolated. In contrast, Feiring and colleagues reported that support from peers was related to hyperarousal, perceived negative reactions from others, increased self-blame, and shame.

Research also suggests that support from caregivers at the time of disclosure of sexual abuse is important to the survivor’s long term outcomes. Wyatt and Mickey (1988) retrospectively surveyed female survivors of CSA and found that they reported a less negative attitude towards men if they experienced support from caregivers at the time of disclosure. Testa, Miller, Downs, and Panek (1992) found that women who received support at the time of the disclosure of CSA reported fewer clinical symptoms and higher self-esteem when compared with women who did not receive positive support.

In summation, research has consistently demonstrated that social support provided by immediate families, extended families, and peers influences the psychological health and adjustment of children and adolescents who have experienced CSA (Bryant, 1985; Coffey et al., 1996; Feiring & Lewis, 1991; Feiring et al., 1998; Runtz & Shallow, 1997; Spaccarelli & Kim, 1995; Testa et al., 1992; Tremblay et al., 1999; Valentine & Feinauer, 1993; Werner & Smith, 1982; Wind & Silvern, 1994; Wyatt & Mickey, 1988). Of these sources, parental support appeared to be the most powerful in buffering CSA survivors from negative effects. Furthermore, the support provided by families following
sexual abuse was found to be critical to children’s perceptions of abuse and subsequent adjustment to the abuse (Johnson & Kenkel, 1991; Spaccarelli, 1994). Emotional support provided by the non-offending parent, if the perpetrator of the abuse was a parent, was related to an improved long-term prognosis, fewer symptoms of anxiety and depression, and higher levels of social competence (Everson, Hunter, Runyan, Edelson, & Coulter, 1989; Hazzard, Celono, Gould, Lawry & Webb, 1995.) Social support appeared to improve psychological adjustment following CSA. In contrast, children who report having an experience of non-supportive or non-believing parent or caregiver following disclosure of abuse were likely to experience increased symptomatology during childhood and adulthood (Adams & Tucker, 1982; Kendall-Tackett, Williams, & Finkelhor, 1993; Wyatt & Mickey, 1988).

Social support researchers have employed various measures of social support, such as the Family Environment Scale (FES; Moos & Moos, 1974), the Interpersonal Support Evaluation List (ISEL, Cohen & Hoberman, 1983), the Interparental Conflict Scale (IPC, Schwart, 1980), the Traditional Family Ideology Scale (Levinson & Huffman, 1955) and the Parent Bonding Instrument (PBI; Parker, Tupling & Brown, 1979). However, after review of these instruments it became apparent that items posed on many of the instruments were not salient or on point with the current research questions. For example, although the FES was a widely employed instrument with good psychometric properties, many of the questions did not appear to be theoretically related to the development of EMS. This social support measure broadly poses questions about families being exposed to cultural activities, involved in formal religious activities, and which valued high achievement. The ISEL, also a widely used instrument, posed questions
about broad support, not just support provided by caregivers. For example, items posed on this instrument questioned whether a respondent received the support from peers if the respondent missed a day of school. Young created a social support inventory that was specifically designed to investigate the impact of parenting on the development of EMS. This inventory was considered for this dissertation. While this instrument was theoretically on point for the present research, it has not been widely used and its psychometric properties have not been firmly established. As a result, another instrument was chosen for the purpose of this research, the Parental Bonding Instrument (PBI; Parker et al., 1979). This instrument has been widely employed (e.g., Gladstone et al., 1999; Mullen, Martin & Anderson, 1993; Richman & Flaherty, 1986). Its psychometric properties have been established, and the questions posed by this instrument appear to capture the impact of parenting on the development of EMS.

The Parental Bonding Instrument

The PBI was designed as a retrospective self report measure that assesses the varying attitudes and beliefs that individuals perceive about their parents. The 25 item inventory asks respondents to recall their interactions with their mother or father within their first 16 years of life. The PBI consists of two subscales, “care” and “overprotection.” The Care scale taps such things as emotional warmth, comfort, understanding, and affection. The Overprotection scale includes items assessing the degree to which individuality and appropriate autonomy were allowed and encouraged. Responses are rated on a 4 point scale, ranging from “Very Like,” “Moderately Like,” “Moderately Unlike,” and “Very Unlike” the parent in question. Some items on each scale are reverse scored. Higher scores reflect higher care on the Care scale and higher overprotection on the
Overprotection scale. As emphasized by the PBI developer, “overprotection” reflects a negative style of control and intrusion, as opposed to intensive positive care-taking.

The PBI was designed for categorical use, and the inventory manual clearly identifies cut scores by sex of parent for high/low care and high/low overprotection. The rationale for these cut off scores was not provided. Scores of 27 and above for ratings of mothers and 24 or above for ratings of fathers reflect high care; scores of 26 or below and 23 or below, respectively, reflect low care. Scores of 13.5 and above for ratings of mothers and 12.5 and above for ratings of fathers reflect high overprotection; scores of 13 and below and 12 and below, respectively, reflect low overprotection. The “cut off” scores were derived from a number of studies reporting normative data. The PBI can also be used to assign participants to one of four parenting quadrants: “affectionate constraint” (high care and high overprotection), “optimal parenting” (high care and low overprotection), “affectionless control” (high overprotection and low care), and “neglectful parenting” (low care and low protection). To date, however, the majority of the research using the PBI has examined the scales separately.

Factor analytic strategies were used to define and refine the PBI, and its psychometric properties appear sound. Internal consistency is strong, with coefficient alphas that have ranged from .87 to .99 (Richman & Flaherty, 1986). A split half reliability of .88 was found for the Care scale and .74 for the Overprotection scale (Parker et al., 1979). Test-retest reliability ranged from .90 to .96 (Parker, 1981). Mackinnon and colleagues (1989) reported test-retest coefficients over varying time frames that ranged from .89 to .94 for parental care, and .74 to .89 for parental overprotection. Please refer to Chapter 3 for a complete discussion of the psychometric properties of the PBI.
The PBI and CSA

The PBI has received some use in studies addressing CSA. For instance, Mullen, Martin and Anderson (1993) administered the PBI to a community sample of women. They found that women with a history of CSA were 2.2 times more likely to rate both parents as low in caring and high in overprotection (a negative parental approach, as previously noted) than the women who reported no history of CSA. Women who indicated that penetration occurred during the abusive event were 4.2 times more likely to describe their mothers as low in caring and high in overprotection. The authors concluded that the women who had experienced CSA also had been exposed to inadequate parenting. The experience of CSA was found to be correlated with an increased risk for a range of long-term mental health problems; however, the risk of mental health problems could only be fully understood when considering the context in which the abuse occurred.

Gladstone, Parker, Wilhelm, Mitchell and Austin (1999) administered the PBI to a sample of clinically depressed women. A portion of this sample reported a history of CSA. The women who reported a history of CSA rated their fathers as significantly less caring than did the control group. Gladstone and her colleagues reported that patients who reported a history of CSA also reported a significantly more adverse parent-child experience. A multivariate regression analysis suggested that clinical depression in adulthood was unlikely to be a direct consequence of CSA and that the dysfunctional family experiences during childhood were associated with depression in adulthood. It should be noted that none of Gladstone and colleague’s subjects reported that they had been sexually abused by either parent. On the other hand, the occurrence of CSA was
found to be a stronger predictor than parenting of self-destructiveness and suicidal ideation. Gladstone et al. reported,

When childhood sexual abuse was considered in conjunction with other negative aspects of the childhood environment, we found that childhood sexual abuse status was a better predictor of higher borderline personality style scores than other parental environment characteristics (p. 436).

In summation, research utilizing the PBI with women who reported the experience of CSA found that they were more likely to rate both of their parents as less caring and more overprotective than women who reported no history of CSA, suggesting that women who experience CSA often also reported the experience of inadequate or ineffective parenting. For unclear reasons, some contrasting findings emerged in relation to psychological dysfunction. Inadequate parenting did not appear to be independently correlated with depression. The occurrence of CSA was, however, found to be a better predictor of borderline personality characteristics than parenting. Although not all findings in this area are consistent, this research illustrates the need to understand the occurrence of CSA within the context of support from primary caregivers. Further, this limited, but promising, research suggests that the PBI is well-suited to this type of study.

CSA and Other Childhood Abuse

Incidents of CSA often co-occur with physical abuse and emotional abuse. Research suggests that differential symptomatology is associated with childhood physical abuse, childhood emotional abuse, and childhood sexual abuse (Briere & Runtz, 1990). The limited research that has investigated the long term sequelae of physical and emotional abuse often reports conflicting results. For example, some research has reported a negative correlation between self-esteem and a history of childhood abuse; however,
other studies employing alternative but conceptually similar scales failed to find a correlation between these two variables. According to Briere and Runtz (1990), the majority of research looked at only one “type” of childhood abuse despite the frequent co-occurrence of multiple types of abuse within families. In addition, research has failed to consider and control for the confounding and possibly exponential impact of multiple childhood abuse histories. As a result, researchers have been encouraged to “disentangle the sources of trauma” (Browne & Finklehor, 1986, p. 76), but this is difficult to do methodologically.

Briere and Runtz (1990) investigated the varying symptomatology associated with retrospective reports of childhood physical, emotional, and sexual abuse with a sample of 277 women undergraduates. The authors failed to report a demographic profile of the sample. The researchers sought to gain a greater understanding as to whether the effects of child abuse were associated with general psychological dysfunction, or whether specific forms of abuse were related to specific symptomatology. Previous research suggested that physical abuse may be related to subsequent reported aggression, criminality (McCord, 1983), and psychological symptoms (Briere & Runtz, 1987; Cole, 1986). As stated earlier, CSA has been related to depression (Briere & Runtz, 1987; Gold, 1984), interpersonal problems (Herman, 1981; Tsai & Wagner, 1978), and sexual problems (Jehu, Gazan, & Klassen, 1984). Briere and Runtz hypothesized that emotional abuse specifically impacts self-esteem, sexual abuse specifically relates to sexual dysfunction, and physical abuse was related to an increase in anger or aggression. Their multivariate analysis suggested that there was a unique relation between reports of emotional abuse and low self-esteem after controlling for the physical and sexual abuse.
A small but significant relation was found between CSA and sexual dysfunction, and between reported physical abuse and anger/aggression. The data further suggested that physical and emotional abuse tended to occur together, and that combined physical and emotional abuse was related to low self-esteem, dysfunctional sexual behavior, and anger/aggression. This research supported the contention that specific “types” of childhood abuse may have a specific long-term symptomatology over and above the effects they have in common, and a combination of the forms of abuse was related to a generalized increase in problems related to self-esteem, sexual dysfunction, and anger/aggression. In summation, childhood maltreatment may have both specific and overlapping effects on long-term psychological adjustment and functioning.

As mentioned, disentangling types of abuse is extremely difficult methodologically. To an extent, this study will account for emotional abuse during childhood (and somewhat, by association, physical abuse, since they often go together) through the use of the PBI, the inventory chosen to measure perceptions of primary caregiver support before the age of 16. Although the PBI does not specifically question respondents as to whether they felt that they had been emotionally or physically abused, the items posed indirectly assess the occurrence of emotional abuse. Relevant items include such things as “Made me feel I wasn’t wanted,” “Spoke to me in a warm and friendly voice,” “Did not praise me,” and “Seemed emotionally cold to me.” Thus, participants who fall into the “low care” group of the study will to some extent have experienced emotional neglect, and in some cases also emotional and physical abuse. The data analytic strategy of this study will allow assessment of both the direct and joint effects of low care and CSA. Direct questions regarding the occurrence of physical or emotional abuse were not
asked in this research due to the varying way an individual may define physical or emotional abuse and the practicality of including additional measures and variables.

Population

Extensive research has explored the impact of CSA with clinical and college populations; however, characteristics inherent to these groups may impact research results. Although these findings are important when providing services to these populations, the findings may not generalize to the non-clinical and non-college population. As a result, an “at risk” sample was chosen for this dissertation. The participants were recruited from a correctional facility housing approximately 500 women in the Midwest.

Empirical research has consistently reported that women involved in the criminal justice system have broadly reported experiences of abuse and maltreatment during their formative years (e.g., Brown, Miller, & Maguin, 1999; Heney & Kristiansen, 1998; Lake, 1993; Maeve, 2000; United States Bureau of Justice Statistics, April 1999). In 1999, the Bureau of Justice Statistics reported that 19% of State prison inmates and 10% of Federal prison inmates reported that they had been physically or sexually abused before their incarceration. Specifically, between 14.4% and 25.5% of female offenders incarcerated in State and Federal prisons reported that they had been sexually abused before the age of 18. Female inmates who reported childhood sexual abuse were more likely to have grown up in the foster care system or had parents who were heavy alcohol or drug users (United States Bureau of Justice Statistics, April 1999).

Brown, Miller, and Maguin (1999) found that a majority of women incarcerated in New York State Penitentiary reported that they experienced physical abuse and/or sexual
abuse during their childhoods. For approximately half of the women interviewed, the sexual victimization occurred before the age of 10. Other researchers have also found high incidence of physical and sexual abuse in this population (e.g., Heney & Kristiansen, 1998; Maeve, 2000). The U.S. Department of Justice (Bureau of Justice Statistics, 1999) reported that at least half of the incarcerated women reported that they had experienced physical, emotional, and sexual abuse during their childhoods. Lake (1993) reported that 85% of her sample of 83 incarcerated women reported that they had been either physically or sexually abused before the age of 18. Bloom, Chesney and Owen (1994) reported that 31% of their sample of women incarcerated in California had experienced sexual abuse as children. Twenty-three percent of this sample reported that they had been victimized sexually as adults.

A study conducted by the Texas Commission on Alcohol and Drug Abuse that interviewed a sample of incarcerated female prisoners in 1999 reported that women who had been sexually abused before the age of 18 were younger at admission to prison and more likely to be European Americans than the non-abused control group (Federal Probation: A Journal of correctional philosophy and practice- June 2004 Newsletter.).

Research further suggested that female inmates were more likely to be diagnosed with Axis I and Axis II disorders than the general population (e.g., Loper, 2003; U.S. Bureau of Justice Statistics, April 1999). Bates (2004) reported that in his sample of 166 incarcerated women, 75% of the sample reported using drugs and/or alcohol on a daily basis prior to their incarceration and 31% had been hospitalized for mental health problems. Bates added that female inmates who reported a history of psychiatric hospitalization were twice as likely to recidivate than women without a history of
psychiatric hospitalization. Bates therefore argued for the need for effective mental health programming within the prison system. Due to the disproportionate number of female inmates who have reported a history of CSA and other abuse, it follows that prisons should also offer the best possible mental health treatment to assist with processing these issues.

As previously reported, many women involved in the criminal justice system have been diagnosed with substance abuse and substance dependence disorders (Bates, 2004; U.S. Bureau of Justice Statistics, April 1999). It is noteworthy that empirical research has consistently found an association between CSA and adult substance abuse disorders in men and women (Kendler et al., 2000; Swett, Cohen, Surrey, Compaine, & Chavez, 1991; Tam, Zlotnick, & Robertson, 2003; Wilsnack, Wilsnack, Krisjanson, Vogeltanz, & Harr, 2004). Additionally, Briere and Runtz (1988) reported that women participating in treatment in a crisis center who reported that they had been sexually abused at some in their lives were ten times more likely to report a history of drug abuse and were over two times more likely to report a history of alcohol abuse in relation to non-abused women. Wilsnack and colleagues (2004) reported that 25% of all homeless women with substance abuse histories also reported a history of CSA. It was theorized that substance use was a form of avoidance or dissociation following traumatic life experiences. The excessive use of alcohol and/or drugs numbed painful feelings related to the abuse, blocked intrusive thoughts, and assisted with sleep disturbances related to the trauma (Swett et al., 1991).

In summation, research clearly demonstrates that incarcerated women frequently report the occurrence of CSA, and this history seems to be related to negative outcomes of a variety of kinds. As a result, the female prison population warrants additional
attention and mental health treatment services that are tailored to their specific needs. Such could both reduce recidivism rates and increase the quality of life for these individuals.

Summary and Research Questions

This dissertation hopes to expand the body of research related to CSA by exploring the association between CSA and schema. It has been hypothesized that CSA may distort a child’s belief about her/himself and her/his world, and this distorted belief system, or schema, may account for psychological distress and maladaptive coping styles in adulthood. Extensive research has identified varying long term sequelae of CSA such as depression (Browne & Finkelhor, 1986; Finkelhor, 1990), symptoms of Post Traumatic Stress Disorder (Briere & Runtz, 1993; Browne & Finkelhor, 1986; Finkelhor, 1990), anxiety (Browne & Finkelhor, 1986; Finkelhor, 1990), personality disorders (Herman, 1986; Herman et al., 1989; Ogata et al., 1990; Stone, 1981; van der Kolk et al., 1991), eating disorders (Fallon, 1988; Hall, Tice, Beresford, Wolley & Hall, 1989), substance abuse disorders (Brown & Anderson, 1991; Finkelhor, 1990; Swett et al., 1991), somatic complaints (Brown & Finkelhor, 1986; Morrison, 1989), and problems with emotional and sexual intimacy (Finkelhor, 1990). Additional long term correlates include promiscuity and prostitution (Brunold, 1980; Meiselman, 1978), as well as a tendency towards revictimization (Jumper, 1995) and general psychiatric disorders (Beck & van der Kolk, 1987; Bryer, Nelson, Miller & Krol, 1987; Goff, Brotman, Kindlon, Waites & Amico, 1991). However, limited research has explored the role of cognitive schema with survivors of CSA and the extent to which underlying cognitions mediate subsequent maladjustment. As research has not yet firmly established the primary link, that between
CSA and maladaptive schema, this research will seek to understand whether that association exists.

The specific guiding theory of this study is Young’s Schema Focused Theory. Young postulates that Early Maladaptive Schema (EMS) may develop as a result of a traumatic experience as well as “a pattern of everyday noxious experiences.” Young identified 5 overarching domains of EMS: (1.) Disconnection and Rejection, (2.) Impaired Autonomy and Performance, (3.) Impaired Limits, (4.) Other Directedness, and (5.) Overvigilance and Inhibition. This study examined the relationship of CSA, in group levels ranging from none to severe, to four of these five overarching EMS domains.

Other Directness was excluded for these reasons. First, many of the subconstructs relevant to CSA appear better operationalized by the Disconnection and Rejection domain. Secondly, Finkelhor’s TDM, which sought to explain varying responses to CSA, suggested that children respond to CSA in four broad ways (i.e. betrayal, powerlessness, stigmatization, and traumatic sexualization) based on the context of the abuse. The four chosen EMS domains were compatible with Finkelhor’s TDM or with features of Post Traumatic Stress Disorder, commonly associated with CSA. Thirdly, the psychometric properties of the Other Directedness domain are weak.

Although it was hypothesized that the occurrence and severity of childhood sexual abuse is associated with increasingly more maladaptive schema (EMS), it is also postulated that perceived social support in the form of high care and low overprotection from a primary childhood caregiver will be significantly related to the development of EMS. Ample empirical findings have consistently shown that family support, especially
parental support, during childhood broadly, and following disclosure of sexual abuse specifically, improve survivors’ short-term and long-term prognosis.

Although both general childhood caregiver support and specific disclosure-related support are important, this research will investigate the perceptions of primary caregiver support during childhood in general for a number of conceptual and methodological reasons. Conceptually, the general backdrop of messages of self-worth throughout childhood from the child’s primary caregiver would seem to be a more basic, foundational level of schema-related inquiry than messages in relation to one event or events. Methodologically, the general sample of incarcerated women will likely include those who did not experience CSA, those who did but did not disclose it to their caregivers, and those who experienced and disclosed CSA, and common caregiver support variables are necessary for all. Additionally, the measurement of primary caregiver support following disclosure of abuse is less well established than the measurement of primary caregiver support generally, as in the PBI.

In sum, the purpose of this study is to examine whether the largely theoretical CSA-maladaptive schema link can be confirmed empirically, and, if so, to determine whether it is moderated by general primary caregiver support throughout childhood. It is hoped that the results of this study will lend themselves both to further theory development and to more effective treatment for girls and women who experienced CSA, many of whom are found in great need of mental health services in the country’s judicial system.

**Primary Research Questions**

1. Will incarcerated women who experienced childhood sexual abuse evidence more negative Early Maladaptive Schemas than women who did not experience
childhood sexual abuse, and those women who experienced more severe incidents of childhood sexual abuse will evidence more negative Early Maladaptive Schemas than those women who experienced less severe abuse?

2. Will incarcerated women who experienced a relatively low level of primary caregiver Care or a relatively high level of Overprotection from their primary caregiver in childhood evidence more negative early maladaptive schema than those women who experienced a relatively high level of primary caregiver Care or a relatively low level of Overprotection?

3. Will primary caregiver Care and primary caregiver Overprotection in childhood be related to the development of Early Maladaptive Schemas?
CHAPTER III

METHOD

This chapter will first discuss the setting and the procedure for the research conducted. This will be followed by a detailed description of the measures used in this study, as well as the psychometric properties of the measures employed. Lastly, the hypotheses and the data analytic procedures will be discussed.

Setting

Participants were recruited from a minimum security Midwestern correctional facility that houses approximately 500 women. As a prison facility, the inmates are unable to leave the premises without direct supervision of correctional staff. The presence of prison guards is apparent, as well as rigid rules and a structured schedule that is not deviated from.

This prison offers numerous mental health treatment programs and educational opportunities to inmates on a voluntary basis. The mental health treatment programs include substance abuse treatment that focuses on the enhancement of self-esteem and independent living skills, a family ties program that is designed to model healthy family interactions including parent-child interaction, and anger management classes. In terms of educational training, inmates are afforded to opportunity to earn the high school equivalency diploma, as well as post secondary education, and vocational training. This correctional facility additionally offers inmates to engage in pro-social activities such as
training dogs for individuals diagnosed with disabilities, crocheting baby clothes for those in need, assisting in the maintenance of State Fairgrounds, and programs that encourage family literacy.

Participants

Incarcerated women were the chosen participant group because of the high prevalence of CSA reported by this sample group (Brown, Miller & Maguin, 1999; Heney & Kristiansen, 1998; Maeve, 2000) and due to the paucity of literature exploring the impact of CSA with this specific target group. Extensive research has explored the impact of CSA with clinical and college populations; however, characteristics inherent to these groups may impact research results. While these finding are important when providing services to these populations, the findings may not generalize to a forensic population.

As described in detail below, the primary analyses of this study are two 2 x 4 MANOVAs with four dependent variables each, both conducted at an alpha level of .05. The dependent variables are the four EMS domains, Disconnection and Rejection, Impaired Autonomy, Impaired Limits, and Overvigilance/Inhibition. An estimate of the sample size needed for adequate power was obtained using the G-Power software. Necessary sample size cannot be obtained directly for MANOVA, but sample size derivatives can be entered until the desired power is obtained. Based on these analyses, it was determined that a sample size of 160 would correspond to power of 1.0 for detecting a medium effect size ($f^2=.15$) for the interaction, the most N intensive effect. Thus the power of analyses with N=160 was considered to be good. Additionally, a sample size of
allows the possibility of 20 subjects per cell, which ensures the robustness of the analysis to any violations of normality (Field, 2006).

Procedure

Inmates, age 18 and older, were asked to volunteer to participate in a study involving the impact of CSA and caregiver support during childhood on the way a person views herself and the world. Flyers were posted throughout the correctional facility a week before the research was conducted inviting the inmates to participate in a study that is investigating the impact of CSA. However, it was clarified that all inmates are invited to participate in the research and not just women who had experienced CSA. A point person at the correctional facility recruited women to participate in the research or two days. The topic of the research was disclosed prior to potential participants’ agreement to complete the inventories due to the sensitive nature of the research questions. The disclosure of the topic of the research also served the purpose of priming the participant to report incidents of childhood sexual abuse. The author of the Finkelhor Sexual Victimization of Children Questionnaire recommended that researchers prime the participants to trigger memories of CSA.

The consent form was read to the potential participants in group settings arranged by prison officials. Although several large groups of women (n=15-20) volunteered to complete the inventories, typically individuals or small groups (n=2-6) volunteered to complete the inventories at a time that was conducive with their schedules. This examiner spent a total 9 hours in the correctional facilities collecting the data. The consent form, Appendix A, indicates that a history of childhood sexual abuse is not necessary in order to participate in the study, and provides assurance that participation is voluntary, that
there is no penalty or loss of benefits for withdrawing from the research, that data will be collected anonymously, and that prison officials will not have access to completed research materials. The information provided in the consent form was provided both in written form and orally to each participant. Participants were offered an opportunity to ask questions about the research project. Signed consent forms were collected from those who chose to participate and were not filed with completed inventories. Participants were given their own copy of the consent form, which included the manner to seek out emergency and non-emergency mental health services both within the correctional facility and in the community. The participants were instructed to submit a kite form, a written request, for mental health services. The kite forms are readily accessible to participants and can be requested from prison staff. The sealed kite is delivered to medical personnel who triage the request for treatment and make the appropriate arrangements for mental health services. The participants were also be given a toll free number that would assist them in locating mental health treatment providers throughout the state of Ohio.

After participants signed the consent form, they were administered a demographic questionnaire and three inventories: the Finkelhor Sexual Victimization Questionnaire (FSVQ), the Young Schema Questionnaire-Short Form (YSQ-S), and the Parental Bonding Instrument (PBI). The three research instruments were counterbalanced to avoid order effects. It was observed that it took 30 to 60 minutes to complete these instruments depending on a participant’s reading skills. Participants were distanced from each other during the administration process so that they were assured of their privacy.
Measures

The next section will provide a description of the inventories employed in this dissertation as well as a description of their psychometric properties.

**Demographic Questionnaire**

The demographic questionnaire (See Appendix B) gathered information about the participant’s age, marital status, race/ethnicity, and level of education. The participants were asked to provide their age range, not their specific age, in order to further assure their anonymity. They were also asked whether they had participated in previous mental health counseling.

**Finkelhor Sexual Victimization of Children Questionnaire (FSVQ)**

An adaptation of the Finkelhor Sexual Victimization of Children Questionnaire (Finkelhor, 1979) was used to assess childhood sexual abuse. This instrument was chosen because of its wide use in the CSA literature. Additionally, empirical findings have supported the use of an instrument such as the FSVQ that uses numerous questions to elicit information about CSA. Studies that relied on a single question to elicit information about CSA obtained relatively low rates of disclosure, 6% to 22% (e.g., Burnam, 1985; Kercher & McShane, 1984; Miller, 1985; Murphy, 1985). Studies that used two to four questions had somewhat higher report rates that ranged from 11% to 35% (e.g., Finkelhor, 1979; 1984; Fromuth, 1983; Lewis, 1985) Lastly, research that utilized 8 or more questions had substantially higher report rates that ranged from 54% to 62% (Russell, 1983, Wyatt, 1985). It was theorized that inventories with a greater number of questions provided the participant additional time to disclose sensitive information (Finklehor, 1986).
Finklehor (1986) also discussed additional concerns with CSA inventories such as the use of vague questions. An example of a vague question is, “As a child were you ever sexually abused?” Per Finkelhor, this question is problematic particularly if a clear definition for sexual abuse was not provided or based on the participant’s perception of an event. As a result, questions about the specific activities that took place and the relationship that the parties had with each other were theorized to provide more accurate information about the occurrence of CSA (Finkelhor, 1986). The FSVQ follows this approach. Studies employing specific questions of this nature have obtained higher reported rates than those using vague questions, 6% to 14% versus 11% to 62% (in Finkelhor, 1986). This higher report rate was in part attributed to a discrepancy between the way an individual may view a childhood event and the definition of CSA used by the researcher. For example, a woman who engaged in sexual activities with a 45 year old man at the age of 14 may not perceive this as sexual abuse if she believes that she consented to this sexual activity; however, by the definition used in this research, the event would fall within the definition of CSA.

In his Sourcebook on Childhood Sexual Abuse, Finkelhor (1986) espoused the use of memory cues about childhood sexual abuse experiences without directly soliciting them, which can result in the reporting of incidents that were important to the respondent. This is accomplished by disclosing the study purpose to participants, including the full title of the FSVQ on the inventory, including examples such as sexual experiences with relatives in the instructions as well as such things as sexual experiences with peers, and asking participants to volunteer “important sexual experiences” before the age of 17 and then answer specific questions about them. This allows the researcher to apply the operational
definition of CSA to sexual experiences meaningful to the respondents and to rate the severity of CSA if it was determined to have occurred under that definition.

The original FSVQ asked respondents to report three important sexual experiences that occurred for them between the ages of 1 and 12 and between the ages of 12 and 17. Briere and Runtz (1985) speculated that disclosing and answering a series of questions about of three separate sexual episodes in each of two time periods may be confusing. As a result, they asked respondents to report and answer questions about a single important childhood sexual incident. They supported the validity of their approach by noting that it yielded results comparable to those of studies that had employed the original FSVQ (Finkelhor, 1984; Russel, 1983; Wyatt, 1985). The current research follows Briere and Runtz by asking participants about the one sexual experience before the age of 17 that “stands out as the most important to you.” Items not relevant to the current study were also eliminated to shorten the length of time needed to complete the questionnaire.

Some items not intended for use in the current study were deleted from this inventory. For example, questions related to the respondent’s parents’ occupation, their parents annual income, whether or not the respondent shared their bedroom with another family member, whether or not the respondents grandparents were immigrant and other unrelated questions were omitted from the inventory. The original questions about mother’s and father’s reactions or imagined reactions to a respondent’s disclosure of the sexual experience remained. These items would allow future analysis concerning support specific to disclosure of CSA, versus the general childhood caregiver support that is the focus of the current study. The modified FSVQ is available in Appendix C.
The multi-part item detailing the important childhood sexual experience is used to determine whether an individual experienced CSA as it was defined by this study and, if so, to categorize its severity. Research discussed in Chapter two provided empirical support for the assertion that CSA severity, as measured by duration, use of force or threat of force, relationship with the perpetrator, and penetration was correlated with more severe emotional distress following the incident (Friedrich et al., 1986; Groth, 1986; Morrow, 1991; Russell; 1986; Wyatt & Newcomb, 1990). As previously discussed, the use of broad definitions of CSA without attention to severity (e.g., not differentiating between mild CSA experiences such as a sexual proposition by a casual acquaintance and severe ones such as forced intercourse with a relative) has been an impediment to the study of CSA and its sequelae (Brand, 2003; Glod et al., 1993; Rind et al., 1998). This research hopes to address this concern by clearly categorizing the severity of the CSA.

As previously noted, CSA is defined in this research as any sexual activity or proposition experienced by an individual under the age of 17 with or by an individual at least 5 years older. If threat of force or use of force occurred, the experience is defined as CSA regardless of the age of the perpetrator (Finkelhor, 1984). Respondents whose most important sexual abuse-cued childhood sexual experience falls outside of this definition (e.g., sexual play with a childhood peer, consensual intercourse between 15 year olds) constitute the “no CSA” group. “Mild CSA” is defined as an invitation or request to do something sexual, kissing or hugging in a sexual way, or another person showing his/her sex organs to the person. The perpetrator must have been at least 5 years older than the participant at the time, and not the person’s father, step-father, or grandfather. “Moderate CSA” is defined as any actual sexual touch involving either the person’s or the
perpetrator’s genital organs short of oral, anal, or vaginal penetration that did not involve the threat of force or the use of force, by a person at least 5 years older than the person excluding her father, stepfather, or grandfather, and that occurred for less than 1 year. “Severe CSA” is defined as the occurrence of any penetration including oral, anal, or vaginal by a person at least 5 years older than the participant, and/or the use of force or threat of force whether or not actual penetration occurred, and/or if the perpetrator of the abuse was the person’s father, step-father, or grandfather regardless of the sexual activity that was requested or occurred, and/or if the sexual activity occurred over the duration of 1 year. To ensure consistency in definitions, the determination that CSA occurred and its severity rating will not consider whether the participant reported that she had consented to the sexual activity or her reported emotional response to the activity.

These classifications of CSA were logically developed for the purpose of this study from empirical findings that longer duration of abuse (Briere & Runtz, 1985; Friedrich et al., 1986; Groth, 1978; Morrow, 1991; Russell, 1986; Tsai et al, 1979; Wyatt & Newcomb, 1990), abuse involving penetration (Groth, 1978; Morrow, 1991; Russell, 1986; Wyatt & Newcomb, 1990), closer relationship with the perpetrator (Briere & Runtz, 1985; Groth, 1978; Finkelhor, 1979; Morrow, 1991; Russell, 1986; Wyatt & Newcomb, 1990), and the use of force or the threat of force (Finkelhor, 1979; Groth, 1978; Morrow, 1991; Russell, 1986; Wyatt & Newcomb, 1990) are correlated with more severe and intense short term and long term sequelae of symptomatology.

As detailed above, CSA is measured as a categorical versus continuous variable in this study. This is the intended use of the FSVQ and rests on a solid conceptual rationale. Although less widely used continuous measures exist, there is little basis for the
assignment of specific quantitative figures (i.e. points on a scale) to specific CSA
experiences. Further, the results of analyses using such measures can be hard to interpret
and generalize to any specific CSA population. The categorical approach, on the other
hand, is based on clear, descriptive operational definitions and yields results that can be
more easily generalized to readily identifiable populations.

*Young Schema Questionnaire-Short Form (YSQ-S)*

In 1994, Young developed the 205 item Young Schema Questionnaire-Long Form
(YSQ-L) with the purpose of validating his Schema Focused Theory and assessing the
occurrence of Early Maladaptive Schemas (EMS). Young’s theory identified five
overarching maladaptive schematic domains and 18 underlying schemas within the broad
domains. The five overarching domains are: 1) Disconnection and Rejection, 2) Impaired
Autonomy and Performance, 3) Impaired Limits, 4) Other Directedness, and 5) Overvigilance and Inhibition. The psychometric properties of the YSQ-L were reviewed
in depth because the YSQ-S was derived from questions posited on the YSQ-L.

Credibility for Young’s theory and the utility of the YSQ-L was supported by a
principle components analysis (PCA) of the instrument. Schmidt, Joiner, Young, and
Telch (1995) administered the YSQ-L to a sample of 1,129 undergraduate college
students, of which 423 were men and 706 were women. The authors failed to report
additional demographic information about this sample. During the first administration to
575 students, 17 components emerged from the PCA, including 15 of the 16 factors
originally hypothesized by Young. With the purpose of cross validating the instrument,
the YSQ-L was administered to a second sample comprised of 554 college students.
Items with loadings equal or greater than .30 on only one component were assigned to
that component; one item that loaded .30 on three components was deleted, and items that loaded at .30 or above on two or more components were assigned to the one on which they loaded most highly. Of the 17 components that emerged from the first sample, 13 clearly emerged again in the second sample. As a result of the PCA, Young revised the YSQ-L and renamed certain EMS/domains to reflect the components that emerged.

Schmidt and colleagues (1995) also investigated the higher order structure of the YSQ-L using the two college samples. Their PCA produced three distinct higher order factors: (1.) Disconnection and Rejection (which included beliefs about being defective), (2.) Overconnection (currently known as Impaired Autonomy and Performance, and which included beliefs about being incompetent and vulnerable), and (3.) Exaggerated Standard (currently known as Overvigilance and Inhibition and related to self-deprivation and perfectionism). An Insufficient Control domain (currently known as Impaired Limits) loaded highly, .60, and equally on all three higher order factors.

Schmidt et al. (1995) also administered the YSQ-L to a predominantly European American outpatient clinical population (n=187), and fifteen components emerged from that PCA. Although a social undesirability EMS did not emerge, the components that did emerge paralleled the first college sample. Social isolation, subjugation, and entitlement did emerge as independent components in this clinical sample.

Schmidt et al. (1995) also sought to establish convergent validity and discriminate validity with the YSQ-L. The YSQ-L was tested in relation to relevant constructs, such as self-esteem, psychological distress, features of personality disorders and depressive symptoms. A sample of 181 undergraduate students was used. Ninety-six of the participants were men, and 85 of the participants were women; the authors failed to
report additional demographic information about this college sample. In addition to being administered the YSQ-L, the students were administered the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961, Beck et al., 1979); the Dysfunctional Attitudes Scale (DAS; Weissman, 1979); the Personality Diagnostic Questionnaire-Revise (PDQ-R; Hyler & Rieder, 1987); the Positive Affectivity/Negative Affectivity Scale (PANAS; Watson & Clark, 1990); the Rosenberg Self-Esteem Questionnaire (SEQ; Rosenberg, 1965), and the Symptoms Checklist-90-Revised (SCL-90-R; Derogatis, 1983). Significant correlations in the expected directions were found between the YSQ-L total score and the PANAS, the BDI, SCL-90-R depression and anxiety subscales, and the DAS. A significant correlation (.71) was also found between the YSQ-L and maladaptive personality traits.

In summation of Schmidt et al.’s (1995) study of the YSQ-L, PCA results generally matched Young’s clinically derived EMS. However, the proposed EMS, social undesirability, did not emerge. As a result, this EMS was not considered a conceptually distinct scale in later revisions of the YSQ-L. The higher order factors that emerged reflected three of Young’s five broad domains and included Disconnection and Rejection, Overconnection (currently known as Impaired Autonomy and Performance) and Exaggerated Standards (currently known as Overvigilance and Inhibition). A fourth broad domain, Insufficient Limits (currently known as Impaired control), was equally associated with these higher order factors. The Other Directedness domain did not emerge in the higher order results. The YSQ-L demonstrated convergent and discriminant validity in relation to measures of a variety of relevant constructs and was found to be significantly correlated with both Axis I and Axis II disorders (Schmidt et al., 1995).
Lee, Taylor, and Dunn (1999) investigated the structure of the YSQ-L in a large clinical population to determine whether the structure that emerged in the Schmidt et al. (1995) study was replicable. Lee and colleagues specifically studied the higher order factors using a large clinical sample of 433 Australian inpatient and outpatient participants. Sixty-two percent of the subjects were diagnosed with an Axis I disorder and approximately one third of the subjects were diagnosed with an Axis II disorder. The participants were administered the YSQ-L. Sixteen components emerged from the PCA and accounted for 60% of the total variance. The Impaired Autonomy (Overconnection), Disconnection, Impaired Limits, and Overcontrol (exaggerated standards) higher order components emerged.

Lee and colleagues (1999) also examined the convergent validity of the YSQ-L. Consistent with Schmidt et al. (1995), the YSQ-L significantly correlated with measures of both Axis I and Axis 2 disorders. It was found that 174 of the 205 items performed as intended, and that the internal consistency of the measure was adequate (.51-.76). The authors concluded that the YSQ-L had good internal consistency reliability and that the primary structure was stable across clinical samples. The authors additionally reported that the higher order structure was consistent with varying theories of psychopathology, including CBT and dynamic perspectives (e.g. Blatt, 1974; Bowlby, 1988). It should be noted the Other-Directedness Domain again did not emerge as a higher order components in the PCA. This provides additional support for not including this domain in the CSA related research at this time.

Due to its length, the YSQ-L was found to be difficult to use in some settings. As a result, in 1998, Young and his colleague Brown revised the YSQ-L for brevity, resulting
in the development of the 75 item Young Schema Questionnaire-Short Form (YSQ-S). Young chose the questions from the YSQ-L that were demonstrated to have the strongest factor loadings (Schmidt, et al., 1995). Each item was rated on a 6 point scale (1=completely untrue of me, 2=mostly true of me, 3=slightly more true than untrue, 4=moderately true of me, 5=mostly true of me, and 6=describes me perfectly).

In 2001, Stopa, Thorne, Waters and Preston investigated the comparability of the YSQ-L and the YSQ-S. The YSQ-L was administered to 69 outpatient clients. Sixty-two percent of the clients were women, 31% were men, and 7% failed to identify their sex. The researchers did not provide information about the racial or ethnic make up of the sample. Items used in the YSQ-S were extracted from the YSQ-L for a comparison. Participants were also administered the SCL-90-R (Derogatis, 1977). Stopa and colleagues first investigated whether the YSQ-L and the YSQ-S had acceptable levels of internal consistency as established by a standard of .70. The authors found that 14 of the 15 YSQ-L subscales had internal consistency coefficients of .70 and above, as did 13 of the 15 YSQ-S subscales. In both versions of the YSQ, vulnerability to harm did not reach an acceptable level of internal consistency.

Stopa and colleagues (2001) also compared the YSQ-L and the YSQ-S by correlating the item mean score for each subscale on these two inventories. The authors reported that the item mean scores of each of the subscales on the two versions of the YSQ were significantly correlated with each other, and that the schema subscales showed a significant and high degree of correlation across 12 of the 15 subscales. Significant but small correlations were found on the dependency, self-sacrifice, and emotional inhibition subscales. Stopa and colleagues argued that while the YSQ-L may be more useful in a
clinical setting to pick up “subtle nuances” with clients, the YSQ-S was more useful in a research setting “because the selection of items that loaded most highly onto the different factors should have minimized the amount of ‘noise’ in the measurement instrument in comparison with the long version” (Stopa et al., 2001, p.269).

Waller, Glenn, Meyer, Caroline, Ohanian and Vartouhi (2001) reported similar findings in comparing the short and long versions of the YSQ with women diagnosed with eating disorders. The sample included 120 non-student women with a mean age of 25. Half of the sample had been diagnosed with an eating disorder. The researchers did not report race or ethnicity. The authors found no significant differences between the YSQ-L and YSQ-S subscales in either the clinical group or the control group. The authors stated, “The overall similarity of the scores suggest that removing a large number of the YSQ-L items has not substantially or systematically affected the central tendency of the scores” (Waller et al., 2001, p.144). The authors further contended that both YSQ instruments have good discriminate properties at the univariate and the multivariate levels. In summation, Waller and colleagues concluded that the YSQ-S could be used with confidence in place of the YSQ-L with bulimic and control populations.

In 2002, Glaser, Campbell, Calhoun, Bates, and Petrocelli investigated the construct validity of specific subscales of the YSQ-S by examining the correlations between the subscales and common clinical symptoms. The sample was composed of 99 women, and 42 men participating in outpatient mental health services at a university counseling training center. Ninety-four percent of the sample was European American, 4.3% was African American, .7% was Hispanic American, and .7% was American Indian. The authors administered the following inventories to 141 students In addition to the YSQ-S,
the SCL-90-R, the BDI, the PANAS and the MCMI-II. Glaser and colleagues reported, similarly to Schmidt et al. (1995), that the scores of the YSQ-S “possess a degree of construct validity comparable (and in some respects greater) to those of the [YSQ-L]” (p.7). The authors found a significant relationship between the YSQ-S subscales and Axis I and Axis II disorders. It was asserted that the YSQ-S was a quite useful inventory because it brought to light the client’s thought processes, which may assist with the development of appropriate treatment plans.

In summation, due to its length, the YSQ-L was difficult to use in some settings. As a result, Young developed a 75 item YSQ-Short Form in 1998. Young chose the questions from the YSQ-L that were demonstrated to have the strongest factor loadings to the subscales (Schmidt et al., 1995). Waller and colleagues (2001) reported that the psychometric properties of the YSQ-S were similar to the YSQ-L. Stopa and colleagues (2001) argued that although the YSQ-L may be more useful in a clinical setting to pick up “subtle nuances” with clients, the YSQ-S was more useful in the research setting “because the selection of items that loaded most highly onto the different factors should have minimized the amount of ‘noise’ in the measurement instrument in comparison with the long version” (p.269). Internal reliability for the YSQ-S subscales has ranged from .71 to .93, with a mean alpha of .83 (Glasser et al., 2002). The factor structure of the YSQ-S has been supported (Lee, Taylor, & Dunn, 1999).

The current research employed 4 of the 5 broad domains, excluding the Other Directness domain assessed with the YSQ-S. As discussed at more length in Chapter 2, the relevance of the Other Directness domain to CSA lacks empirical support, and, in contrast to the other broad domains, also lacks conceptual correspondence to Finkelhor’s
Trauma Dynamic Model (TDM). While it could be argued that Other Directedness, or the subjugation of one’s needs for the needs or approval of others, is related to low self-esteem or the dependence on others for support, these concepts are more clearly addressed in a manner keeping with Finkelhor’s concepts in the Disconnection and Rejection domain and the Impaired Autonomy and Performance domain. Finally, the Other Directedness domain appears psychometrically weak in comparison to the other domains. Thus, incorporating this schema domain into a CSA related study would not appear productive on either theoretical and/or empirical grounds at this time. As a result, although the 10 items measuring the Other Directedness Domain were not excluded from the YSQ-S, the items were not analyzed.

Domain scores for the YSQ-S were calculated by summing the item ratings and dividing by the number of items in the domain. Scores range from 1 to 6, with higher scores indicating more maladaptive schema. As an aid to interpretation, scores above 4 indicate that features of the overarching domain are present (Young, 1996). The YSQ-S, as used in this study, is included in Appendix D.

*Parental Bonding Instrument (PBI)*

As discussed in Chapter 2, social support researchers have employed various measures of social support such as the Family Environment Scale (FES; Moos & Moos, 1974), the Interpersonal Support Evaluation List (ISEL; Cohen & Hoberman, 1983), the Interparental Conflict Scale (IPC; Schwartz, 1980), the Traditional Family Ideology Scale (Levinson & Huffman, 1955) and the Parental Bonding Instrument (PBI; Parker, Tupling & Brown, 1979). It was apparent in review of these instruments that many contained items not salient to or on point with the current research questions. For example, while
the FES has been widely employed and demonstrates good psychometric properties, many of the questions posed did not appear to be theoretically related to the development of EMS. This social support measure broadly poses questions about families being exposed to cultural activities, involved in formal religious activities, and valuing of high achievement. The ISEL, also a widely used instrument, poses broad questions about support. Items include such things as receiving support from peers if a day of school was missed. A measure created by Young that was specifically designed to tap into parenting and the development of EMS was considered for this dissertation. While this instrument was theoretically on point for the present research, it has not been widely used and its psychometric properties have not been firmly established. As a result, another instrument was identified and chosen, the Parental Bonding Instrument (PBI). This instrument has been widely employed. Its psychometric properties have been established, and the questions posed by this instrument appear consistent with Young’s Schema-based theory.

The PBI was designed as a retrospective self-report measure that assesses the varying attitudes and beliefs (on a 4-point scale) that individuals perceive about their parents. The PBI asks respondents to recall their interactions with their mother or father within their first 16 years of life. Factor analytic strategies were used to define and refine the 25 items that measure the inventory’s two subscales, “Care” and “Overprotection” (reflecting a negatively controlling and intrusive style). The inventory manual clearly identifies cut off scores by sex of parent for high/low care and high/low overprotection. The PBI can also be used to assign participants to one of four parenting quadrants, although in general researchers have examined the scales separately. These quadrants were identified as “Affectionate constraint” (high care and high overprotection, “Optimal parenting” (high
care and low overprotection), “Affectionless control” (high overprotection and low care), and “Neglectful parenting” (low care and low protection).

The PBI is a very well researched instrument and has been employed in a variety of research areas, including eating disorders (e.g., Brandl, 1993; Fitcher, Quadflieg & Noegel, 1990; Gomez, 1984;), personality disorders (e.g., Paris, Frank, Buonvino, & Bond, 1991; Paris & Frank, 1989; Togerson & Alnaes, 1992; Truant, 1994), depression (e.g., Parker, 1979; Richman & Flaherty, 1990; Saler & Skolnick, 1992; Whisman & Know, 1992), anxiety (e.g., Faravelli, Panichi, Pallanti, Grecu & Rivelli, 1991; Parker, 1979; Parker, 1986; Richman & Flaherty, 1990) alcoholism and drug dependence (e.g., Bernardi, Jones & Tennant, 1989; Gomez, 1984; Richman & Flaherty, 1990; Schweitzer & Lawton, 1989), adolescent delinquency (e.g., Mak, 1990; Rey & Plapp, 1990), and CSA (e.g., Gladstone, Parker, Wilhelm, Mitchell, & Austin, 1999; Mullen, Martini, Anderson, Romans, & Herbison, 1993; Romans, Martin & Mullen, 1996). This inventory has been translated into several different languages including Italian, Spanish, and Japanese, and its psychometric properties have been demonstrated after translation with the varying ethnic groups (e.g., Arrindell, Hanewald, & Kolk, 1989; Kitamura & Suzuki, 1993). However, research has not specifically investigated the validity of the PBI with African American, Hispanic American, Asian American and Native American ethnic groups.

Several studies have explored the factor structure of the PBI (e.g., Cubis, Lewin, & Dawes, 1989; Mackinnon, Henderson, Scott & Duncan-Jones, 1989). Cubis and colleagues (1989) factor analysis of the PBI indicated that all 12 of the care items had their highest loading on the “care” factors. The factor analysis also identified two
subfactors that fell within the overprotection variable. One, labeled “protection-social domain” reflected the extent to which freedom was restricted, and the other, labeled “protective-personal domain,” reflected the extent to which a person felt dominated as a child.

The PBI was demonstrated to have good internal consistency. The scale authors (Parker et al. 1979) first reported the split-half reliability was .88 for the care scale and .74 for the overprotection scale in a non-clinical sample. The racial composition of the sample was not reported. In a subsequent study, Richman and Flaherty (1986) reported the following coefficient alphas with a sample of medical students: maternal care = .91, paternal care = .93, maternal overprotection = .99, and paternal overprotection = .87. With another general population sample, Mackinnon, Henderson, and Andrews (1989) reported that the PBI had internal consistency with coefficients for both maternal and paternal scales that ranged from .87 to .94 during the initial testing, and .89-.95 during a second administration of the test.

With regard to test-retest reliability, Parker et al. (1979) reported that in their non-clinical sample the test-retest agreement was .76 for the care scale and .63 for the overprotection scale over a three week time span. Parker (1981) replicated his test-retest study with a sample of individuals diagnosed with depression and found test-retest coefficients ranging from .90 to .96, over a three week span. Whisman and Know (1992) reported a reliability estimate of .86 for the care scale and .85 for the overprotection scale with a sample of undergraduate students after an interval of 3 months. With a community sample, Mackinnon and colleagues (1989) reported test-retest coefficients over varying
time frames that ranged from .89 to .94 for parental care, and .74 to .89 for parental overprotection.

The scale authors (Parker et al., 1979) acknowledged that the validity of retrospective instruments is often difficult to establish due to possible discrepancies between a respondents’ perceptions of their parents’ attitudes and behaviors and the parents’ actual attitudes and behaviors. Even so, Parker and colleagues argued that the perception of events is more important and more likely to have a greater impact than the actual experience itself. This instrument was also difficult to validate because it measures attitudes and behaviors over a period of 16 years, and such parental attitudes and behaviors may have changed over time. Although PBI scores would not be able to perfectly reflect historical “reality,” the strong test-retest reliability findings do suggest that respondents are able to report stable perceptions of their caregivers’ typical levels of care and overprotection throughout childhood.

Parker (1983) also investigated the validity of the PBI with regard to the “actual” attitudes and behaviors of parents, versus respondents’ perceptions, by having sibling groups and monozygotic and dizygotic twins complete the PBI. With regard to sibling groups, the mean coefficient of agreement was .62 for parental care, and .47 for parental overprotection. It should be noted that women identified their fathers as more overprotective towards them in childhood than did men. This discrepancy may account for the low correlation for parental overprotection. The agreement coefficients were higher for twins than siblings, although not higher for monozygotic twins than dizygotic ones. Specifically, coefficients of .70 and .71 were found for the monozygotic and dyzygotic twins, respectively. Mackinnon, Henderson, and Andrews (1991) conducted a
more comprehensive study using 672 twins. Their research demonstrated a weaker correlation for the dizygotic twins (r=.56) than the monozygotic twins (r=.69). In sum, agreement coefficients ranged from a low of .47 to a high of .71 across studies and sibling types. The roughly one-fourth to one-third shared variance in siblings’ PBI scores would seem to indicate that respondents are tapping into some common historical ‘reality” in their parents’ behaviors and attitudes. Although the common variance in scores is not high, this may not be surprising given that parents would not be expected to respond to all their children in exactly the same way.

When validating the PBI, researchers compared it to other measures of social support. Sarason, Shearin, Pierce and Sarason (1987) compared responses to the PBI with the Social Support Questionnaire (SSQ), a broader measure of support during childhood. The authors reported that the inventories correlated between .43 and .63 with regard to maternal care, .40 and .48 with regard to paternal care, -.21 to -.32 with regard to maternal overprotection, and -.17 to -.26 with regard to paternal overprotection. Although both the PSI and SSQ measure social support, the SSQ’s items measure the number of the perceived available supports and the quality of the perceived support. The SSQ item extend beyond questions about maternal and paternal support. As a result, the authors commented that results may have been influences by rating all interpersonal relationships and social support.

The PBI was also compared with the EMBU-A with a sample of 1,153 children (Amato, 1990). The children’s age ranged from 10 to 15 years, and both genders were equally represented. Additional demographic information was not reported. Amato reported that the PBI care scale was positively correlated with the EMBU-A Emotional
Warmth scale, .70 with regard to maternal support and .64 with regard to paternal support; and negatively correlated with the EMBU-A Rejection scale, .65 with regard to maternal support and .60 with regard to paternal support. Amato reported that correlation between the PBI protection scale and the EMBU-A Overprotection scale was .59 for maternal support and .56 for paternal support. The Amato research provides support for the validity of the PBI.

In his longitudinal study, Rodgers (1990) interviewed 3,262 subjects born in Great Britain in March of 1946. The participants were interviewed about their recollections of childhood mistreatment. The author reported that there was a consistency between the participants’ recollection of childhood mistreatment and their responses to the PBI. Rodgers reported that participants who recalled episodes of physical, emotional or sexual abuse during their childhood rated their parents as very low on the PBI caring scale and high on the PBI protection scale. Participants who recalled a pleasant childhood reported that their parents were high on the PBI scales. As expected, participants who reported neglect during their childhood rated their parents as low on the PBI Care scale, but not high on the PBI Overprotection scale. Although Rodgers results are not based a comparison of quantitative measures, his findings lend support for the validity of the PBI.

The PBI instructions were slightly revised for the purpose of this research. Respondents were asked to assess their primary caregiver as opposed to their mother or father. This change was made for two reasons. First, respondents may have been raised by someone other than a mother or father. Second, the interest in this study is the relationship between EMS and the perceived support of the individual most centrally involved in the respondent’s upbringing, regardless of whether that individual was a man
or a woman. (Although for purposes of assignment to care and overprotection categories using appropriate cut scores, respondents were asked to indicate the sex of their primary caregiver.) For consistency with prior PBI research and for various statistical reasons, respondents will be assigned to separately analyzed care and overprotection categories versus caregiving quadrants. Statistical considerations include the lower reliability of categories based on two scales versus one, the reduced statistical power associated with adding more levels to the caregiver support factor for any one analysis, and the increased likelihood of distribution problems with a large number of cells in the analysis. The PBI, as adapted for this study, is included in Appendix E.

Hypotheses and Data Analytic Procedures

The following section will provide the primary analyses of the data and the specific hypotheses and statistical analysis of the data.

Primary Analyses

The following questions were addressed prior to conducting the primary analyses. The results provided descriptive information and information pertinent to the interpretation of the primary analyses.

1. What are the demographic characteristics of the sample?

2. What is the prevalence of CSA in this forensic sample, overall, and by degree of severity?

3. What is the internal consistency reliability for this sample of the PBI?

4. What is the internal consistency reliability for this sample of the YSQ-S?
Hypotheses and Analyses

The following primary hypotheses were addressed in this research.

1. Participants reporting more severe experiences of CSA will evidence more negative EMS across the four EMS domains. This hypothesis was tested using MANOVA and univariate tests as appropriate.

2. Participants reporting high primary caregiver Care will evidence less severe EMS as compared to those reporting low primary caregiver Care. This hypothesis was tested using MANOVA and univariate tests as appropriate.

3. There will be a statistically significant interaction effect between CSA status and the level of primary caregiver Care with the participants who experienced high primary caregiver Care and severe CSA group reporting less severe EMS as compared to the low primary caregiver Care group. This hypothesis was tested using MANOVA and univariate tests as appropriate.

4. Participants reporting low primary caregiver Overprotection will evidence less severe EMS as compared to participants who experienced high primary caregiver Overprotection. This hypothesis was tested using MANOVA and univariate tests as appropriate.

5. There will be a statistically significant interaction effect between CSA status and the level of primary caregiver Overprotection with the participants who experienced low primary caregiver Overprotection and severe CSA group reporting less severe EMS as compared to the high primary caregiver Overprotection group. This hypothesis was tested using MANOVA and univariate tests as appropriate.
Conclusion

Although a cause and effect relationship cannot be determined by the research design, significant multivariate interaction effects on the MANOVAs with simple effects in the expected directions would provide support for the overarching hypothesis of this study: The experience of childhood sexual abuse correlates with the development of early maladaptive schemas about self and others, but the negative effects can be mitigated by the perception of a highly caring and minimally controlling primary childhood caregiver. Assuming some degree of support for the hypotheses, future research will then be needed to sort out the multiple and likely confounding variables that might influence childhood sexual abuse, primary caregiver behavior, and schema development. It is hoped, however, that this study will lay a solid foundation for those efforts by empirically examining the long-assumed theoretical link between childhood sexual abuse and schema and by examining one key potentially moderating variable, primary caregiver support. It is further hoped that the results of this research suggest applied implications of help to clinicians working with incarcerated women, a group at high risk and high need for effective psychological services.
CHAPTER IV
RESULTS

This chapter presents the results of the study. First, demographic information for the research sample is provided including data related to the prevalence of CSA as determined by the participants’ responses to the Finkelhor Sexual Victimization Questionnaire (FSVQ). Second, estimates of internal consistency reliability for the Care and Overprotection scales of the Parental Bonding Instrument (PBI) and the four Early Maladaptive Schema (EMS) domains as measured by the Young Schema Questionnaire-Short Form (YSQ-S) are reported. Third, results of the tests of the research hypotheses are presented.

Demographic Information

One hundred and sixty-four women volunteered to complete the inventories; however, only 161 women actually completed all of the inventories in their entirety. Data from an additional four women were excluded because of an uneven distribution of participants across cells. Specifically, only one woman reported “mild” CSA and only three women reported that they had experienced “moderate” CSA. Rather than ambiguously collapsing these data into the no abuse and severe abuse groups, data from these participants were excluded. Therefore, all subsequent statistical analyses pertain to
women who reported experiencing no CSA or “severe” CSA as previously defined (N=157).

Demographic characteristics of the participants are shown in Figure 4.1. The majority of the respondents were under the age of 35. Eighteen percent of the respondents (n=28) reported that they were within the age range of 18-24, 22% (n=34) were within the age range of 25-30, and 24% (n=38) were within the age range of 31-35. Of the remaining respondents, 14% (n=22) reported that they were within the age range of 36-60, and 22% (n=35) were 61 years or older. In order to comply with requirements of the Institutional Review Board for the Protection of Human Subjects of both The University of Akron and the Ohio Department of Correction and Rehabilitation, the respondents were asked their age range and not their specific age in order to protect their anonymity. As a result, an exact age range and the mean age could not be determined.

In terms of race/ethnicity, 59.2% of the respondents (n = 93) self-identified as European American, 29.3% (n = 46) as African American, and 2.5% of the respondents (n = 4) self-identified as Hispanic. Of the remaining participants, 1.9% (n = 3) self-identified as Native American, and 3.2% (n = 5) as Biracial. Four respondents endorsed “other” and two respondents did not report their race. Based on a comparison with the overall population demographics of the facility, the demographic of this population is representative of the incarcerated women in the facility.

With regard to marital status, 51.6% of the women (n = 81) reported that they were single, and 21% of the women (n = 33) were married. Of the remaining women, 5.7% (n = 9) reported that they were separated, 18.5% (n = 29) reported that they were divorced, and 3.2% (n = 5) reported that they were widowed.
### Table 4.1

**Demographic Characteristics (N=157)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood sexual abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>68</td>
<td>43%</td>
</tr>
<tr>
<td>Severe</td>
<td>89</td>
<td>57%</td>
</tr>
<tr>
<td>Ethnic Background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>European American</td>
<td>93</td>
<td>59%</td>
</tr>
<tr>
<td>African American</td>
<td>46</td>
<td>29%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>Native American</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Biracial</td>
<td>5</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>Not reported</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Marital Status *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>81</td>
<td>52%</td>
</tr>
<tr>
<td>Married</td>
<td>33</td>
<td>21%</td>
</tr>
<tr>
<td>Separated</td>
<td>9</td>
<td>6%</td>
</tr>
<tr>
<td>Divorced</td>
<td>29</td>
<td>19%</td>
</tr>
<tr>
<td>Widowed</td>
<td>5</td>
<td>3%</td>
</tr>
<tr>
<td>Education (highest level completed) *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7th grade</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>8th grade</td>
<td>7</td>
<td>5%</td>
</tr>
<tr>
<td>9th grade</td>
<td>8</td>
<td>5%</td>
</tr>
<tr>
<td>10th grade</td>
<td>19</td>
<td>12%</td>
</tr>
<tr>
<td>11th grade</td>
<td>28</td>
<td>18%</td>
</tr>
<tr>
<td>12th grade (high school diploma)</td>
<td>39</td>
<td>25%</td>
</tr>
<tr>
<td>GED (high school equivalency diploma)</td>
<td>23</td>
<td>15%</td>
</tr>
<tr>
<td>Some college</td>
<td>26</td>
<td>17%</td>
</tr>
<tr>
<td>Associate’s degree</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Not reported</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Previous participation in mental health treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>85</td>
<td>54%</td>
</tr>
<tr>
<td>No</td>
<td>71</td>
<td>45%</td>
</tr>
<tr>
<td>Not reported</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>

* Sum of percentages exceeds 100% because of rounding

In terms of education, 40% of the respondents (n = 63) had not graduated from high school. Twenty-four percent (n = 39) graduated from high school, 14.6% (n = 23) earned
their high school equivalency diploma, and 16.6% \((n = 26)\) completed some college. Two participants (1.3%) earned an associate’s degree, and 1 respondent (.6%) earned a bachelor’s degree. Three women did not report their education level.

Fifty-four percent of the respondents \((n = 85)\) indicated that had participated in mental health treatment. Seventy-one of the remaining participants indicated they had not participated in mental health treatment and one participant did not provide a response to the item.

With regard to the experience of CSA, 43% of the respondents \((n=68)\) had not experienced CSA based on their responses to the FSVQ. The remaining 57% of the respondents \((n=89)\) indicated that they had experienced severe CSA as determined by their responses to the FSVQ.

Based on scoring recommendations for the PBI, participants were placed into the low Care/high Care groups and the high Overprotection/low Overprotection groups using “cut off” scores based on the sex of respondents’ primary caregiver before the age of 17 (a cut off score of 27 and higher for high Care primary caregivers that are women, and a cut off score of 24 and higher for high Care primary caregiver that are men; a cut off score of 14 and higher for high Overprotection primary caregivers that are women, and a cut off score of 13 and higher for high Overprotection primary caregivers that are men). Five respondents did not answer one item on the PBI Overprotection subscale. These respondents’ mean scale scores were used to replace their missing data points, and were included in the analysis of the PBI.
Table 4.2

PBI Cut off Scores

<table>
<thead>
<tr>
<th></th>
<th>High Care “cut off” score</th>
<th>High Overprotection “cut off” score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Primary Caregiver</td>
<td>27 or higher</td>
<td>14 or higher</td>
</tr>
<tr>
<td>Male Primary Caregiver</td>
<td>24 or higher</td>
<td>13 or higher</td>
</tr>
</tbody>
</table>

Although participants were asked to identify whether their primary caregiver was either a man or a woman, many participants either failed to respond to the question or indicated that they had both a man and a woman as primary caregivers. Eight percent of the respondents ($n=12$) reported that their primary caregiver had been a man, 71% ($n=112$) reported that their primary caregiver during childhood had been a woman, 17% ($n=26$) identified both a man and a woman as their primary caregivers, and 4% of the respondents ($n=7$) did not respond to this item. The participants who either failed to identify the sex of the primary caregiver or reported that their primary caregiver(s) had been both a man and a woman, met the more stringent cut off scores for high Care and high Overprotection for primary caregivers regardless of the sex of the caregiver.

With regard to primary caregiver Care, 53% of the women ($n=83$) rated their primary caregiver during childhood as low with regard to Care. Seventy four (47%) rated their primary caregiver as high with regard to Care. For primary caregiver Overprotection, 27% of the women ($n=43$) rated their primary caregivers as low with regard to Overprotective, and 72% the women ($n=114$) rated their primary caregiver as high in Overprotection in their responses to the PBI.
Table 4.3
Percentages of high and low primary caregiver Care and Overprotection

<table>
<thead>
<tr>
<th></th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Caregiver Care</td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>Primary Caregiver Overprotection</td>
<td>72%</td>
<td>27%</td>
</tr>
</tbody>
</table>

In terms of CSA and race/ethnicity, 48% of the European American women \((n = 45)\) reported they had experienced severe CSA, while 71% of the African American women \((n = 33)\) reported they had experienced severe CSA. Two of the four Hispanic women reported they had experienced severe CSA, two of the three Native American women, and two of the five biracial women reported they had experienced severe CSA. Four women endorse “other” with regard to race/ethnicity. Of these four women, three indicated that they had experienced severe CSA. A chi square analysis of CSA by race/ethnicity was performed. Because of the small sample size for all but the European American and African American groups \(< 5 \text{ participants per cell}\), this was a 2 x 2 comparison. This analysis revealed a statistically significant difference between European American women and African American women reporting the experience of CSA \((\chi^2 = 6.82, \text{ df}=1, \ p < .01)\) with African American women reporting severe CSA more frequently. These findings are not consistent with previous epidemiological studies (see Russel, 1986; Wyatt, 1985; Wyatt et al., 1999) which reported no significant differences between racial/ethnic groups and the occurrence of CSA. However, the results of the current study are not likely to be generalizable to broader populations because of the relatively small sample size.
Data Screening

Prior to examining the primary research questions, the data were inspected for missing data points, outliers, linearity, normality, and multicollinearity. Eleven respondents did not answer one or two items on the YSQ-S, the inventory that measured EMS. These respondents’ mean subscale scores were used to replace their missing data points, and were included in the analysis of the YSQ-S. As previously indicated four participants did not respond to one item on the PBI Care scale. These respondents’ mean scale scores were similarly used to replace their missing data points, and were included in the analysis of the PBI.

Histograms were utilized to inspect for univariate outliers for the four subscales of the Young Schema Questionnaire-Short Form (YSQ-S). Four univariate outliers were identified in this process and replaced with a value 1 unit above the next highest score in the data set (Field, 2005). The data were then analyzed with and without the alterations. These alterations did not make significant differences in terms of the results of the analyses. Consequently, analyses based on the transformed data are reported.

The data were additionally inspected for multivariate outliers using the Mahalanobis Distance significance level of $p \leq 0.01$ to identify outliers as recommended by Tabachnick and Fidell (2001). The following variables were examined for multivariate outliers: Disconnection and Rejection domain, Impair Autonomy domain, Overvigilance/Inhibition domain, Impaired Limits domain, primary caregiver Care, primary caregiver Overcontrol, and CSA. Results indicated the absence of multivariate outliers in the data set.
Next, normality was examined through a visual inspection of histograms and the calculation of skewness after the outliers were replaced. When visually inspecting the distributions, the Disconnection and Rejection domain and the Impaired Autonomy domain appeared to be positively skewed. The degree of skewness was statistically calculated and converted to a z-score. As suggested by the histograms, the Disconnection and Rejection domain was positively skewed with a z-score of 2.96 \( (p < .05) \). The Impaired Autonomy and Performance domain was positively skewed with a z-score of 3.06 \( (p < .05) \). Although these variables were positively skewed, the data were not transformed because the distributions in the sample are more likely a reflection of the distribution of these variables in this population. In other words, the fact that the distributions are skewed is not an artifact of this sample, but instead a reflection of the actual occurrence of these characteristics within the population. The z-scores for the Impaired Limits domain and the Overvigilance and Inhibition domain were not significantly skewed with z-scores of 1.6 \( (p > .05) \) and 1.31 \( (p > .05) \) respectively.

The kurtosis z-score for the Disconnection and Rejection domain was -1.08 \( (p > .05) \), the Impaired Autonomy and Performance domain was -1.49 \( (p > .05) \), and the Overvigilance and Inhibition domain was .607 \( (p > .05) \). Theses values were not statistically significant. However, the kurtosis z-score for the Impaired Limits domain was significantly negatively skewed at -2.08 \( (p > .05) \). Despite this deviation from normality, the data were not transformed as the distribution is likely to reflect the true distribution of the population.

Finally, the data were examined for multicollinearity. According to Tabachnick and Fidell (2001), Pearson-correlation coefficients exceeding .90 are indicative of
multicollinearity. Multicollinearity is a problem when variables are too highly correlated and indicate that the data contains redundant information (Tabachnick & Fidell). Figure 4.2 provides the correlation matrix of the four EMS domains, primary caregiver Control and Overprotection, and CSA. While there were statistically significant correlations between many of the variables, none of the bivariate correlations in the data set approached the criterion for multicollinearity.

To summarize, there were univariate outliers in this data set. As a result, four responses were replaced to address concerns related to outliers. The distributions of the Disconnect and Rejection and the Impaired Autonomy domains were positively skewed. However, as these variations from normality seemed reasonable given the population that the sample was drawn from so the data were not transformed.

Internal Consistency Reliability

Total sample estimates of the internal consistency reliability, means and standard deviations were computed for the two PBI scales, Care and Overprotection. As presented in Figure 4.2, internal consistency reliability estimates ranged from moderate to high (.77 and .92). Additionally, the reliability estimates found in the current research were consistent with those reported in previous research (Parker et. al., 1979; Richmond & Flaherty, 1986). Specifically, Parker and colleagues reported that the internal consistency reliability was .88 for the Care scale and .74 for the Overprotection scale with a non-clinical sample. Richman and Flaherty (1986) reported internal consistency reliability coefficients with a non-clinical sample of .93 and .88 for Care and Overprotection respectively. Estimates of internal consistency reliability, means and standard deviations for the total sample were also computed for the four researched EMS domains, for the
current sample and are reported in Table 4.2. As indicated, moderate to high internal consistency reliability estimates were obtained, ranging from .79 to .95. Additionally, the reliability estimates found in the current research were consistent with previous research (Stopa et al., 2001).

Test of the Hypotheses

The next section will discuss each of the hypotheses in turn including the statistical analysis employed by the researcher.

Hypothesis 1

Hypothesis 1 stated that women in progressively more severe CSA groups, from “none,” “mild,” “moderate,” to “severe,” would evidence progressively more severe early maladaptive schemas. Specifically, it was hypothesized that participants reporting a more severe experience of CSA would evidence more negative EMS across each of the four domains investigated in this study. Because of the extremely low cell sizes for mild and moderate abuse categories, the analysis of the hypothesis focused on differences in the EMS domains as a function of the no CSA versus severe CSA categories. As noted earlier, participants were placed into the no CSA group and the severe CSA group based on their responses to the FSVQ.

A MANOVA investigating differences in the EMS domains as a function of CSA status was conducted. Results were significant (Wilks $\lambda = .83$, $F= 7.94$, df=4, 152, $p \leq .05$ $\eta^2 = .17$), indicating statistically significant differences across the four EMS domains as a function of CSA status (ie., no CSA versus severe CSA).

The results of follow-up ANOVAs indicated no significant differences between the CSA groups on the EMS domains with the exception of the Disconnection and Rejection
Table 4.4
Means, Standard Deviations, Coefficient Alphas, and Pearson correlation coefficients for the EMS domains, Primary Caregiver Care, Primary Caregiver Overprotection, and CSA

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Stand. Dev.</th>
<th>Coefficient Alpha</th>
<th>DR</th>
<th>IA</th>
<th>OI</th>
<th>IL</th>
<th>Care</th>
<th>Over</th>
<th>CSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>DR</td>
<td>2.78</td>
<td>1.14</td>
<td>.95</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IA</td>
<td>2.09</td>
<td>.84</td>
<td>.85</td>
<td>.54**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OI</td>
<td>2.09</td>
<td>.99</td>
<td>.79</td>
<td>.50**</td>
<td>.41**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IL</td>
<td>2.61</td>
<td>1.01</td>
<td>.84</td>
<td>.34**</td>
<td>.47**</td>
<td>.49**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care</td>
<td>1.53</td>
<td>.50</td>
<td>.92</td>
<td>.47**</td>
<td>.34**</td>
<td>.23**</td>
<td>.23**</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over</td>
<td>1.73</td>
<td>.48</td>
<td>.77</td>
<td>.23**</td>
<td>.16*</td>
<td>.22**</td>
<td>.03</td>
<td>.28**</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>CSA</td>
<td></td>
<td></td>
<td></td>
<td>.35**</td>
<td>.01</td>
<td>.12</td>
<td>.04</td>
<td>.20*</td>
<td>.03</td>
<td>-</td>
</tr>
</tbody>
</table>

*  $p < .05$
** $p < .01$

Note. DR = Disconnect and Rejection, IA = Impaired Autonomy and Performance, OI = Overvigilance and Inhibition, IL = Impaired Limits, Care = Primary Caregiver Care, Over = Primary Caregiver Overprotection, CSA = Childhood Sexual Abuse.
domain (F=21.89, df=1, 155, p ≤ .05, η²=.12). As indicated in Table 4.5, the severe CSA group scored higher on this domain than the no CSA group as hypothesized with higher scores on the EMS domain reflecting more negative EMS. However, contrary to the hypothesis, there were no significant differences between the no CSA group and the severe CSA group on the three remaining EMS domains.

Table 4.5

ANOVA results investigating EMS domain differences as a function of CSA status

<table>
<thead>
<tr>
<th>Factors</th>
<th>M</th>
<th>SD</th>
<th>df</th>
<th>F</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disconnect and Rejection</td>
<td></td>
<td></td>
<td>1, 155</td>
<td>21.89*</td>
<td>.12</td>
</tr>
<tr>
<td>no CSA</td>
<td>2.31</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>severe CSA</td>
<td>3.13</td>
<td>1.12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impaired Autonomy</td>
<td></td>
<td></td>
<td>1, 155</td>
<td>.06</td>
<td>.00</td>
</tr>
<tr>
<td>no CSA</td>
<td>2.07</td>
<td>.91</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>severe CSA</td>
<td>2.11</td>
<td>.78</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overvigilance/Inhibition</td>
<td></td>
<td></td>
<td>1, 155</td>
<td>2.21</td>
<td>.01</td>
</tr>
<tr>
<td>no CSA</td>
<td>2.77</td>
<td>.89</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>severe CSA</td>
<td>3.01</td>
<td>1.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impaired Limits</td>
<td></td>
<td></td>
<td>1, 155</td>
<td>.32</td>
<td>.00</td>
</tr>
<tr>
<td>no CSA</td>
<td>2.55</td>
<td>1.12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>severe CSA</td>
<td>2.65</td>
<td>.92</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. n’s for no CSA and severe CSA are 68 and 89 respectively
* indicates statistical significance at p ≤ .05

Thus, the results of these analyses partially supported the hypothesis that participants who reported severe CSA would evidence more negative EMS than their counterparts who did not report CSA. However, the severe CSA group only evidenced more negative EMS on the Disconnection and Rejection domain. Briefly, individuals who score higher on this domain generally experience more feelings of shame, mistrust, and fears of abandonment as opposed to those who scored lower.
Hypothesis 2

The second hypothesis stated that women who reported high primary caregiver Care scale scores during their childhood would present with less negative EMS across the four EMS domains, than women who reported low Care from their primary childhood caregiver.

A MANOVA investigating differences in the EMS domain scores as a function of high versus low Care status was significant (Wilks $\lambda = .77$, $F=11.53$, $df=4$, $152$, $p < .05$, $\eta^2=.23$). The follow-up ANOVA results, as displayed in Table 4.6, demonstrated that the high Care group scored significantly lower on each of the EMS domains than the low Care group as hypothesized. However, as reported in Table 4.4, the effect sizes of the Overvigilance/Inhibition domain and the Impaired Limits domain, although statistically significant, only accounted for a very small amount of variance.

Table 4.6

<table>
<thead>
<tr>
<th>Factors</th>
<th>$M$</th>
<th>$SD$</th>
<th>df</th>
<th>$F$</th>
<th>$\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disconnect and Rejection</td>
<td></td>
<td></td>
<td>1, 155</td>
<td>44.21*</td>
<td>.22</td>
</tr>
<tr>
<td>high care</td>
<td>2.21</td>
<td>.93</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>low care</td>
<td>3.29</td>
<td>1.08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impaired Autonomy</td>
<td></td>
<td></td>
<td>1, 155</td>
<td>19.77*</td>
<td>.11</td>
</tr>
<tr>
<td>high care</td>
<td>1.80</td>
<td>.68</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>low care</td>
<td>2.36</td>
<td>.88</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overvigilance/Inhibition</td>
<td></td>
<td></td>
<td>1, 155</td>
<td>8.33*</td>
<td>.05</td>
</tr>
<tr>
<td>high care</td>
<td>2.67</td>
<td>.88</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>low care</td>
<td>3.11</td>
<td>1.04</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impaired Limits</td>
<td></td>
<td></td>
<td>1, 155</td>
<td>8.44*</td>
<td>.05</td>
</tr>
<tr>
<td>high care</td>
<td>2.36</td>
<td>1.01</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>low care</td>
<td>2.82</td>
<td>.97</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. $n$’s for low Care and high Care are 83 and 74 respectively

* indicates statistical significance at $p \leq .05$
Consistent with the hypothesis, the results of the MANOVA indicated that respondents who reported high Care scale score from their primary caregiver prior to the age of 17 evidenced less severe EMS than respondents who reported low Care. These differences were evidenced across all four EMS domains to varying degrees.

**Hypothesis 3**

The third hypothesis stated that there would be an interaction between CSA status and the level of care with regard to the EMS domain. Specifically, respondents who reported both high primary caregiver Care scale scores and severe CSA would evidence less severe EMS across the four domains, as compared to those who experienced low primary caregiver Care and severe CSA. A 2 x 2 multivariate analysis of variance investigated the role of CSA status and Care across the four EMS domains. Contrary to the hypothesis, the analysis did not reveal a statistically significant interaction between Care and CSA status across the four EMS domains (Wilks $\lambda = .96$, $F=1.49$, df=4, 150, $p > .05$, $\eta^2 = .04$ ). Thus, hypothesis 3 was not supported.

A post hoc ANOVA did not reveal statistically significant differences across the individual EMS domains as a function of the interaction between CSA status and the level of primary caregiver Care.

**Hypothesis 4**

The fourth hypothesis stated that women who reported low Overprotection (less domination) from their primary childhood caregiver would evidence less severe EMS, across the four EMS domains, than women who reported high Overprotection from their primary childhood caregiver. A MANOVA investigating difference in the EMS domains
as a function of high versus low Overprotection status was significant (Wilks $\lambda = .92$, $F=3.49$, df=4, 152, $p \leq .05$, $\eta^2=.08$). Follow-up ANOVAs, as displayed in Table 4.7 indicated that the high Overprotection group scored significantly higher on three of the four EMS domains.

Table 4.7  
ANOVA investigating the EMS domain differences as a function of high Overprotection and low Overprotection

<table>
<thead>
<tr>
<th>Factors</th>
<th>$M$</th>
<th>$SD$</th>
<th>df</th>
<th>$F$</th>
<th>$\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disconnect Rejection</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>low Overprotection</td>
<td>2.36</td>
<td>1.07</td>
<td>1, 155</td>
<td>8.33*</td>
<td>.05</td>
</tr>
<tr>
<td>high Overprotection</td>
<td>2.94</td>
<td>1.14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impaired Autonomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>low Overprotection</td>
<td>1.84</td>
<td>0.78</td>
<td>1, 155</td>
<td>5.46*</td>
<td>.03</td>
</tr>
<tr>
<td>high Overprotection</td>
<td>2.19</td>
<td>0.84</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overvigilance/ Inhibition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>low Overprotection</td>
<td>2.55</td>
<td>0.84</td>
<td>1, 155</td>
<td>8.06*</td>
<td>.05</td>
</tr>
<tr>
<td>high Overprotection</td>
<td>3.04</td>
<td>1.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impaired Limits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>low Overprotection</td>
<td>2.55</td>
<td>1.09</td>
<td>1, 155</td>
<td>.19</td>
<td>.00</td>
</tr>
<tr>
<td>high Overprotection</td>
<td>2.63</td>
<td>0.98</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. $n$’s for low Overprotection and high Overprotection are 43 and 114 respectively * indicates statistical significance at $p \leq .05$

Thus, the results of the MANOVA partially supported the hypothesis suggesting that respondents who experienced high Overprotection or domination from their childhood/adolescent primary caregiver evidence more severe EMS than respondents who experienced low Overprotection on the following domains; Disconnection and Rejection, Impaired Autonomy, and Overvigilance. However, the experience of low
Overprotection, while statistically significant, only accounted for a very small portion of the variance across the three EMS domains (.03-.05, respectively). The results did not reveal statistically significant differences between the high and the low Overprotection groups on the Impaired Limits domain.

**Hypothesis 5**

The fifth hypothesis stated that there would be an interaction between CSA status and primary caregiver Overprotection across the four EMS domains. Specifically, it was hypothesized that respondents who had experienced low primary caregiver Overprotection and severe CSA would evidence less severe EMS across the four EMS domains, as compared to those who had experienced high primary caregiver Overprotection and severe CSA. A 2 x 2 multivariate analysis of variance was conducted to analyze the role of CSA, primary caregiver Overprotection and the interaction of CSA and primary caregiver Overprotection on the four EMS domains. Contrary to the hypothesis, the analysis did not reveal a statistically significant interaction between Overprotection by CSA across the four EMS domains (Wilks $\lambda = .99$, $F = .38$, df=4, 150, $p > .05$ $\eta^2 = .01$). Thus, hypothesis 5 was not supported.

A post hoc ANOVA did not reveal statistically significant differences across the individual EMS domains as a function of the interaction between CSA status and the level of primary caregiver Overprotection.

**Summary**

In summation, the majority of the respondents (57%) indicated that they had experienced severe CSA. The research hypotheses were only partially supported but indicated that the severe CSA group evidenced more severe EMS on the Disconnect and
Rejection domain as compared to the no CSA group. An interaction between CSA and primary caregiver Care and Overprotection on the four EMS domains was not evidenced. However, respondents who had experienced low primary caregiver Care evidence more severe EMS across the four domains than respondents in the high primary caregiver Care group, and respondents who had experienced high primary caregiver Overprotection evidenced more severe EMS across three of the four domains than did respondents in the low primary caregiver Overprotection group.
Childhood sexual abuse (CSA) is considered a widespread problem in the United States that often has lasting implications for the survivors (e.g., Beitchman, Zucker, Hood, daCosta, Akman, & Cassavia, 1992; Coffee et al., 1996; Finkelhor, 1990; Fossati et al., 1998). Although, extensive research has investigated the etiology, epidemiology, and the short and long-term sequelae of CSA in depth, there has been a paucity of theory driven research that has investigated the impact of CSA on the development of early maladaptive schema (EMS). This study was an attempt to advance theory driven research investigating the impact of primary caregivers on the development of these maladaptive schema, with the intent of improving the understanding and the treatment of child and adult survivors of CSA.

This chapter will first report the most relevant demographic findings including the prevalence of CSA within this prison population. Next, the first research hypothesis will be discussed. Although the statistical analysis only partially supported the first hypothesis that asserted that women who had experienced CSA would evidence more negative EMS than women who had not experienced CSA, the argument will then be made that these findings should not be minimized in light of the implications of the Disconnection and Rejection schema on interpersonal relationships. This chapter will then jointly explore the partially supported hypotheses related to primary caregiver Care and primary caregiver
Overprotection scale scores and EMS. Specifically, these hypotheses separately asserted that individuals who experienced high primary caregiver Care in their responses to the PBI would evidence less severe EMS than women who reported low primary caregiver Care, and women who reported low primary caregiver Overprotection in their responses to the PBI would evidence less severe EMS than women who experienced high primary caregiver Overprotection. This will be followed by the discussion of failure of the data to support the hypotheses that asserted that primary caregiver Care and primary caregiver Overprotection in their responses to the PBI separately will moderate the CSA-EMS relationship. Lastly, this chapter will address the implications of the research findings, the limitations of the study and suggestions for future research.

**CSA and Incarcerated Women**

The research sample in the current study was composed of 157 women incarcerated in a minimum security prison. Information about the nature of their crimes, the length of their incarcerations, education, marital status and the frequency that they had participated in research was not available for the women incarcerated in this correctional facility. Preliminary data analysis indicated that CSA was prevalent in this sample with 54% reporting the experience of “severe” CSA, 1.9% reporting the experience of “moderate” CSA, and 0.6% reporting the experience of “mild” CSA. The remaining 43% of the sample reported that they had not experienced CSA. By comparison, the prevalence of CSA reported in the general population has ranged from as low as 6.8% (Seigel et al., 1987) to as high as 62% (Wyatt, 1985). The disparity in the reported prevalence of CSA in previous studies has been attributed to the definition of CSA and the self-report nature of the research question. However, the majority of the epidemiological research has
suggested that CSA occurs in approximately one third of the general population (see Wyatt et al., 1999; Finkelhor et al., 1990; Sanders, 1992). In terms of criminal populations, the reported occurrence of CSA before the age of 18 has varied between 31% (Bloom, Chesney, & Owen, 1994) and 85% (Lake, 1993). The current research findings are consistent with previously reported data suggesting that women involved in the criminal justice system tend to report higher rates of CSA than those in the general population. This difference in occurrence is not surprising because the long term sequelae of CSA has been reported to include behaviors related to criminal activities such as substance abuse (Brown & Anderson, 1986; Finkelhor, 1990; Swett et al., 1991) and prostitution (Brunold, 1980; Meiselman, 1978).

It is noteworthy that only 2.5% of the respondents who had reported an experience of CSA experienced “mild” or “moderate” abuse. This suggests that the occurrence of CSA is more severe in the current sample than with the general population (see Finkelhor et al., 1990; Saunders et al., 1992), or the measure employed enabled the researcher to categorize the severity of the CSA experience.

Approximately 60% of the respondents identified themselves as European American, approximately 30% identified themselves as African American, and the remaining respondents identified themselves as Hispanic, Native American or Biracial. As previously reported, this sample is representative of the population in the Franklin Pre-Release Center.

In terms of CSA and race/ethnicity, 48% of the European American respondents reported that they had experienced CSA, 71% of the African American respondents reported that they had experienced CSA, and 50% of the Hispanic respondents reported
that they had experience CSA. In addition, 66% of the Native Americans reported that they had experienced CSA, and 40% of the Biracial respondents reported that they had experienced CSA. As a result of the small number of Hispanic women, Native American women, and biracial women, a Pearson Chi Square analysis was performed with the European American and African American women in terms of the experience of CSA. This analysis revealed a statistically significant difference between European American women and African American women, with African American women reporting a higher occurrence of CSA. The current research findings were not consistent with previous epidemiological studies (see Russel, 1986; Wyatt, 1985; Wyatt et al., 1999) which reported no significant differences between racial/ethnic groups in terms of the occurrence of CSA. However, previous research has not considered differences between racial/ethnic groups within a prison sample.

CSA and EMS

The research findings partially supported the hypothesis that respondents who had experienced severe CSA would evidence more negative EMS. When comparing the severe CSA group and the no CSA group, the MANOVA revealed that the severe CSA group demonstrated more negative EMS only on the Disconnection and Rejection Domain. This section will discuss the impact of the severe CSA group evidencing more negative EMS on the Disconnection and Rejection domain, specifically the impact of this schema on an individual’s ability to form and maintain genuine interpersonal relationships, the overlap between the Disconnection and Rejection domain and features of Borderline Personality Disorder, and the consistency between the current research findings and previous research. This section will then address the failure of the data to
support the research hypotheses in terms of the remaining three domains, the Impaired Autonomy domain, the Overvigilance/Inhibition domain, and the Impaired Limits domain.

A controversial meta-analysis by Rind et al. (1998) concluded that college students who had experienced CSA were only “slightly less adjusted” than their counterparts (p.39). This article received national scrutiny because it appeared to minimize the impact of CSA on later emotional adjustment of adult survivors. Although, arguably, the partial support of the research hypotheses may be interpreted as finding support for Rind et al. with a forensic population, the implications of an individual presenting with a worldview/schema consistent with the Disconnection and Rejection domain should not be minimized. In addition, the present population of incarcerated women is significantly different from Rind’s et al.’s sample of college students, and arguably these samples have experienced drastically different childhood experiences regardless on the occurrence of CSA.

According to the Young Schema Focused Theory, the Disconnection and Rejection theme centers around the belief that relationships with others will not be nurturing, supportive or empathetic. This belief ultimately stems from the individual’s inherent belief that she is defective, inferior, and unlovable. Based on the interpretation of the Disconnect and Rejection domain, the severe CSA group appears to fear that significant others will abandon them, abuse them, and fail to support or protect them more (Young, 1996; 1999) as compared with the no CSA group. As a result, individuals endorsing higher scores on this domain feel insecure, inadequate and self-conscious. They
additionally may feel more isolated, humiliated and fear that they will be mistreated or abused (Young, 1996; 1999).

Although a causal relationship cannot be inferred from these data, Young’s Schema Focused Theory opined that children who were raised in homes where abuse and other traumatic experiences had occurred may not feel a sense of connection to others and fear future abuse or rejection in intimate relationships (Young, 1996; 1999). As a result of this world view, individuals will have difficulty forming and maintaining genuine interpersonal relationships. Without the cornerstone of supportive and consistent relationships with others, individuals are likely to experience significant emotional distress and dysfunction in many areas of their lives (Young, 1996; 1999). Arguably, many clients seen in varying mental health treatment settings, present with issues that center around these themes.

As discussed at length in Chapter 2, previous research has also reported relations between the Disconnect and Rejection domain and personality disorders (e.g., Emes, 1996; Loper, 2003; Meyer et al., 2001, Petrocelli et al., 2001). Briere and Runtz (1993) theorized that the personality of the childhood victim of sexual abuse was shaped by the adaptation to victimization rather than healthy development. As a result of this adaptation to victimization, maladaptive cognitive and behavioral patterns develop in adulthood such as cognitive distortions, mood dysregulation, and relational problems develop in adulthood (Briere, 1989). Specifically, Meyer and her colleagues (2001) reported a statistically significant correlation between the individual schemas that compose the Disconnection and Rejection domain and Borderline Personality Disorder in their sample of 61 women (Emotional Deprivation r=.65, Abandonment r=.53, Mistrust/Abuse r=.59,
Social Isolation r=.76, Defectiveness/Shame r=.74). They hypothesized that personality disorders occur as a result of maladaptive core beliefs about the world. Specifically, Meyer and colleagues postulated that:

Shame and the belief that one is inherently flawed will lead to the development of a general sense of social insecurity (abandonment, isolation) and subsequent compensatory behaviors (e.g. impulsiveness, dependency), which frequently are collectively described as borderline symptoms (p. 439).

In addition, Loper (2003), in his sample of incarcerated women, reported that Borderline Personality Disorder was related to the Disconnection and Rejection Domain as well as the Impaired Limits Domain. These findings are not surprising because empirical research has reported significant correlation between CSA and traits of Borderline Personality Disorder (see Briere, 1989; Briere & Runtz, 1993).

Individuals presenting with features of Borderline Personality Disorder exhibit challenging symptomatology which includes “a pattern of disruptive, unstable, and superficial relationships” (Jankowski, 2002, p.98). The repeated dissolution of relationships often results in feelings of dejection and reinforces fears of abandonment and mistreatment. When these fears of abandonment surface, impulsive and emotionally reactive behaviors are likely to occur (Jankowski). Similarly, women endorsing items on the Disconnection and Rejection domain have difficulty forming and maintaining genuine and intimate relationships with others as a result of fears of being abused, rejected, or abandoned (Young, 1999). Consistent with characteristics of personality disorders, EMS “refer to extremely stable and enduring themes that …are elaborated throughout an individual’s lifetime and…serve as a template for processing later experiences” (Young, p.9). These maladaptive perceptions and interpretations of self and the world are self-
perpetuating and very difficult to alter. As such, these enduring schema are likely to result in lifelong adversity.

The current research findings were consistent with previous research that indicated that individuals who had experienced a series of traumatic life experiences such as CSA may have difficulty perceiving relationships as stable and supportive (McFarlane, Norman, Streiner, & Roy, 1983). Other associated features with CSA include poor social adjustment, feelings of isolation (Harter, Alexander, & Neimeyer, 1988), fear and distrust of others (Briere & Runtz, 1987), and difficulty forming and maintaining intimate relationships (Courtois, 1988; Herman, 1981; Jehu, 1989). Briere and Runtz speculated:

[A]dults victimized as children may see themselves as unworthy of relationships with people they consider good or healthy, and that some victims may attempt to gain mastery over the abuse by recreating it in the form of involvement in poor or abusive relationships (p.317).

As such, some survivors of CSA may recreate or replicate the unhealthy abuse dynamics in subsequent relationships.

Previous research has failed to investigate specifically the relations between CSA and EMS. However, three studies did investigate the relations between the occurrence of CSA and schemas in adult survivors (see Ponce et al., 2004; Cloitre et al., 2002; Vig, 1997). Of these articles, only one was central to the current research findings, Ponce and colleagues. These researchers reported that in their undergraduate sample of 315 women and 118 men, respondents who had experienced maltreatment as a child that was not limited to CSA evidenced more disturbed cognitive schemas. According to the Constructivist Self Development Theory, a disturbed cognitive schemas “fractionate personal identity, damage emotional and interpersonal life outside of the traumatic
environment, and interfere with the ability to meet central psychological needs” (p. 98).
Ponce specifically reported that individuals evidencing these disrupted schemas are more likely to tolerate violence in future relationships because such individuals accepted blame for their experiences of childhood abuse. Arguably, Ponce and colleague’s description of disturbed schema and the implications of blame for childhood experiences overlap with characteristics of Young’s Disconnect and Rejection domain. Namely, feeling responsible for abuse and the anticipation of future abuse is consistent with Disconnect and Rejection domain. Additionally, the Constructivist Self-Development Theory schema focused on “fractionate personal identity” is consistent with features of Borderline Personality Disorders. As previously discussed, research has documented the correlation between the Disconnect and Rejection EMS and features of Borderline Personality Disorder (see Loper, 2003; Meyer et al., 2001). In sum, the only relevant research study in this area was consistent with the current research findings.

Contrary to the research hypothesis, women who experienced severe CSA failed to evidence more negative EMS on the Impaired Autonomy domain, Impaired Limits domain, and Overvigilance and Inhibition domain as compare to the women who did not report CSA. The lack of support for this research hypothesis may simply suggest that CSA status (i.e., no CSA and severe CSA) is not associated with these EMS, and that schema reflected by the Disconnect and Rejection domain are unique to the experience of CSA in this prison sample.

The lack of support for the research hypotheses may also be attributed to the homogeneity of this population or reflect characteristics consistent with an incarcerated population. According to Young (1996, 1999), EMS evolves from both traumatic
experiences such as CSA and pervasive negative childhood experiences. Arguably, many incarcerated women have experienced traumatic experiences and/or pervasive negative child experiences. For example, researchers have documented that problematic childhoods of one kind or another are pervasive among women in the judicial system (e.g., Brown, Miller, & Maguin, 1999; Heney & Kristiansen, 1998; Lake, 1993; Maeve, 2000; United States Bureau of Justice Statistics, April 1999). Specifically, empirical research has consistently reported that women involved in the criminal justice system have reported experiences of physical abuse, emotional abuse, and neglect during their formative years (United States Bureau of Justice Statistics). In addition, female inmates in particular were more likely to have grown up in foster care systems, presumably because they had been abused, neglected or abandoned by their parents, or they had parents who were heavy alcohol or drug users (United States Bureau of Justice Statistics). The similar life experiences, particularly during their formative years, reported by female inmates may account for the failure of the research hypotheses to differentiate between the women who reported that they experienced CSA and women who reported that they did not experience CSA on three of the four EMS domains.

The general homogeneity of this sample may also be reflected in the high prevalence of mental health diagnoses in this population, and may account for the lack of significant difference across the Impaired Autonomy, Overvigilance/Inhibition, and Impaired Limits domains based on CSA status. Researchers have reported a high prevalence of Axis I and Axis II disorders within the prison population regardless of the occurrence of CSA (e.g., Bates, 2004; Loper, 2003, United States Bureau of Justice Statistics, April 1999). For example, Bates (2004) reported that, in his sample of 166 incarcerated women, 75%
reported using drugs and/or alcohol on a daily basis prior to their incarceration and 31% had been hospitalized for mental health problems. Also, EMS have been found to correlate with Axis II disorders (see Loper, 2003; Meyers et al., 2001, Petrocelli et al., 2001; Emes, 1996). As such, features of Axis I and Axis II disorders may have masked or superceded differences across EMS as a function of CSA.

In terms of substance abuse issues, many women involved in the criminal justice system have been diagnosed with substance abuse and substance dependence disorders (Bates, 2004; U.S. Bureau of Justice Statistics, April 1999). The high prevalence of substance abuse/dependence disorders was not surprising in this population because it was theorized that substance use was a form of avoidance or dissociation following traumatic and/or negative life experiences (Swett et al., 1991). As previously reported, many incarcerated women have reported negative life experiences during childhood and adolescence (e.g., Brown, Miller, & Maguin, 1999; Heney & Kristiansen, 1998; Lake, 1993; Maeve, 2000; United States Bureau of Justice Statistics). According to Swett and colleagues, the excessive use of alcohol and/or drugs numbed painful feelings related to the abuse, blocked intrusive thoughts, and assisted with sleep disturbances related to traumatic experiences. Arguably, the impact of chronic substance abuse and lifestyle choices related to the abuse of drugs and alcohol impacted the individual’s responses to the YSQ-S and in turn the severity of EMS across the domains. As such, the failure of the data to support the research hypotheses may be related to the high prevalence of Axis I and Axis II disorders, and the correlation between these mental health diagnosis and EMS.
The failure of the data to fully support the hypothesized differences between women who reported that they experienced CSA and women who reported that they did not experience CSA across three of the four EMS domains may also be related to behaviors likely exhibited by incarcerated women that overlap with features of the EMS domains, specifically the Impaired Limits domain. Arguably, criminal behaviors and personality characteristics that underlie criminal behaviors may have superseded or masked differences in the severity of EMS as a function of CSA. For example, according to Young’s Schema Focused Theory, individuals endorsing higher responses on the Impaired Limits domain present with a sense of entitlement, grandiosity, and a lack of empathy for others, arguably features not inconsistent with individuals who have engaged in asocial or antisocial behaviors presented by a forensic population (Loper, 2003). The Impaired limits domain is additionally associated with impulsivity and poor self-control. This lack of self-control may be related to a desperate attempt to avoid pain, discomfort, and memories or responsibility at the expense of personal fulfillment (Young, 1996; 1999). Arguably, the failure to delay gratification and consider the consequences of choices is related to criminal behaviors. These personality characteristic may have masked differences in EMS as a function of CSA or no CSA status.

In summation, the women who reported that they experienced severe CSA did evidence more severe maladaptive schema on the Disconnect and Rejection domain than the non-CSA group which provided partial support for the research hypotheses. Although the data did not indicate that the women who reported that they experienced severe CSA evidenced more severe EMS on the remaining three domains, these results should not be minimized. Arguably, individuals presenting with characteristics of the Disconnect and
Rejection domain are likely to negatively impact their self-worth, their tolerance of abuse in future relationships, and their ability to form and maintain healthy and genuine relationships. The data failed to reveal significant differences between the women who reported that they experienced CSA and women who reported that they did not experience CSA on the remaining three domains. This indicated that meaningful differences did not exist between the CSA and non-CSA groups on the Impaired Autonomy domain, Overvigilance/Inhibition domain, and the Impaired Limits domain. The lack of support for the research hypotheses may also be attributed to the homogeneity and broad characteristics of this population. However, in light of the general homogeneity of this population and the high prevalence of mental health disorders, the support for the differences between the CSA and non-CSA group on the Disconnect and Rejection domain is very compelling.

Primary Caregiver Care, Primary Caregiver Overprotection, CSA and Incarcerated Women

The Parental Bonding Inventory (PBI; Parker et al., 1979) was designed to assess respondents’ retrospective perception of experiences with their primary caregivers during the first 16 years of their lives. The instrument specifically explored the level of Care and Overprotection that the respondent had experienced during their childhood and adolescence. Questions evaluating the level of Care on the PBI were related to nurturing and supportive communication between the respondents and their primary caregiver before the age of 17. Although the vast majority of the respondents (71%, n=112) identified their primary caregiver as a women, some (17%, n=26) indicated that both their mother and father had been their primary caregiver during childhood and adolescence.
Forty-seven percent of the respondents reported that their primary caregiver had provided them high Care during their childhood and adolescence as defined by the PBI.

In terms of the Overprotection scale of the PBI, questions posed inquired whether the respondent felt controlled or dominated by her primary caregiver and thus unable to make responsible choices on her own. It was striking that only 27% of the respondents rated their primary caregiver as low with regard to Overprotection which may be interpreted as the majority of the respondents feeling that they were dominated or controlled by their caregivers. Perhaps the criminal or deviant behaviors that resulted in their incarceration were a form of rebellion against controlling caregivers. However, there are no data to support this contention.

In terms of primary caregiver Care and CSA, 46% of the high Care respondents experienced CSA, and 69% of the low Care women experienced severe CSA. With regard to Overprotection and CSA, 56% of the low Overprotection respondents and 57% of the high Overprotection respondents reported that they had experienced severe CSA. These findings are contrary to Rind et al. (1998). In their meta-analysis, Rind and colleagues concluded that, “College students with a history of CSA come from more problematic home environments than control students.” (p.39). The current research suggests that incarcerated women with a history of CSA do not necessarily come from more problematic homes than incarcerated women without a history of CSA. However, this may be a function of the homogeneity of the sample in that incarcerated women in general have experienced more dysfunctional family environments than college students and the general population (e.g., Brown, Miller, & Maguin, 1999; Heney & Kristiansen, 1998; Lake, 1993; Maeve, 2000; United States Bureau of Justice Statistics, April 1999).
This difference may additionally be related to the definition of “problematic” and Rind et al.’s broader criteria of family environment that was not limited to primary caregiver care.

Primary Caregiver Care, Primary Caregiver Overprotection and EMS

As previously indicated, the research findings that provided support for the research hypotheses related to primary caregiver Care scale and primary caregiver Overprotection scale and EMS will be discussed jointly. In the following section, the implications of primary caregiver Care scale scores and the primary caregiver Overprotection scale scores across each of the four EMS domains in turn will be explored. This will be followed by an integration of the current research findings with previous research.

It was hypothesized that women who experienced a relatively low level of primary caregiver Care in their responses to the PBI or a relatively high level of Overprotection from their primary caregiver in childhood in their responses to the PBI will evidence more negative EMS than those women who experienced a relatively high level of primary caregiver Care scale scores or a relatively low level of Overprotection scale scores.

In the current study, regardless of the occurrence of CSA, women who experienced low primary caregiver Care in their responses to the PBI evidenced more negative EMS across the four domains than women who reported high primary caregiver Care scale scores. However, the effect sizes of the Overvigilance/Inhibition and the Impaired Limits domains, only accounted for a small amount of the variance.

The research findings additionally provided partial support for the hypotheses that women who experienced high primary caregiver Overprotection according to their
responses to the PBI evidenced more negative EMS. Specifically, women who experienced high primary caregiver Overprotection according to their responses to the PBI evidenced more negative EMS across three of the four EMS domains than women who reported low primary caregiver Overprotection. However, the effect sizes of the Disconnect and Rejection domain, Impaired Autonomy domain, and the Overvigilance/Inhibition domain, while significant, only accounted for a small amount of the variance. In other words, women who felt domineered and controlled by their primary caregiver during childhood reported more maladaptive cognitive schemas related to their self-worth, ability to act independently, and in terms of feelings of entitlement and impulsivity.

Regardless of the relatively low variance accounted for, these findings provided support for Young’s Schema Focused Theory and for the contention that experiences with primary caregivers during childhood and adolescence may be related to the development of EMS with a prison population, particularly when considering the aforementioned homogeneity of this population. According to Young’s Schema Focused theory, the development of EMS may be a result of not only traumatic events like CSA, but “a pattern of everyday noxious experiences” during an individual’s formative years (Young, 1999, p. 11). Arguably, this daily pattern of negative experiences may include interactions with emotionally cold and distant, or domineering caregivers.

In terms of the Disconnection and Rejection domain which stress issues of self-worth and the anticipation that others will harm them in some manner, Young (1999) opined that children raised in safe and stable environments that provided them with love, nurturance, and understanding were able to establish a sense of connectedness to others.
Less than half of the entire sample (47%) reported that they had experienced an emotionally supportive relationship with their primary caregiver in their responses to the Care scale of the PBI. This suggests that approximately half of the remaining respondents failed to experience such emotional support possibly because they may have been exposed to homes with excessive fighting, substance abuse, chronic mental illness, neglect and abuse. Arguably, primary caregivers preoccupied with their own safety, substance abuse, and who struggle with chronic mental health issues are unlikely to have the psychic and physical energy needed to develop a nurturing relationship with their children/wards. According to Young (1999, 1996), children raised in such unhealthy environments were theorized to be prone to develop an EMS within the Disconnection and Rejection domain.

With regard to Disconnection and Rejection and primary caregiver Overprotection, children who experience emotionally cold and domineering relationships with their primary caregivers may feel insecure and inadequate, and anticipate similar interpersonal relationships later in life. As previously discussed, Briere and Runtz (1987) speculated that adult survivors of CSA may recreate abuse in their relationships in an attempt to gain control over the victimization. While these authors were addressing sexual victimization during childhood, arguably, the involvement in abusive relationships may only reinforce their beliefs that they are inherently defective or worthless and deserving of mistreatment. These beliefs may have been reflected in their responses to the Young Schema Questionnaire-Short Form (YSQ-S), the assessment tool that measured EMS in this study.
With regard to the Impaired Autonomy domain, Young hypothesized that children who failed to experience healthy and nurturing interactions with primary caregivers, consistent with low primary caregiver Care, may doubt themselves, numb their emotions, or experience an unstable or poorly defined self-identity. As a result, such individuals may have difficulty managing their lives in an independent and confident manner, without excessive support from others.

Similarly, women who experienced domineering or controlling interactions with caregivers, consistent with the high Overprotection scale, were not offered the opportunity to make many choices in their life. As a result, they may evidence Impaired Autonomy by second guessing themselves and having difficulty making even everyday decisions. Arguably, children who experienced domineering parenting interactions may not have been encouraged or taught to make independent choices, even with regard to dress (according to the PBI) during their formative years, and as result may have difficulty making everyday choices as an adult without excessive encouragement from others.

According to Young (1999, 1996), the Overvigilance and Inhibition domain is characterized by rigid rules and high expectations for one's own behaviors. Individuals endorsing items on this domain are likely to be critical of themselves if they fall short of their internal standards. Their unrelenting standards for perfection are not limited to themselves; however, as they tend to judge others harshly for making mistakes and they are often described as intolerant, impatient, and unforgiving of others (Young, 1996; Young, 1999). Arguably, these behaviors may be attributed to individuals emulating or reenacting the emotionally cold, distant (consistent with low primary caregiver Care),
critical, and domineering experiences (consistent with high primary caregiver Overprotection) that they encountered with their primary caregiver during childhood and adolescence.

Additionally, individuals who failed to experience warm and nurturing experiences with primary caregivers failed to learn how to interact in emotionally supportive manner during adulthood. According to Young, these individuals often suppress both positive and negative feelings including vulnerability and happiness. This research found that individuals who experienced low Care and high Overprotection from primary caregivers during childhood endorsed more negative responses on the Overvigilance and Inhibition domain suggesting that these individuals may be modeling or re-enacting the dynamics with their primary caregivers in adulthood.

Lastly, only respondents who reported low primary caregiver Care in their responses to the PBI evidenced more negative EMS on the Impaired Limits domain. As previously discussed, respondents endorsing items on the Impaired Limits domain may present with a sense of entitlement, poor impulse control, and a lack of concern for others. Perhaps, individuals who failed to experience warm and emotionally supportive relationships with primary caregivers may not have had the opportunity to develop empathic relationships with others. Although attachment theories were not discussed in Chapter 2, elements of these theories may offer an explanation for the research findings. According to attachment theorists, absent nurturing, protective and consistent interactions with caregivers, children fail to develop empathetic and genuine relationships with others (see Bowlby, 1988; Mercer, 2006; Prior & Glaser, 2006). Similar to features of the Impaired Limits domain, attachment disorders including Reactive Attachment Disorder is
characterized by a lack of genuine attachment with others, impulsive and destructive behaviors, lack of cause and effect thinking, and a lack of conscience. According to attachment theory and features of the diagnosis of Reactive Attachment Disorder, this constellation of behaviors stem from either traumatic events during a child’s formative years, and/or pervasive patterns of abuse and/or neglect by primary caregivers.

The support for research hypotheses that asserted that individuals who experienced low primary caregiver Care according to their responses to the PBI and high primary caregiver Overprotection according to the responses to the PBI would evidence more negative EMS was not surprising considering extensive research providing evidence for the correlation between general social support and adaptive coping skills. As discussed in Chapter 2, numerous researchers have reported that family environment impacts psychological adjustment later in life, regardless of the experience of childhood trauma (e.g., Finkelhor, 1993; Fromuth, 1986; Goodman et al., 1992; Hazzard et al., 1995; Kendall-Tackett et al., 1991). Broadly, social support has been defined as assistance given to individuals who are coping with stressful events (Thoitis, 1986). Cohen and Willis (1995) theorized that the presence of social support acts as a “buffer” during and following traumatic events, helps individuals more effectively cope with high levels of stress, and serves as protection from developing psychological symptomatology and maladaptive coping strategies, and influences the cognitive appraisal of the experience (Tremblay, 1999). Stressful life events are not limited to “traumatic” events, but can include a pervasive pattern of dysfunctional in the home environment, a pattern common among women involved in the judicial system (e.g., Brown, Miller, & Maguin, 1999;

Research has additionally identified parental support (versus primary caregiver support) as a confound with CSA in college populations (e.g., Fromuth, 1986, Rind et al., 1998), and within clinical samples (e.g., Beitchman et al., 1991). For example, although Rind and his colleagues (1998) reported that college students who had experienced CSA were “on average, slightly less adjusted than controls” (p. 22), they further reported that this maladjustment could not be fully attributed to CSA because “family environment was consistently confounded with CSA” (p. 22). They elaborated that family environment “explained considerably more adjustment variance than CSA, and CSA-adjustment relations generally became nonsignificant when studies controlled for family environment” (p.22).

Specifically, Rind et al. (1998) explored the relation between CSA and six family environment factors. These factors were abuse and neglect, adaptability, conflict or pathology, family structure, support or bonding, and traditionalism. For each of these six factors, the effect size measuring the relations between CSA and the six family environment factors was statistically significant which suggests, “that college students with a history of CSA are more likely to come from problematic home environments than control students, implying that CSA and family environment are confounded in this population” (p. 39). The authors added that, “in terms of variance accounted for, family environment outperformed CSA in explaining symptoms” (p.39). Therefore, these results suggested that family environment is a more important predictor of pathology than is CSA in the college population.
Similarly, Mullen, Martin and Anderson (1993) administered the PBI to a community sample of women. They found that women with a history of CSA were 2.2 times more likely to rate both parents as low in caring and high in overprotection (a negative parental approach, as previously noted) than the women who reported no history of CSA. Women who indicated that penetration had occurred during the abusive event were 4.2 times more likely to describe their mothers as low in Care and high in Overprotection. The authors therefore concluded that the women who had experienced CSA also had been exposed to inadequate parenting. According to these authors, the experience of CSA was found to be correlated with an increased risk for a range of long-term mental health problems; however, the risk of mental health problems could only be fully understood when considering the family context in which the abuse occurred.

In 1986, Fromuth explored the relation between CSA and later psychological distress in a sample of female college students. Although a significant negative correlation was found between CSA and later psychological adjustment, when parental supportiveness was controlled, the relation between CSA and psychological turmoil was significantly reduced. Thus, the results of this study suggested that psychological turmoil may be largely attributed to the confounding variable, the family environment.

Gladstone, Parker, Wilhelm, Mitchell and Austin (1999) administered the PBI to a sample of clinically depressed women. The women who reported a history of CSA rated their fathers as significantly less caring than the no CSA group. Gladstone and her colleagues reported that patients who reported a history of CSA also reported a significantly more adverse parent-child experience. A multivariate regression analysis suggested that clinical depression in adulthood with this sample was unlikely to be a
direct consequence of CSA, and that the dysfunctional family experiences during childhood were associated with depression in adulthood. However, consistent with the initial research hypothesis, Gladstone and her colleagues reported that CSA was a better predictor of Borderline Personality Disorder than parental/environment characteristics.

In summation, although respondents who reported that they had experienced CSA did evidence more severe EMS on the Disconnection and Rejection domain, women who experienced low Care from primary caregivers according to their responses to the PBI evidenced more negative EMS across each of the four EMS domains, and women who experienced high Overprotection according to their responses to the PBI evidenced more negative EMS across three of the four domains. This suggests that relationships with primary caregivers may play a critical role in later psychological adjustment with the criminal population, consistent with non-criminal populations. Specifically, incarcerated women who experienced nurturing and supportive experiences that encouraged developmentally appropriate autonomy presented with more adaptive perceptions of themselves and others. In addition, relationships with primary caregivers may have a more critical impact on psychological adjustment in adulthood than CSA.

The Interaction of CSA and Primary Caregiver Care and Overprotection on EMS

The current study hypothesized that relatively high primary caregiver Care according to their responses to the PBI and relatively low primary caregiver Overprotection according to their responses to the PBI in childhood would buffer the hypothesized negative effect of CSA on the development of EMS. In other words, nurturing and supportive relationships with primary caregivers that encouraged developmentally
appropriate problem solving and independence would ameliorate the impact of CSA on negative cognitive schema. However, contrary to the research hypotheses, the interaction between CSA and primary caregiver Care scale scores and Overprotection scale scores separately did not evidence differences on the EMS domains. The research finding only found partial support for the hypotheses that the women who had experienced severe CSA. Specifically, women who had experienced CSA only evidenced more negative EMS on the Disconnect and Rejection domain as compared to women who had not experienced CSA. As a result of the limited support for this hypothesis, an interaction between CSA and primary caregiver Care scale scores and Overprotection scale scores was not expected.

These research findings were not consistent with previous research that has repeatedly reported that parental support moderated the relation between CSA and the long-term emotional distress that many survivors of CSA experience (e.g., Coffey et al., 1996; Eisenhower, 2001; Feiring, Taska, & Lewis, 1998; Spaccarelli & Kim, 1995; Tremblay, Hebert, & Piche, 1999). However, many of these studies investigated the impact of parental support with children and adolescents who had experienced CSA and not retrospectively with an adult survivor population. Possibly, parental support is more salient shortly after the CSA experience, and has little impact on the relation between CSA and psychological adjustment in adulthood.

In sum, the research data in this study failed to support the hypothesis that women who had experienced CSA and high primary caregiver Care according to their responses to the PBI and low primary caregiver Overprotection according to their responses to the PBI would evidence less severe EMS. As statistically significant differences between the
women who reported that they experienced severe CSA and the women who reported that
they had not experienced CSA were only evidenced on one of the EMS domains, these
findings were not surprising. However, respondents who reported low Care and high
Overprotection from primary caregivers in childhood in their responses to the PBI
evidenced more severe EMS than women who had experienced high Care and low
Overprotection according to their responses to the PBI regardless of CSA status. As
previously stated, nurturing and supportive relationships with primary caregivers that
encouraged developmentally appropriate problem solving and autonomy would
ameliorate the negative impact of CSA on maladaptive beliefs about oneself and others.

Implications

Scholars have reported a high incidence of emotional, physical, and sexual abuse
during childhood with incarcerated women (see Brown, Miller, & Maguin, 1999; Heney
& Kristiansen, 1998; Lake, 1993; Maeve, 2000). In addition, the U.S. Department of
Justice (United States Bureau of Justice Statistics, 1999) reported that at least half of the
incarcerated women indicated that they had experienced physical, emotional, and sexual
abuse during their childhoods. The current research reflects these epidemiological studies
with 54% of the sample reporting that they had experienced severe CSA. As a majority
of the participants reported CSA and a majority of the participants experienced low Care
and high Overprotection in their relationships with their primary caregivers during
childhood, it follows that prisons should be at the front line of offering the best possible
mental health treatment to assist with processing CSA and dysfunctional primary
caregiver/child relationships.
In light of these research findings, forensic settings should screen inmates for CSA and provide appropriate mental health treatment. As the Disconnection and Rejection domain may theoretically include feelings of inadequacy, involvement in abusive relationships, a lack of connection to a positive support group, as well as impulsive behaviors, unstable moods, and self-destructive behaviors, providing efficacious treatment may improve the lifestyle of these women and reduce the recidivism rates within this population. Young’s Schema Focused therapy provides an empirically validated treatment to refute the belief systems espoused by women impacted by characteristics of the Disconnection and Rejection domain, and increase their self-worth.

Although the research hypotheses in this study were only partially supported by the data, women who experienced CSA did endorse more severe EMS on the Disconnection and Rejection domain than the no CSA group. As previously argued, the characteristics of the Disconnection and Rejection domain overlap with features of Borderline Personality Disorder. The implications of an individual espousing beliefs consistent with the Disconnection and Rejection domain and presenting with features of Borderline Personality Disorder are often devastating and can severely compromise an individual’s emotional stability, and her ability to form and maintain genuine relationships (Janokowski, 2002), and her ability to parent children in a consistent and nurturing manner (Lawson, 2004). As features of Borderline Personality Disorder include difficulty regulating emotions, controlling impulses, and engaging in self-destructive behaviors, it is not surprising that women diagnosed with this personality disorder and other personality disorders are overrepresented in the criminal population (Loper, 2003; U.S. Bureau of Justice Statistics, April 1999). As a result, the female prison population
warrants additional attention and mental health treatment services that are tailored to their specific needs. Mental health therapy, such as Young’s Schema Focused Therapy, could ideally reduce recidivism rates and increase the quality of life for these individuals.

Young’s Schema Focused therapy provides an empirically validated treatment to refute the belief systems espoused by women impacted by the characteristics of the Disconnection and Rejection domain, and increase their self-worth (see Giesen-Bloo, van Dyck, Spinhoven et al., 2006; Hoffart & Sexton, 2002; Kellogg & Young, 2006; Nordahl & Nysaeter, 2005). For example, Giesen-Bloo and her colleagues (2006) reported that Schema Therapy is twice as effective as Transference Focused Therapy in addressing features of Borderline Personality Disorder. These researchers recruited 86 patients, age 18-60 years, from mental health treatment providers. The patients participated in two weekly sessions of either Schema Therapy or Transference Focused Therapy for three years. The researchers reported that, after three years, 45% of the individuals who participated in Schema Therapy no longer met the criteria for Borderline Personality Disorder in comparison with 24% of the individuals that participated in Transference Focused Therapy. This research is particularly salient for the forensic population in light of the relation between the Disconnect and Rejection domain and Borderline Personality Disorder.

As briefly discussed in Chapters One and Two, Young’s Schema Focused Therapy as an extension of cognitive therapy, first assists the individual in identifying her EMS by exploring early childhood experiences. Young’s inventories assists the client and the clinician in identifying her EMS and building evidence to refute these schema. In contrast with traditional cognitive approaches, Young additionally employs experiential
techniques similar to Gestalt therapy such as imagery and role playing to obtain an emotional catharsis, and assist the client in processing and ventilating painful emotions from childhood (Young, 1999). Young additionally uses the therapeutic relationship as a method for changing schema. Specifically, the therapists role is “to provide a therapeutic relationship that counteracts Early Maladaptive Schema” (p.53). The final step of Young’s Schema Focused Therapy is to “change schema-driven behaviors...this involves pushing the patient to change long-term behavioral patterns that have reinforced the schemas” (p. 54).

In addition, as many women involved in the criminal justice system have been diagnosed with substance abuse and substance dependence disorders (Bates, 2004; U.S. Bureau of Justice Statistics, April 1999), and empirical research has consistently found an association between CSA and adult substance abuse disorders (see Briere & Runtz, 1988; Kendler et al., 2000; Swett et al., 1991; Tam, Zlotnick, & Robertson, 2003; Wilsnack et al., 2004), it also follows that drug and alcohol treatment programs offered in correctional facilities should screen for CSA in order to more effectively treat the disease of addiction and the underlying impetus of the substance abuse. According to Swett et al., (1991), the excessive use of alcohol and/or drugs numb painful feelings related to the abuse, block intrusive thoughts, and assist with sleep disturbances related to the trauma. Perhaps, substance abuse treatment programs should offer inmates the opportunity to process CSA and other unhealthy childhood experiences, as these issues may interfere with their ability to establish and maintain sobriety. This in turn may ultimately reduce their recidivism rates.
Additionally, respondents who had experienced low Care and/or high Overprotection in their relationships with their primary caregivers regardless of the occurrence of CSA evidenced more negative EMS across the domains. In other words, women who experience nurturing and supportive relationships with primary caregivers that encouraged developmentally appropriate would report more adaptive beliefs about oneself and others. The majority of the respondents indicated that they had experienced low primary caregiver Care and high primary care Overprotection. As previously discussed, these findings were consistent with previous research that indicated that incarcerated women disproportionately experienced dysfunctional childhoods (e.g., Brown, Miller, & Maguin, 1999; Heney & Kristiansen, 1998; Lake, 1993; Maeve, 2000; United States Bureau of Justice Statistics, April 1999). They additionally have been disproportionately diagnosed with Axis I and Axis II (e.g. Emes, 1996; Loper, 2003; Meyer et al., 2001; Petrocelli et al., 2001). It therefore follows that mental health treatment provided in correctional facilities should address mental health diagnosis from a theoretical framework that processes early childhood experiences with primary caregivers. Young’s Schema Focused Therapy can assist inmates in identifying their EMS, and teach them to refute these negative core beliefs. Ideally, this empirically validated therapy will reduce recidivism rates and generally improve an inmate’s ability to function adaptively in society.

The data revealed that unhealthy relationships with primary caregivers were reported by a majority of the respondents. In addition, previous research has revealed that a disproportionate number of incarcerated women who reported a history of CSA had grown up in the foster care system or had parents who were heavy alcohol or drug users.
(United States Bureau of Justice Statistics, April 1999). As a result, many experienced poor parental or primary caregiver role models. The Franklin Pre-Release Center houses the majority of the pregnant inmates incarcerated in Ohio’s prison system because of its proximity to the prison hospital. As such, approximately 15-20 percent of the women who responded to the inventories were pregnant. Although an exploration of the impact of EMS and personality disorders on an individual’s parenting skills is beyond the scope of this research, arguably, these pervasive personality themes and poor parental role modeling may adversely impact an individual’s ability to parent her children in a consistent and nurturing manner. As a result, the need to provide an intensive parenting skills program appears to be warranted and particularly salient with this sample.

In summation, the research revealed that the majority of respondents reported the occurrence of CSA, and this history appears to be related to negative outcomes. As a result, the female prison population warrants additional attention and mental health treatment services that are tailored to their specific needs with the hope of reducing recidivism rates and improving the quality of life for these individuals. At the front lines, these mental health treatment professions have a unique opportunity to initiate assistance with a captured audience. Positive experiences with these treatment providers may assist these women with following through with community mental health providers and children services agencies. As the prison mental health system is not capable of fully addressing the complex needs of its population, these women would benefit from participating in additional services in the community. Continued mental health counseling and intensive parenting programs can assist parents in providing positive and supportive messages to their children through verbal and non-verbal interactions.
This research also provided broad support for the importance of supportive and nurturing relationships with primary caregivers. As such, intensive parenting skills programs should ideally broadly target high risk populations. While parenting classes and early childhood development classes have been taught in High Schools, these programs are typically not intense in nature and fail to model nurturing and supportive parent/child dynamics. Parenting classes are often facilitated by teachers who provide concrete information and direction about disciplining children, and attending to their basic physical needs. However, counselors and psychologists may assist parents in developing a nurturing and supportive relationship with their children which encourages children to make developmentally appropriate decisions in their life; thereby, assisting their children in making responsible and thoughtful choices later in life.

Lastly, as EMS are pervasive and enduring themes that are difficult to refute, it is critical for mental health treatment providers to intervene with children who have experienced CSA and/or maladaptive experiences with caregivers before they accept these experiences as a template for future experiences (see Hyman, Gold & Cott, 2003; Young, 1999; 1996). According to Young, these traumatic experiences shape the manner in which children see themselves and impact how they interact with their environment. In summation, counselors and psychologists are in the unique position to assist children in processing the manner in which they perceive experiences of abuse and neglect. Mental health treatment professionals can also provide consultation to the primary caregivers of children who have experienced abuse and neglect, and assist them in develop nurturing relationships that encourage children to make developmentally appropriate choices.
Limitations

The self-report nature of this research is a primary limitation. Unfortunately, this very challenging limitation is a critical flaw of all research investigating CSA as many survivors of CSA never disclose the incident when it occurs. For example, in their national study that investigated the prevalence of CSA with a sample of 2,626 men and women, Finkelhor, Hotaling, Lewis and Smith (1990) found that 42% of males and 33% of females interviewed had never disclosed the CSA prior to their interview. Additionally, verifying the actual reported experienced is not feasible considering the nature of these criminal offenses. Specifically, many survivors of CSA fail to disclose the abuse and as a result many perpetrators of abuse are not criminally prosecuted for the offense. In addition, prosecutors often do not have the resources to prosecute each allegation of CSA particularly when the allegations are based solely on the survivors’ self-reports.

The retrospective nature of this research is another limitation. Specifically, responses to the PBI and the FSVQ were subjective and retrospective reports. Primary caregivers and the perpetrators of abuse were not interviewed to assess their perceptions of their interactions with the respondent. In terms of the PBI, the scale authors (Parker et al., 1979) acknowledged that the validity of retrospective instruments is often difficult to establish due to possible discrepancies between respondents’ perceptions of their parents’ attitudes and behaviors and the parents’ actual attitudes and behaviors. Although PBI scores would not be able to perfectly reflect historical “reality,” the strong test-retest reliability findings do suggest that respondents are able to report stable perceptions of their caregivers’ typical levels of care and overprotection throughout childhood (e.g.,
Mackinnon, Henderson, & Andrews, 1991; Parker, 1983). As such, Parker and colleagues argued that the recalled or perceived experiences versus the “reality” may be more salient.

In addition, only volunteers participated in this research. As a result of the sensitivity of the research question and research sample chosen, respondents could not be compelled to participate in the study from an ethical perspective. As such, this sample may be biased and results may only generalize to women willing disclose information about their relationship with primary caregivers and/or sexual victimization during childhood.

Fifty-four percent of the respondents indicated that they had participated in mental health treatment. It is unclear whether such treatment remediated the development or the experience of EMS. This research did not query about the nature and the intensity of the treatment services provided. Although a true experimental design is not an ethical option when investigating the experience of CSA or relationships with primary caregivers, future research may seek to control for as many variable as possible while maintaining the robustness of the research.

Another limitation of this study was the lack of psychometric support for the YSQ-S and the PBI with a racially/ethnically diverse population. The research that provided psychometric support for the YSQ-S were either predominantly composed of European American participants or the researchers failed to report the demographic characteristics of the sample (see Glasser et al, 2002; Stopa et al., 2001; Waller et al, 2001 ). Although the PBI boasted empirical support with culturally diverse populations, the culturally diverse populations were composed of samples in different countries and not varying racial/ethnic groups within the United States. As a result, the PBI has not been validated
with the various ethnic/cultural groups within the United States. Possibly, different “cut off” score may be warranted with different ethnic/cultural samples.

Lastly, numerous confounds likely impacted the research findings such as the relation between CSA and experiences with primary caregivers, and other abusive experiences. Arguably, experiences in adulthood could also impact EMS such as involvement in violent relationships, chronic substance abuse, sexual assault in adulthood, and prior participation in mental health treatment. In addition, the context of the prison may have impacted the participants’ responses to the inventories. For example, clients may feel more hypervigilant in this prison setting and therefore their score on the Overvigilance/Inhibition domain of the YSQ-S may have reflected this contextual issue.

Future Research Questions

The present research sought to broadly explore the experience of CSA and relationships with primary caregivers under the theoretical framework of Young’s Schema Focused Therapy. As the present research highlighted the differences between positive and negative experiences with primary caregivers and EMS, future research may seek to explore these differences with other populations. Additionally, future research may explore the research findings from the perspective of alternative theories. For example, Attachment Theory appeared to provide a plausible explanation for the relation between primary caregiver Care and the Impaired Limits domain.

Another salient question related to the experience of severe CSA is the survivor’s perception of the sexual experience and whether or not she considered the experience abusive. As asserted by Parker and colleagues (1983), perception of reality may be more salient than the actual experience. As it was opined that some women who met the
criteria of severe CSA by the research definition may not consider the experience as abusive, the participants were asked to respond to the following statement on the FSVQ: “I believe that the sexual experience that I identified was abusive in nature.” The vast majority of women who reported that they had experienced severe CSA \((n=89)\), also reported that they considered the experience abusive \((n=78)\). However, five of the women who had experienced severe CSA indicated that they had not considered the experience abusive, and three of the eight women did not respond to the question. In their responses to the FSVQ, seven of these eight women met the criteria for severe CSA because they had a sexual experience prior to the age of 17 that included intercourse without the threats or force with a non-relative man over five years their senior. Curiously, one woman reported that that she had been threatened or forced to engage in intercourse, and yet she did not identify the experience as abusive. Future research may wish to explore whether perceptions of the incident as abusive in nature are related to emotional distress in adulthood. Possibly, the perception of the incident is critical to the long term sequelae of emotional problems; however, the violation of personal boundaries may be replayed in future relationships and translate into abusive or exploitative relationships during adulthood.

As previously discussed, research had not validated the YSQ-S and the PBI with varying racial/ethnic groups within the United States. As a result, future research should validate these instruments with culturally diverse populations. The PBI provided for different “cut off” based on the sex of the primary caregiver. Likewise, alternative “cut off” scores may be warranted for different racial/ethnic groups.
The current research elicited interesting comments on the FSVQ from the respondents. Many of the respondents approached the examiner and provided unsolicited information. These women each had a story to be told. Qualitative research would provide accounts of these women’s individual experiences with regard to CSA and relationships with primary caregivers that cannot be captured in quantitative data thereby providing a far more detailed account of their experiences.

Future research may additionally explore the impact of deficient parenting practices generally within the criminal population as compared with the non-criminal population. Through potentially highlighting differences in parenting experiences with the criminal population and with the general population, parenting skill training may be targeted to remediate deficits in at risk populations.

Future research may also wish to explore additional ecological factors that may be pervasive in other high risk groups such as the age and maturity of the parent, and parents who have been raised in economically and educationally impoverished environments. Future research may explore the impact of CSA, EMS and primary caregiver support with other “at risk” populations such as parents involved in child protection services. Research may then explore the impact of such individual’s actual parenting skills and interactions with their children in light of their early childhood experiences.

Summary and Conclusions

While the research findings only partially supported the research hypotheses, the long term sequelae of CSA can not be underestimated, nor can the impact of a nurturing relationship with primary caregivers that encourages developmentally appropriate decision making be underestimated. While women who had experienced CSA only
evidenced more severe EMS on the Disconnect and Rejection domain, it was argued that this domain is related to difficulties forming healthy relationships with others, feelings of adequacy, regulating emotions, and tolerating future mistreatment in relationships during adulthood. As a result, treatment programs providing mental health services for incarcerated women should screen for CSA and provide empirically validated treatment to address the underlying schema that reflect the Disconnection and Rejection domain.

Although this research did not reveal an interaction between primary caregiver Care and Overprotection and CSA on EMS, it did identify that women who experienced low primary caregiver Care and high Overprotection evidenced more severe EMS across the four domains. This furthered research related to understanding the critical role of relationships with primary caregivers during childhood on subsequent psychological adjustment. Regardless of the specific experiences, dysfunctional relationships with primary caregivers appear to leave an indelible mark on individuals. The implications may be lasting and difficult to resolve without intensive mental health services. Arguably, the intergenerational patterns of CSA, substance abuse, Axis I and Axis II disorders and possibly criminal behaviors are correlated with primary caregiver parenting practices. Counseling Psychologists working with high risk populations should not underestimate the impact of these experiences with primary caregivers and should assist children and adults who have had such unhealthy experiences refute the negative messages that shape their perception of themselves and their world.
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APPENDICES
APPENDIX A

INFORMED CONSENT FORM

The Impact of Childhood Sexual Abuse on the development of Maladaptive Cognitive Schemas.

You are invited to participate in a research project being conducted by Aimee Thomas, a doctoral student in the Department of Counseling, at the University of Akron.

You must be 18 years of age or older to participate in the research.

You do NOT need to have experienced childhood sexual abuse to participate in this research.

The purpose of the study is to gain a richer understanding of the impact of childhood sexual abuse on the mental health of survivors by understanding how the childhood sexual abuse impacts a person’s thoughts and feelings about self and others. This study will also investigate whether having a caring and supportive caregiver during childhood can help prevent mental health problems in the future.

It is estimated that 200 women will participate in this research project.

Procedure

You will be asked to complete a brief demographic instrument that will ask your age range, race/ethnicity, marital status, level of education, and whether or not you had previously participated in mental health services. The demographic page will NOT ask for your name or other identifying information.

You will also be asked to complete three inventories. It is anticipated that it will take you 30 minutes to 60 minutes to complete these inventories. These inventories will be used for research only.

Risks and Discomforts

The inventories will ask for sensitive information about the occurrence of childhood sexual abuse and about relationships with caregivers. This can be very difficult for
some participants. The possibility of emotional discomfort in responding to the questions about child abuse and caregiver support is the only anticipated risk to participants, and is one for which mental health services are available. Emergency and non-emergency mental health services are available at Franklin Pre-Release Center to assist participants in processing any discomfort that participating in this research may cause. Please kite, meaning submit a written request for mental health services from the Franklin Pre-Release Center mental health department if you experience emotional distress. The kite forms are readily available to you and may be requested from prison staff. If a participant wishes to participate in mental health services after their release from the Franklin Pre-Release Center, the following toll free number will provide you mental health resources throughout the state of Ohio (877)-275-6364.

Benefits

There are no direct benefits to participating in this research.

While participants may not directly benefit from participation in the study, their participation may assist others in the future. It is hoped that this research may assist clinicians in conceptualizing and treating childhood traumas in children and adult survivors of sexual abuse.

Compensation

According to the ODRC policy 06-RES-02, participants may not receive any payment or compensation of any kind to participate in this research.

Right to Refuse or Withdraw

Participation in this study is voluntary. Refusal to participate or withdrawal from the study at any time will involve no penalty or loss of benefit to which a participant is entitled. Participation or non-participation will in no way impact a participant’s sentence length or legal case.

Anonymous Data Collection

No identifying information will be included in your data aside from the broad demographic information. Your signed consent form will be kept separate from your data, and nobody will link the responses to you. The Franklin Pre-Release Center staff will not have access to the consent forms or to the completed inventories. Only Aimee Thomas and her advisor, Dr. James Rogers, will have access to the scored research information.
The consent forms and the inventories will be stored separately and locked in a filing cabinet at Aimee Thomas’s place of employment for 5 years. After which time, the consent forms and the inventories will be destroyed.

**Whom to Contact with Questions**

If you have any questions about this study, you may call Aimee Thomas at (330)494-5155, or Dr. Karen Scheel at (330)-972-7777. If you have any questions about your rights as a research participant, you may call the University of Akron IRB at (330)-972-7666 or 1-888-232-8790.

I have read the information provided above and all of my questions have been answered. I voluntarily agree to participate in this study. I will receive a copy of this consent form for my information.

__________________________________            _______________
Participant’s Signature                                            Date
APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

Please circle the response that best describes you.

Age:

18-24  25-30  31-35  36-40  41-60  61+

Race/Ethnicity:

Caucasian  African American  Asian American  Hispanic
Pacific Islander  Native American  Biracial  Other

Marital Status:

Single  Married  Separated  Divorced  Widowed

Highest Level of Education: ____________

Have you participated in mental health treatment?  Yes  No
APPENDIX C

FINKELHOR SEXUAL VICTIMIZATION SCALE

Developed by David Finkelhor, Ph.D.

It is currently recognized that many people have had sexual experiences during their childhood and adolescence. Some of these were with playmates, friends, boyfriends, or girlfriends. Some of these experiences were with relatives and family members. We would like for you to try to remember sexual experiences you had in your childhood and in your adolescence and answer questions related to them. By “sexual,” we mean a broad range of things, anything from playing “doctor” to sexual intercourse – in fact, anything that might have seemed “sexual” to you.

1.) Did you have any of the following experiences before the age of 17 (approximately 11th grade? Circle the number which applies to you with 1 = Yes and 2 = No.

<table>
<thead>
<tr>
<th>Experience</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.) An invitation or request to do something sexual.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b.) Kissing and hugging in a sexual way</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c.) Another person showing his/her/sex organs to another person</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>d.) You showing your sex organs to another person</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>e.) You touching or simulating another person’s sex organs</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>f.) Another person’s sex organs coming in contact with your without penetration</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>g.) Another person putting their mouth on your sex organs</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>h.) You putting your mouth on another person’s sex organs</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>i.) Vaginal intercourse</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
2.) Think about a sexual experience that you had before the age of 17 that stands out as the most important to you. Answer the following questions about it.

a.) How old were you at the time?

b.) How old was the other person? (Give best estimate)

c.) Sex of the other person?

d.) Relationship to other person: (Circle the numbers in the right hand column that represent the people who were involved in your sexual experience. Circle as many numbers in each column that apply.)

   1 = Stranger
   2 = Neighbor
   3 = Acquainance

   4 = Boyfriend/Girlfriend
   5 = Friend of yours
   6 = Friend of your parents
   7 = Authority figure (preacher, scout leader, etc.)
   8 = Cousin
   9 = Aunt or Uncle

   10 = Grandparent
   11 = Brother
   12 = Sister

   13 = Father
   14 = Stepfather
   15 = Mother

   16 = Stepmother
   17 = Other (Please specify: ______________________)

e.) What happened?

   Yes        No

   1.) An invitation or request to do something sexual

   2.) Kissing and hugging in a sexual way
3.) Another person showing his/her/sex organs to another person   1  2
4.) You showing your sex organs to another person            1  2
5.) Other person stroking you in a sexual way (thigh, arm, etc.)  1  2
6.) You stroking the other person in a sexual way        1  2
7.) Other person touching or stimulating your sex organs  1  2
8.) You touching or simulating another person’s sex organs 1  2
9.) Another person’s sex organs coming in contact with your without penetration           1  2
10.) Another person putting their mouth on your sex organs  1  2
11.) You putting your mouth on another person’s sex organs           1  2
12.) Vaginal intercourse                                      1  2
13.) Anal intercourse                                        1  2
14.) Other: (Please describe experience:____________________) 1  2

f.) Who started this?                        You   Other person

g.) Did the other person threaten or force you? Yes   A little  No

h.) Did you threaten or force the other person? Yes   A little  No

i.) Did you want this experience? Yes   A little  No

j.) Had the other person been drinking or using drugs? Yes   No   Don’t know

k.) Had you been drinking or using drugs?       Yes   No

l.) How many times did you have a sexual experience with this person? (Give best guess.)______________________________

m.) For how long did this go on? (Give estimate of number of days, months, years.)______________________________
n.) Which of these best describe your reaction at the time of your experience? (Circle the numbers in the column that are descriptive of your reaction to your sexual experience.)

1 = Fear
2 = Shock
3 = Surprise
4 = Confusion
5 = Interest
6 = Pleasure
7 = Anger
8 = Embarrassment
9 = Stimulation

o.) In retrospect, would you say this experience was (Circle the number that most applies.)

1 = Mostly positive
2 = Positive
3 = Neutral
4 = Negative
5 = Mostly negative

p.) Who did you tell about this experience, if anyone? (Circle the numbers in the column that apply.)

1 = No one
2 = Mother
3 = Father
4 = Other adult
5 = Brother/Sister
6 = Friend
7 = Aunt or Uncle
8 = Grandparent
9 = Preacher or church leader
10 = Other (Please identify: ____________________________________________)

q.) If you told your mother about your sexual experience, how did she react? (If you did not tell your mother, how do you think she would have reacted?)
<table>
<thead>
<tr>
<th></th>
<th>Very</th>
<th>Mildly</th>
<th>A little</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Angry at you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>B. Supportive of you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

r.) If you told anyone else instead of, or in addition to your mother (other than your father), about your sexual experience, how did they react? (If you did not tell anyone else, how do you think they would have reacted?)

<table>
<thead>
<tr>
<th></th>
<th>Very</th>
<th>Mildly</th>
<th>A little</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Angry at you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>B. Supportive of you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

s.) If you told your father about your sexual experience, how did he react? (If you did not tell your father, how do you think he would have reacted?)

<table>
<thead>
<tr>
<th></th>
<th>Very</th>
<th>Mildly</th>
<th>A little</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Angry at you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>B. Supportive of you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

3.) I believe that the sexual experience that I identified was abusive in nature.

Yes          No
APPENDIX D

YOUNG SCHEMA QUESTIONNAIRE-SHORT FORM

Developed by Jeffrey Young, Ph.D.

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 you are not sure, base your answer on what you emotionally feel, not on what you think to be true. Choose the highest rating from 1 to 6 that describes you and write the number in the space before the statement.

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

1. _____Most of the time, I haven’t had someone to nurture me, 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, or understands my true needs and feelings.

5. _____I have rarely had strong person to give me sound advice or direction when I’m not sure what to do.

6. _____I find myself clinging to people I’m close to because I’m afraid they’ll leave me.

7. _____I need other people so much that I worry about losing them.

8. _____I worry that people I feel close to will leave me or abandon me.

9. _____When I feel someone I care for pulling away from me, I get desperate.

10. _____Sometimes I am so worried about people leaving me that I drive them away.
11. ___ I feel that people will take advantage of me.

12. ___ I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me.

13. ___ It is only a matter of time before someone betrays me.

RATING SCALE:

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

14. ___ I am quite suspicious of other’s people’s motives.

15. ___ I’m usually on the lookout for people’s ulterior motives.

16. ___ I don’t fit in.

17. ___ I’m fundamentally different from other people.

18. ___ I don’t belong; I’m a loner.

19. ___ I feel alienated from other people.

20. ___ I always feel on the outside of groups.

21. ___ No man/woman I desire could love me once 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.

26. ___ Almost nothing I do at work (or school) is as good as other people can do.

27. ___ I’m incompetent when it comes to achievement.

28. ___ Most other people are more capable than I am in areas of work and achievement.
29. ___ I’m not as talented as most people are at their work.

30. ___ I’m not as intelligent as most people when it comes to work (or school).

31. ___ I do not feel capable of getting by on my own in everyday life.

32. ___ I think of myself as a dependent person, when it comes to everyday functioning.

RATING SCALE:

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

33. ___ I lack common sense.

34. ___ My judgment cannot be relied upon in everyday situations.

35. ___ I don’t feel confident about my ability to solve everyday problems that come up.

36. ___ I can’t seem to escape the feeling that something bad is about to happen.

37. ___ I feel that a disaster (natural, criminal, financial or medical) could strike at any moment.

38. ___ I worry about being attacked.

39. ___ I worry that I’ll lose all my money and become destitute.

40. ___ I worry that I’m developing a serious illness, even though nothing serious has been diagnosed by a physician.

41. ___ I have not been able to separate myself from my parent(s), the way other people my age seem to.

42. ___ My parent(s) and I tend to be over-involved 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.
46. ___ I think that 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.

RATING SCALE:

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

48. ___ In relationships, I let the other person have the upper hand.

49. ___ I have always let other make choices for me, so I really don’t know what I want for myself.

50. ___ I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account.

51. ___ I’m the one who usually ends up taking care of the people I’m close to.

52. ___ I am a good person because I think of others more than myself.

53. ___ I’m so busy doing for the people that I care about, that I have little time for myself.

54. ___ I’ve always been the one who listens to everyone else’s problems.

55. ___ Other people see me as doing too much for others and not enough for myself.

56. ___ I am too self-conscious to show positive feelings to others (e.g. affection, showing I care.)

57. ___ I find it embarrassing to express my feelings to others.

58. ___ I find it hard to be warm and spontaneous.

59. ___ I control myself so much that people think I am unemotional.

60. ___ People see me as uptight emotionally.

61. ___ I must be the best at most of what I do; I can’t accept second best.

62. ___ I try to do my best; I can’t settle for “good enough.”
63. ___I must meet all my responsibilities.

64. ___I feel there is constant pressure for me to achieve and get things done.

65. ___I can’t let myself off the hook easily or make excuses for my mistakes.

RATING SCALE:

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

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.

71. ___I can’t seem to discipline myself to complete routine or boring tasks.

72. ___If I can’t reach a goal, I become easily frustrated and give up.

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

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

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

PARENTAL BONDING INVENTORY

Please think of your relationship with your primary care giver during your first 17 years of life. A primary caregiver is the person who was most responsible for taking care of you during your childhood and adolescence. Please check the box that best describes that person.

Was your primary caregiver a man or a woman? ________

<table>
<thead>
<tr>
<th></th>
<th>Very Like</th>
<th>Moderately Like</th>
<th>Moderately unlike</th>
<th>Very unlike</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spoke to me in a warm and friendly voice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not help me as much as I needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Let me do those things I liked doing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seemed emotionally cold to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appeared to understand my problems and worries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was affectionate to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Like me to make my own decisions</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Did not want me to grow up</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Tried to control everything I did</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invaded my privacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoyed talking things over with me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequently smiled at me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tended to baby me</td>
<td></td>
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<td></td>
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<tr>
<td>Statement</td>
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<td>--------------------------------------------------------------------------</td>
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<td></td>
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<tr>
<td>Did not seem to understand what I wanted and needed</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Let me decide things for myself</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Made me feel I wasn’t wanted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Could make me feel better when I was upset</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not talk very much</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tried to make me feel dependent on him/her</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt I could not look after myself unless he/she was around</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Gave me as much freedom as I wanted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Let me go out as often as I wanted</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Was overprotective of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not praise me</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Let me dress in any way I pleased</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
May 11, 2007

Jimee Thomas
155 Delaware Trail
Copley, OH 44321

Ms. Thomas:

The University of Akron's Institutional Review Board for the Protection of Human Subjects (IRB) completed a review of your request for a change in your protocol entitled “The Impact of Childhood Sexual Abuse on the Development of Underlying Schemas and the Moderating Impact of Caregiver Support during Childhood”. The IRB application number assigned to this project is 200703182.

The request qualified for Expedited Review and was approved on May 10, 2007. The protocol represents minimal risk to subjects and matches the following federal category for expedited review:

45 CFR 46.110 (b) (2) Minor changes in previously approved research during the period of one year or less for which approval is authorized

This protocol was reviewed according to 45 CFR 46 Subpart D, “Additional Protections for Children Involved as Subjects in Research.” The IRB has determined that the study represents research permissible under 45 CFR 46.404.

This approval is valid until April 11, 2008 or until modifications are proposed to the current project protocol, whichever may occur first. In either instance, an application for Continuing Review must be completed and submitted to the IRB.

Enclosed is the informed consent document, which the IRB has approved for your use in this research. A copy of this form is to be submitted with any application for continuation of this project.

Please note that within one month of the expiration date of this approval, the IRB will forward an annual review reminder notice to you by email, as a courtesy. Nevertheless, please note that it is your responsibility as principal investigator to remember the renewal date of your protocol's review. If your project is funded, failure to comply with IRB requirements could jeopardize your continued funding. Please submit your continuation application at least two weeks prior to the renewal date, to ensure the IRB has sufficient time to complete the review.

Please retain this letter for your files. If the research is being conducted for a master's thesis or doctoral dissertation, you must file a copy of this letter with the thesis or dissertation.

Sincerely,

Sharon Naftofer
Associate Director

To: Jim Rogers, Advisor
Rochelle Hays, IRB Chair

The University of Akron is an Equal Education and Employment Institution