**Abstract**

**Background**

Cognitive theorists posit that inflated responsibility beliefs contribute to the development of obsessive compulsive disorder (OCD). Salkovskis et al. (1999) proposed that experiencing heightened responsibility, overprotective parents and rigid rules; and thinking one influenced or caused a negative life event act as “pathways” to the development of inflated responsibility beliefs, thereby increasing risk for OCD. Studies in adults with OCD and non-clinical adolescents support the link between these experiences and responsibility beliefs (Coles et al., 2015; Halvaiepour & Nosratabadi, 2015), but the theory has never been tested in youth with current OCD.

**Aims**

We provided an initial test of the theory by Salkovskis et al. (1999) in youth with OCD. We predicted that childhood experiences proposed by Salkovskis et al. (1999) would correlate positively with responsibility and harm beliefs and OCD symptom severity.

**Method**

Twenty youth with OCD (age 9-16) completed a new child-report measure of the experiences hypothesized by Salkovskis et al. (1999), the Pathways to Inflated Responsibility Beliefs Scale – Child Version (PIRBS-CV). Youth also completed the Obsessive Beliefs Questionnaire-Child Version (Coles et al., 2010) and the Obsessive Compulsive Inventory, Child Version (Foa et al., 2010).

**Results**

Consistent with hypotheses, the PIRBS-CV was significantly related to responsibility and harm beliefs and OCD symptom severity.

**Conclusions**

Results provide initial support for the theory proposed by Salkovskis et al. (1999) as applied to youth with OCD. Future studies are needed to further assess the model in early-onset OCD.

**Key Words:** cognitive theory, obsessive beliefs, responsibility, pediatric OCD

A preliminary investigation of pathways to inflated responsibility beliefs in children with obsessive compulsive disorder

Obsessive compulsive disorder (OCD) is a disabling disorder affecting approximately 1-2% of children and adolescents (Geller, 2006; Zohar, 1999). Pediatric OCD is characterized by distressing, intrusive thoughts and/or repetitive behaviors (American Psychiatric Association, 2013), is equally as impairing and chronic as adult-onset OCD, and often poses an additional strain on the child and family (Murphy & Flessner, 2015). Examining potential psychosocial risk factors for early-onset OCD is crucial for the development of prevention and early intervention programs. Unfortunately, the etiology of OCD is largely unknown. Genetics appear to play a role, particularly in the etiology of pediatric OCD versus adult-onset OCD (van Grootheest, Cath, Beekman, & Boomsma, 2005). However, considering that genes only account for 50% of the variance in the heritability of OCD, the importance of environmental contributions to pediatric OCD should not be underestimated (van Grootheest et al., 2005).

The most widely studied theories of the development and maintenance of OCD are cognitive models (Rachman, 1993, 1997; Salkovskis, 1989). Cognitive models of OCD posit that dysfunctional, obsessive beliefs lead to negative interpretations of intrusive thoughts which create or trigger distress, and subsequently, a desire to neutralize the thoughts (Rachman, 1993, 1997; Salkovskis, 1985, 1989). Six obsessive beliefs, grouped into three domains, have been identified as primarily involved in OCD (Obsessive Compulsive Cognitions Working Group, 1997). First, it is posited that individuals with OCD overestimate the potential harm of behaviors, thoughts, and events, and hold themselves personally responsible for the safety of others (*overestimation of threat and* *inflated responsibility*; Salkovskis, 1985). Second, those with OCD see a great importance in thoughts, think that thoughts correspond to actions, and feel the need to control them in an effort to reduce harm to others (*importance and* *control of thoughts*; Salkovskis, 1985; Shafran, Thordarson, & Rachman, 1996). Third, those with OCD often experience discomfort when their behaviors and/or environment are not perfect and when safety is not guaranteed (*perfectionism and* *intolerance of uncertainty;* Frost & Steketee 1997; Tolin, Abramowitz, Brigidi, & Foa, 2003)*.* In adults with OCD, these obsessive beliefs identified by the Obsessive Compulsive Cognitions Working Group (OCCWG, 1997) correlate with OCD symptom severity (Abramowitz, Whiteside, Kalsy, & Tolin, 2003; Frost & Steketee, 2002; OCCWG, 2001; Torres et al., 2007). Further, in adults, longitudinal analyses have demonstrated that dysfunctional beliefs predict future OCD symptoms (Abramowitz, Khandker, Nelson, Deacon, & Rygwall, 2006; Coles, Pietrefesa, Schofield, & Cook, 2008; Coles & Horng, 2006). Additionally, obsessive beliefs have been found to correlate with OCD symptom severity in youth (see Reynolds & Reeves, 2008) and these beliefs exist at higher levels in youth with OCD compared to youth with anxiety disorders (Barrett & Healy-Farrell, 2003; Libby, Reynolds, Derisley, & Clark, 2004).

Given evidence for the link between dysfunctional beliefs and OCD, researchers have attempted to understand how these beliefs develop. In his original theory, Beck (1976) states that childhood is a crucial time for the formation of attitudes and beliefs about the world. Similarly, experts have proposed specific early childhood experiences that are hypothesized to lead to obsessive beliefs (Salkovskis, Shafran, Rachman, & Freeston, 1999). Arguing that beliefs of *inflated responsibility* were the most consistently linked to OCD, Salkovskis et al. (1999) proposed multiple “pathways” by which inflated responsibility beliefs could develop. According to the authors, these pathways include 1) heightened responsibility as a child, 2) rigid or extreme codes of conduct, 3) parental overprotection, 4) causing a negative life event, and 5) influencing a negative life event. Refer to Table 1 for a comprehensive outline of these pathways. Additionally, Salkovskis et al. (1999) hypothesize that experiencing or assuming one’s own behaviors contributed to a coincidental negative life event is likely to result in a more rapid onset of responsibility beliefs. Of these potential pathways, Salkovskis et al. (1999) identified three (heightened responsibility, rigid or extreme codes of conduct, and overprotection) that can lead to the development of obsessive beliefs in childhood. These experiences might relate to obsessive beliefs in youth with OCD.

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One method for assessing the experiences discussed by Salkovskis et al. (1999) is the Pathways to Inflated Responsibility Beliefs Scale (PIRBS; Coles & Schofield, 2008). This questionnaire was developed to measure childhood experiences proposed to play a role in the development of inflated responsibility beliefs through adult retrospective reports. Studies with undergraduate and community samples have found that PIRBS scores correlate moderately with responsibility and harm beliefs (Coles & Schofield, 2008; Smári, Þorsteinsdóttir, Magnúsdóttir, Smári, & Ólason, 2010). Coles, Schofield, & Nota (2015), in a study of 39 adult OCD patients, found that the PIRBS total score correlated with self-reported beliefs regarding inflated responsibility and overestimation of threat. The PIRBS subscales of “overprotection” and “actions that influenced or caused a negative life event” were found to have the strongest link to inflated responsibility and threat beliefs (Coles et al., 2015).

Research examining these experiences in younger samples has just begun. Halveiapour and Nosratabadi (2015) extended the use of the adult PIRBS to adolescents. Specifically, they had 547 randomly selected high school students (age 15-18) complete the adult PIRBS and found small positive correlations between the PIRBS total and self-reported beliefs of heightened responsibility, overestimation of threat, perfectionism, and importance of thoughts (Halvaiepour & Nosratabadi, 2015). These results are generally consistent with the model, but the restricted age range limits the generalizability to younger samples. Using a structured interview of experiences corresponding to the pathways to inflated responsibility beliefs (Salkovskis et al., 1999), Lawrence and Williams (2011) found that adolescents with remitted OCD (N=16) reported more experiences in which they felt they had influenced or caused a negative event (pathways 4 and 5) than adolescents never diagnosed with OCD. The findings in prior studies on adolescents (Halvaiepour & Nosratabadi, 2015; Lawrence & Williams, 2011) suggest that the cognitive theory by Salkovskis et al. (1999) could apply to youth. Further, examining these experiences in youth might be more valid than examining them in adults, because they have occurred more recently in time and are therefore less prone to memory biases than retrospective reports of experiences (Brewin, Andrews, & Gotlib, 1993; Hardt & Rutter, 2004). The relations between experiences proposed by Salkovskis et al. (1999) and beliefs regarding responsibility have not to our knowledge been investigated in youth with a current diagnosis of OCD.

In the present study, we provide an initial test of the theory for the development of inflated responsibility beliefs (Salkovskis et al., 1999) in youth (both children and adolescents) meeting criteria for a diagnosis of OCD. First, given the theory that responsibility beliefs are the most important in OCD (Salkovskis, 1985), we predicted that childhood experiences corresponding to each pathway hypothesized by Salkovskis et al. (1999) and their combined total would be positively associated with beliefs regarding responsibility and harm. Second, consistent with evidence suggesting that responsibility beliefs are highly related to other obsessive beliefs in children (Coles et al., 2010), we predicted that each pathway and their total would correlate positively to a lesser degree with other obsessive beliefs. Third, given that cognitive theories of OCD posit that early life experiences confer risk for OCD symptoms through the development of dysfunctional beliefs (e.g. Salkovskis & Forrester, 1998) we predicted that each pathway and their combined total would correlate positively with OCD symptom severity. Fourth, given that pathways 4 and 5 (influencing or causing a negative life event) are hypothesized to lead to a more rapid onset of symptoms (Salkovskis et al., 1999) and have uniquely differentiated non-clinical from remitted OCD adolescents (Lawrence & Williams, 2011), we hypothesized that these pathways might represent a slightly different construct than the other pathways. Therefore, we calculated a total score of pathways 1-3 (heightened responsibility, rigid rules, and overprotection) and hypothesized that more experiences in these domains would also correlate positively with beliefs regarding responsibility and harm and OCD symptoms. To test our hypotheses, we adapted the adult version of the PIRBS scale for children with sensitivity to developmental norms.

**Method**

**Participants**

Participants were 20 youth, 9-16 years of age (M= 12.10, SD= 2.51) who were diagnosed with primary OCD. Just over half (55%) of the sample was female. Age 9 was set as the lower limit given that the obsessive beliefs questionnaire (OBQ), has been not validated in younger children (Coles et al., 2010). Comorbidities included social anxiety disorder (n= 6), generalized anxiety disorder (*n* = 5), specific phobia (*n* = 4), mood disorders (*n* = 4), attention deficit hyperactivity disorder (*n*=2), separation anxiety disorder (*n*=1), and Tourette syndrome (*n*=1). Out of all patients, 70% had at least one comorbid diagnosis (*n* = 14), and 40% had more than one comorbid diagnosis (*n* = 8). Nineteen of the patients’ parents identified their children as Caucasian, and one parent identified their child as African American.

**Measures**

**Anxiety Disorders Interview Schedule – Child and Parent Versions (ADIS IV, CV/ PV; Silverman & Albano, 1996).** The ADIS CV/PV are semi-structured diagnostic interviews that correspond to Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; American Psychiatric Association, 2000) criteria for anxiety disorders and common comorbid conditions (e.g. mood disorders, behavior disorders) in children and adolescents.Children and parents are interviewed separately. Diagnoses are assigned if either the child or parent endorse the necessary diagnostic criteria and clinically significant interference and/or distress. The clinical threshold for diagnosis is a 4 or higher on the clinician severity rating ranging from 0 (no illness) to 8 (very severe) based on either the child or parent interview. In the present study, inter-rater agreement was calculated for 20% of the sample using Fleiss kappa (Fleiss, 1971). For a principal diagnosis of OCD, inter-rater agreement was excellent (к = 0.85). In a sample of 9 children with other primary anxiety disorders, inter-rater agreement ranged from 0.64 (specific phobia) to 1.0 (separation anxiety disorder).

**Pathways to Inflated Responsibility Beliefs Scale – Child Version (PIRBS-CV).** ThePIRBS-CV (see Appendix A) is a 23-item child self-report measure of the pathways to inflated responsibility beliefs proposed by Salkovskis et al. (1999). The PIRBS-CV was adapted from the 23-item adult version of the PIRBS (Coles & Schofield, 2008) for this study to be developmentally appropriate for children and adolescents. Specifically, the wording and complexity of items were modified for use with children and the tense was changed from past to present. Attempts were made to conserve the essence of the constructs measured. Sample items from the child version of the PIRBS corresponding to each pathway are shown in Table 1. A factor analysis of the adult PIRBS revealed 4 subscales: heightened responsibility (HR); rigid rules (RR); overprotection (OP); and actions causing or influencing a negative life event (ACI; Coles & Schofield, 2008). Total and subscale scores of the adult version of the PIRBS have demonstrated strong internal consistency in adults with OCD (α’s > .77; Coles and Schofield, 2008). In non-clinical adolescents, a Persian version of the adult PIRBS demonstrated adequate to strong internal consistency (α= .60-.85), had strong retest reliability (r= .71), and supported the four-factor solution found by Coles and Schofield (2008; Halvaiepour & Nosratabadi, 2016). A total score and 4 subscale scores (HR, RR, OP, and ACI) can also be derived for the PIRBS-CV. The PIRBS-CV total demonstrated strong internal consistency in the present sample (α = .83). The PIRBS-CV subscales of heighted responsibility (α=.82), rigid rules (α=.83), and actions that influenced or caused a negative event (α=.82) had moderate to strong internal consistency in this sample. The full overprotection subscale did not have adequate internal consistency (α=.48). Upon closer inspection, items 7, 9, and 12 were found to refer to parental beliefs about the need for overprotection (e.g. “My parents think I can’t handle danger”) whereas items 5 and 13 refer to overprotective behaviors (e.g. “My parents do many things to protect me”). The internal consistency of items 7, 9, and 12 was adequate (α=.76), so a revised overprotection subscale (OP-3) was used in the analyses conducted herein. [[1]](#footnote-1)

**Obsessive Beliefs Questionnaire-44, Child Version (OBQ-44-CV).** The OBQ-44-CV is a 44-item self-report measure of obsessive beliefs for youth (Coles et al., 2010). The OBQ-44-CV measures obsessive beliefs in three domains: responsibility and harm (OBQ- RH); perfectionism and intolerance of uncertainty (OBQ-PC); and importance and control of thoughts (OBQ-IT). Subscale scores corresponding to these domains can be derived. The OBQ-CV total and subscale scores have demonstrated strong internal consistency (Cronbach α = .91-.96) and convergent validity in clinical samples (Coles et al., 2010). In the present sample, the OBQ-CV total demonstrated strong internal consistency (α = .94) as did the subscales (α=.81-.93).

**Obsessive Compulsive Inventory- Child Version (OCI-CV)**. The OCI-CV is a 21-item self-report measure of OCD symptom severity for youth (Foa et al., 2010). The OCI-CV demonstrated strong internal consistency (Cronbach α = .85) and retest reliability (*r* = .77). The OCI-CV correlates moderately with clinician-rated OCD symptom severity (Child Yale-Brown Obsessive Compulsive Scale), child and parent reported dysfunction related to OCD, and self-reported anxiety (Foa et al., 2010). In the current sample, the OCI-CV total score demonstrated strong internal consistency (α = .99).

**Procedure**

Information was gathered from patients seeking cognitive behavioral therapy at a specialty anxiety clinic. Diagnoses were assigned using the ADIS-IV CV/PV (Silverman & Albano, 1996). To ensure that the sample comprised individuals that fit the current definition of OCD, diagnoses were assigned based on DSM-5 (American Psychiatric Association, 2013) criteria. Information about symptoms and interference gathered from separate child and parent interviews was then combined to assign composite diagnoses. OCD had to represent the most distressing/interfering problem. All interviews were conducted by advanced level graduate students or licensed psychologists, and all interviewers were trained to reliability using established training procedures (Albano & Silverman, 1996). Specifically, assessors were required to match gold standard diagnoses on six interviews (three conducted by the trainer and three conducted by the trainee; cf. Brown, Di Nardo, Lehman and Campbell, 2001). Finally, a licensed psychologist reviewed all diagnostic interviews. Patients completed the OCI-CV, OBQ-CV, and PIRBS-CV.

Analyses were conducted using Statistical Package for the Social Sciences 23 (SPSS 23). Given the preliminary nature of our study, relatively modest sample size, and directional hypotheses based in theory, we computed all correlations using one-tailed significance tests. To characterize the present sample, descriptives for the primary study measures are presented in Table 2. The severity of our sample (mean OCI-CV total = 19.16) was comparable to other samples of children with OCD (mean OCI-CV total = 17.02 and 15.32; Foa et al., 2010; Jones et al., 2012). The mean subscale scores for the OBQ-CV in the present sample are comparable to the pediatric OCD sample from the original paper on the OBQ-CV (Coles et al., 2010).

**Results**

------ TABLE 2 -------

**Testing the Hypothesis That Pathways to Inflated Responsibility Beliefs Correlate Positively with Beliefs Regarding Responsibility and Harm**

First, we examined the correlation between childhood experiences and inflated beliefs of responsibility and harm. Consistent with the primary hypothesis, total scores on the PIRBS-CV were found to be strongly and significantly related to OBQ-CV Responsibility and Harm beliefs (see Table 3). Further, the PIRBS-CV subscales assessing heightened responsibility, rigid rules, and Actions Caused/Influenced were all moderately and significantly correlated with OBQ-CV Responsibility and Harm beliefs. Next, we examined whether the PIRBS-CV scores would be more modestly correlated with other beliefs shown to be important in OCD, but not emphasized in the Salkovskis et al. (1999) model (see Table 3). The PIRBS-CV total was significantly correlated with OBQ-CV Perfectionism/Intolerance of Uncertainty, but not with OBQ-CV Importance/Control of Thoughts. Turning to the domains of childhood experiences, the PIRBS-CV Actions Caused/Influenced subscale was significantly correlated with OBQ-CV Perfectionism/Intolerance of Uncertainty.

**Testing the Hypothesis that Childhood Experiences Correlate Positively with OCD Symptom Severity**

Next, we tested the relations between childhood experiences and OCD severity. PIRBS-CV total was significantly correlated with OCI-CV total (see Table 3). Turning to specific pathways, PIRBS-CV Actions Caused/Influenced was significantly related to OCI-CV total. However, PIRBS-CV Heightened Responsibility, Rigid Rules, and the revised Overprotection subscale were not significantly related to OCI-CV total.

**Testing the Hypothesis that Total Experiences of Heightened Responsibility, Rigid Rules, and Overprotection (without Actions Caused/Influenced) Will Be Positively Correlated with Beliefs Regarding Responsibility and Harm**

Finally, given that the pathways proposed by Salkovskis et al. (1999) regarding the occurrence of a bad event are different in nature from the other three pathways, we tested whether a total of the PIRBS-CV without the Actions Caused/Influenced subscale would be associated with increased responsibility beliefs. In support of our hypothesis, this revised total was significantly related to OBQ-CV Responsibility and Harm.

----- TABLE 3 -----

**Discussion**

The results found herein provide initial support for the pathways to responsibility beliefs theory proposed by Salkovskis et al. (1999) in youth with OCD. Total youth-reported experiences across the 5 pathways to responsibility beliefs (PIRBS-CV total) was significantly associated with stronger responsibility beliefs and OCD symptoms. Looking at individual pathways, self-reported experiences of heightened responsibility, experiences of rigid rules, and experiences in which the youth felt as if they had influenced or caused a negative life event were significantly correlated with beliefs regarding responsibility and harm but not OCD symptoms. Finally, the total of the first three pathways (PIRBS-CV Total minus ACI) was significantly correlated with beliefs regarding responsibility and harm, but not OCD symptoms. These results are similar to findings in adults and adolescents (Coles et al., 2015; Coles & Schofield, 2008; Halvaiepour & Nosratabadi, 2015; Lawrence & Williams, 2011; Smári et al., 2010). The PIRBS-CV total and three of the four subscale scores demonstrated good internal consistency, but future studies are needed to further evaluate whether this scale is a reliable measure of the experiences proposed to lead to the development of responsibility beliefs (Salkovskis et al., 1999) in youth.

A novel finding was that experiences of heightened responsibility and rigid rules were moderately correlated with beliefs regarding responsibility and harm. In contrast, Coles et al. (2015) did not find these variables to be correlated in adults. Salkovskis et al. (1999) hypothesized that rigid rules, heightened responsibility, and actions that influence/cause a negative life event can lead to beliefs regarding responsibility as early as childhood. Therefore, these experiences might be more strongly related to responsibility beliefs in our younger sample that has had fewer alternative experiences to buffer the development of these beliefs. Studies suggest that obsessive beliefs strengthen with age (Farrell, Barrett, & Piacentini, 2006), and that beliefs are more related to OCD symptom severity in adolescents than younger children (Farrell, Waters, & Zimmer-Gembeck, 2012). The literature on OCD also suggests that early-onset OCD (mean onset = 11 years) is characterized by a greater genetic load, greater proportion of males to females, and a greater comorbidity with tics and OC spectrum disorders than late-onset OCD (mean age = 23 years; Taylor, 2011; van Grootheest, Daniel, Cath, Beekman, & Boomsma, 2007). Given this, one might expect the relation between childhood experiences, obsessive beliefs, and OCD symptoms to look different in adult-onset and child-onset OCD. Future research comparing these relations across the lifespan are needed to further understand these and other potential influences on the development of responsibility beliefs.

The current work is preliminary in nature, and thus has some limitations. First, the sample size was relatively small thereby limiting our ability to detect statistically significant effects (Cohen, 1988). In other words, some of the insignificant results might be due to low power (.80 power for *r* > .50) and we encourage readers to note effect sizes observed. Our small sample size also limited our ability to generalize to all youth with OCD and robustly examine the internal consistency and validity of the PIRBS-CV. Small samples are common in many investigations of pediatric OCD (see Barrett, Shortt, & Healy, 2002; Lawrence & Williams, 2011; Libby, Reynolds, Derisley, & Clark, 2004). Therefore, results will need replication with larger samples within or across research teams. A second limitation was that the internal consistency of the overprotection subscale was moderately low in our sample. This is similar to prior studies that found that the overprotection subscale was not as internally consistent as the other subscales of the adult PIRBS (Halvaiepour & Nosratabadi, 2015; Smári et al., 2010). Further investigation of the internal consistency, retest reliability, structure, and the relation of the PIRBS-CV to other measures of childhood experiences and parenting would increase confidence in the reliability and validity of the PIRBS-CV. Third, our investigation of the etiological model put forth by Salkovskis et al. (1999) was limited given the cross-sectional nature of the analyses and lack of a comparison group. Our results do not allow for conclusions regarding causal connections between childhood experiences and responsibility beliefs. To expand the investigation of the model proposed by Salkovskis et al. (1999), future studies could test the specificity of the relation between the PIRBS-CV and responsibility beliefs, utilize longitudinal designs, compare children with and without current OCD, directly examine the indirect relationship between experiences and symptoms through beliefs regarding responsibility, and investigate moderators of this relationship (e.g. age and gender). Finally, Salkovskis et al. (1999) suggest that these childhood experiences might confer risk for other disorders (e.g. depression) and specific subtypes of OCD, and may interact with internal states (e.g. guilt) to confer risk for anxiety/mood disorders. Future studies might investigate the relation between proposed pathways to inflated responsibility beliefs, responsibility beliefs, and other outcomes.

In conclusion, the present study provides initial support for the pathways to inflated responsibility beliefs theory (Salkovskis et al., 1999) in youth with OCD and suggests that PIRBS-CV is a reliable measure of 4 out of 5 pathways. Future studies in larger samples are needed to further assess the reliability and validity of the PIRBS-CV and examine the appropriateness of the model proposed by Salkovskis et al. (1999) to early-onset OCD. As we develop an increased understanding of the experiences that lead to potential cognitive vulnerabilities for OCD, prevention efforts can be targeted at modifying these experiences, and the development of obsessive beliefs.

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**Ethical Statements**

The study was approved by the Human Subjects committee of the university in which the authors are affiliated and all procedures followed American Psychological Association ethical standards.

**Conflict of Interest**

The authors of this publication have no conflict of interest with respect to this publication.

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Appendix A

**PIRBS-CV**

This questionnaire asks about what things are like for you. There are no right or wrong answers. Please read each sentence carefully and then fill in the circle that shows how often the statement is true for you.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | Never | Rarely | Some-times | Often | Always |
| 1. | I am taught to follow an exact set of rules |  |  |  |  |  |  |
| 2. | I am responsible for cooking |  |  |  |  |  |  |
| 3. | My family cares a lot about following rules |  |  |  |  |  |  |
| 4. | I am responsible for keeping our house running smoothly |  |  |  |  |  |  |
| 5. | My parent(s) often do things for me rather than let me do them myself |  |  |  |  |  |  |
| 6. | I am taught that I will be punished for not following rules |  |  |  |  |  |  |
| 7. | My parent(s) think I that I can’t handle danger |  |  |  |  |  |  |
| 8. | My parent(s) care a lot about obedience |  |  |  |  |  |  |
| 9. | My parent(s) think I can’t handle things |  |  |  |  |  |  |
| 10. | I am responsible for keeping everyone happy |  |  |  |  |  |  |
| 11. | Adults around me are strict about rules |  |  |  |  |  |  |
| 12. | My parent(s) think I can’t protect myself |  |  |  |  |  |  |
| 13. | My parent(s) do many things to protect me |  |  |  |  |  |  |
| 14. | I have to take care of myself more than most kids my age |  |  |  |  |  |  |
| 15. | I am responsible for taking care of my parents |  |  |  |  |  |  |

***Now, please read the directions carefully to answer questions 16 through 23.***

Sometimes things that we do, or decide to not do, cause something *terrible* to happen. For example, a doctor might make a mistake and then find out it really hurt his patient. Or, a mechanic might forget to do something when he fixes a car and then find out the car had an accident. These bad things can really mess up someone’s health or well-being. Also, these really bad things can happen to other people or us. We are interested in whether something you did or did not do has ever caused something *terrible* to happen.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | Never | Rarely | Some-times | Often | Always |
| 16. | I’m *sure that* something *I did* made something terrible happen to *someone else* |  |  |  |  |  |
| 17. | I’m *sure that* something *I did* made something terrible happen to me |  |  |  |  |  |
| 18. | I’m *sure that* something *I did not do* made something terrible happen to *someone* *else* |  |  |  |  |  |
| 19. | I’m *sure that* something *I did not do* made something terrible happen to *me* |  |  |  |  |  |

Sometimes it *seems like* something we think or do *may have* caused something terrible to happen. For example, a child might wish an adult dead and soon after the adult dies. Therefore, it *may seem like* their thoughts made the bad thing happen. We are interested in whether it has ever *seemed like* your thoughts or actions have caused something terrible to happen.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | Never | Rarely | Some-times | Often | Always |
| 20. | It *seems like* something *I did or did not do* might havemade something terrible happen to someone else |  |  |  |  |  |
| 21. | It *seems like* something *I did or did not do* might have made something terrible happen to me |  |  |  |  |  |
| 22. | It *seems like* something *I thought* *about* might havemade something terrible happen so*meone else* |  |  |  |  |  |
| 23. | It *seems like* something *I thought* *about* might have made something terrible happen to *me* |  |  |  |  |  |

PIRBS-CV

Scoring Instructions

Total and subscale scores can be derived by calculating the total (sum) of the following items.

**Rigid Rules:** Items 1, 3, 6, 8 and 11

**Heightened Responsibility:** Items 2, 4, 10, 14 and 15

**Overprotection:** Items (5), 7, 9, 12 and (13)

\*Responses on items 5 and 13 were inconsistent with items 7,9, and 12 and were dropped from the present analyses.

**Actions Caused/Influenced:** Items 16-23

**Total Score:** Items 1-23

**Total minus Actions Caused/Influenced**: Items 1-15

1. Items removed from the overprotection subscale (5 and 13) were retained in the PIRBS-CV total score. Correlations between the PIRBS-CV total and other measures were very similar when including vs. excluding items 5 and 13. [↑](#footnote-ref-1)