PROFESSIONAL DOCTORATES

Attributional style and self concept in sex offenders with persecutory delusions : an exploratory study

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Bangor University

Attributional Style and Self-Concept in Sex Offenders with Persecutory Delusions: An exploratory study

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University of Wales, Bangor

Thesis Submitted in Partial Fulfilment of the Requirement of the Degree of Doctorate in Clinical Psychology (D.Clin.Psy)

July 2002

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Summary

To date no study has explored persecutory delusions in people who commit sexual offences, and whether attributional style and self-concept are any different between sex offenders with and without persecutory delusions. The present study is preceded by a literature review exploring literature on mentally ill sexually offenders. As this area of research is extremely limited to further understanding of mentally ill sex offenders, literature on individuals with persecutory delusions, specifically attributional style and self-esteem will be presented. Finally, research on attributions and self-esteem in sexual offenders is reviewed. The literature review concludes with implications for future research and clinical interventions. This is followed by a research study that aims to explore the relationship between attributional style and self-concept in men with persecutory delusions who commit sexual offences. Sex offenders with persecutory delusions, sex offenders without delusions and normal controls were compared on implicit and explicit measures of attributional style and self-esteem. The three groups were found to have similar attributional styles and levels of self-esteem and no significant differences were found between the three groups. The results are discussed in light of these findings. Limitations of the study are discussed together with future implications for research and treatment of mentally ill sex offenders.

The research paper is followed by a critical review that outlines the strengths and weaknesses of this study, as well as the process issues that arose during the course of the research and the clinical implications.

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Acknowledgements

I would firstly like to thanks friends and family for their unfailing support and continual encouragement throughout my clinical training. In particular thanks are due to Louise Gee for her ongoing support and friendship over the last three years. Thanks are also due to Liz Whitehead for her friendship, support and for her proof reading abilities.

Secondly, thanks to all the participants that took part in the study and the staff at Ashworth Hospital.

Finally, thanks to my supervisors Isabel Hargreaves and Louise Horne

Section 1

Ethics Proposal

SPECIAL HOSPITALS' APPLICATION FORM FOR THE APPROVAL OF RESEARCH BY RESEARCH AND ETHICS COMMITTEES

		FOR HOSPITAL USE ONLY											
HOSPITAL		PROJECT NO.					DATE OF RECEIPT						

TITLE OF PROJECT	Attributional style and self concept in sex offenders with persecutory delusions: An exploratory study.

SECTION 1

PRINCIPAL RESEARCHER

		Tick if you personally will require access to patient hospital records	Tick if you personally will require access to patients
NAME	Emma Pearce	√	√

PROFESSIONAL QUALIFICATIONS	
SUBJECT/DISCIPLINE	Clinical Psychology
TITLE OF PRESENT POST	Clinical Psychologist in Training

ADDRESS FOR CORRESPONDENCE	
University of Wales Bangor, NWCPC, 43 College Road, Bangor, Gwynedd, LL57 2DG	
TELEPHONE NUMBER	01492 514535
FAX NUMBER	01248 383718

OTHER RESEARCHERS		TICK BOXES IF REQUIRING ACCESS TO:	
FULL NAMES & TITLE	POST HELD	RECORDS	PATIENTS

SECTION 2

SUPERVISOR'S DETAILS

ACADEMIC SUPERVISOR (S) WHERE DIFFERENT FROM PRINCIPAL RESEARCHER	
NAME	POST HELD
Dr Isabel Hargreaves	NWCPC Director

ADDRESS (Principal supervisor only)	
University of Wales Bangor, NWCPC, 43 College Road, Bangor, Gwynedd, LL57 2DG	
TELEPHONE NUMBER	01248 382204
FAX NUMBER	01248 383718

SPECIAL HOSPITAL BASED 'SPONSOR' OR CONTACT WHERE NO SPECIAL HOSPITAL STAFF MEMBER OF THE RESEARCH TEAM *	
NAME	Dr Louise Horne (see appendix 1)
POST HELD	Consultant Clinical Psychologist
ADDRESS	Psychology Department, Ashworth Hospital, Parkbourn, Maghull,
	Liverpool, L31 1HW

* The `sponsor' or contact is the person who will support and advise you in matters of security or access to patients or research material in the event of the project receiving approval. They will normally be a member of your discipline or a senior manager.

DETAILS OF PROJECT

Please give a concise description of the research proposal below. Please attach a comprehensive protocol (maximum 3 pages) to the application.

Scientific background

A number of authors have attempted to use attribution theory to explain persecutory delusions. Kaney and Bentall (1989) compared attributional styles of depressed and delusional individuals. The ratings for both groups illustrated excessively global and stable attributions for negative events. However whereas the depressed individuals' attributions were excessively internal for negative events and excessively external for positive events, the delusional participants' attributions were overly external for negative events and overly internal for positive events. A study conducted by Lyon, Kaney and Bentall (1994), using implicit measures of attributional style, indicated that in reality delusional individuals attributed negative events to internal factors more often than positive events. This study's results gave support to the suggestion that self-serving biases are defensive mechanisms protecting against low self-esteem (Bentall, Kinderman & Kaney, 1994).

Approximately 10 per-cent of all restricted inpatients detained under the legal classification of mental illness have been convicted of an index sexual offence(s) (Home Office, 1997). However, a review of the literature concerning sexual offending in the context of mental illness confirmed that there has been very little empirical study of this group. Smith and Taylor (1999) examined the relationship of mental illness and psychotic symptoms to sex offending in men with a diagnosis of schizophrenia. They examine Home Office records for 84 men, who were all inpatients on restriction orders with a diagnosis of schizophrenia. This review of records showed that at the time of their offences 80 were considered psychotic and half of them were experiencing delusions or hallucinations related to their offences.

Sahota and Chesterfield (1998) found similarities between mentally ill sex offenders and non-mentally ill sex offenders in the extent of cognitive distortions regarding their offences. The mentally ill sex offenders displayed lower self-esteem than the non-mentally ill group. Craissati and Hode's (1992) descriptive account of 11 psychotic offenders convicted of sexual offences suggested a complex relationship between illness and offending. Most offences appeared to have been impulsive and to have occurred during the early onset of their illness, when inhibitory controls break down.

In 1998, Chesterman and Sahota examined 20 mentally ill, male, sex offenders, which included 12 men with a diagnosis of schizophrenia who were viewed by psychiatrists as being psychotic at the time of their offence. Seven of the 12 men admitted experiencing psychotic symptoms such as hallucinations and delusions at the time of their offences but felt that these symptoms were not directly related to their offending behaviour. It was reported that the mentally ill sample as a whole, had higher levels of sexual obsession, sexual dysfunction, cognitive distortions and faulty knowledge as examined by questionnaires (Sahota & Chesterman, 1998).

To date no study has explored persecutory delusions in people who commit sexual offences and whether attributional style and self-concept are any different to sex offenders with no mental health problems. The current study aims to explore the relationship between attributional style and self-concept in men with persecutory delusions who commit sexual offences. The study will aim to examine whether the attributions these clients verbalise are the views they really hold, or are they protecting themselves from low self-esteem. Sex offender treatment groups are currently the treatment of choice; these groups have a large emphasis on cognitions and responsibility. The current study may provide information regarding sex offenders with persecutory delusions attributional style, which is directly relevant to facilitating sex offender groups with clients with persecutory delusions.

Method

Participants:
The study will recruit three groups of participants: (1) sexual offenders with persecutory delusions, (2) sexual offenders with no psychotic disorders and (3) a non- forensic control group, each comprising of 21[1] participants. Participants will be male and the age range will be between 18-65 years.

(1) **Sexual Offenders with persecutory delusions (SOPD):** Criteria for inclusion into the study will include those patients who have a diagnosis of schizophrenia, schizophrenifrom, schizoaffective disorder or psychosis and who are recorded as displaying persecutory delusions. These patients will also have a conviction for sexual offending[2]. For the purpose of the study participants should not have completed a sex offender treatment group, as one of the fundamental aims of sex offender treatment groups is to challenge and enable patients to re-evaluate their cognitions and attributions regarding their offending behaviour. However, the study does not aim to interfere or impede patient's treatment or care in any way. At the time of writing there are currently no sex offender treatment groups running within Ashworth. A treatment group is scheduled to commence in 2002 and the researcher will aim to recruit participants from the waiting list before this group starts.

(2) **Sexual Offenders group (SOG):** Criteria for inclusion into the study will include those patients convicted of sexual offending[2]. These patients will not have a diagnosis of schizophrenia, schizophreniform, schizoaffective disorder and will not display delusional ideation. As above the participants should not have completed a sex offender treatment group. The researcher will aim to recruit participants prior to them starting any treatment groups.

(3) **Control group (CG):** These participants will be recruited via the School of Psychology Community Research Panel at the University of Wales, Bangor. The Research panel includes a large cross section of the local community who have volunteered to take part in research conducted by researchers from the University. The volunteers are aged between 18-65. Participant's will matched (by age and gender) to the SOPD and SOG groups on a case-by-case basis.

Exclusion criteria: Exclusion criteria include participants with a primary diagnosis of depression, bipolar disorder, and dual diagnosis with either learning disability, substance/alcohol abuse within the last year or evidence of organic pathology that could explain their presentation.

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[1] A target number of 21 participants will be sought for each group. This is based on a power requirement of 0.8 with a large effect size and significance of $p=0.05$. This value is calculated from the tables quoted in Cohen's 1992 paper which details the sample sizes required to achieve power whilst also attaining a large effect size and a significance level of $p=0.05$ for analysis of variance ($n=21$).

[2] Sexual offences against either adults or children including heterosexual, homosexual, familial and non-familial offences and involving acts such as voyeurism, exhibitionism, genital touching or fondling, fellatio, cunnilingus, vaginal and/or anal penetration.

Procedure

Participants (SOPD and SOG) will only be approached if their RMO and/or Clinical Team feel that they are able to give informed consent and participate in testing. Participants will be recruited from the Sex Offender Group's waiting list or referred by their RMO and/or Clinical Team. Participants will be given a verbal rationale for the study, including a description of the measures/tests that will be administered (written information will also be provided; Appendix 2). Participants will be assured that during testing they will be able to take breaks as required by them if necessary and that they are free to withdraw from the study at any point and that this will have no negative impact on their usual treatment and care. Both oral and written consent will be obtained (Appendix3).

Before approaching the patient for psychometric testing, their medical notes will be assessed to further assess suitability in terms of diagnostic criteria, offending history and clinical history. If considered suitable for inclusion, the demographic, offending and clinical information will be collected (Appendix 4).

Tests will be administered in the following order: (see section 4b, Page 8-10, for details)

1. **Screening measures**:
(a) The Peters *et al.* Delusions Inventory
(b) The Hospital Anxiety and Depression Scale
(c) The National Adult Reading Test

2. **Implicit measures**: The presentation of overt measures first may prime participants to the nature of the implicit tests. For this reason the implicit measures will administered first and in the following order:
    a. The Pragmatic Inference Test
    b. The Emotional Stroop Test

3. **Overt measures**:
    a. The Robson Self Esteem Questionnaire
    b. The Attributional Style Questionnaire – parallel form. The attributional style questionnaire is the most positive in nature and therefore is the best to finish on.

Following completion of the measures, participants will be de-briefed and given the opportunity to raise any concerns that may have arisen as a result of the procedure. It is not anticipated that this will be a problem as these measures have been widely used amongst both sexual offending and psychiatric populations with no reports of ill effects.

SECTION 3

SUMMARY OF PROJECT

SUMMARY OF PROJECT
INCLUDING A STATEMENT OF PURPOSE OR AIMS
(Maximum of 200 words)

Research investigating persecutory delusions in psychiatric populations has found that persecutory delusions appear to serve as a defensive mechanism, protecting against low self-esteem. Previous research has also found that the attributional style of people with persecutory delusions varies depending on whether overt or implicit methods of assessment are used.

To date no study has explored persecutory delusions in people who commit sexual offences, and whether attributional style and self-concept are any different in sexual offenders with no mental health problems. The current study aims to explore the relationship between attributional style and self-concept in men with persecutory delusions who commit sexual offences.

Aims

- To examine the relationship of attributional style and self concept in sex offenders who experience persecutory delusions
- To examine any differences in attributional style and self concept between sex offenders with a mental illness and sex offenders with no psychotic symptoms
- To examine any differences between overt and implicit measures of attributional style
- To provide descriptive information (e.g. onset of illness in relation to offence, sex offending history, victim details etc) about sex offenders with a psychotic illness

SECTION 4: METHOD

4a. THE SUBJECTS

NUMBER OF SUBJECTS AND CONTROLS (where relevant)	(a) Experimental Group: 21 (b) Comparison Group: 21 (c) Control Group: 21
HOW WILL SUBJECTS BE SELECTED?	Groups (a) and (b) will be selected from the waiting lists of sex offending groups in Ashworth Hospital. Participants may also be nominated by their RMO and/or Clinical Team. Group (c) will be recruited via the University of Wales, Bangor
LOCATION OF SUBJECTS?	Groups (a) and (b) will be individuals detained within Ashworth Special Hospital Group (c) will be individuals linked to the University of Wales, Bangor
PROPOSED DURATION AND FREQUENCY OF PROCEDURES: 1) FOR RESEARCH SUBJECTS? 2) FOR CONTROLS?	Each participant will be seen for a one off meeting, which will last approximately 2 hours.

	YES	NO
PROPOSED PAYMENT (IF ANY) TO SUBJECTS		√

	YES	NO
IS IT PROPOSED TO USE STAFF MEMBERS OF THE HOSPITAL AS SUBJECTS IN THIS STUDY?		√

	YES	NO
DOES THE RESEARCHER FORESEE ANY INTERFERENCE WITH THEIR DUTIES?		√

	YES	NO
IS THE USE OF HOSPITAL STAFF TIME FORESEEN FOR ANY OTHER PURPOSE?	√	

IF SO, PLEASE SPECIFY
Escorts where required

4b. DETAILS OF STUDY DESIGN AND INVESTIGATION TOOLS TO BE USED

Please specify the data collection procedures / Interventions /and assessments you propose to use in your project. Please reference such procedures or assessments already in use and if new assessments /procedures, attach copies of the proposed schedules.

Measures:

Measures divide into three categories (a) screening measures, (b) overt measures, and (c) implicit measures. Clinical and demographic information will also be collected from case notes. Each of the sets of measures is detailed below.

Screening Measures:

Peter *et al.* Delusions Inventory (PDI)

The PDI (Appendix 5; Peters, Day & Garety, 1999) is a 21-item questionnaire, which is designed to measure delusional ideation in the normal population (it originated from the 40-item version of the questionnaire; Peters, Joseph & Garety, 1999). The multidimensionality of delusions is incorporated by including measures of distress, preoccupation and conviction. For each item, the participant scores 1 if the belief is endorsed, and 0 if the belief if not endorsed. If the belief is endorsed, the participant is asked to rate on a scale of 1 to 5 the degree of distress, preoccupation and conviction with which the belief is held. The final score is the sum of the scores for each item, including the ratings on the three flanking scales. The range of possible scores is 0-336, where higher scores are associated with greater delusional ideation. There is normative data available for delusional and non-deluded participants, which can be compared with participants in the present study.

The Hospital Anxiety and Depression Scale (HADS)

The HADS (Appendix 6; Zigamond and Snaith, 1983) was developed for the assessment of anxiety and depression in medical outpatients' populations. It has also been used with psychiatric samples and more recently amongst people with psychosis (Chubb & Bisson, 1996; Hardy, et al., 1999). The HADS includes 14 items (7 anxiety, 7 depression). Each item is scored on a 4-point scale, ranging from the absence or the presence of positive features (scoring 0) to the presence of maximum symptomatology or the absence of positive features, which score 3. The HADS is a self-report measure and takes approximately 5 minutes to complete.

Overt Measures

These measures allow the participants to rationalize what concept is being assessed and to answer according to the image they wish to present. Using overt measures in conjunction with implicit measures is a useful way to highlight discrepancies between responses. In the present study 2 overt measures will be used, one measuring attributional style and the second assessing self esteem. Both are described below:

The Attributional Style Questionnaire – parallel form (ASQ-pf)

The ASQ-pf (Appendix 8; Lyon, Kaney and Bentall, 1994) is based on the original Attributional Style Questionnaire (ASQ) developed by Peterson, Semmels, Von Baeyer, et al, (1982). The ASQ-pf was designed as a parallel form of the implicit measure the Pragmatic Inference Test (PIT; Winters and Neale, 1983 – see below). The ASQ-pf comprises of 12 items (6 positive and 6 negative). Participants are required to generate possible causes to hypothetical events involving themselves that are either positive (e.g. You pass someone who smiles at you), or negative (e.g. your steady romantic relationship ends). After generating causes for each event, participants are asked to self-rate their causal statements on three 7-point scales for internality vs. externality, stability vs. instability, and globality vs. specificity.

The items for the ASQpf were drawn from two sources: 18 items were derived from Peterson and Villanovas' 1988 version of the ASQ that contained only negative items. None of these items had appeared in the original ASQ. A further 12 negative items and 10 positive items were designed by the authors. 48 medical students then completed these 40 items. Twelve items (6 negative and 6 positive) were then chosen on the basis of "adequate" item-whole internality correlations, normality of distribution and "adequate" variance. To improve the internality of the positive scale a further 6 items were drawn up by the authors and together with the six best items from the previous scale these items were tested using 64 medical students. The final six items were chosen from these 12.

Recent commentary review by Garety and Freeman (1999) indicates that the use of the ASQpf alongside the PIT is a valid approach for assessing attributional style by comparative overt and implicit measures.

The Robson Self Esteem Questionnaire (RSEQ)

The RSEQ (Appendix 9; Robson, 1989) consists of 30 items that represent five factors: (1) attractiveness, approval by others, (2) contentment, worthiness, significance, (3) autonomous self regard, (4) competence, self efficacy and, (5) the value of existence. The above items are based on a factor analysis of the whole RSEQ. Scoring is calculated on a 7-point likert scale with four anchors ranging from 'completely disagree' to 'completely agree'. Average completion time of the RSEQ is 10 minutes.

Implicit Measures

Implicit measures are developed to assess a given factor without the participant being fully aware of what is being measured. This aims to minimize the participant not completing the measure honestly or answering questions how they feel the researcher would wish them to respond. These measures, therefore, have the advantage of allowing indirect measurement of factors such as attributional style or self esteem and provide data that has a higher validity.

The Pragmatic Inference Test (PIT)

The PIT (Appendix 10; Winters and Neale, 1983) is a verbally administered implicit assessment of attributional style. The PIT can be delivered as a parallel form of the ASQ-pf, which allows for direct comparisons between the two measures. The PIT consists of 12 items, like the ASQ-pf, in the form of scenarios (6 positive and 6 negative). The PIT is presented as a test of memory with four responses to each item. The first items are a test of memory, but the final items require the participant to make a hypothetical attribution. Each story contains the implication of both an internal and external locus of causality. A PIT self-serving bias can be calculated by subtracting the number of internal responses for negative events from the number of internal responses for positive events.

The Emotional Stroop Test (EST)

The EST (Appendix 11; Stroop, 1935) has been developed to measure implicit beliefs about self-concept. Participants are first presented with meaningless stimuli, in this case a row of X's, which are presented in colour blocks (see Fig. 1 for illustration).

Fig. 1 Stroop test meaningless stimuli

XXXX XXXX XXXX XXXX XXXX

Participants are asked to state the colour of each block of X's. The task is timed and provides a baseline response time. The same colour order is repeated but this time using neutral words (see Fig. 2 for illustration).

Fig. 2 Stroop test neutral word stimuli

Handy Residential Currency Wooded Routine

Participants are again asked to state what the colour of each word is, and this task is also timed. The final two trials involve presenting positive words, followed by negative words (see Fig. 3 for illustration).

Fig. 3 Stroop test emotional words

Positive.	Successful	Entertaining	Respected	Important	Skilful
Negative.	Inferior	Weak	Pathetic	Inadequate	Worthless

Once more the individual is asked to state the colour of the word and again the task is timed. The purpose of the task is not to attend to the words but to simply state the colour the word is printed in. The theory follows that participants will attend to words that hold greater salience to them. This will lead to them taking longer to state the colours for the words in these lists. From this task it will be possible to evaluate positive and negative self-concept in an implicit manner.

Data collection from patient notes Information will be collected from patients' notes (Appendix 4) including clinical, offending and demographic details.

Is there a risk of discomfort or side effects in conducting this project? Where a risk(s) exists please describe what steps will be taken to prevent harm to your subjects.	Yes	No √
As stated in section 4a there are no apparent risks to participants. The proposed measures have been widely used with this client group with no adverse effects. Following the completion of measures participants will be de-briefed and given the opportunity to raise any worries or concerns. Should such a situation arise concerns will be explored at the point of application of measures and the Clinical Team will be made aware of any concerns raised by the patient.		

SECTION 5

STATISTICAL ADVICE

Have you already obtained statistical advice on this project?	Yes	No
	√	

Have you made arrangements for advice from a trained statistician?	Yes	No
	√	

Have you made arrangements for other aspects of data processing?	Yes	No
	√	

Please confirm source of such advice and arrangements.
The School of Psychology within the University of Wales has a number of experienced researchers who are available for consultation regarding analysis of data.

SECTION 6

DATA STORAGE

Briefly describe how the data will be stored
a) During the studies. Data and test information will be kept in a locked filing cabinet at all times. No names or identifying factors will be kept. b) After the study is completed. The test results will be stored in a locked cabinet, and eventually destroyed.

If you are intending to use a computer system. has the system been registered under the DATA PROTECTION ACT?	YES	NO

Please indicate how you will protect the CONFIDENTIALITY of the data.
Once accepted on to the study each participant will be allocated a number. Only the number of the patient will ever appear on any data relating to them in order to keep their responses anonymous.

Will you be using audio or visual records? If so, please specify details of use and storage.	Yes	No
		√

SECTION 7

CONSENT (where relevant)

PLEASE INDICATE FROM WHICH GROUPS CONSENT WILL BE OBTAINED	Please Tick
None	
Patients/Subjects	√
Relatives	
Patient's Consultant/RMO	√
Other (please specify)	

WHERE CONSENT TO BE OBTAINED FROM SUBJECT PLEASE SPECIFY HOW CONSENT WILL BE OBTAINED	Oral	Written	N/A
	√	√	

SECTION 8

FINANCIAL AND PRACTICAL SUPPORT

If the project is to be conducted within your current contract as a special hospital employee using more than one session per week or significant other hospital staff time is to be used please confirm that funding and management approval is available for that.	Yes	No	N/A √
Where Yes, state approving Manager's name.			

	YES	NO	N/A
Are funds required to complete this project?		√	

	YES	NO	N/A
Has a grant application been made?		√	

Specify source of POTENTIAL/ACTUAL grant.			√

Who is the grant holder?			√

	YES	NO	N/A
Where relevant, have you obtained indemnity from the sponsoring industrial or drug company?			√

	YES	NO	N/A
Where relevant, have you obtained certification from the Committee on the Safety of Medicines?			√

	YES	NO	N/A
Where relevant have you obtained a Certificate from the Administration of Radioactive Substances Act Committee (ARSAC)?			√

SECTION 9

OTHER EFFECTS ON THE HOSPITAL

WILL THERE BE ANY CAUSE TO CHANGE CLINICAL PRACTICE DURING THE COURSE OF THE STUDY?	YES	NO √
IF YES-PLEASE INDICATE THE NATURE OF CHANGES AND GROUPS INVOLVED		

ARE OTHER SPECIAL HOSPITALS INVOLVED IN THIS STUDY OR LIKELY TO BE APPROACHED	YES/NO

IF YES: WHICH HOSPITALS? WHAT IS THE STATUS OF YOUR APPLICATION?	APPROVED	AWAITING	SUBMITTED	REJECTED
ASHWORTH				
BROADMOOR				
CARSTAIRS				
RAMPTON				

PLEASE INDICATE ANY OTHER INSTITUTIONS/ORGANISATIONS INVOLVED IN THE PROJECT AND STATE OF ETHICAL APPROVAL OR PROGRESS ON PROJECT.
University of Wales Bangor

IS THE PROJECT PART OF A COURSE LEADING TO A DEGREE. DIPLOMA. OR OTHER QUALIFICATION?	Yes	

IF YES, PLEASE SPECIFY QUALIFICATIONS AND AWARDING BODY
Doctorate in Clinical Psychology

SECTION 10

DURATION OF PROJECT

HOW DO YOU INTEND TO DISSEMINATE THE RESEARCH FINDINGS?
Reports / presentations of findings Publication of research

NB. Please note that the Hospital Management requires a final report, which should be submitted to the Director of Research.

ANTICIPATED START DATE		July	2001	ANTICIPATED COMPLETION DATE		May	2002

I/We agree to comply with both the Ethics and Research guidelines set out by our own professional bodies and also in the notes accompanying this application form. I/We further agree to adhere to any conditions deemed necessary by the Ethics Committee to protect the well-being and safety of research subjects.

SIGNATURE (S)	[signature]
DATE	28 /03 /2001

12/95

Appendix 1.1

References

References

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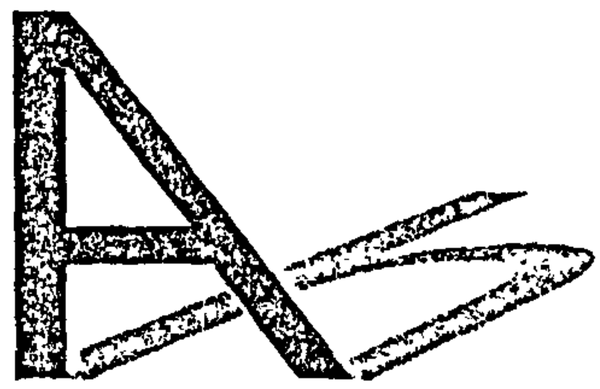
Appendix 1.2

Correspondence with Ashworth Hospital

PSYCHOLOGICAL SERVICES

Telephone: *0151-472-2444*
Fax: *0151-471-2332*
Our Ref: *LH/JBB*
Date: *23 May 2000*

Ms. Emma Pearce
University of Wales, Bangor
School of Psychology
43 College Road
Bangor, Gwynedd
North Wales, LL57 2DG



Ashworth
Hospital Authority

Dear Emma

RE: PEOPLE WITH PSYCHOSIS WHO COMMIT SEXUAL OFFENCES

Thank you for your letter. I think that there are patients at Ashworth Hospital who fit your criteria. However, as I do not work on the Mental Health Directorate, I do not have any idea how many patients there are.

Nevertheless, I have recently been referred about 30 Mental Illness patients for the next Sex Offender Assessment Group so the numbers should be substantial!!

I would be happy to support your research although it must first go through the Research and Ethics Committee at Ashworth.

I look forward to hearing from you again.

Best wishes.

Yours sincerely

Louise

DR. LOUISE HORNE
Acting Consultant Clinical Psychologist

Parkbourn Maghull Liverpool L31 1HW Telephone: 0151-473 0303 Fax: 0151-526 6603
Chairman: Mrs Abdy Richardson

Appendix 1.3

Information sheet for Sex Offenders with Persecutory Delusions

Information Sheet

You are being asked to take part in a research study. Please read the following information carefully before you make any decisions. You are free to ask about anything that is not clear. Take your time to decide whether you wish to take part.

The study

The study is looking at how people with experiences like yours view themselves and events that happen to them. Understanding this will help to explain some of the symptoms you experience and will help to structure treatments aimed at reducing symptoms and offending. At the moment, it is not understood how people, with persecutory experiences and a history of sexual offending, view themselves and events that happen to them. We are interested in whether your beliefs are different to others who commit similar offences but have no persecutory experiences. We hope to try and start to explain this by measuring people's beliefs.

What the study will involve

If you agree to take part in the study, you will complete 7 short tests related to the main aims of the study. Very little writing will be necessary when completing the tests. If you have any questions or issues you wish to discuss after the tests have been completed, we can spend some time discussing these. The tests take approximately 1 to 1 ½ hours and will be completed in one session, you are free to take as many breaks as you like during this period. We will also need to collect certain information from your hospital notes this includes: your age, mental health and offending history. This is the only information that will be taken from your notes.

Confidentiality and anonymity

Any information that is collected from you will be kept in strictest confidence. Only the researcher will have access to the information. The medical staff that treat you will not have access to the test results. At no time will any personal details be discussed in any written material relating to the research. You will be given an address, which you can contact should you want a copy of the finished research report.

Withdrawal from the study

It is entirely up to you whether you decide to take part. You will be given this information leaflet to keep. After approximately one week if you decide to take part in the study, then you will be asked to sign a consent form. Following this, if you change your mind, you are free to withdraw from the study at any time without giving reason. Your withdrawal from the study will not affect the standard of care you receive.

Complaints

Should you wish to make a compliant about any part of the study or the researcher, these should be addressed to:

Professor CF Lowe,
Head of Department,
School of Psychology,
University of Wales,
Bangor, Gwynedd, LL57 2DG.

Lezley Boswell, Chief Executive,
Ashworth Special Hospital,
School of Psychology,
Maghull, Liverpool.

Thank you for considering taking part in the study. You may keep this information leaflet and if you agree to take part in the study you will be given a signed copy of the consent form to keep.

The main researcher in this study is Emma Pearce, Clinical Psychologist in Training, Psychology Department, Personality Disorder Service, Ashworth Hospital.

Appendix 1.4

Information sheet for Sex Offenders

Information Sheet

You are being asked to take part in a research study. Please read the following information carefully before you make any decisions. You are free to ask about anything that is not clear. Take your time to decide whether you wish to take part.

The study

You have been invited to take part in a study as a participant to contribute to a comparison group of offenders with no psychotic symptoms. The study is designed to assess how people with persecutory delusion and a history of sexual offending view themselves and events that happen to them. Understanding this will help to explain some of the symptoms they experience and will help to structure treatments aimed at reducing symptoms and offending. We are interested in whether your beliefs are different to others who commit similar offences but who have persecutory experiences as well. We hope to try and start to explain this by measuring people's beliefs.

What the study will involve

If you agree to take part in the study, you will complete 7 short tests related to the main aims of the study. Very little writing will be necessary when completing the tests. If you have any questions or issues you wish to discuss after the tests have been completed, we can spend some time discussing these. The tests take approximately 1 to 1 ½ hours and will be completed in one session, you are free to take as many breaks as you like during this period. We will also need to collect certain information from your hospital notes this includes: your age, mental health and offending history. This is the only information that will be taken from your notes.

Confidentiality and anonymity

Any information that is collected from you will be kept in strictest confidence. Only the researcher will have access to the information. The medical staff that treat you will not have access to the test results. At no time will any personal details be discussed in any written material relating to the research. You will be given an address, which you can contact should you want a copy of the finished research report.

Withdrawal from the study

It is entirely up to you whether you decide to take part. You will be given this information leaflet to keep. After approximately one week if you decide to take part in the study, then you will be asked to sign a consent form. Following this, if you change your mind, you are free to withdraw from the study at any time without giving reason. Your withdrawal from the study will not affect the standard of care you receive.

Complaints

Should you wish to make a compliant about any part of the study or the researcher, these should be addressed to:

Professor CF Lowe,
Head of Department,
School of Psychology,
University of Wales,
Bangor, Gwynedd, LL57 2DG.

Lezley Boswell, Chief Executive,
Ashworth Special Hospital,
Maghull,
Liverpool.

Thank you for considering taking part in the study. You may keep this information leaflet and if you agree to take part in the study you will be given a signed copy of the consent form to keep.

The main researcher in this study is Emma Pearce, Clinical Psychologist in Training, Psychology Department, Personality Disorder Service, Ashworth Hospital.

Appendix 1.5

Information sheet for Control Group

Information Sheet

You are being asked to take part in a research study. Please read the following information carefully before you make any decisions. You are free to ask about anything that is not clear. Take your time to decide whether you wish to take part.

The study

You have been invited to take part in a study as a participant to contribute to a comparison group of 'healthy individuals'. The study is designed to assess how people with persecutory delusion and a history of sexual offending view themselves and events that happen to them. Understanding this will help to explain some of the symptoms they experience and will help to structure treatments aimed at reducing symptoms and offending. We are interested in whether your beliefs are different to people who commit sexual offences and have persecutory delusions. We hope to try and start to explain this by measuring people's beliefs.

What the study will involve

If you agree to take part in the study, you will complete 7 short tests related to the main aims of the study. Very little writing will be necessary when completing the tests. If you have any questions or issues you wish to discuss after the tests have been completed, we can spend some time discussing these. The tests take approximately 1 to 1 ½ hours and will be completed in one session, you are free to take as many breaks as you like during this period.

Confidentiality and anonymity

Any information that is collected from you will be kept in strictest confidence. Only the researcher will have access to the information. At no time will any personal details be discussed in any written material relating to the research. You will be given an address, which you can contact should you want a copy of the finished research report.

Withdrawal from the study

It is entirely up to you whether you decide to take part. You will be given this information leaflet to keep. After approximately one week if you decide to take part in the study, then you will be asked to sign a consent form. Following this, if you change your mind, you are free to withdraw from the study at any time without giving reason. Your withdrawal from the study will not affect the standard of care you receive.

Complaints

Should you wish to make a compliant about any part of the study or the researcher, these should be addressed to:

Professor CF Lowe,
Head of Department,
School of Psychology,
University of Wales,
Bangor,
Gwynedd, LL57 2DG.

Thank you for considering taking part in the study. You may keep this information leaflet and if you agree to take part in the study you will be given a signed copy of the consent form to keep.

The main researcher in this study is Emma Pearce, Clinical Psychologist in Training, Psychology Department, Personality Disorder Service, Ashworth Hospital.

Appendix 1.6

Consent Form for Participants from Ashworth Hospital

ASHWORTH HOSPITAL
RESEARCH CONSENT FORM

Part 1	should be signed and dated by patient
Part 2a	should be signed and dated by the Responsible Medical Officer
Part 2b	should be signed and dated by the Responsible Medical Officer
Part 3	should be signed by the researcher(s)
Parts 1 & 2	should be held on the researcher's file
Part 3	should be kept by the patient

Part 1

I .....agree to be involved in the study carried out by ..... I am satisfied that the purpose and procedures of the study have been fully explained to me by ..... I have also received a written explanation of the study. I understand that my involvement in the study will be confidential and without prejudice to me, and that I can withdraw at any time.

Signed .....Date.....

Part 2 - Section A

I .....Responsible Medical Officer to..... hereby give my approval to the involvement of the above-named patient in the research project conducted by .....I have received a written explanation of the study.

Signed .....Date.....

Part 2 - Section B

I .....Responsible Medical Officer to ..... am satisfied that the patient is capable of giving consent to his/her involvement in the proposed research project.

Signed .....Date.....

ASHWORTH HOSPITAL

Part 3 - To be retained by the patient

I.....

confirm to .....

that all information relating to him/her in the study will be confidential without prejudice to her/her.

Signed..... Date.....

Signed..... Date.....

Signed..... Date.....

Appendix 1.7

Consent Form for Control Group

Consent Form

Please initial

- I have read and understand the information sheet and have been able to ask questions ( )

- I understand that my participation is voluntary and that I am free to withdraw at anytime without penalty ( )

- I agree to take part in the above study ( )

Name Date Signature

Researcher Date Signature

Appendix 1.8

Background Information Sheet for Participants from Ashworth Hospital

Participant Background information sheet

(To be collected from participants notes)

Age Marital status

Admission date to Ashworth Index offence

Current diagnosis Legal status

Substances: Cannabis ( ) Opiates ( ) Amphetamines ( )
Cocaine ( ) LSD ( ) Benzos ( )
Alcohol ( )

Psychiatric History (prior to index offence)

Previous recorded contact with Mental Health Services ( )
Age at first contact
Diagnosis given

Previous detention under Sect. 2 MHA 1983 Y / N Dates.....
Previous detention under Sect. 3 MHA 1983 Y /N Dates .....
Previous admission to locked facility Y / N Dates .....

Diagnosis of Personality disorder ever given Y / N .. Dates .....

Offending History (prior to index offence)

Criminal History:

Conviction (s) Y / N

First conviction ..... date .....
Other recorded convictions

Outcomes - Prison, probation, MSU, RSU other

Past sexual offending history: (rape, attempted rape, indecent assault and exposure)

Conviction(s) Y /N

List convictions, dates and outcomes...

Index Offence

Conviction .....

Treatment at time of offence Y / N

If yes what.....

Substance use at time of index offence Y / N / NR

If yes what.....

Victim details

Number of victims 1 2 3 4 5 other

Gender of Victim(s) M.( ) F.( )

Age of victim(s)

Relationship to victim Stranger ( ) Acquaintance ( ) Friend ( ) family member ( ) Other ( )

Excessive violence[1] used Y / N / NR

---

[1] Any violence involved in restraining the victim including hitting, punching, kicking , and ABH

Physical injuries sustained by victim(s) Y / N / NR
details.....

Psychotic symptoms at time of offence? Y / N / NR

If yes (a) Delusions ( ) (b) Hallucinations ( )

Details...

Motives explanations given by offender for index offence:
Revenge ( ) Sexual ( ) Frustration ( ) Anger ( ) Arousal ( ) Other ( )

If other, detail.....

Appendix 1.9

Peters *et al.* Delusions Inventory (PDI)

P.D.I.

This questionnaire is designed to measure beliefs and vivid mental experiences. We believe that they are much more common than has previously been supposed, and that most people have had such experiences during their lives. Please answer the following questions as honestly as you can. There are no right or wrong answers, and there are no trick questions. **Please note that we are NOT interested in experiences people may have had when under the influence of drugs.**

Only for the questions you answer YES to, we are interested in: (a) how distressing these beliefs or experiences are; (b) how often you think about them; (c) how true you believe them to be. In the section below the question, we would like you to circle the number which corresponds most closely to how distressing this belief is, how often you think about it, and how much you believe that it is true.
If you answer 'No' please go straight on to the next question.

SEX ..... **ETHNIC BACKGROUND** ..... **AGE** .....

RELIGION ..... **PROFESSION** ..... **DATE** .....

Examples only:

Do you ever feel as if people are reading your mind? (NO) YES

Please circle if answered YES

Not at all distressing 1 2 3 4 5 **Very distressing**

Hardly ever think about it 1 2 3 4 5 **Think about it all the time**

Don't believe it's true 1 2 3 4 5 **Believe it is absolutely true**

Do you ever feel as if you can read other people's minds? NO (YES)

Please circle if answered YES

Not at all distressing 1 2 3 (4) 5 **Very distressing**

Hardly ever think about it 1 (2) 3 4 5 **Think about it all the time**

Don't believe it's true 1 2 (3) 4 5 **Believe it is absolutely true**

PLEASE ANSWER ALL QUESTIONS

(1) Do you ever feel as if people seem to drop hints about you or say things with a double meaning? YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it's absolutely true
		1	2	3	4	5

(2) Do you ever feel as if things in magazines or on TV were written especially for you? YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

(3) Do you ever feel as if some people are not what they seem to be? YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

P.T.O

PLEASE ANSWER ALL QUESTIONS

(4) Do you ever feel as if you are being persecuted in some way?	YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it absolutely true
		1	2	3	4	5

(5) Do you ever feel as if there is a conspiracy against you?	YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

(6) Do you ever feel as if you are or destined to be someone very important?	YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

P.T.O

PLEASE ANSWER ALL QUESTIONS

(7) Do you ever feel that you are a very special or unusual person?	YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

(8) Do you ever feel that you are especially close to God?	YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

(9) Do you ever think that people can communicate telepathically?	YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

P.T.O.

(10) Do you ever feel as if electrical devices such as computers can influence the way you think? YES /NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

(11) Do you ever feel as if you have been chosen by God in some way? YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

(12) Do you believe in the power of witchcraft, voodoo or the occult? YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

P.T.O.

PLEASE ANSWER ALL QUESTIONS

(13) Are you often worried that your partner may be unfaithful?	YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

(14) Do you ever feel that you have sinned more than the average person?	YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

(15) Do you ever feel that people look at you oddly because of your appearance?	YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

P.T.O.

PLEASE ANSWER ALL QUESTIONS

(16) Do you ever feel as if you had no thoughts in your head at all? YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

(17) Do you ever feel as if the world is about to end? YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

(18) Do your thoughts ever feel alien to you in some way? YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

P.T.O.

PLEASE ANSWER ALL QUESTIONS

(19) Have your thoughts ever been so vivid that you were worried other people would hear them?	YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

(20) Do you ever feel as if your own thoughts were being echoed back to you?	YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

(21) Do you ever feel as if you are a robot or zombie without a will of your own?	YES / NO

If you answered YES, please circle the response which corresponds most closely to how you feel for all three questions below

How distressing do you find this?	→	Not at all distressing				Very distressing
		1	2	3	4	5
How often do you think about it?	→	Hardly ever think about it				Think about it all the time
		1	2	3	4	5
How true do you believe it is?	→	Don't believe it's true				Believe it is absolutely true
		1	2	3	4	5

THANK YOU VERY MUCH

Appendix 1.10

The Hospital Anxiety and Depression Scale (HADS)

Please read each item below and tick the box ☑ that comes *closest* to the way you have been feeling in the *past week*. Don't take too long over your replies. your immediate reaction to each item will probably be more accurate than a long thought out response.

1. I feel tense or wound up.

a. Most of the time ☐
b. A lot of the time ☐
c. From time to time occasionally ☐
d. Not at all ☐

2. I still enjoy the things I used to enjoy.

a. Definitely as much ☐
b. Not quite so much ☐
c. Only a little ☐
d. Hardly at all ☐

3. I get a sort of frightened feeling as if something awful is going to happen.

a. Yes definitely and quite badly ☐
b. Yes but not too badly ☐
c. A little. but it doesn't worry me ☐
d. Not at all ☐

4. I can laugh and see the funny side of things.

a. As much as I always could ☐
b. Not quite so much now ☐
c. Definitely not so much now ☐
d. Not at all ☐

5. Worrying thoughts go through my mind.

a. A great deal of the time ☐
b. A lot of the time ☐
c. Not too often ☐
d. Very little ☐

6. I feel cheerful

a. Never ☐
b. Not often ☐
c. Sometimes ☐
d. Most of the time ☐

7. I can sit at ease and feel relaxed

a. Definitely ☐
b. Usually ☐
c. Not often ☐
d. Not at all ☐

8. I feel as if I am slowed down

a. Nearly all the time ☐
b. Very often ☐
c. Sometimes ☐
d. Not at all ☐

9. I get a sort of frightened feeling like 'butterflies' in the stomach

a. Not at all ☐
b. Occasionally ☐
c. Quite often ☐
d. Very often ☐

10. I have lost interest in my appearance

a. Definitely ☐
b. I don't take as much care as I should ☐
c. I may not take quite as much care ☐
d. I take as much care as ever ☐

11. I feel restless as if I have to be on the move

a. Very much indeed ☐
b. Quite a lot ☐
c. Not very much ☐
d. Not at all ☐

12. I look forward with enjoyment to things

a. As much as I ever did ☐

b. Rather less than I used to ☐

c. Definitely less than I used to ☐

d. Hardly at all ☐

13. I get sudden feelings of panic

a. Very often indeed ☐

b. Quite often ☐

c. Not very often ☐

d. Not at all ☐

14. I can enjoy a good book or radio or television programme

a. Often ☐

b. Sometimes ☐

c. Not often ☐

d. Very seldom ☐

*****Please check that you have answered all the questions*****

Thank you for completing the questionnaire

Appendix 1.11

The National Adult Reading Test (NART)

National Adult Reading Test (NART)

SECOND EDITION

Word Card

Hazel E. Nelson

CHORD	SUPERFLUOUS
ACHE	SIMILE
DEPOT	BANAL
AISLE	QUADRUPED
BOUQUET	CELLIST
PSALM	FACADE
CAPON	ZEALOT
DENY	DRACHM
NAUSEA	AEON
DEBT	PLACEBO
COURTEOUS	ABSTEMIOUS
RAREFY	DETENTE
EQUIVOCAL	IDYLL
NAIVE	PUERPERAL
CATACOMB	AVER
GAOLED	GAUCHE
THYME	TOPIARY
HEIR	LEVIATHAN
RADIX	BEATIFY
ASSIGNATE	PRELATE
HIATUS	SIDEREAL
SUBTLE	DEMESNE
PROCREATE	SYNCOPE
GIST	LABILE
GOUGE	CAMPANILE

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National Adult Reading Test (NART)

SECOND EDITION

Answer/Record Sheet

Name:..... Date of test:.....

	Errors		Errors
CHORD		SUPERFLUOUS	
ACHE		SIMILE	
DEPOT		BANAL	
AISLE		QUADRUPED	
BOUQUET		CELLIST	
PSALM		FACADE	
CAPON		ZEALOT	
DENY		DRACHM	
NAUSEA		AEON	
DEBT		PLACEBO	
COURTEOUS		ASSTEMIOUS	
RAREFY		DETENTE	
EQUIVOCAL		IDYLL	
NAIVE		PUERPERAL	
CATACOMB		AVER	
GAOLED		GAUCHE	
THYME		TOPIARY	
HEIR		LEVIATHAN	
RADIX		BEATIFY	
ASSIGNATE		PRELATE	
HIATUS		SIDEREAL	
SUBTLE		DEMESNE	
PROCREATE		SYNCOPE	
GIST		LABILE	
GOUGE		CAMPANILE	

Appendix 1.12

The Attributional Style Questionnaire Parallel Form (ASQpf)

The Attributional Style Questionnaire

Instructions

Please try to imagine yourself in the situations that follow. If such a situation happened to you, what would you feel had caused it? While events may have many causes we want you to pick only one.

THE MAJOR CAUSE IF THIS EVENT HAPPENED TO YOU

Please write the cause in the blank provided after each event. Next, we want you to answer three questions about the cause that you provided.

(1) Is the cause of this event something about you or something about other people or circumstances?

(2) Is the cause of this event something that will persist across time or something that will never again be present?

(3) Is the cause of this event something that affects all situations in your life, or something that just affects this situation in you life?

To summarise, we want you to:

(1) Read each situation and vividly imagine it is happening to you.

(2) Decide what you feel would be the one major cause of the situation if it happened to you.

(3) Write the cause in the blank provided.

(4) Answer three questions about the cause.

(1) You win a competition.

a. Write down the one major cause:

b. Is the cause of this due to something about you or something about other people or circumstances? (Circle one number).

Totally due to others	1	2	3	4	5	6	7	Totally due to me

c. In the future, will the cause be present again? (Circle one number).

Never present	1	2	3	4	5	6	7	Always present

d. Is this cause just something that affects this type of situation, or does it always influence other areas of your life? (Circle one number).

Just this situation	1	2	3	4	5	6	7	All situations

2. Your steady romantic relationship ends.

a. Write down the one major cause:

b. Is the cause of this due to something about you or something about other people or circumstances? (Circle one number).

Totally due to others	1	2	3	4	5	6	7	Totally due to me

c. In the future, will the cause be present again? (Circle one number).

Never present	1	2	3	4	5	6	7	Always present

d. Is this cause just something that affects this type of situation, or does it always influence other areas of your life? (Circle one number).

Just this situation	1	2	3	4	5	6	7	All situations

3. You pass somebody who smiles at you.

a. Write down the one major cause:

b. Is the cause of this due to something about you or something about other people or circumstances? (Circle one number).

Totally due to others	1	2	3	4	5	6	7	Totally due to me

c. In the future, will the cause be present again? (Circle one number).

Never present	1	2	3	4	5	6	7	Always present

d. Is this cause just something that affects this type of situation, or does it always influence other areas of your life? (Circle one number).

Just this situation	1	2	3	4	5	6	7	All situations

4. You experience a personal injury.

a. Write down the one major cause:

b. Is the cause of this due to something about you or something about other people or circumstances? (Circle one number).

Totally due to others	1	2	3	4	5	6	7	Totally due to me

c. In the future, will the cause be present again? (Circle one number).

Never present	1	2	3	4	5	6	7	Always present

d. Is this cause just something that affects this type of situation, or does it always influence other areas of your life? (Circle one number).

Just this situation	1	2	3	4	5	6	7	All situations

5. Going on a journey to a strange place you get there very quickly.

a. Write down the one major cause:

b. Is the cause of this due to something about you or something about other people or circumstances? (Circle one number).

Totally due to others	1	2	3	4	5	6	7	Totally due to me

c. In the future, will the cause be present again? (Circle one number).

Never present	1	2	3	4	5	6	7	Always present

d. Is this cause just something that affects this type of situation, or does it always influence other areas of your life? (Circle one number).

Just this situation	1	2	3	4	5	6	7	All situations

6. Your spouse (girlfriend/boyfriend) has not been paying you much attention lately.

a. Write down the one major cause:

b. Is the cause of this due to something about you or something about other people or circumstances? (Circle one number).

Totally due to others	1	2	3	4	5	6	7	Totally due to me

c. In the future, will the cause be present again? (Circle one number).

Never present	1	2	3	4	5	6	7	Always present

d. Is this cause just something that affects this type of situation, or does it always influence other areas of your life? (Circle one number).

Just this situation	1	2	3	4	5	6	7	All situations

7. You are asked to make a speech at a colleagues leaving party.

a. Write down the one major cause:

b. Is the cause of this due to something about you or something about other people or circumstances? (Circle one number).

Totally due to others	1	2	3	4	5	6	7	Totally due to me

c. In the future, will the cause be present again? (Circle one number).

Never present	1	2	3	4	5	6	7	Always present

d. Is this cause just something that affects this type of situation, or does it always influence other areas of your life? (Circle one number).

Just this situation	1	2	3	4	5	6	7	All situations

8. You are involved in a car accident.

a. Write down the one major cause:

b. Is the cause of this due to something about you or something about other people or circumstances? (Circle one number).

Totally due to others	1	2	3	4	5	6	7	Totally due to me

c. In the future, will the cause be present again? (Circle one number).

Never present	1	2	3	4	5	6	7	Always present

d. Is this cause just something that affects this type of situation, or does it always influence other areas of your life? (Circle one number).

Just this situation	1	2	3	4	5	6	7	All situations

9. You win money in a game of cards.

a. Write down the one major cause:

b. Is the cause of this due to something about you or something about other people or circumstances? (Circle one number).

Totally due to others	1	2	3	4	5	6	7	Totally due to me

c. In the future, will the cause be present again? (Circle one number).

Never present	1	2	3	4	5	6	7	Always present

d. Is this cause just something that affects this type of situation, or does it always influence other areas of your life? (Circle one number).

Just this situation	1	2	3	4	5	6	7	All situations

10. Your room-mate tells you that s/he is moving to another room.

a. Write down the one major cause:

b. Is the cause of this due to something about you or something about other people or circumstances? (Circle one number).

Totally due to others	1	2	3	4	5	6	7	Totally due to me

c. In the future, will the cause be present again? (Circle one number).

Never present	1	2	3	4	5	6	7	Always present

d. Is this cause just something that affects this type of situation, or does it always influence other areas of your life? (Circle one number).

Just this situation	1	2	3	4	5	6	7	All situations

11. You enjoy yourself at a social event.

a. Write down the one major cause:

b. Is the cause of this due to something about you or something about other people or circumstances? (Circle one number).

Totally due to others	1	2	3	4	5	6	7	Totally due to me

c. In the future, will the cause be present again? (Circle one number).

Never present	1	2	3	4	5	6	7	Always present

d. Is this cause just something that affects this type of situation, or does it always influence other areas of your life? (Circle one number).

Just this situation	1	2	3	4	5	6	7	All situations

12. You have trouble with one of your instructors.

a. Write down the one major cause:

b. Is the cause of this due to something about you or something about other people or circumstances? (Circle one number).

Totally due to others	1	2	3	4	5	6	7	Totally due to me

c. In the future, will the cause be present again? (Circle one number).

Never present	1	2	3	4	5	6	7	Always present

d. Is this cause just something that affects this type of situation, or does it always influence other areas of your life? (Circle one number).

Just this situation	1	2	3	4	5	6	7	All situations

Appendix 1.13

The Robson Self-Concept Questionnaire (RSCQ)

The Robson Self-Concept Questionnaire

This questionnaire deals with the attitudes and beliefs that some people have about themselves.

Please indicate how much you agree or disagree with each statement by ringing a single number in each section which represents how you typically feel most of the time.

Since people vary so much in the opinions they hold. there are no right or wrong answers.

The answer scale is as follows:

0	1	2	3.	4	5	6	7
completely disagree		disagree		agree			completely agreee

Statements	**Answers** *(please circle one number for each statement)*							
1. I have control over my own life.	0	1	2	3	4	5	6	7
2. I am easy to like	0	1	2	3	4	5	6	7
3. I never feel down in the dumps for very long.	0	1	2	3	4	5	6	7
4. I can never seem to achieve anything worthwhile.	0	1	2	3	4	5	6	7
5. There are lots of things I'd change about myself if I could.	0	1	2	3	4	5	6	7
6. I am not embarrassed to let people know my opinions.	0	1	2	3	4	5	6	7
7. I don't care what happens to me.	0	1	2	3	4	5	6	7
8. I seem to be very unlucky.	0	1	2	3	4	5	6	7

The answer scale is as follows:

0	1	2	3	4	5	6	7
completely disagree		disagree		agree			completely agreee

Statements	Answers *(please circle one number for each statement)*							
9. Most people find me reasonably attractive.	0	1	2	3	4	5	6	7.
10. I'm glad I'm who I am.	0	1	2	3	4	5	6	7
11. Most people would take advantage of me if they could.	0	1	2	3	4	5	6	7
12. I am a reliable person.	0	1	2	3	4	5	6	7
13. It would be boring if I talked about myself.	0	1	2	3	4	5	6	7
14. When I'm successful. usually a lot of luck involved.	0	1	2	3	4	5	6	7
15. I have a pleasant personality.	0	1	2	3	4	5	6	7
16. If a task is difficult that makes me all the more determined.	0	1	2	3	4	5	6	7
17. I often feel humiliated.	0	1	2	3	4	5	6	7
18. I can usually make up my mind and stick to it.	0	1	2	3	4	5	6	7
19. Everyone else seems much confident and contented that me.	0	1	2	3	4	5	6	7
20. Even when I quite enjoy myself there doesn't seem much purpose to it all.	0	1	2	3	4	5	6	7

The answer scale is as follows:

0	1	2	3	4	5	6	7
completely disagree		disagree		agree			completely agreee

Statements	**Answers** *(please circle one number for each statement)*							
21. I often worry about what other people are thinking of me.	0	1	2	3	4	5	6	7
22. There's a lot of truth in the saying "what will be will be".	0	1	2	3	4	5	6	7
23. I look awful these days.	0	1	2	3	4	5	6	7
24. If I really try I can overcome most of my problems.	0	1	2	3	4	5	6	7
25. It's pretty tough to be me.	0	1	2	3	4	5	6	7
26. I feel emotionally mature.	0	1	2	3	4	5	6	7
27. When people criticise me I often feel helpless and second rate.	0	1	2	3	4	5	6	7
28. When progress is difficult I often find myself thinking it's Just not worth the effort.	0	1	2	3	4	5	6	7
29. I can like myself even when others don't.	0	1	2	3	4	5	6	7
30. Those who know me are are fond of me.	0	1	2	3	4	5	6	7

Please check that you have responded to every statement.

Thank you for completing the questionnaire.

Appendix 1.14

The Pragmatic Inference Task (PIT)

The Pragmatic Inference Test

(Transcripts of vignettes presented orally to the participant)

A. You decide to open your own dry cleaning shop in a small but growing town near the border. Your shop will be the only one of its kind for miles around. In the first year of business, the town's population doubles and your business prospers. Your advertising campaign is a big success and reactions from your customers indicate that the cleaning is of good quality. Your sales exceed expectations. You wonder whether it would be to your advantage t open a chain of shops, so you go to the bank and apply for a loan. As you had hoped, the bank approves the loan.

B. You have been looking unsuccessfully for a job as a factory worker. The unemployment rate has risen recently, and jobs are especially tight in your field. Sales have been hurt by foreign competition. You decide to talk to a friend about the situation. He reminds you that you've had difficulties with management in the past because of a poor performance record. Your search for a job is frustrating and you go for six weeks without finding work.

C. You pride yourself on you appearance. You recently spent some money on new clothes and a new hair-style. The next day you receive a number of compliments at work, especially from one colleague. However, this person angers you later on in the day, by asking you for a lift home. This is a great inconvenience because this person lives a great distance from your destination.

D. A neighbour mentions to you that their teenager has a drinking problem. You wonder whether the neighbour is going to ask you for advice. This neighbour is an independent and headstrong person who rarely seeks advice from others. You are uncomfortable because you do not have any children of your own and you are not very good at counselling people. The neighbour leaves without asking for your advice.

E. You and a colleague decide to go out one night for a bite to eat. You wonder whether you will have a good time since your colleague is a moody person. The night starts out badly when you forget to call a taxi out for the both of you and you also fail to make dinner reservations. You and the colleague wait for an hour at the restaurant.

F. you have a date with somebody new. You go to a film and your date has a poor opinion of it and for most of the evening, your date does not say much. You also do not initiate much conversation, and when you do talk you have a difficult time keeping up your end of the conversation. When the evening is over, your date expresses disappointment about how the evening went.

G. A lonely, elderly person sits next to you on a park bench while you are reading a book and begins to talk to you. You are not surprised by this since strangers are often friendly towards you. After some small talk, you find out that this person is down on their luck and needs help. You and the person talk for some time, and it seems to you that this person continues to enjoy your company.

H. The company you work for is always very busy around holiday time. It is the day before the Christmas holiday and everyone in the office is exhausted. At short notice you decide to throw an office party. You prepare an interesting mix of gin and fruit punch, which draws a number of, compliments from others. Everyone seems to enjoy themselves. You make friends with a couple of new colleagues and everyone laughs at your jokes.

I. You give and important talk on a controversial topic to a group of town residents. You present a point of view that is in the short term unpopular but will probably benefit the town in the long run. The audience reacts negatively, especially to your suggestion that the town should purchase more lorries. The next speaker presents a point of view that is opposite to your own. As you listen to the speech, you realise that this person is a very fluent and persuasive speaker. It becomes obvious to you that the second speaker receives a positive reaction from the audience.

J. Recently, you haven't done all the work that your boss expects of you. The boss begins to complain about your performance. The job is often difficult for you because it is quite difficult and the hours are a burden. Also, you recently discover through your office grapevine that the boss's nephew is very interested in you position.

K. You take a college course in English literature because you like to write. One of your assignments is to write a paper on a famous contemporary author. You choose an author called John Fowles. This decision is met with great praise by your teacher who is a fan of John Fowles. The teacher tells you that Fowles is perhaps the most influential contemporary writer. You work hard on your paper and think it is well written. You are pleased when the paper is returned. The teacher comments that your interpretation of Fowles work is consistent with her own, and you receive an excellent mark.

L. You recently receive a salary increase at work. While you are a bit surprised by this since you had no prior notice, you feel you have been a reliable worker. Indeed others have received wage increases in the past when you did not. The day after you receive this news, a memo is sent to all workers indicating that in the last few months a number of employees have voluntarily left the company. The company's owner offers to be sensitive to suggestions that he may help improve job satisfaction.

After each vignette is read the participant is asked a series of questions that correspond with the vignette they have just heard.

A. 1 What kind of shop do you open?

a. Hardware

b. Dry cleaning.

A.2 In what part of the country is the shop located?

a. Birmingham

b. Carlisle

A.3 Where is the loan obtained?

a. A finance company

b. A bank

A.4 What is the reason for the success of you business?

a. You are a clever businessman

b. You had no competition

B.1 Why do you discuss your situation with a friend?

a. Need advice

b. Your friend is recruiting staff

B.2 How long do you go for without finding work?

a. Six weeks

b. Six months

B.3 Why do you have trouble finding work?

a. Poor job record

b. Poor job market

B4. What kind of job interests you?

a. A big company

b. A small company

C1. Why do you receive a compliment from your colleague?

a. Your appearance is perceived as genuinely worth a comment

b. This person needs a favour from you

C.2 Why do you spend money on your appearance?

a. Self pride

b. You enjoy compliments

C.3 Who gives you the most compliments at work?

a. Same sexed people

b. Opposite sexed people

C.4 On what do you spend your money?

a. Shoes

b. Hair style

D.1 Who comes to you for advice?

a. Colleague

b. Neighbour

D.2 What is the nature of the problem?

a. Stealing

b. Drinking

D.3 What gender is the person with the problem?

a. Male

b. Female

D.4 Why doesn't the neighbour ask you for advice?

a. This person is the type not to ask for advice

b. You are inexperienced in this area

E.1 Where do you and the colleague go?

a. To a film

b. To a restaurant

E.2 At what time of day does the activity take place?

a. Afternoon

b. Evening

E.3 Why does the colleague act hostilely to you?

a. The person is jealous of you

b. The person is angry that you forgot to call a taxi and make the dinner arrangements.

E.4 Who initiates the activity?

a. You

b. The colleague

F.1 With whom do you have a date?

a. A close friend

b. A new acquaintance

F.2 Where do you go on the date?

a. To a film

b. For dinner

F.3 Why does the date go badly?

a. Your date was a boring person

b. You were not interesting enough for the person

F.4 Where did you go after the date?

a. For a drive

b. Nowhere

G.1 Who starts the conversation with you?

a. A tourist

b. A stranger

G.2 Why does this person talk with you for so long?

a. You are friendly

b. This person wants your help

G.3 What are you doing when you are approached by this person?

a. Reading a newspaper

b. Reading a book

G.4 Why is this person down on their luck?

a. Illness

b. Deserted by the family

H.1 Why is the party a success?

a. Your colleagues are in the mood to unwind

b. You know how to throw a good party

H.2 What is popular at the party?

a. The drink

b. The food

H.3 At what time of year is the party?

a. Christmas

b. Summer

H.4 Is the party well attended

a. Yes

b. No

I.1 Where do you give the speech?

a. A political convention

b. A town hall meeting

I.2 Why does the audience react negatively to your speech?

a. You were an ineffective speaker

b. The second speaker took the less controversial viewpoint

I.3 How do you learn about the audience's reaction to the second speaker?

a. Someone tells you

b. You witness it

I.4 What is being discussed at the meeting

a. Road repair

b. Rubbish removal

J.1 With whom do you talk about your problems at work?

a. No one

b. Your spouse

J.2 What kind of skill does this job require?

a. Manual

b. Technical

J.3 Why does your boss complain about your work performance?

a. You have poor technical skills

b. The boss wants you to leave to make room for a relative.

J.4 What shift do you work?

a. Day

b. Night

K.1 What kind of course do you take?

a. English literature

b. Writing course

K.2 Why do you take the course?

a. Compulsory

b. Pleasure

K.3 Why does the teacher like your paper?

a. You are a good writer

b. Your viewpoints are similar to the teachers

K.4 Why do you choose to write about John Fowles?

a. He is your favourite author

b. The teacher tells you to

L.1 What kind of income raise do you receive?

a. Bonus payment

b. Wage increase

L.2 How do you hear about the raise?

a. A memo

b. Told personally

L.3 Why do you get the raise?

a. The company wants to prevent further resignations

b. You deserve the raise because of good performance

L.4 Who else gets a raise?

a. No one

b. Everyone

Appendix 1.15

The Emotional Stroop Test (EST)

Stroop non-word practice sheet

XXXXX XXXXX XXXXX XXXXX XXXXX

XXXXX XXXXX XXXXX XXXXX XXXXX

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XXXXX XXXXX XXXXX XXXXX XXXXX

XXXXX XXXXX XXXXX XXXXX XXXXX

XXXXX XXXXX XXXXX XXXXX XXXXX

XXXXX XXXXX XXXXX XXXXX XXXXX

Handy Residential Currency Wooded Routine

Specifically Lamp Tendency Metaphor Lamp

Neutral Wooded Routine Pod Tendency Lamp

Handy Residential Modern Pod Metaphor

Routine Neutral Pod Residential Tendency

Metaphor Currency Pod Specifically Modern

Lamp Neutral Tendency Lamp Specifically

Residential Pod Currency Handy Metaphor

Wooded Handy Tendency Modern Currency

Routine Currency Metaphor Wooded Modern

Residential Neutral Handy Routine Modern

Specifically Wooded Neutral Specifically

Successful Entertaining Respected Important

Optimistic Sociable Skilful Confident Important

Outgoing Valuable Capable Confident Sociable

Optimistic Entertaining Respected Valuable

Successful Outgoing Important Respected

Entertaining Successful Sociable Dynamic

Optimistic Capable Confident Dynamic Capable

Valuable Dynamic Important Confident Skilful

Capable Respected Skilful Confident Optimistic

Important Entertaining Optimistic Successful

Outgoing Dynamic Skilful Entertaining Capable

Dynamic Respected Valuable Sociable Valuable

Skilful Outgoing Successful Sociable Outgoing

Inferior Weak Pathetic Inadequate Worthless

Weak Useless Inadequate Incompetent Stupid

Unwanted Unloved Deficient Unloved Inferior

Stupid Deficient Unloved Unwanted Worthless

Pathetic Inadequate Inferior Deficient Weak

Worthless Useless Stupid Pathetic Inadequate

Deficient Unwanted Useless Worthless Pathetic

Useless Worthless Failure Stupid Incompetent

Failure Inferior Incompetent Failure Unloved

Inadequate Pathetic Stupid Weak Unwanted

Unloved Failure Incompetent Inferior Failure

Incompetent Weak Unwanted Useless Deficient

Stroop Scoring

colour	*baseline*	*neutral*	*negative*	*positive*	*colour*	*baseline*	*neutral*	*negative*	*positive*
Red					Yellow				
Blue					Green				
Green					Black				
Black					Blue				
Yellow					Green				
Yellow					Red				
Black					Yellow				
Green					Black				
Blue					Blue				
Red					Blue				
Black					Yellow				
Blue					Black				
Yellow					Red				
Red					Green				
Green					Black				
Yellow					Red				
Green					Yellow				
Blue					Green				
Black					Blue				
Red					Red				
Black					Black				
Red					Yellow				
Blue					Blue				
Yellow					Green				
Green					Red				
Black					Blue				
Red					Black				
Green					Yellow				
Blue					Green				
Yellow					*TIME*				
Red					*ERRORS*				

Appendix 1.16

Psychometric Properties of Measures

The Hospital Anxiety and Depression Scale (HADS)

In relation to internal consistency, item subscale correlations found significant associations of between 0.76 and 0.41 for the anxiety scale, and between 0.60 and 0.30 for the depression scale. Cronbach alpha was found to be 0.93 for the anxiety scale and 0.90 for the depression scale. Test re-test values were also robust; depression scale (r = 0.92) and anxiety scale (r = 0.89).

The National Adult Reading Test (NART)

The NART test manual reports a high spilt half reliability (0.93) for the NART. High levels of inter-rater (0.96-0.98) and test re-test (0.98) reliabilities have been reported.

The Peters et al. Delusions Inventory (PDI)

PDI shows robust internal reliability value (cronbach alpha; 0.82).

Robson Self-Concept Questionnaire (RSCQ)

Internal reliability of items using three methods (split half, cronbach alpha and Intraclass correlation) gave robust reliability values (.89 - .96). Test re-test values were also robust (r = >.87). Convergent validity with the most widely used self-report measure of self-esteem the Rosenberg Questionnaire was also high (r = .80 - .85). Comparison using an 8-point visual analogue scale along which patients estimated their global self-esteem was also high (r = .7). The measure also displayed discriminant validity and sensitivity in comparisons between depressed and anxious, anxious and controls and anxious patients before and after treatment.

Attributional Style Questionnaire parallel form (ASQpf)

Convergent validity with the ASQ found moderate correlations for the negative events for attributional style, stability and globality, and which reached adequate levels assuming reasonable concurrent validity (Fallowfield, 1993). A significant moderate correlation was also found between the ASQ and ASQpf self-serving bias scores (r = .5, p = <.001). The positive events subscale displayed significant but poor correlations (r = .21 - .30) with the ASQ. However, the ASQ has been criticized for poor reliability (Kinderman & Bentall, 1996), and therefore this may be a reflection of the poor psychometric properties of the ASQ by comparison to the ASQpf, which appears to have undergone rigorous development procedures.

Subsequently, the ASQpf has been used by other researchers (Krstev, Jackson & Maude, 1999).

Section 2

Literature Review

Sex offenders who experience persecutory delusions: Causal Attributions and Self-Esteem

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Literature review written in the style appropriate for 'The Journal of Sexual Aggression'. For authors instructions see appendix 2.2.

Summary

Due to the limited research investigating mentally ill sex offenders it would seem that research from the general psychosis field may have something to offer, specifically the work on attributional style and self-esteem in individuals with persecutory delusions. Therefore, the review begins with definitions and prevalence rates followed by a review of the literature on mentally ill sexual offenders. As outlined above this area of research is extremely limited so to further understanding of mentally ill sex offenders, literature on individuals with persecutory delusions, specifically attributional style and self-esteem will be presented. Finally, research on attributions and self-esteem in sexual offenders will be reviewed. The literature review concludes with implications for future research and clinical interventions.

Keywords: mentally ill sex offenders; sex offenders; persecutory delusions; attributional style and self-esteem.

Introduction

The majority of people experiencing severe and enduring mental illness have no history of offending or violence, and pose no significant threat to others. The MacArthur Violence Risk Assessment study (Steadman, Mulvey, Robbins, Appelbaum et al. 1998) investigated the rate of violence by former mentally ill inpatients compared to the rate of violence displayed by members of the community. The study found the prevalence of violence among people discharged from hospital was the same as their counterparts in the community. The acts of violence (e.g. hitting), the target (e.g. family member) and the location (e.g. at home) were not significantly different within the two groups. The factor that increased the risk of violence in both groups was the presence of substance abuse. However, there is some evidence for a small but significant link between schizophrenia and violence towards others (Swanson, Holzer, Ganju *et al.*, 1990; Link, Andrews and Cullen, 1992). Phillips, Heads, Taylor and Hill (1999) argue that over previous years research investigating the topic of dangerousness and schizophrenia has been substantial, in contrast to the stark lack of research examining people with schizophrenia who commit sexual offences or who display antisocial sexual behaviour. Although it is generally acknowledged that this group of individuals are few and far between, when compared to the general population of sex offenders the possible link between schizophrenia and sexually violent offending frequently gives rise to public concern. Phillips *et al.* (1999) illustrates this point by citing national newspaper descriptions such as "psychotic sex killer sent to Broadmoor" (Independent, 1995). Such sensationalist headlines can create a distorted public perception of the association between sex offending and mental illness, especially within a climate of public concern regarding the effectiveness and safety of community care.

Due to the limited research investigating mentally ill sex offenders it would seem that research from the general psychosis field may have something to offer, specifically the work on attributional style and self-esteem in individuals with persecutory delusions. This body of research has developed over the past ten years and led to the development of theoretical models and implications for treatment (e.g. Kaney and Bentall, 1989; Lyon, Kaney and Bentall, 1994). Therefore, the review begins with definitions and prevalence rates followed by a review of the literature on mentally ill sex offenders. As outlined above this area of research is extremely limited and so to further understanding of mentally ill sex offenders, literature on individuals with persecutory delusions, specifically attributional style and self-esteem will be presented. Finally, research on attributions and self-esteem in sexual offenders will be reviewed. The literature review concludes with implications for future research and clinical interventions.

Definitions

Attribution

Attributions are the causal explanations that people use in order to attempt to understand why events happen to them (Addington, Addington and Robinson, 1999). Internal attributions signify causes within the person and external attributions indicates causes outside of the person. In general, people use a combination of the two. Within the general population, when an individual attributes negative events externally this is referred to as a self serving bias, and is thought to function as a way of maintaining positive self esteem.

Self esteem

The term self-esteem has been well defined by Robson (1989) as: *"The sense of contentment and self acceptance that results from a person's appraisal of his own worth, significance, attractiveness, competence, and ability to satisfy his aspirations." (Robson, 1989 pg. 514).*

Sex offenders

Throughout this review the term 'sex offender' refers to a broad range of individuals who have been convicted of one or more of the following offences; heterosexual and homosexual rape or sexual assault against adult victims, familial and non-familial sexual offences against child victims, exhibitionism, voyeurism and any other acts which would be encompassed by the term 'paraphilia' (American Psychiatric Association, 1994).

Persecutory delusions

There has been much controversy concerning the definition and diagnosis of delusions (Bentall et al., 2001). Within DSM-IV defines delusions as *'fixed, false beliefs, held with absolute conviction and not amenable to reason'* (American Psychiatric Association, 1994). Garety and Freeman (2000) have developed operational criteria for classifying a delusion as persecutory, arguing that the imagined perpetrator must clearly intend to cause harm to the individual. Throughout this review persecutory delusions will be defined as above.

Prevalence

Persecutory Delusions

Persecutory delusions have received more attention than other kinds of abnormal beliefs. This may be because they are very commonly observed in clinical practice (Bentall *et al.*, 2001). Garety, Everitt, and Hemsley (1988) found that persecutory delusions were the most common, with 35.2% of their sample of 55 psychiatric patients experiencing them. Jorgenson and Jensen (1994) found that 37 of 88 deluded patients had persecutory beliefs. The exact number of individuals with persecutory delusions is unclear. However, it is generally accepted that these are the most common type of delusion.

Sexual Offending

The total number of sexual offences recorded in 2000/2001 was 37311 (Home Office, 2001). This figure has consistently risen over the past 6 years, by an average of 2,000 each year. The total number of recorded rapes in 2000/2001 was 7929, gross indecency with a child was 1336, and indecent assaults on females were 20301 (Home Office, 2001). All of these recorded statistics have increased every year.

Mentally ill sex offenders

Although the numbers of recorded sexual offences are a matter of record, it is unclear how many of those are committed by mentally ill sex offenders. However, approximately 10 per-cent of all restricted inpatients detained under the legal classification of mental illness have been convicted of an index sexual offence(s) (Home Office, 1997).

Mentally Ill Sex Offenders

As stated earlier, the study of sex offenders who experience psychotic symptoms appears to be an area that has received little empirical study. Smith and Taylor (1999) examined the relationship of mental illness and psychotic symptoms to sexual offending. They examined Home Office records for 84 men, who were all inpatients on restriction orders with a diagnosis of schizophrenia. This review of records showed that at the time of their offences, 80 were considered psychotic and half of them were experiencing delusions or hallucinations related to their offences.

Sahota and Chesterman (1998) found similarities between mentally ill sex offenders and non-mentally ill sex offenders in relation to cognitive distortions regarding their offences. However, the mentally ill sex offenders displayed lower self-esteem than the non-mentally ill group. In 1998, Chesterman and Sahota examined 20 mentally ill male sex offenders, which included 12 men with a diagnosis of schizophrenia who were viewed by psychiatrists as being psychotic at the time of their offence. Seven of the 12 men admitted experiencing psychotic symptoms such as hallucinations and delusions at the time of their offences but felt that these symptoms were not directly related to their offending behaviour. It was reported that the mentally ill sample as a whole, had higher levels of sexual obsession, sexual dysfunction, cognitive distortions and faulty knowledge as examined by questionnaires (Sahota and Chesterman, 1998).

Murrey, Briggs and Davis (1992) reviewed the records of 106 special hospital patients who were convicted sexual offenders. The study compared those with a legal classification of mental illness (n=32), psychopathic disorder (n=36), and learning

disability (n=35). They found that the mentally ill group and 'psychopathic' were similar in regard to the type of victim(s), who were predominantly female with the largest proportion being pubescent and (particularly in the mentally ill group) adult females. Another finding indicated that more 'psychopathic' offenders than mentally ill or learning disabled had a history of violence during at least one sexual assault. The 'psychopathic' group also had nearly three times the amount of convictions for sexual offences as compared to the mentally ill group. However, Murrey *et al.* highlight the limitations of relying on secondary information sources (e.g. hospital records and notes).

Smith (2000) explored the motivations underlying sexual offending against women by men with psychosis. Smith applied the Massachusetts Treatment Centre Rapist Typology Version 3 (MTC:R3) to the case notes of 80 restricted mentally ill sexual offenders. Smith discovered that the primary motivations for sexual offending based on the MTC:R3 were: sexual (54%); opportunistic (29%); vindictive (11%); and passively angry (6%). Smith advocates the use of a structured classification system such as the MTC:R3 to provide a basic framework to inform clinical opinion regarding the overall factors and patterns of behaviour, which may be relevant to this client group.

The unclear evidence regarding the exact relationship between active psychotic symptoms and sexual offending has been highlighted by Phillips *et al.* (1999). Craissati and Hode's (1992) descriptive account of 11 psychotic offenders convicted of sexual offences suggested a complex relationship between illness and offending. Four of the 11 cases (of which 10 had a diagnosis of schizophrenia) had no previous contact with mental health services but did display acute psychosis shortly before or soon after

committing the offence. Although the remainder of the sample (n=7) possessed a previous psychiatry history, only one client was in touch with services and on medication at the time of their offence. Craissati and Hode argue that in their sample there was clear evidence of relapse, prior to the offence, in three of the cases. Most offences appeared to have been impulsive and to have occurred during the early onset of their illness, when inhibitory controls break down.

A number of researchers have attempted to explore whether sexual offending is more directly associated with specific symptoms such as delusions or hallucinations. In 1992, Jones, Huckle and Tanaghow attempted to examine whether sexual offending within a mental health population was linked to command hallucinations. They described 4 cases of clients with schizophrenia who had committed sexual assaults whilst reportedly experiencing auditory command hallucinations.

Phillips *et al.* (1999) investigated 15 men with a diagnosis of schizophrenia who had committed a sexual offence. They investigated the neuropsychological functioning of these clients and provided descriptive factors regarding their offending from their medical records. The majority of these men appeared to be experiencing symptoms at the time of their offence(s), with ten of the men suffering from active persecutory delusions. The findings revealed that the clients with a history of sexual violence perceived themselves to have particular difficulties in forming close relationships. The clients were found to display neuropsychological impairments, which were consistent with non-forensic patients with schizophrenia, but no significant differences were observed between patients with sexual offences or antisocial sexual behaviour and

seriously violent but nonsexual offending peers on a range of different tests, including those believed to have a sensitivity to possible disinhibition.

Persecutory Delusions

Attributional Style

A number of authors have attempted to use attribution theory to explain persecutory delusions. Kaney and Bentall (1989) gave deluded, depressed and normal controls the Attributional Style Questionnaire (ASQ; Peterson, Semmel, von Bayer, Abramson, Metalsky and Selgiman, 1982). This questionnaire requires participants to generate likely causes for a number of hypothetical events, which are divided into positive and negative occurrences. Having generated causal statements, the participants are then asked to self-rate these statements on scales on internality (i.e. the degree to which the events are attributed to the self or external causes), stability (i.e. the degree to which the causes are likely to be present in the future) and globality (i.e. the degree to which the causes are likely to influence other areas of their life in addition to the specific event in the questionnaire). When the ratings on the ASQ were evaluated it was found that the deluded group made excessively external attributions for the negative events and excessively internal attributions for the positive events. This was completely in contrast to the depressed group who made excessively internal attributions for negative events and excessively external attributions for positive events.

A follow-up study conducted by Lyon, Kaney and Bentall (1994) expanded on the above study by giving individuals with persecutory delusions, depressed and normal controls a covert attributional style measure. In this opaque test, the Pragmatic Inference

Task (PIT; Winters and Neale, 1985) participants are presented short hypothetical stories describing successful or unsuccessful outcomes involving themselves (e.g. they set up a dry cleaning business which is successful). Following each story participants have to answer a number of multiple choice questions, including one which requires them to make an attributional inference based on the ambiguously worded information in the story (e.g. they have to decide whether their business did well because they had no competition or because they have good business sense). Lyon et al. also administered a version of the ASQ (ASQpf), which replicated Kaney and Bentall's (1989) original finding of a high self-serving bias in participants with persecutory delusions. However, on the PIT the same individuals with persecutory delusions, like the depressed group, made more internal attributions for negative events than for positive events. So, when requested to make implicit judgements on the PIT, participants experiencing persecutory delusions tended to blame themselves for negative outcomes. However conversely, when asked to make explicit attributions for blame via their responses on the ASQ, they had a strong tendency to blame others for negative outcomes. The attributional style of the persecutory delusional group on the PIT closely resembled those of the depressed group. Both groups displayed extreme external attributions for positive events and internal attributions for negative events, whereas the normal control group showed the opposite. The persecutory delusional group, however, showed a vast transition in attributional style between the two measures, changing from an extremely self-serving bias to an extremely self-disparaging bias according to the type of measure (overt or covert). This finding parallels similar studies with bipolar patients (Winters and Neale, 1985; Lyon, Bentall and Startup, 1999).

Garety and Freeman (1999) conducted a review of current research investigating delusions. They concluded that people with persecutory delusions, when presented with self-referent information, are particularly likely to perceive other people as responsible for negative events. Numerous studies have found clear evidence that individuals with persecutory delusions, when compared to depressed and non-depressed control groups show a bias to excessively externalise attributions for negative events.

Unlike previous studies (e.g. Kaney and Bentall, 1989) Candid and Romney's (1990) study examined the attributions of individuals who were paranoid (n=15), depressive (n=15) and individuals with both paranoia and depression (n=15). Using overt measures they found that the depressive group reported the lowest self-esteem, the paranoid group the highest, while the paranoid depressive group fell in between. The paranoid group tended to attribute positive events to themselves in contrast to the depressed group who attributed 'good' outcomes to external factors; again the paranoid depressive group fell in between. Conversely, the depressed participants were more likely to attribute negative events to themselves, and the paranoid and paranoid depressive groups were less likely to attribute negatives events internally. The paranoid group attributed 'good' events as internal, global and stable, with the opposite for bad events; the depressed group attributed good events as external, unstable and specific with the reverse for bad events. The paranoid depressive group were positioned between the two latter groups for good events.

Bentall and Kaney (1989) studied people with persecutory delusions, depressed and normal participants by administering an emotional Stroop task in which they were asked to name the ink colours of threat-related, depression-related and neutral words. They

found that the persecutory delusion group were specifically slower at colour-naming the threat-related words, showing that they were unable to avoid attending to those words. In a second study, Kaney, Wolfenden, Dewey and Bentall (1991) requested people with persecutory delusions, depressed and normal participants to recall stories, which either did or did not have threatening themes. They discovered that the group with persecutory delusions recalled less of the stories overall content but remembered more of the specifically threatening elements when compared to the normal control group. Further, Bentall, Kaney and Bowen-Jones (1999) asked individuals with persecutory delusions, depressed and normal participants to recall items from a list of threat-related, depression-related and emotionally neutral words. As expected the group experiencing persecutory delusions displayed a recall bias towards both the depression-related and threat-related words. The depressed group showed a recall bias towards only the depression-related words. This group of studies conducted by Bentall *et al.* suggest a pattern of information processing biases similar to those previously observed in individuals with depression. However, whereas the schemas underlying the biases in the depressed individuals related to negatively based material (Williams, Watts, MacLeod and Matthews, 1988), the biases underlying individuals with persecutory delusions also incorporate material relating to personal threat.

In order to explore whether people with persecutory delusions experience abnormalities in the processing of information relevant to self-concept (as observed in people with depressed mood; Sweeney, Anderson and Bailey, 1986). Kinderman (1994) employed the Stroop task, which accesses automatic cognitive processes. Kinderman assessed three groups of participants; 16 experiencing persecutory delusions, 16 diagnosed with depression, and 16 non-psychiatric controls. The study

revealed that for the people with persecutory delusions, there exists a specific attentional bias for information of relevance to the self-concept. This group displayed a pattern of interference with colour naming of personally descriptive words of both positive and negative content similar to those with depression. The time taken to name the colours differed between the three groups, with the two clinical groups taking significantly longer then the normal controls. These findings are similar to those found in previous studies (Kaney and Bentall, 1989) and may be seen as a general effect of the presence of psychiatric difficulties. The results appear to indicate that for individuals with persecutory delusions and depression, information relating to the self-concept is highly salient. More specifically, for both groups, negative (low self-esteem) words resulted in greater interference with colour naming than did positive words.

Sex Offenders

Marshall and Marshall (2000) argue that the origins of sexual offending grow from the offender's experience of poor quality childhood relationships with their parents. This poor relationship is believed to increase the probability of them experiencing sexual abuse or other childhood abuse, which can feed into the sexual fantasies they develop. A central tenet of these experiences is low self-esteem and a lack of confidence regarding relationships. Marshall and Marshall argue that these individuals tend to masturbate more frequently in adolescence than their peers and associate fantasising and masturbation as a way of coping with stress and their view of themselves. These high levels of masturbation, combined with their lack of confidence about relationships, increases the likelihood that sexual fantasies will incorporate elements of control and power and will become more deviant over time. These factors can create a disposition to

offend that will be acted out only when the male's social constraints are disinhibited and he is presented with the opportunity to offend.

Sex Offenders: Attributional Style

It is widely reported that denial and minimisation are commonly observed in sex offenders (Marshall, 1994). Barbaree (1991) conducted one study that specifically investigated the occurrence of denial and minimisation in sex offenders. He reported that 66% of the convicted sex offenders against children studied denied their offences and a further 33% minimised their responsibility. Similarly, 54% of rapists interviewed denied and 42% minimised their offences. Based on these findings, Barbaree (1991) proposed that sexual offenders present three distinct types of denial: - (i) denial of the offence taking place; (ii) admission that sexual relations took place with the victim but denial that this was an offence, for example claiming that the victim was a willing consenting partner; and (iii) admission that physical contact occurred but denial that the contact was sexual. Barbaree further reported that sex offenders frequently minimise their offence, for example by reporting a reduced number of offences than occurred in reality, in order to reduce perceived culpability.

A study by Kennedy and Grubin (1992), in which they interviewed 102 incarcerated sex offenders, concluded that four groups of offender exist based on their 'pattern of denial'. The groups are: - 1) rationalisers – offenders who admit to the offence but deny that any harm was caused; 2) externalisers – offenders who attribute responsibility for the offence to external factors or other individuals, including the victim; 3) internalisers – these offenders attribute the offence to a 'temporary aberration of behaviour or mental state which was out of their normal character'; and 4) 'absolute denial' offenders.

Gudjonsson and Petursson (1991) reported that although sex offenders are more likely to express guilt and remorse for their offence than offenders against property, they also have a greater tendency to attribute the cause of their offences to internal, mental or external factors. However, this study did not indicate whether these external attributions were associated with a specific subtype of offence, for example if rapists were considered to be equally as likely to make external attributions as non-familial sex offenders against children.

A report commissioned by the Home Office (STEP; Beckett, Beech, Fisher and Fordham, 1994) evaluated seven sex offender treatment programmes based in the community. Prior to treatment, offenders completed the Adult Nowicki-Strickland Internal-External Locus of Control Scale (Nowicki and Duke, 1974). Forty four percent of the mixed sex offenders, across all programmes, were classified as external with regard to locus of control and only 28% of the offenders assessed believed that events were contingent upon their own behaviour. These findings have implications for treatment as it has been proposed that sex offenders who report external attributions for negative events (for example, their offences) will be less likely to acknowledge their need to change, show poor motivation in treatment and, ultimately, display limited improvement (Beckett *et al.*, 1994).

It has been proposed that external attributions for offences occur due to fear of punishment (Jackson and Thomas-Peter, 1994; Gocke, 1991). However, it could be argued that a self-serving bias where negative events (i.e. sexual offences) are attributed to external factors, and positive events to internal factors, may function as a

psychological coping mechanism to protect against negative affect and low self-esteem, as seen in delusional individuals (Bentall, Kinderman and Kaney, 1994). In support of this possibility, Graham (1993) argues that external attributions of blame found within sex offenders are more than denial or minimisation, but are in fact an almost 'delusional belief' in an external force.

Ward, Hudson and Marshall (1995) put forward a theory regarding the role of cognitions in sexual offending. They argue that offenders engage in a process of cognitive deconstruction related to events surrounding their offence(s). According to Ward *et al.*, cognitive deconstruction is a process in which, *"people attempt to avoid the negative implications of self-awareness in order to escape from the effects of traumatic or particularly stressful experience"* (p.71). When the individual is in a state of cognitive deconstruction, self-awareness is suspended and the person is typically focused on sensations in the here and now. Ward *et al.* believe that this suspension from self-awareness serves to help individuals reduce inhibitions and be more likely to violate their usual moral and personal standards.

In a study investigating the causal attributions regarding offending, sexual arousal and behaviour, McKay, Chapman and Long (1996) compared 50 convicted child sex offenders with 150 males convicted of criminal offences (rape against adults, property offences and violence). They found evidence that the different groups of offenders attributed their offending behaviour to differing causes and to different attributional dimensions. The child sex offenders were different to the other groups in that they reported approaching children in a sexual way either to have their non-sexual emotional needs for acceptance fulfilled, or because they found the children physiques sexually

arousing. Although some of these offenders labelled the source of their sexual arousal and subsequent offending as external (i.e. the children's bodies), they defined the effect of the children on their arousal system as being internal. Thus, child sex offenders attributed the causes of their offending behaviour and sexual arousal to internal, stable and uncontrollable dimensions.

A large proportion of rapists and violent offenders also reported that they fulfilled their emotional needs through offending. However, for the majority of these offenders the characteristics of their attribution dimensions differed from those of child sexual offenders. Rapists reported that the emotional needs their offending met were primarily sexual. Violent offenders viewed their offending as a way of achieving power, revenge and urges to be violent, whereas property offenders' emotional needs were the enjoyable elevated feelings associated with the excitement of offending. Violent offenders perceived their emotional needs as being powerful forces, which they experienced as internal, stable and uncontrollable, whereas, rapists and property offenders believed their emotional needs to be external to them, unstable over time, and controllable.

Sex Offenders: Self-esteem

For many years researchers have claimed that low self-esteem and sexual offending are related (Finklhor, 1984; Groth, 1979). Marshall, Anderson and Champagne (1996) reviewed extensive literature, which established that low self-esteem is a common factor in sex offenders.

Horley and Quinsey (1994) compared the cognitions of three groups: child molesters, offenders without sexual offences, and non-offending men living in the community. The findings suggested that overall relatively few differences were found among the three groups. However significant differences were found between child molesters and non-molesters in relation to their ratings of themselves, their ideal selves, women and spouses. Horley and Quinsey believed that the child molesters might have been displaying a negative self-image when describing themselves as less seductive, sexy, and erotic in addition to feeling softer and dirtier, compared to non-sex offenders. This finding lends support to Marshall and Barbaree's (1990) observations that child molesters exhibit lower self-esteem.

In addition to research implying that low self-esteem is present in sex offenders, many studies have shown a clear association between low self-worth and other factors linked to offending. For example, Marshall, Hudson, Jones and Fernandez (1995) found that sex offenders possess deficits in empathy, and Hutton (1991) found that offenders with low self-esteem have difficulty empathising with others.

Marshall *et al.* (1999) believe that the relationship between low self-esteem and poor empathy skills may be a result of more general difficulties in social competency. Bausmeister (1993) described the difficulties that individuals with low self-esteem have in social relationships. Specifically, sex offenders frequently experience problems in their interactions and relationships with others (Marshall, Barbaree and Fernandez, 1995; Stermac, Segal and Gillis, 1990). Seidman, Marshall, Hudson and Robertson (1994) found that sex offenders report more loneliness and a greater lack of intimacy compared to violent offenders and control groups.

Marshall *et al.* (1999) argue that the cognitive distortions frequently presented by sex offenders (Ward, Hudson, Johnston and Marshall, 1997) may be related to their self-esteem. These cognitive distortions represent the offenders' use of "self-serving biases", which are commonly displayed by all individuals (Bradley, 1978; Miller and Ross, 1975; Zuckerman, 1979). These cognitive biases allow individuals to interpret their own behaviour, events and the actions of others in a way that reinforces their view of themselves. Information that opposes a person's view of himself or herself will be interpreted as threatening, particularly by those with low self-worth. Self-serving biases protect individuals with low self-esteem by allowing them to maintain a tolerable self-evaluation, even though this is often negative. In relation to sexual offenders these self-serving biases may take the form of their attempts to deny and minimize the nature and severity of their offences (Barbaree, 1991; Marshall, 1994). These cognitive distortions serve to attempt to protect the offender against negative appraisals by others, and in this sense they also serve to boost the fragile self-esteem these men possess.

Implications and Future Research

The above literature review highlights the lack of empirical research into the area of mentally ill sex offenders. The studies that have been conducted have tended to be derived from patients' notes and Home Office records, or from qualitative studies with very small numbers. To date, no study has included face-to-face measures with this clinical population.

The review presents research from the areas of psychosis and sex offending. Studies investigating attributional style in sex offenders have predominantly focused on the attributions offenders display in relation to their offending behaviour. No study has explored the general attributional style of this group and compared it to a non-offending population.

The current treatment of choice for sex offenders is a cognitive behavioural approached delivered in a group setting. The core treatment programme developed by the prison service (HM Prison Service, 2000) actually has 'mental illness' as an exclusion criterion. This obviously has huge treatment implications for mentally ill sex offenders, if the treatment of choice excludes them. This highlights the importance of more systematic research aimed at understanding the complex relationship between mental health problems and sexual offending in order to adapt the currently available treatments.

It could be hypothesised that the presence of persecutory delusions in sex offenders may be an additional risk factor for offending, rather than a causal component. Again, in relation to treatment this would seem an important factor to unravel in relation to offending.

Given the lack of research with this group, an important initial starting point for developing research may be to apply theories and findings from work with psychotic populations; in order to explore whether mentally ill sex offenders have similar attributions and self-concept.

Appendix 2.1

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Appendix 2.2

Authors Instructions

AIMS

The Journal of Sexual Aggression is devoted to theory, research and the dissemination of information regarding all forms of sexual aggression, taking into account the abuser's age, gender, culture and sexual preference. The editors welcome the opportunity to consider occasional papers on the prevention or impact of sexual aggression upon victims, other family members and carers, judicial and social policy responses, as well as reviews, information and abstracts enabling an increased understanding of sexual aggression. Priority will be afforded to articles containing original material which describe practice or research in depth, within defined theoretical perspectives and professional context.

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NOTES FOR CONTRIBUTORS

Papers may be theoretical, empirical or review articles. They will usually be no longer than 6000 words although, where merited, longer submissions will be considered. Shorter articles on research findings, methods and techniques, or book reviews and commentaries are also invited. Manuscripts are welcomed from any country although the language of the journal is British English.

All contributions will be anonymously reviewed by members of the Editorial Board or Panel of Reviewers drawn from clinicians, practitioners, managers, researchers and academics who have made a significant contribution to this area of work. Decisions regarding publication will be made by the Editors with advice from the Editorial Board, with feedback provided to authors on decisions taken.

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Submission of Manuscripts

Manuscripts must be typed, double spaced throughout, on A4 paper, allowing 4 cm minimum margins. Either British or American orthography is permitted, but usage must be consistent. The approximate number of words should be stated.

Authors should supply three paper copies of their manuscript. An additional copy should be retained by the author(s). The manuscript title should be brief and indicate the main

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Authors' names should be given in full on a separate sheet, with an indication of present post (and previous post if relevant to the article). Authors should provide brief details (up to 50 words) of professional autobiography. Authors' address, telephone, fax and e-mail details should be included. Where there are two or more authors, a single contact for correspondence and proofs should be indicated.

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This journal uses the Harvard system of referencing. References should be indicated in the text by putting in brackets the author's name and year of publication. References should then be listed in alphabetical order at the end of the article. Authors MUST follow the publishers' house style for punctuation and use of upper and lower case letters and italics as in the examples below:

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Articles:
Finkelhor, D. and Baron, L. (1986) Risk factors for child sexual abuse. *Journal of Interpersonal Violence*, 24, 2, 43-71

Edited Books:
Finkelhor, D. and Russell, D. (1984) Women as perpetrators. in D. Finkelhor (ed) *Child Sexual Abuse: New theory and research.* New York: Free Press

Only works actually cited in the text should be included in the references.

Publications from the same author in a single year should use a, b, c etc. Where there are more than two authors the reference within text should be cited as et al, e.g. (Smith et al, 1928), and the names of all authors should be included in the reference list. Spelling in the reference list should follow the original.

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Footnotes are not normally permitted but endnotes may be used if necessary. Tables should be laid out clearly and supplied on separate pages, with an indication within the text of their approximate location. Vertical lines should be omitted, and horizontal lines limited to those indicating the top and bottom of the table, below column headings and above summed totals. Totals and percentages should be labelled clearly.

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Section 3

Research Paper

Attributional Style and Self-Concept in Sex Offenders with Persecutory Delusions

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Research paper written in the style appropriate for 'The Journal of Abnormal Psychology'. For authors instructions see appendix 3.2.

Abstract

To date no study has explored persecutory delusions in people who commit sexual offences, and whether attributional style and self-concept are any different between sex offenders with and without persecutory delusions. The current study aimed to explore the relationship between attributional style and self-concept in men with persecutory delusions who commit sexual offences. Sex offenders with persecutory delusions (n = 14), sex offenders without delusions (n = 12) and normal controls (n = 14) were compared on implicit and explicit measures of attributional style and self-esteem. The three groups were found to have similar attributional styles and levels of self-esteem and no significant differences were found between the three groups. The discussion focuses on possible explanations for these results. Limitations of the study are discussed together with future implications for research and treatment of mentally ill sex offenders.

Introduction

Approximately 10 per-cent of all restricted inpatients detained under the legal classification of mental illness have been convicted of an index sexual offence(s) (Home Office, 1997). However, a review of the literature concerning sexual offending in the context of mental illness confirmed that there has been very little empirical study of this group. Smith and Taylor (1999) examined the relationship of mental illness and psychotic symptoms to sex offending in men with a diagnosis of schizophrenia. They examined Home Office records for 84 men, all of whom were inpatients on restriction orders with a diagnosis of schizophrenia and convictions for sexual offending. This review of records showed that at the time of their sex offences, 80 were considered psychotic and half of them were experiencing delusions or hallucinations related to their offences.

Sahota and Chesterman (1998) found similarities between mentally ill sex offenders and non-mentally ill sex offenders in the extent of cognitive distortions regarding their offences. The mentally ill sex offenders, however, displayed lower self-esteem than the non-mentally ill group. Craissati and Hode's (1992) descriptive account of 11 psychotic men convicted of sexual offences suggested a complex relationship between illness and offending. Most offences appeared to have been impulsive and to have occurred during the early onset of their illness, when inhibitory controls break down.

In 1998, Chesterman and Sahota examined 20 mentally ill, male, sex offenders. This included 12 men with a diagnosis of schizophrenia who were viewed by psychiatrists as being psychotic at the time of their offence. Seven of the 12 men admitted experiencing psychotic symptoms such as hallucinations and delusions at the time of their offences

but felt that these symptoms were not directly related to their offending behaviour. It was reported that the mentally ill sample as a whole, had higher levels of sexual obsession, sexual dysfunction, cognitive distortions and faulty knowledge as examined by questionnaires (Sahota & Chesterman, 1998).

A number of authors have attempted to use attribution theory to explain persecutory delusions. Kaney and Bentall (1989) compared attributional styles of depressed and delusional individuals. The ratings for both groups illustrated excessively global and stable attributions for negative events. However whereas the depressed individuals' attributions were excessively internal for negative events and excessively external for positive events, the delusional participants' attributions were overly external for negative events and overly internal for positive events.

A follow-up study conducted by Lyon, Kaney and Bentall (1994) using implicit and explicit measures of attributional style, indicated that on implicit measures delusional individuals attributed negative events to internal factors more often than positive events. On the explicit measures the deluded group made excessively external attributions for negative events and internal attributions for positive events compared to controls. This study replicated the findings of previous research that deluded individuals showed a greater self-serving bias than either depressed or control participants on explicit measures of attributional style more than on implicit measures (Kaney & Bentall, 1989, 1992; Candido & Romney, 1990).

Purpose of present study

To date no study has explored persecutory delusions in people who commit sexual offences, and whether attributional style and self-concept are any different between sex offenders with and without persecutory delusions. The current study aimed to explore the relationship between attributional style and self-concept in men with persecutory delusions who commit sexual offences. The study compared responses to explicit and implicit measures of attribution and how this related to low self-esteem. Sex offender treatment groups are currently the treatment of choice; these groups have a large emphasis on cognitions and responsibility. The current study aimed to provide information regarding the attributional style of sexual offenders who experience persecutory delusions. It was predicted that sex offenders with persecutory delusions would display a greater self-serving bias than either non mentally ill sex offenders and control particpants on explicit measures of attribution more than on implicit measures. This information would be, potentially, highly relevant to facilitating sex offender groups with clients who have persecutory delusions.

Method

Participants

Three groups of participants were recruited for the study. The two clinical groups were inpatients in a high security setting who were identified by the patient care team and Responsible Medical Officer. The control group was gained from the community.

Group 1: Sex offenders with persecutory delusions (SOPD)

The initial number of patients identified for SOPD was 30. Patients were excluded on the basis of having no conviction for a sexual offence (n = 4) and co-morbidity (n = 3). Ten participants refused to participate in the study. Therefore, the SOPD group

comprised 14 male inpatients who had a diagnosis of schizophrenia, schizophrenifrom, schizoaffective disorder or psychosis and were recorded as displaying persecutory delusions. These patients all had convictions for sexual offending. None of these patients had completed a sex offender treatment group, as one of the fundamental aims of sex offender treatment groups is to challenge and enable patients to re-evaluate their cognitions and attributions regarding their offending behaviour.

Group 2: Sex offenders (SO)

The initial number of patients identified for the non-persecutory delusions sex offender group was 28, of these 10 declined to participate and 6 were excluded on the basis of having no conviction for a sexual offence. The SO group comprised 12 male inpatients, all of whom had convictions for sexual offending. These patients did not have a diagnosis of schizophrenia, schizophreniform, schizoaffective disorder and did not display delusional ideation. These patients all had convictions for sexual offending. None of these patients had completed a sex offender treatment group, as one of the fundamental aims of sex offender treatment groups is to challenge and enable patients to re-evaluate their cognitions and attributions regarding their offending behaviour.

Group 3: Control group

Group 3 (C) comprised 14 male non-patient controls, who were recruited via informal contacts.

The groups were found to be matched for age and IQ as assessed by the National Adult Reading Test (NART; Nelson, 1991), a brief measure of verbal intelligence based on the correct pronunciation of English words that are spelt in a non-phonetic manner

(e.g. depot, chord). A number of participants (n=5) were illiterate so were unable to complete the NART, these participants were also unable to complete the Stroop task.

The SOPD group mean age was 46 years (SD=11.08, range 29-68 years), and their full scale IQ was 115 (SD=9.17, range 100-126). All were restricted patients in a High Secure Hospital; mean length of stay was 11.3 years (SD=6.84, range 1-24 years). Five were convicted of indecent assault on a female, 2 had convictions for indecent assault on a child and 7 had conviction for rape. The mean age of the SO group was 42 years (SD=12.24, range 31-69 years) and their full scale IQ was 116 (SD=7.15, range 105-127). All were restricted patients in a high secure Hospital; mean length of stay was 12 years (SD=4.11, range 4-18 years). 5 were convicted of indecent assault on a female, 6 had convictions for indecent assault on a child and 1 had a conviction for rape. All were diagnosed with a personality disorder. The control groups mean age was 42 years (SD=5.12, range 33-52 years), and their full scale IQ was 115 (SD=7.19, range 101-127). All were recruited from the community. All were employed by the NHS or by Social Services and thus all had undergone a criminal records check. None, therefore, had to date received a conviction for sexual offending.

Measures

In addition to the NART, six measures were administered. These measures can be divided into three categories; screening measures, explicit measures, and implicit measures.

Screening Measures. The Peters et al. Delusion Inventory (PDI; Peters, Day & Garety, 1999) is a 21-item questionnaire, which is designed to measure delusional

ideation in the normal population (it originated from the 40-item version of the questionnaire; Peters, Joseph & Garety, 1999). The multidimensionality of delusions is incorporated by including measures of distress, preoccupation and conviction. For each item, the participant scores 1 if the belief is endorsed, and 0 if the belief if not endorsed. If the belief is endorsed, the participant is asked to rate on a scale of 1 to 5 the degree of distress, preoccupation and conviction with which the belief is held. The final score is the sum of the scores for each item. The range of possible scores is 0-336, where higher scores are associated with greater delusional ideation.

The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) was developed for the assessment of anxiety and depression in medical outpatient populations. It has also been used with psychiatric samples and more recently among people with psychosis (Chubb & Bisson, 1996; Hardy, et al., 1999). The HADS includes 14 items (7 anxiety, 7 depression). Each item is scored on a 4-point scale, ranging from the absence or the presence of positive features (scoring 0) to the presence of maximum symptomatology or the absence of positive features, which score 3. The HADS is a self-report measure and takes approximately 5 minutes to complete.

Explicit Measures. These measures allow the participants to recognise what concept is being assessed and to answer according to the image they wish to present. Using explicit measures in conjunction with implicit measures is a useful way to highlight discrepancies between responses.

Two explicit measures were used, one measuring attributional style and the second assessing self-esteem. The Attributional Style Questionnaire – parallel form (ASQpf;

Lyon, Kaney and Bentall, 1994) is based on the original Attributional Style Questionnaire (ASQ) developed by Peterson, Semmels, Von Baeyer, et al, (1982). But was designed as a parallel form of the implicit measure used in this study (see below). The ASQ-pf comprises 12 items (6 positive and 6 negative). Participants are required to generate possible causes to hypothetical events involving themselves that are either positive (e.g. you pass someone who smiles at you), or negative (e.g. your steady romantic relationship ends). After generating causes for each event, participants are asked to self-rate their causal statements on three 7-point scales for internality vs. externality, stability vs. instability, and globality vs. specificity. The ASQpf has been used by other researchers (Krstev, Jackson & Maude, 1999). A recent commentary review by Garety and Freeman (1999) indicates that the use of the ASQpf alongside the PIT is a valid approach for assessing attributional style by comparative overt and implicit measures.

The Robson Self Concept Questionnaire (RSCQ; Robson, 1989) consists of 30 items that represent five factors: (1) attractiveness, approval by others, (2) contentment, worthiness, significance, (3) autonomous self regard, (4) competence, self efficacy and, (5) the value of existence. The above items are based on a factor analysis of the whole questionnaire. Scoring is calculated on a 7-point likert scale with four anchors ranging from 'completely disagree' to 'completely agree'. Average completion time of the RSCQ is 10 minutes.

Implicit Measures. Implicit measures are developed to assess a given factor without the participant being fully aware of what is being measured. This aims to minimize the participant not completing the measure honestly or answering questions how they feel

the researcher would wish them to respond. These measures, therefore, have the advantage of allowing indirect measurement of factors such as attributional style or self esteem and provide data that has a higher validity.

The Pragmatic Inference Task (PIT; Winters and Neale, 1983) is a verbally administered implicit assessment of attributional style. The PIT can be delivered as a parallel form of the ASQ-pf, which allows for direct comparisons between the two measures. The PIT consists of 12 items, like the ASQ-pf, in the form of scenarios (6 positive and 6 negative). The PIT is presented as a test of memory with four responses to each item. The first items are a test of memory, but the final items require the participant to make a hypothetical attribution. Each story contains the implication of both an internal and external locus of causality. A PIT self-serving bias can be calculated by subtracting the number of internal responses for negative events from the number of internal responses for positive events.

The Emotional Stroop Test (EST; Stroop, 1935) has been developed to measure implicit beliefs about self-concept. The EST in the present study used the positive and negative words from the Self-Referent Incidental Recall Task (SPIRT, Bentall and Kaney, 1996). The SPIRT was based on similar tasks designed to study the role of self-schemata in depressed individuals (Hammen et al. 1985; Dent and Teasdale, 1988). The neutral words in the EST were taken from the EST used in a study by Lyon, Bentall and Startup (1999).

Participants are first presented with meaningless stimuli, in this case a row of X's, which are presented in colour blocks. Participants are asked to state the colour of each

block of X's. The task is timed and provides a baseline response time. The same colour order is repeated but this time using neutral words (handy, residential, currency, wooded, routine, specifically, lamp, tendency and metaphor). Participants are again asked to state what the colour of each word is, and this task is also timed. The final two trials involve presenting positive words (successful, entertaining, respected, important, optimistic, sociable, skilful, valuable and confident) followed by negative words (inferior, weak, pathetic, inadequate, worthless, useless, deficient, failure and stupid). Once more the individual is asked to state the colour of the word and again the task is timed. The task is not to attend to the words but to simply state the colour the word is printed in. The theory follows that participants will attend to words that hold greater emotional salience to them. This will lead to them taking longer to state the colours for the words in these lists. From this task it will be possible to evaluate positive and negative self-concept in an implicit manner.

Procedure

Following the completion of the consent form, tests were presented in the following order: the NART, the PDI, the HADS, the PIT, the EST, the RSCQ, and finally the ASQpf.

Results

Statistical analysis

A target number of 21 participants were sought for each group. This was based on a power requirement of 0.8 with a large effect size and significance of $p=0.05$[1]. In the

[1] This value is calculated from the tables quoted in Cohen's (1992) paper that details the sample sizes required to achieve power whilst also attaining a large effect size and a significance level of $p=0.05$ for analysis of variance ($n=21$).

current study the power requirement was not reached. Therefore, in order to minimise the potential of a Type I error, the significance level was restricted to 0.01 (Cramer, 1998).

Data screening

Tests for normal distribution and heterogeneity of variance were conducted. A Kolmogorov-Smirnov test was conducted that indicated all variables were normally distributed within the SOPD group. Within the SO group, all persecution items from the PDI were skewed at p=.002 as expected. All other variables, however, were normally distributed. Finally, within the control group all persecution items from the PDI were found to be skewed at p=.0007, with all remaining variables being normally distributed. This skew in data can be accounted for the fact that only the SOPD group reported persecutory delusions, whereas the SO and C groups did not report these symptoms.

Screening measures

<Insert Table 1 here>

One-way Analysis of Variance between groups for anxiety (F=.19, df-2, ns) and depression (F= .40, df=2, ns) indicated no significant main effects. HADS scores for the three groups are given in Table 1. The scores for all three groups fell within the 'normal' clinical cut off range (Zigmond & Snaith, 1983).

An ANOVA was conducted between groups for persecutory delusion total score indicated a significant main effect (F=18.02, df=2, p=<.001). A post hoc comparison demonstrated significant pair wise difference between SOPD and SO groups and

between control and mentally ill sex offender groups (see table 1 for groups mean scores).

Self–esteem (explicit measure)

One-way analysis of variance between groups for the total RSCQ score indicated no significant difference (F=1.79, df=2, ns).

Attributional style (explicit measure)

<Insert Table 2 here>

Group mean data for the ASQpf and the PIT are shown in Table 2. A two-way analysis of variance on the ASQpf internality scores indicated no significant effect between groups (F=2.85, df=2, ns). To explore whether there were significant differences in the self-serving biases, a one-way analysis of variance between groups was performed. No significant differences were found (F= .88, df=2, ns). Two-way ANOVA was performed on ASQpf stability scores, which indicated no significant main effects between the three groups (F= 2.07, df=2, ns). Finally, a two-way ANOVA was conducted on the ASQpf globality scores; again this revealed no significant differences in scores (F=2.07, df=2, ns).

Attributional style (implicit measure)

A two-way ANOVA similar to that carried on the ASQpf internality scores was conducted on the PIT data, which indicated the three groups did not differ significantly (F=2.60, df=2, ns).

Self-esteem (implicit measure)

<Insert Table 3 here>

Response times on the Stroop task are presented in Table 3. Comparisons between groups across each of the Stroop conditions using a three-way ANOVA indicated no significant main effects (F=3.57, df=2, ns).

Discussion

The results of the current study found no differences between the three groups in relation to self-esteem. The results on both the ASQpf and the PIT revealed no differences between the three groups and the data showed no excessive attributional styles as with previous studies (e.g. Kaney and Bentall, 1989; Lyon, Kaney and Bentall, 1994). None of the three groups exhibited self-serving biases on either the PIT or ASQpf and there was no differences observed on the EST. However the mean scores on the RSCQ reveal that the SOPD group scores were very low and were comparable to mean scores obtained from general psychiatric populations (Robson, 1989). Whereas the control groups mean total score was similar to that of a 'healthy' population, the SO group fell in between (Robson, 1989).

An interesting finding from the current study was the type of sexual offences that the two clinical groups had committed. The SOPD group predominantly committed offences against adult females whereas the SO group committed more offences against children. It is unclear from the present study why this might be the case, but it would appear important for the delivery of treatment to explore this issue further.

There appears to be an underlying view, from many clinicians based on clinical experience rather than empirical research, that in order to commit sexual offences individuals have a fundamental flaw in their personality (often diagnosed as some form of personality disorder). If this view is correct this may go some way to explaining why no differences were found between the two clinical groups in relation to general attributional style and self-esteem. Taking this view it could be argued that the fundamental factor in sexual offending is the offenders personality type/style, and that having a mental illness is an additional vulnerabilty rather than a causal factor. If this argument is endorsed it may explain why no differences were found between the two clinical group and the control group. In relation to general attributional style and self-esteem offenders in the current study presented as similar to non-offending groups. The three groups in the current study displayed similar mean scores to the control groups in previous attributional studies (Lyon, Bentall and Kaney, 1994). It may only be when assessed in relation to their offences that they display different attitudes, attributions and view of themselves.

Reviews of the psychometric properties of the parallel form Attributional Style Questionnaire (ASQpf), particularly the ASQ, have consistently highlighted the poor reliability of these measures (Reivich, 1995; Tennen & Herzenberger, 1985). More recently the internal reliability of the parallel form ASQ (and the PIT) have also been questioned (Krstev, Jackson & Maude, 1999). Unfortunately it is the internality dimension, which is of central importance to the current study, that is also the least satisfactory. Nevertheless the lack of viable alternatives has meant that these measures have continued to be used, as in the present study. A solution to the above difficulties

may be in the form of a novel measure developed by Kinderman and Bentall (1996). Their Internal, Personal and Situational Attributions Questionnaire (IPSAQ; Kinderman & Bentall, 1996) has good psychometric properties and has demonstrated reliable assessments of attributional style separate from the ASQ. The IPSAQ distinguishes between two types of external attribution, those that implicate situational factors and those that assess the actions of others. The IPSAQ specifically provides measures of externalising bias (the tendency to attribute negative rather than positive events to external causes) and personalising bias (the inclination to make personal-external as opposed to situational-external attributions for negatives events).

However, a recent commentary review by Garety and Freeman (1999) indicates that the use of the ASQpf alongside the PIT is a valid approach for assessing attributional style by comparative overt and implicit measures. Bentall (1999) discusses the inherent concerns with all measures that have been used in the field of research in psychosis. He advocates the need for researchers to continue to develop measures and work towards generic definitions regarding constructs such as self-esteem.

In relation the Pragmatic Inference Task (PIT) used in the current study, it is not clear whether participants took the self-reference aspect of the measure seriously or whether they understood it to refer to someone else. This may be particularly pertinent when considering the sample included in the present study in which the two clinical population were long stay forensic in patients (the mean length of time in a High Secure Hospital being 12 years). Thus, situations used in the measure may not have been personally relevant to participants.

Methodological problems such as small sample size are frequently encountered by researchers who attempt to contribute to research into psychosis (Garety & Freeman, 1999). Other limitations of this (and previous studies) include the practicalities of controlling for the effects of prolonged use and level of medication, or disorder chronicity and length of hospitalisation. Increased attention to the severity of negative symptoms in the mentally ill groups (given that the current battery of measures required substantial motivation and cognitive attention), or further screening for organic abnormalities might also be considered in future research (Krstev *et al.* 1999). If more time and resources were available, the inclusion of a psychotic non-offending group would have provided an interesting and useful comparison to the offending samples. However, since, every possible attempt was made to preserve the integrity of the restricted experimental design chosen, the difficulties encountered would not seem beyond those typical when working with research participants who experience a severe psychopathology.

It is appreciated that mentally ill sex offenders are complex individuals and the current research has only focused on one small group, namely sex offenders who experience persecutory delusions. The current research attempted to draw on a wealth of research into attributional style conducted with non-offending individuals with persecutory delusions. This research appeared particularly relevant to a forensic group as their attributions form part of the way they make sense of themselves and the world.

As already stated, so little research has been conducted with this group that the present study is a small step on which to build further research. Future research needs to address the limitations highlighted earlier. Research combining attributional measures

and offence-focused assessments may yield findings that could be translated into therapy. In relation to treatment, research should aim to identify whether any specific psychotic symptoms are more associated with sexual offending. There is a wealth of research citing the efficacy of cognitive behavioural therapy with psychosis (for review see Gould, Mueser, Bolton, Mays & Goff, 2001). The current treatment of choice for sexual offenders is cognitive behavioural group work. More knowledge about their symptoms and cognitions may help to tailor the standard sex offender treatment programmes by including psychosocial interventions aimed at ameliorating psychotic symptoms prior to offence work with a mentally ill sex offender group.

Table 1
Mean Scores (and Standard Deviations) of SOPD, SOG and C participants on the Hospital Anxiety and Depression Scale (HADS) and Persecution Sub-scale of the Peters et al. Delusion Inventory.

	Group					
	SOPD		SO		Control	
Measure	M	SD	M	SD	M	SD
HADS						
Anxiety	6.85	3.86	5.92	6.33	5.93	2.79
Depression	4.57	3.98	4.67	4.87	3.49	3.16
PDI						
Persecution Sub-Scale	0.93	0.62	0.08	0.29	0.07	0.27

Table 2
SOPD, SO, and C participants' Mean Attributional Style Questionnaire, Parallel Form (ASQpf) Internality, Stability, and Globality Scores, Together with the Pragmatic Inference Task (PIT) Internality Scores

	Group					
	SOPD		SO		Control	
Measure	M	SD	M	SD	M	SD
ASQpf						
Internality						
Positive	28.14	5.25	29.08	4.19	26.93	6.18
Negative	27.00	6.83	29.75	3.70	23.93	4.07
Stability						
Positive	31.21	5.60	29.67	3.97	28.79	5.27
Negative	25.43	5.72	24.67	4.60	25.36	3.20
Globality						
Positive	26.21	6.84	28.00	6.61	25.29	5.76
Negative	23.07	7.71	23.58	5.99	21.71	4.18
PIT						
Internality						
Positive	2.71	1.20	3.00	1.21	2.92	1.21
Negative	2.36	1.34	2.58	0.99	1.79	0.98

Table 3
Mean Scores (and Standard Deviations) of SOPD, SOG and C participants on the Emotional Stroop Test

	Group					
	SOPD		SO		Control	
StroopTime (seconds)	M	SD	M	SD	M	SD
Neutral words	73.66	30.52	73.83	33.52	51.14	7.20
Negative words	60.37	27.65	51.47	21.88	51.08	8.90
Positive words	65.05	26.65	58.20	30.23	50.09	5.97

Appendix 3.1

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Appendix 3.2

Authors Instructions

Journal of Abnormal Psychology

Manuscript Submission Guidelines

Mail manuscripts to the Editor:

Timothy B. Baker, PhD
Department of Psychology
University of Wisconsin—Madison
1202 West Johnson Street
Madison, WI 53706

Authors should submit three (3) hard copies of their manuscripts along with an electronic copy contained on a clearly labeled diskette. All copies must be clear, readable, and printed on paper of good quality. A dot matrix or unusual typeface is acceptable only if it is clear and legible. It is suggested that authors keep a copy of the manuscript to guard against loss. Manuscripts are not returned except on request.

In addition to postal addresses and telephone numbers, authors are requested to supply electronic mail addresses and fax numbers, if available, for use by the editorial and production offices.

Masked reviews are optional, and authors who desire a masked review must specifically request one when they submit their manuscript. For masked reviews, each copy of the manuscript must include a separate title page with the authors' names and affiliations, and these ought not to appear anywhere else in the manuscript. Footnotes that identify the authors must be typed on a separate page. Authors are to make every effort to see that the manuscript itself contains no clues to their identities.

Most of the articles published in the *Journal of Abnormal Psychology* are reports of original research, but other types of articles are acceptable. Short Reports of replications or of failures to replicate previously reported results are given serious consideration. Comments on articles published in the journal are also considered. Case studies from either a clinical setting or a laboratory will be considered if they raise or illustrate important questions that go beyond the single case and have heuristic value. Manuscripts that present or discuss theoretical formulations of psychopathology, or that evaluate competing theoretical formulations on the basis of published data, may also be accepted. Finally, the *Journal* will consider articles that present, explicate, or evaluate experimental or analytic methods of particular relevance to psychopathology. For further information on content, authors may refer to the Journal Description.

Authors must prepare manuscripts according to the *Publication Manual of the American Psychological Association* (5th ed.). All manuscripts must include an abstract that contains a maximum of 120 words typed on a separate sheet of paper. All copy must be double-spaced, and further typing instructions, especially in regard to tables, figures, references, metrics, and abstracts, appear in the *Manual*. Also, all manuscripts are copyedited for bias-free language (see chap. 2 of the *Publication Manual*). Original color figures can be printed in color

provided the author agrees to pay half of the associated production costs.

Papers will be published in six different sections of the *Journal:* Short Reports, Articles, Extended Articles, Case Studies, Commentaries, and Theories and Methods. In preparing a Short Report, authors should to set the character–space limit at 60 characters per line and should not exceed 410 lines of text and references (exclusive of the title page, abstract, author note, footnotes, tables, and figures). There should be no more than two figures or tables. For Short Reports, the length limits are exact and must be strictly followed.

Regular articles and papers addressing Theories and Methods should not exceed 36 manuscript pages (text and references). Extended papers are published within regular issues of the *Journal* (they are not free-standing) and are reserved for manuscripts that require extended exposition (beyond what is possible in the 36-page limit for Regular Articles). Typically, Extended Articles will report multiple experiments, multifaceted longitudinal studies, transdisciplinary investigations, or studies that are extraordinarily complex in terms of methodology or analysis. Case Studies and Commentaries ought not to exceed 18 manuscript pages.

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Section 4

Critical Review

Critical Review

Background

This study emerged from an interest on the part of the researcher in the areas of psychosis and sexual offending. The researcher had previously spent time working with both of these client groups and conducting research in the area of psychosis. Following a review of the literature examining mentally ill sex offenders the researcher was surprised to discover the lack of empirical studies with this client group. In one sense this was exciting, but in another it seemed almost overwhelming to decide what aspect of mentally ill sexual offenders to explore. This is where the researcher's previous experience and knowledge of research into the area of psychosis came into play, specifically the work on attributional style and self-esteem in individuals with persecutory delusions. A body of research has developed over the past ten years and led to the development of theoretical models (Kaney & Bentall, 1989; Lyon, Kaney & Bentall, 1994). As with all investigations into clinical populations that have not been systematically and empirically studied, researchers have to decide upon a starting point in which to increase understanding and structure interventions. Therefore, this appeared a logical place to initiate empirical research with psychotic sex offenders, using the methodology previously applied to a general psychosis sample. On the basis of this, the present study was initiated as a large-scale project for the doctoral course in clinical psychology.

Methodology

The current study was perceived from the outset as an exploratory study aimed at investigating the relationship of attributional style and self-concept in sex offenders who experience persecutory delusions. A further aim was to examine any differences in attributional style and self-concept between sex offenders with and without psychotic symptoms. A final aim was to examine any differences between overt and implicit measures of attributional style.

Recruitment

A significant amount of time was put into identifying potential participants, whilst also engaging and working with staff. As the research was conducted within a high security setting, a large number of professionals were involved with each individual patient, and this inevitably translated into a enormous amount of time liaising with the participant's staff group.

The recruitment of participants was conducted in a series of stages:

1. Meeting all RMO's in the hospital, presenting the research and asking them to nominate any of their patients who fitted the criteria but whom they also felt would be willing for them to be approached to take part in the research

2. Screen of named patients records to check that they had a conviction for a sexual offence and the nature of their clinical diagnosis

3. Liaise with each individual patient's primary nurse and ward manager to check whether they were happy for the researcher to approach the patient. Where requested the researcher also attended the patient's care team meeting (this was not requested in all cases)

4. Fifteen minute meeting with patient in order for the researcher to introduce herself and to explain the nature of the research (this approximately entailed 15 hours of face to face contact with patients)

5. One off meeting to complete measures lasting approximately 1 ½ to 2 hours (this approximately translated into 56 hours of face to face contact with participants)

The above process of recruiting participants had obvious implications specifically regarding time. A number of logistic issues had to be overcome such as fitting round the shifts of key workers and having to have adequate numbers of staff around to supervise meetings where it was identified that the patient posed a significant risk of violence. For this reason, the majority of testing participants was conducted in the evenings.

A significant issue for a number of the patients was confidentiality. This was a problematic area for a number of patients in relation to the level of risk they posed, as perceived by their care team. A number of patients (n=7) were deemed to be too 'risky' to be seen by the researcher alone and in these cases at least one member of staff needed to be present during the initial meeting and testing. This was a situation in which the

researcher had no control over, and obviously followed staff's advice. However, the implication was that a number of patients felt their responses would not be confidential due to the presence of staff and consequently refused to take part in the project.

Design

The inclusion criteria developed for the current study, namely that participants had a conviction for sexual assault, significantly limited the number of participants within the high secure setting who fitted the criteria. From initial meetings with clinicians, a large number of patient's names were put forward as potential participants. However many of these individuals had not been convicted of a sexual offence, even though the evidence suggested they had engaged in this type of offending (for example someone with a conviction for murder who had also raped their victim was found to have only been charged and convicted for murder). The above criteria also excluded patients who were known to have been actively sexually aggressive whilst in hospital (against staff and their peers), although no formal charges had been brought against them.

Another inclusion criteria was for participants not to have undertaken therapeutic work aimed at addressing their sexual offending behaviour. The high secure hospital has a long history of delivering sex offender treatment groups and has recently adopted the prison based core treatment programme. Due to this focused intervention of sexual offending, many of the patients within the hospital had already received this service. This severely limited the number of patients who could be included in the study. However, this left the researcher with an interesting groups of untreated and generally 'unengaged' individuals who predominantly choose not to engage with therapeutic activities and professionals (and for some reason particularly psychology). Therefore,

many of the patients identified as appropriate by clinicians for the study were unwilling to engage in research. The timing of the current study further hindered this, as another research project was also being conducting simultaneously, in addition to two larger studies over the previous three years which may have led to this group being over researched.

With hindsight the researcher questions whether the exclusion criteria was too strict on the issue of not approaching patients who had undergone offence-focused treatment. The initial rationale for not including this group was the large emphasis that sex offender treatment groups place on helping offenders re-evaluate and change the cognitions and attributions regarding their offending behaviour. When designing the current project it was felt that individuals who had undergone an intensive treatment programme may have 'altered' attributions and cognitions. However, the treatment specifically focuses on beliefs and behaviour relating to their offending and therefore may leave patients general attributional style intact. Research evaluating offenders post treatment has shown that patients self-esteem increases following treatment but their attributions regarding general life events that happen to them has not been assessed.

Sample

Due to the above factors, the sample was significantly smaller than had been proposed. However the sample consisted of a range of individuals from different backgrounds and across a wide range of ages. Due to the small number of participants, the observed sample demonstrated a wide variation in the offences participants had committed. If the initial sample pool had been larger it would have been interesting to explore attributional style and self-concept in relation to the type of offence that

individuals had committed, for example to compare child sexual offenders with adult sexual offenders.

Measures

The National Adult Reading Test (NART; Nelson, 1991) was adopted as a screening assessment for IQ. However a number of patients were found to be illiterate. One third of the SOPD group (n=4) were unable to complete the NART. In addition this meant that they were also not able to complete the Stroop task. An alternative measure of IQ could have been the Weschler Abbreviated Scale of Intelligence two form version (Jainjun, 1999). A full scale IQ can be estimated from administering two sub-scales, namely vocabulary and matrix reasoning that takes approximately 15 minutes to complete. This assessment would not have excluded those patients who were unable to read and write. In view of the sample being a forensic one, in which one of the common factors associated with criminal activities is disruptive schooling (Farrington, 1990), the above alternative measure may have held more face validity for participants.

Reviews of the psychometric properties of the parallel form Attributional Style Questionnaire (ASQpf), particularly the ASQ, have consistently highlighted the poor reliability of these measures (Reivich, 1995; Tennen & Herzenberger, 1985). More recently the internal reliability of the parallel form ASQ (and the PIT) has also been questioned (Krstev, Jackson & Maude, 1999). Unfortunately it is the internality dimension, of central importance to the current study that is also the least satisfactory. Nevertheless the lack of viable alternatives has meant that these measures have continued to be used, as in the present study. A solution to the above difficulties may be

in the form a novel measure proposed by Kinderman and Bentall (1996). Their Internal, Personal and Situational Attributions Questionnaire (IPSAQ; Kinderman & Bentall, 1996) has good psychometric properties and has demonstrated reliable assessments of attributional style separate from the ASQ. The IPSAQ distinguishes between two types of external attribution, those that implicate situational factors and those that assess the actions of others. The IPSAQ specifically provides measures of externalising bias (the tendency to attribute negative rather than positive events to external causes) and personalising bias (the inclination to make personal-external as opposed to situational-external attributions for negative events).

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In relation to the Pragmatic Inference Task (PIT) used in the current study, it is not clear whether participants took the self-reference aspect of the measure seriously or whether they understood it to refer to someone else. This may be particularly pertinent when considering the sample included in the present study, in which the two clinical populations were long stay forensic in patients (the mean length of time in a high secure setting being 12 years). Thus, situations used in the measure may not have been personally relevant to participants.

The current study did not administer any offence related measures, for example the Multiphasic Sex Inventory (MSI; Nichols & Molinder, 1984). These, however, were deliberately excluded due to the restraints on time and an aim to keep the project from being too ambitious. In addition, the issue of engaging this population was always a real concern and by focusing on beliefs and attitudes in general the researcher aimed to minimise attrition. The battery of assessments was also already substantial, taking between 1 ½ to 2 hours to complete, which in reality meant that participants could be tested in one session. However, it is obvious that it would have been informative to assess participant's views and beliefs about their offending, particularly in relation to the mentally ill group and their views about whether their mental health problems impacted on their offending or vice versa.

The other area that the researcher would have liked to explore with the clinical group was psychopathology. This could have been assessed by administering personality measures such as the International Personality Disorder Examination (IPDE; Loranger, Sartorius, Andreoli, Berger, Buchheim et al., 1994). This would also have established whether there were in fact personality differences between the two offending groups.

General limitations

Methodological problems such as small sample size are frequently encountered by researchers who attempt to contribute to research into psychosis (Garety & Freeman, 1999). Other limitations of this (and previous studies) include the practicalities of controlling for the effects of prolonged use and level of medication, or disorder chronity and length of hospitalisation. Increased attention to the severity of negative symptoms in the mentally ill groups (given that the current battery of measures required substantial

motivation and cognitive attention), or further screening for organic abnormalities might also be considered in future research (Krstev, *et al.* 1999). If more time and resources were available the inclusion of a psychotic non-offending group would have provided a interesting and useful comparison to the offending samples. However, since every possible attempt was made to preserve the integrity of the restricted experimental design chosen, the difficulties encountered would not seem beyond those typical when working with research participants who experience a severe psychopathology.

Process issues

Due to the nature of participants it was particularly important for the researcher to establish firm boundaries in relation to the research process, for example exactly what was expected of participants and what they could expect in return. When working with clients with personality disorders, and individuals with a history of sexual offending, it is important to be aware of personal and professional boundaries. For example one participant attempted to engage the researcher in conversation about her personal life, whilst another appeared to sexualise some of his responses on a questionnaire. Fortunately the researcher had a large amount of previous clinical experience with this group of clients so felt competent to handle these occurrences. The collection of data also coincided with a clinical placement within the high secure setting, so the researcher was able to use clinical supervision to discuss any issues that arose during the research process.

Conducting research in a large closed institution, such as a high secure environment, also presented a number of issues in relation to working within an environment with it's own established culture and ethos. This seemed to be further compounded by the fact

the researcher was female. Although it should be stated at the outset that the majority of ward staff were very encouraging, interested and supportive, a small number of staff had reservations about the project.

Future research

It is appreciated that mentally ill sex offenders are complex individuals and the current research has only focused on one small group, namely sex offenders who experience persecutory delusions. The current research has attempted to draw on a wealth of research into attributional style conducted with non-offending individuals with persecutory delusions. This research appeared particularly relevant to a forensic group as their attributions form part of the way they make sense of themselves and the world.

As already stated, so little research has been conducted with this group that the present study is a small step on which to build further research. Future research needs to address the limitations highlighted earlier. Research combining attributional measures and offence-focused assessments may yield findings that could be translated into therapy. In relation to treatment, research should aim to identify whether any specific psychotic symptoms are more associated with sexual offending. There is a wealth of research citing the efficacy of cognitive behavioural therapy with psychosis (for review see Gould, Mueser, Bolton, Mays & Goff, 2001). The current treatment of choice for sexual offending is cognitive-behavioural group work and if more can be established about the symptoms mentally ill sex offenders experience, the standard sex offender treatment programmes could be combined with psychosocial interventions aimed at ameliorating symptoms prior to focused offence work.

The researcher aims to continue to collect data for the present study in order to increase the sample size. In addition to the assessments administered within the study, descriptive data has also been collected from patients' notes regarding treatment and details of offences and the researcher aims to explore this data and disseminate this information in the form of a journal article.

Appendix 4.1

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Appendix 5.1

Copy of ethics approval letter from the School of Psychology

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c.c. Dr. David Nightingale

March 30, 2001

Emma Pearce
Clinical Trainee
North Wales Clinical Psychology
University of Wales
Bangor
Gwynedd
LL57 2DG

Dear Colleage

Attributional style and self concept in sex offenders with persecutory delusions: an exploratory study

Your research proposal (referred to above and on the attached sheet) has been reviewed by the School of Psychology Research Ethics Committee and they are satisfied that the research proposed accords with the relevant ethical guidelines.

If you wish to make any substantial modifications to the research project, please inform the committee in writing before proceeding. Please also inform the committee as soon as possible if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

Good luck with your research.

Kath Chitty
Coordinator -School of Psychology Research Ethics Committee

Athro a Phennaeth yr Ysgol
Professor and Head of School
C Fergus Lowe, Prif FBPsS

Appendix 5.2

Copy of ethical approval letter from Ashworth Hospital

20 June 2001

Ms Emma Pearce
Clinical Psychologist in Training
University of Wales Bangor
NWCPC
43 College Road
BANGOR
Gwynedd
LL57 2DG

Ashworth
Hospital Authority

Dear Ms Pearce,

Re: 05/01 Attributional style and self concept in sex offenders with persecutory delusions: an exploratory study

Thank you for submitting your revised protocol for the above study. This has now been seen by members of the Ethics Committee and I am pleased to be able to inform you that this study has been approved.

Please forward a copy of the final report of this study to me when you have completed the study.

May I take this opportunity to wish you all the best with your research. If you need any further assistance please contact Maggie Clifton, Research & Clinical Effectiveness Coordinator, on 0151-471-2265.

Yours sincerely

HARRY QUILLIAM
Chair
Ethics Committee

Appendix 5.3

Statement of word count for components of thesis

Statement of word count

Thesis component		Words
Title		13
Main abstract (summary)		239
Ethics proposal		3985
Literature review		5044
Research paper		4059
Critical review		2635
	Total	15,975

Components of appendices		Words
Contents section (excluding abstract)		606
Tables (section 3)		221
References:		
Ethics proposal		511
Literature review		1434
Research paper		666
Critical review		336
Appendix 1		9215
Appendix 2		985
Appendix 3		1013
Main appendices (section 5)		309
	Total	15,296