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Childhood trauma and dissociation as factors affecting adult male sexual offending behaviour.

Hislop, Fiona

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Childhood Trauma and Dissociation as Factors Affecting Adult Male Sexual Offending Behaviour

Fiona Hislop

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Appendix 1, page 71
Appendix 2, pages 72 – 73
Appendix 3, pages 74 – 75

Readers may consult the original thesis if they wish to see this material.

Abstract

This study examined childhood trauma and dissociation as possible factors affecting adult male sexual offending behaviour. The issue of personality disorder was also explored in relation to dissociation. Two groups of participants were involved in the investigation, a group of convicted rapists (n = 34), and a non-clinical control group (n = 45). Participants completed the Dissociative Experiences Scale (Bernstein & Putnam, 1986), the Special Hospitals Assessment of Personality and Socialisation (Blackburn, 1982) and the Social History Questionnaire (Hillbrand, Foster & Hirt, 1988).

The present study found a higher prevalence of childhood abuse reported among the prison group (52.94 per cent) than that cited in previous studies of incarcerated rapists.

Correlational investigations revealed the following results:

i) as predicted, significantly greater levels of dissociation were reported in the prison population than in the control population.

ii) as expected, dissociation was positively correlated with childhood trauma in the prison group. The result for the control group yielded a positive yet not significant correlation.

iii) although the relationship between dissociation and personality disorder (as ascertained by the SHAPS) was in a positive direction, it was not statistically significant for the prison group. This relationship was found to be significant for the control group.

Possible implications regarding the treatment of sexual offenders in the light of these results are discussed. Recommendations for further psychological research in this area are included.

This thesis also contains three small scale research projects completed during placements in Learning Disabilities, Elderly and Child.

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Childhood Trauma and Dissociation as Factors Affecting Adult Male Sexual Offending Behaviour

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A Study of Stress, Job Perception and Role in Staff Employed in Day Centres for People with Learning Disabilities

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A Single Case Study Employing Graduated In-Vivo Exposure for a Child Displaying a Phobia of the Dark

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Contents

Childhood Trauma and Dissociation as Factors Affecting Adult Male Sexual Offending Behaviour

A Review of Psychological Service Provision for Clients Aged Over 65 Years in a Health District

A Single Case Study Employing Graduated In-Vivo Exposure for a Child Displaying a Phobia of the Dark

Childhood Trauma and Dissociation as Factors Affecting Adult Male Sexual Offending Behaviour

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1.0 Introduction

This study aims to investigate the possibility of a link existing between experiencing childhood trauma and the development of dissociative symptoms in adulthood, and, in turn, how the presence of these factors may be involved in adult male sexual offending behaviour. In view of the nature and scope of this project, the topic of childhood trauma is firstly addressed, the emphasis of which is largely focused on physical and sexual abuse, with some consideration of psychological/emotional abuse. The possible long term consequences of being a victim of such abusive experiences are also examined. This is followed by a discussion of dissociation and dissociative disorders, including multiple personality disorder, which are considered to be somewhat common, albeit severe, sequelae to childhood trauma. Finally, the subject of male offending behaviour/criminality, with a particular focus on rape, is considered. The objectives of this study are; a) to provide a general description of the level of childhood trauma and dissociation in two different population groups - a prison group comprised of convicted rapists, and a general population group; b) to investigate any identified differences in the levels of these variables between the two groups; and c) to investigate the relationship between dissociation and personality disorder in both the prison and the general population groups.

1.1 *Childhood trauma*

Childhood psychic trauma appears to be a crucial etiological factor in the development of a number of serious disorders both in childhood and adulthood (Terr, 1991). Psychic trauma has been defined as the result of an individual being exposed to an overwhelming event resulting in helplessness in the face of intolerable danger, anxiety, and instinctual arousal (Eth & Pynoos, 1985). Terr (1987), has recently attempted to differentiate between the single abusive act as a 'Type 1' form of abuse, and multiple 'Type 2' forms of abuse, which are long standing traumatic acts accompanied by extreme stress.

Throughout life, there are three major types of abuse that one individual can subject a fellow being to; physical, sexual and emotional. When this abuse occurs during childhood it is referred to as child abuse. Child abuses can be divided into sexual abuse, physical abuse, emotional abuse and neglect (Coons, Cole, Fellow & Milstein, 1990). In addition, sexual abuse is generally subdivided into the categories of incestuous and non-incestuous, depending

on the relationship of the perpetrator to the victim. Indeed, all forms of child abuse may occur either as intra or extra-familiar events. However,recent research has suggested that children are more likely to suffer sexual abuse by members of their own families and by acquaintances than by strangers. For example, in the clinical sample described by Conte & Schuerman (1987), only 4 per cent of child victims were abused by adults unrelated and not previously known by the child or family. It has been postulated, however, that such intra-familial abuse is more traumatic for the child, due to the degree of trust and unquestioning power inherent in family relationships (Anna Freud, 1981). In addition, Baker & Duncan (1985), claim that abuse by strangers results in less long term trauma when the child victim is able to tell parents, be believed and not be held responsible for the abusive incident(s). Evidence has also suggested that it is rare for a single form of abuse to occur in isolation. For example, sexual abuse is often associated with physical assault, neglect and, unavoidably, emotional abuse (Frude, Peake, Sambrooks, Stratton & Cullen, 1990). Schetky (1990) has suggested that there is considerable morbidity associated with a history of childhood sexual abuse, especially as it often occurs in conjunction with other forms of abuse. Physical abuse is reported to be almost invariably accompanied by psychological abuse and neglect (Wilbur, 1985).

It has been argued that the important difference between physical and sexual abuse is the egosyntonic aspect of the sexual abuse, and the 'kick' the abuser gains from it (Furniss, 1991). The knowledge that the abuse is wrong, the damage to the child, the tension relief, guilt feelings and repetition compulsion are common elements in both physical and sexual abuse. However it is only in a very small minority of severe cases of physical abuse that the perpetrator displays open sadistic pleasure during the physical assault of a child. Kluft (1990) argues that among the most deleterious of real traumata is incest, which he refers to as the sexual exploitation of a child by another person in the family, who stands toward them in a parental role, or in another relationship invested with significant intimacy and authority.

With the recent increase in public awareness of and media attention to the area of child abuse, a common misconception is that such abuse is a relatively recent phenomenon. Yet over the past century, several authors have attempted to establish the importance of childhood trauma. For example, Tardieu (1860), published the equivalent of the battered child syndrome

and publicised the high incidence and tragic effects of childhood sexual assault, but he was immediately discredited. Freud's retraction of his 1896 claim that early childhood seduction was the basis (the 'source of the Nile') for neurosis, has been regarded as responsible for reinforcing a climate of prejudice towards any subsequent investigation into extra-psychic trauma. Then, in 1962, Kempe published his work on the battered child syndrome, which evoked the rediscovery and seeming acknowledgement of child abuse. However, sexual abuse was only recognised once again as a form of child abuse during the 1970's, some fifteen years after the renewed interest in physical abuse (Sgroi, 1975), and only then due to insistent pressure from feminists and journalists representing adult survivors of incest (Armstrong, 1978).

Present evidence indicates a prevalence of child sexual abuse that is approaching the incidence of non-accidental injury in all age groups. Current estimates vary between 6 and 60 per cent of females in the United States (Taylor, 1989), and at least 5 per cent of males (Bagley & King, 1990). In Britain, the corresponding figures stand at 12 per cent of females and 8 per cent of males (Baker & Duncan, 1985), though Glaser & Frosh (1988) have argued that this is likely to be and underestimate. The prevalence of abusive experiences, including incest, amongst clinical populations varies according to the populations surveyed. In all studies to date, the abuse rate among clinical populations has been higher than the rate for non-clinical populations (Jacobson, Koehler & Jones-Brown, 1987). For example, in 190 consecutive out-patient evaluations, Herman (1986), found that one third of female patients had been victims of physical or sexual violence, whilst the prevalence of childhood sexual abuse among women with multiple personality disorder varies from 75 to 90 per cent (Putnam, Guroff & Silberman, 1986). In fact, Putnam (1984) suggested that 70 per cent of multiple personality disordered patients are victims of incest. In an attempt to draw figures together, Peters, Wyatt & Finkelhor (1986) carried out a comprehensive review of studies on the incidence and prevalence of child sexual abuse, in which they reported that estimates of the prevalence range from 6 to 62 per cent for females and from 3 to 31 per cent for males. As they point out, this variation may be accounted for by a number of methodological factors, such as differences in definitions

of abuse, sample characteristics and the number of questions used to elicit information about abusive experiences.

Male victims of childhood abuse have been less well studied, and there are a number of possible reasons why this is so. These include the fact that a major source of the current attention to child sexual abuse is the women's movement, which, not surprisingly, has been especially concerned about the plight of female victims. There is also some societal reluctance to recognise abused boys as victims rather than willing participants in abusive sexual encounters (Jehu, 1991). Greater reluctance in men to report abusive childhood experiences is considered a probable reason to account for their lower representation in most studies (Rogers & Terry, 1984). However, there exists considerable anecdotal evidence that in the most severely disturbed families, all children - male and female - are sexually and/or otherwise abused, often by multiple family members - both male and female (Goodwin, 1985).

Briere, Evans, Runtz & Wall (1988), conducted what has been described as probably the first empirical study of psychological symptomatology among men who had been sexually abused in childhood. The abused men in the sample were found to display significantly higher symptomatology scores, and to have previously made significantly more suicide attempts then the non-abused group. These findings are very consistent with a number of clinical reports (Dimock, 1988). Briere et al. (1988), also found that there were no significant differences between abused males and abused females regarding their histories of suicide attempts or in the symptoms covered in the study. Thus it would seem that despite the overwhelming focus on female child abuse in society, male children are and have been at clear risk of sexual victimisation and misuse. Gender differences, often assumed to protect against this risk do not, in fact, do so. Finkelhor (1986), describes the greater attention, study and analysis focused upon female child abuse victims as 'unfortunate', in the sense that it contributes to the mistaken impression held by the public that male children are rarely sexually victimised. Additionally, it has contributed to the abbreviation of the knowledge base regarding male children who have been sexually abused, especially compared to the ever expanding knowledge base regarding females.

As has been suggested above, recent research has documented an association between child abuse and long term psychological problems, not only in terms of physical victimisation (Lamphear, 1985), but also sexual abuse (Brown & Finkelhor, 1986), and psychological maltreatment (Briere & Runtz, 1988). However, despite the substantial prevalence rates for child abuse that are reported in the general population, only a proportion of those victimised experience psychosocial problems in adulthood that appear to be related to the abuse and its surrounding circumstances. The size of the proportion affected has been estimated as ranging from 13 per cent (Baker & Duncan, 1985), to at least 25 per cent (Bagley & King, 1990).

Such adult problems may arise from the abuse per se and/or from other surrounding circumstances, such as the adverse family situations in which many victims grow up. At present it is not possible to distinguish the respective causal contributions of these two sources (Briere, 1988). Obviously, each victim's experience of abuse will be different and that person's response to it will be determined by his or her own personal resources and perspective on life. This makes the prediction of trauma associated with child abuse very difficult, and, as a result, much ambiguity exists as to how abuse characteristics influence trauma (Davenport, Browne & Palmer, 1994). As far as the abuse is concerned, several features have been identified as being especially traumatic and pathogenic. These include; i) extended duration; ii) multiple perpetrators; iii) bodily penetration; iv) bizarre sexual activities, such as rituals; v) abuse by father figures; vi) use of force or coercion; vii) a substantial age difference between victim and offender; viii) negative reactions to abuse by victims; ix) negative reactions from others upon disclosure or discovery (Jehu, 1988).

In a small percentage of victims, resulting symptoms are quite severe and potentially disabling. Severe symptoms have been associated with the presence of a parental perpetrator, long duration of abuse and the use of serious threats of violence associated with the abuse (Herman, Russell & Trocki, 1986), and with the degree of family disruption (Goodwin, Cormier & Owen, 1983). Adult incest survivors have been found to report a higher frequency of severe symptoms. Dissociative symptoms are reported in 33 per cent (Lindberg & Dystad, 1985), and 8 per cent are diagnosed as having multiple personality disorder (Goodwin, 1990). Borderline personality disorder is the diagnosis in 17 per cent (Herman & Schatzow, 1984),

and an increased vulnerability to being raped or subjected to other crime victimisation in adulthood has been reported to be evident in 20 to 46 per cent (Cole, 1985). Criminality and violent behaviour have also been reported as consequences of childhood victimisation (Widom, 1989), as has becoming a sexual abuser (Barnard, Fuller & Robbins, 1988).

Indeed, recent research and clinical experience has shown that many adults who have experienced childhood abuse may present with difficulties in at least three major areas of psychological disturbance: dissociative symptoms (Chu & Dill, 1990); post-traumatic symptoms (Ulman & Brothers, 1988); and disruption of personality development and maturation as is seen in borderline personality disorder (Herman, Perry & van der Kolk, 1989). Those patients who have been most severely abused may present with complex clinical syndromes, which may include all three of these areas, with extreme forms of symptomatology such as multiple personality disorder.

To summarise, the traumatic aspects of childhood abuse include exploitation, violation of trust, a damaged sense of self, and in the case of sexual abuse, premature sexualisation. On top of this is often the loss of childhood and the loss of 'normal' parenting (Schetky, 1990). Post traumatic syndromes have been recognised, especially in regard to incest victims, from pre-school age to adulthood (Goodwin, 1985). It is thought that the development of such symptoms occurs in order to help the child accommodate to the disturbed environment in which they find themselves. However, as noted above, this symptomatic adaptation often persists into adulthood, often rendering the individual dysfunctional.

As mentioned previously, dissociative symptoms are a somewhat common result in victims of incest (Lindberg & Dystad, 1985). In fact, it has been suggested recently that dissociative disorders may be more common in clinical populations than previously suspected. For example, Sanders & Giolas (1991) reported an association between dissociative symptoms and self reported childhood abuse (all categories) in adult psychiatric in-patients. Plus, Bliss (1985) reported high rates of dissociative disorders in male sex offenders. Such findings are in line with those of Bernstein & Putnam (1986), that dissociative disorders cut across a wide range of psychiatric disorders. Additionally, Braun (1990), has suggested that while incest may be involved in child abuse that underlies 96 to 98 per cent of multiple personality disorder

cases, the more important factor may be that the abuse is administered unpredictably by an adult who is a nurturing relative at other times. This suggests that the severity of dissociation and multiple personality disorder is more directly related to abuse that is administered by parents or other family members who are also able to give the child love and protection at other times. DiTomasso & Routh (1993) concluded in their study that when investigating the origins of dissociation, both sexual and physical abuse should be considered. Thus it would seem that child abuse should be suspected in individuals who display substantial levels of dissociation. However, obviously not all of those with such symptoms will have such histories, and clinicians therefore need to exercise caution and judgement to avoid encouraging the possible emergence of fantasy (Chu & Dill, 1990).

1.2 *Dissociation and dissociative disorders*

Dissociation and dissociative disorders have recently been described as representing one of the most important areas in the study of human mental life (Loewenstein, 1993). There are a number of reasons why this is so, including the fact that dissociative disorders are among the most common psychiatric disorders in North America and probably throughout the world (Mulhern, 1991). Dissociative disorders are believed to develop in part as a response to severe trauma (e.g. physical or sexual abuse, rape, and human made or natural disasters) (Putnam, 1989). Spiegel & Cardena, (1991) offer support for this position by proposing that post traumatic phenomenology frequently involves alterations in the relationship to the self (e.g. depersonalisation and multiple personality disorder), to the world (e.g. derealization and hallucinatory phenomena), and to memory processes (e.g. psychogenic amnesia, fugue and multiple personality disorder). Thus it has been argued that systematic attempts to decrease the occurrence of such avoidable traumas represents the single most important area for preventative mental health in society (Loewenstein, 1993). Recent studies have suggested that as many as 10 per cent of the general population suffer from a dissociative disorder and that 1 per cent may have multiple personality disorder (Ross, 1991).

Dissociation is usually understood in one of three ways: as a pathology; as a psychobiological process related to hypnotizability, altered states and focused attention; and as

an intrapsychic defence. In DSM IV, dissociation is described descriptively as a form of psychopathology, as 'a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment' (American Psychiatric Association, 1994, p. 477). DSM IV divides dissociative disorders into five categories: dissociative identity disorder (formerly referred to as multiple personality disorder); dissociative fugue; dissociative amnesia; depersonalisation disorder; and dissociative disorder not otherwise specified. All forms of dissociative disorders involve a dysfunction of memory and identity (Putnam, 1985). An alternative definition of dissociation is that of Putnam (1991*a*), who stated that 'dissociation is a process that produces a discernible alteration in a person's thoughts, feelings or actions so that for a period of time, certain information is not associated or integrated with other information as it normally or logically would be' (p. 145).

Most authorities on dissociation identify it as occurring in both minor and major or pathological forms (Ludwig, 1983). These different forms are generally conceptualised as lying along a continuum, ranging from the minor normative dissociation's such as daydreaming, through to severe psychiatric conditions such as multiple personality disorder (Bernstein & Putnam, 1986). Multiple personality disorder is thus seen as the most extreme and chronic dissociative disorder, which has been shown to be more common than previously believed (Kluft, 1985). If dissociation is viewed in this way, then it stands that a range of clinical and behavioural phenomena may be displayed, involving alteration in memory and identity that play important roles in normal and pathological mental processes. For example, a disturbance in an individuals memory may occur, which is usually manifested by amnesia for past events or complex acts (Putnam, 1985).

As a form of intrapsychic defence, dissociation is unique in that it is hypothesised to operate initially at the time of the actual traumatic experience(s). Accordingly, Spiegel (1986) stated that 'dissociation has recently been understood as a defence not simply against memories of warded-off unconscious wishes, but rather as a defence against the traumatic experience itself ' (p. 22). Similarly, Kluft (1992) described dissociation as 'a defence in which an overwhelmed individual cannot escape what assails them by taking meaningful action or

successful flight, and escapes by altering instead his or her internal organisation, i.e. by inward flight' (p. 143).

Yet it has been proposed that the concept of dissociation lacks clarity and that on occasion it has come to preempt the attributes usually assigned to defences, including repression (Frankel, 1990). Indeed, experts are reportedly divided as to whether or not they consider dissociation to be different from repression in a broad sense. In response, a distinction has been offered in which repression is seen as 'a pushing (or pulling) of ideas deep into the unconscious where they cannot be accessed', and dissociation as a 'severing of the connection between various ideas and emotions' (Singer & Sincoff, 1990, p. 481).

As was the case with child abuse, interest in dissociation is not a recent phenomena, yet there has been a recent resurgence of interest in dissociative disorders in general, and in multiple personality disorder in particular (Ross, Norton & Wozney, 1989). It is generally accepted that the term dissociation was actually introduced by Janet (1889), since which many have attempted to elaborate on this elusive construct. Janet proposed that split-off parts of the personallity exist and are capable of independent functioning (c.f. Putnam, 1989). Interest in dissociation has risen and fallen since Janet's (1889) original theorising until the last decade, which has witnessed a strong revival of interest in dissociative processes. A number of possible reasons have been cited to account for this current interest, including; the widespread diagnosis of post traumatic stress disorder (PTSD) and multiple personality disorder; the current research on the incidence of childhood physical and sexual abuse and other traumas with dissociative sequelae (Terr, 1991); the feeling that psychoanalytical theory and dissociation are not necessarily incompatible (Erderlyi, 1985); and the appearance of models within cognitive psychology, including the concept of parallel processing, that provide compatible modern formulations for the notion of dissociation (Spiegel, 1990).

As mentioned previously, traumatic events are regarded as important antecedents of dissociative symptomatology when attempting to understand the origins of dissociative disorders. For Janet, dissociation was 'the crucial psychological process with which the organism reacts to overwhelming trauma' (c.f. van der Kolk & van der Hart, 1989, p. 1523). In accordance with this view, contemporary theorists have hypothesised that dissociation is a

normal defensive process, used to cope with traumatic experiences (Beahrs, 1990). Thus dissociation is seen as serving to block painful events from awareness, and as such it is adaptive in the sense that it allows individuals to go about their lives as if nothing traumatic had occurred (Sandberg & Lynn, 1992). However, although the operation of dissociation-based defensive mechanisms may be successful in the short run, profound dissociation can have long term personal costs, such as the development of multiple personality disorder (Putnam, 1989). In addition, as stated by Loewenstein & Ross (1992), not only is the trauma dissociated, but the person frequently has little conscious awareness that basic assumptions about the self, relationships, other people, and the nature of the world have been altered by the trauma. Thus, the trauma can cause profound developmental and adaptational shifts that are also often shrouded in amnesia. It should be noted, however, that as the majority of dissociation studies have been retrospective in nature, it has not definitely been shown that trauma causes dissociative pathology (Putnam, 1989). In view of this, it has been argued that prospective longitudinal studies, that follow cohorts of traumatised children and matched controls forward in time, could provide fresh insight into many of the 'nature versus nurture' questions that plague psychology and psychiatry, as well as identifying new opportunities for early clinical interventions (Putnam, 1991*b*). However, Sandberg & Lynn (1992) nevertheless point out that the trauma-dissociation connection is supported by an impressive body of research.

The notion that dissociative experiences range along a continuum has led to the suggestion, for which some tentative evidence exists, that less severe or long-standing abuse (such as occasionally being hit with a belt as a form of punishment, or a single incident of sexual fondling in childhood) may be associated with less debilitating or extensive dissociative experiences (Sandberg & Lynn, 1992). Only a few studies exist which have examined less severe forms of dissociation to provide normative data regarding dissociative experiences and their correlates in the general population and non-clinical samples. For example, Sanders, McRoberts & Tollefson (1989) reported a relationship between dissociation scores and retrospective self reports of physical and psychological abuse during childhood in a college

population. Similarly, Briere & Runtz (1988) found a relationship between college student dissociation scores and childhood sexual abuse variables.

Children exhibit a range of normative dissociative behaviour, which is thought to peak at approximately 9 to 10 years of age, and then rapidly decline during adolescence so that relatively low and stable levels are achieved by early adulthood (Putnam, 1991*a*). The observations that childhood trauma is commonly associated with pathologically increased levels of dissociation in adults (Chu & Dill, 1990), suggests that such trauma may interfere with the normal age-related decline in dissociative capacity. The result of which is an enhanced capacity and/or propensity to dissociate in adults who suffered abuse as children.

It is thought that repeated entry into a dissociative state of consciousness, as can occur during abusive experiences, appears to lead to a generalisation of dissociative coping responses to lesser stressors. This can lead to the occurrence of pathological dissociation when the frequency and/or duration of the dissociative episodes produce significant disturbances in the continuity of an individuals memory and integration of self (Putnam, 1993). Thus, while dissociation serves the function of defending consciousness from the immediate experience of traumatic events, such as physical pain, fear, anxiety and helplessness, it may become an entrenched part of the individual's overall view of the self. The process of dissociation thus becomes part of the individual's identity, to be remobilised in the face of subsequent stress or even imagined situations reminiscent of this previous stress. Thus, the experience of dissociation, which occurs as a normal and even pleasant experience, has been contaminated for such individuals by its repeated use to defend against trauma (Spiegel, 1990).

As has been noted, multiple personality disorder is regarded as the most extreme and chronic of the dissociative disorders. According to DSM IV (American Psychiatric Association, 1994), the essential feature of dissociative identity disorder (multiple personality disorder) is the presence of two or more distinct identities or personality states (Criterion A), that recurrently take control of behaviour (Criterion B) (p. 484). Putnam (1989) defined multiple personality disordered personalities as 'highly discrete states of consciousness organised around a prevailing affect, sense of self (including body image), with a limited repertoire of behaviours and a set of state dependent memories' (p. 103). Such a definition

suggests that the creative elaboration of the multiple personality disordered personalities, such as varying names, interests and habits is actually a secondary phenomena, related to the shaping and structuralisation of the dissociation.

Virtually all multiple personality disordered patients have histories of sexual and/or physical abuse in childhood (Loewenstein, 1993). The abuse is usually severe, prolonged and perpetrated by family members (Coons, 1986). Putnam (1991*b*) has described how multiple personality disorder and related disorders have increasingly been recognised in children and adolescents. He argues that the systematic study of childhood dissociative disorders is central to early interventions for prevention and for early treatment. Such work would also help to clarify the impact of psychological trauma on childhood development.

Regarding the aetiology of dissociative disorders, Kluft (1988) has described a Four Factor Theory, in which necessary features involve the capacity and predisposition to dissociate (factor 1); events that overwhelm the non-dissociative capacities of the child, primarily child abuse (factor 2); 'shaping' factors from a variety of developmental, social and familial sources that lead to the secondary structuring of the multiplicity and of alter personalities (factor 3); and lack of soothing, comforting and restorative experiences, so that the traumatised child is left to comfort itself (factor 4). Fahy (1988) has suggested that with some modifications, Kluft's (1988) theory can be applied to view multiple personality disorder as the convergence point of a wide variety of psychological disturbances.

Dissociative disorders, including multiple personality disorder, are still rare in contrast with other disorders, although this may be due to the fact that until recently there were no validated clinical measures of dissociation (Putnam, Helmers & Trickett, 1993). The under-recognition of dissociation has serious implications, as patients with dissociative disorders often present with symptoms that resemble other diagnoses. For example, Saxe, van der Kolk, Berkowitz, Chinman, Hall, Lieberg & Schwartz (1993), found that 15 per cent of the psychiatric in-patients in their sample met the criteria for a dissociative disorder, and at least 4 per cent met the criteria for multiple personality disorder. In addition, they found that those with a dissociative disorder were very likely to also have post traumatic stress disorder, substance abuse and borderline personality disorder, and to have had at least one episode of major

depression. Fortunately, in this respect, it now appears that these disorders are being reported with increasing frequency, and Spiegel & Cardena (1991) suggest that they hold unusual fascination as models of psychopathological as well as normal aspects of cognitive processing. Indeed, enquiry into non-pathological dissociative processes may shed light on many basic areas of psychology, including attention, memory and emotion. Of particular clinical importance is the reconceptualization of dissociative disorders as a common form of reaction to trauma (Spiegel & Cardena, 1991). Patients with dissociative symptoms often present difficult clinical challenges, in that they may deny awareness of past actions or experiences. They may quickly change states which may be interpreted as either a 'resolution' of psychiatric problems, or a manipulation of the therapeutic environment (Saxe et al. 1993).

Despite the difficulties such patients present in terms of treatment, there is a growing body of literature that suggests psychotherapy may hold considerable impact, by addressing such patients habitual patterns of responding to stress by depersonalising, forgetting or assuming alternative identities (Putnam, 1989). There are data that suggest that patients whose dissociation is recognised and treated will improve at far greater rates than those who receive no such treatment (Kluft, 1984). In addition, a number of recent studies have suggested that such treatment is associated with significant reductions in health care costs, through a reduced need for in-patient care (Ross & Dua, 1993). Thus it would appear that the proper recognition and subsequent treatment of dissociative disorders is a matter of great importance.

Finally, when treating such patients the possibility of the existence of a traumatic aetiology underlying the current disturbance should be acknowledged, as acknowledging the reality of the abuse enables the clinician to sympathise with the patients' effort to cope with such overwhelming circumstances, and to help them understand their impact. Chu & Dill (1990) argue that this shift in attitude is essential for the treatment of such patients, and makes the often difficult task not only more tolerable, but much more productive.

1.3 *Male offending behaviour/criminality*

As has been highlighted, survivors of childhood abuse may present with complex post traumatic symptoms and dissociative symptoms, as well as significant disturbance of

characterological development. These difficulties may lead to the use of a variety of dysfunctional and self destructive patterns of behaviour, including criminality and violent behaviour (Widom, 1989), and the possibility of becoming a sexual abuser (Barnard et al. 1988). Childhood victims of abuse and neglect have also been shown to be at greater risk of being arrested (Widom, 1989). However, the relationship between psychiatric disorder and crime remains a complex and controversial issue. It becomes even more so with regard to any association between specific psychiatric conditions and specific crimes (Kunjukrishnan & Varan, 1992). Criminal behaviour can be described as a complex phenomenon of multifactorial origin, and the concept of crime changes as societal attitudes alter (Hagan, 1987). While discussing the more specific type of criminal activity, namely recurrent aggressive anti-social behaviour, Lewis (1989) stated that:

> clearly there is no single cause of recurrent aggressive anti-social behaviour. Most socio-economically disadvantaged, abused, neurologically impaired, psychiatrically disturbed and intellectually retarded people are neither criminals nor aggressive. As evidence accumulates, it becomes clear that much recurrent anti-social aggressive behaviour is the final common pathway of the interaction of these kinds of biopsychosocial vulnerabilities (p. 1403).

Male violence against women has been described as a major source of fear, distress, injury and even death for women, crossing lines of ethnicity, economic status, sexual orientation and age (Goodman, Koss & Russo, 1993). Yet the majority of both physical and sexual assault of women is perpetrated by male intimates, as opposed to strangers. For example, using a conservative definition of rape, Russell (1982) found 14 per cent of the ever-married women in his sample reported being raped by a husband or ex-husband - more than twice as many as were assaulted by strangers.

Although no perfect correlation exists between previous victimisation and future perpetration, there have been suggestions that there is some relationship (Haynes, 1985). The sexual offences arelegally categorised as offences against the person (Faulk, 1988). The link between childhood sexual victimisation and subsequent aggressive sexual behaviour by adolescent or adult sex offenders is posited by the literature (Ryan, Lane, Davis & Isaac,

1987). It has been suggested that such hypotheses find predominant support in theories which suggest that victimised children become victimisers in an attempt to master the trauma of their own experiences, and take on the power that the adult victimisers held over them (Russell, 1984).

Seghorn, Prentky & Boucher (1987) addressed this controversial assumption that sexual victimisation in childhood should have some adverse impact on the normal course of psychosexual development. In order to do so, they examined the incidence of childhood physical and sexual abuse in a sample of incarcerated rapists and child molesters. They argued that in a population where the manifest adult pathology is explicitly, albeit not exclusively, sexual in nature, it is psychologically meaningful to posit that one of the important antecedents of such pathology is childhood sexual experiences. As pointed out by Gelles (1982), the actual effects of sexual abuse per se must be understood in terms of the emotional deprivation, physical abuse and neglect, and general family disintegration that may be associated with the sexual experience(s). The four most salient findings of the Seghorn et al. (1987) study were that; a) the incidence of sexual assault in childhood among child molesters was higher than the incidence of such abuse reported in both clinical and non-clinical samples in the literature; b) the incidence of sexual assault in childhood among child molesters was 57 per cent, more than twice as high as the 23 per cent incidence reported among the rapists; c) rapists were three times more likely to have been victimised by a family member, typically thefather, than were child molesters; and d) when a sexual assault did occur, it was associated with many other indices of familial disturbance. In view of these findings, Seghorn et al. (1987), have hypothesised that as children, these men may have become enmeshed in a family dynamic marked by aberrant and aggressive sexuality, and an identification with the aggressor (i.e. father). They conclude that psychological survival in such a family may have depended, in part, on projection of blame onto the female victims, thereby fostering a pathological view of women.

Sexual assault refers to a variety of behaviours, including rape and child molestation. Yet this distinction has been argued against, as it is based solely on the age of the victim irrespective of the severity of the assault (Mair, 1993). For example, the sexual assault of an

adult female by an adult male may range from uninvited sexual touching, to rape, and similarly, the sexual molestation of children may range from fondling the genitals, to actual or attempted penile penetration of the vagina or anus. There are some who view all sexual relations where there is an imbalance of power as coercive (Marshall & Barbaree, 1989).

Rape can be defined as coercing or forcing a non-consenting person to engage in sexual activity (Abel & Osborn, 1992). The problem of rape was virtually ignored before the feminist movement of the 1970's helped to expound it as a significant social problem (Burgess, 1985). Despite known under-reporting, statistics indicate an alarming number of reported rapes. For example, in England and Wales during 1987, 2471 rape offences were recorded by the police, almost double the figure recorded 10 years previously. Yet it is thought that estimated crime figures double when unreported rapes are included (Dormanen, 1980). Lack of reporting, for whatever reasons, not only hinders attempts to gain an accurate profile of the frequency of sexual assault, but also reduces the chances that victims will receive appropriate treatment.

In the past, the rapist was popularly viewed as a unique, psychologically disturbed individual, whose assault was sexually motivated (Brownmiller, 1975). However, more recently, rape has been viewed more as a violent and aggressive act, rather than an act of sexual maladjustment. For example, Marshall & Christie (1981), found that 71 per cent of rapists and 58 per cent of child molesters physically assaulted their victims in excess of the force necessary to secure their sexual goals with an uncooperative victim. It should be noted that not all rapists are equally violent (Prentky, Cohen & Seghorn, 1985), but that even the least aggressive are forceful to some degree (Gibbens, Way & Soothill, 1977).

Abel, Mittelman & Becker (1985) have documented the multiple paraphilia (i.e. sexually deviant) feature of sex offenders, showing that 50.6 per cent of rapists had molested children, 29.2 per cent had exposed themselves, 20.2 per cent had engaged in voyeurism, and 12.4 per cent were also frotteurs. Child molesters yielded a similar pattern of results. Such evidence has led Abel & Osborn (1992) to argue that if early life experiences or specific emotional conflicts lead to the development of specific paraphilic behaviour, it is unlikely that such crossings as described above would occur. They suggest that a more likely explanation would

be that such individuals have a general deficit of control, leading them to carry out a variety of sexually assaultive behaviour with various categories of victims.

A number of theories of causation of sexual offences exist, including situational, feminist, psychoanalytical, and behavioural theories. All these theories include the experience of childhood trauma as a common feature influencing rape or child molesting behaviour to some degree, although it is generally recognised that other factors must also influence the course of these actions. Marshall & Barbaree (1984) have developed a more complex, but still essentially a learning based view of the development of sexual aggression, which attempts to integrate biological endowment, childhood experiences, and the influence of the socio-cultural environment, with both situational factors (e.g. anger, intoxication), and particular circumstances (e.g. easy access to a victim or temporary lack of constraints).

As regards their childhood experiences, rapists and child molesters have been found to be similar to other criminals, in that their parents provide poor role models, fathers are typically aggressive and in trouble with the law, and sexual abuse within the family is not uncommon (Langevin, Paitich & Russon, 1985). Perhaps not surprisingly, delinquency among boys from such families is not uncommon, and Knight, Prentky, Schneider & Rosenberg (1983) have shown that such anti-social behaviour in boys increases the likelihood that they will commit rape as adults. Knight et al. (1983) also found that childhood social skills deficits, which are not uncommonly found in such dysfunctional families, were also a strong predictor of adult sexual deviance, especially the tendency to rape.

Thus it would seem that men who are ill-prepared by their childhood experiences to deal with negative socio-cultural influences are at an increased risk of failing to develop constraints against sexual aggression. However, this does not mean all such men will necessarily offend, and often particular proximal circumstances may be required to elicit such aggression, i.e. alcohol or opportune circumstances.

Caution should be exercised when reviewing data about sex offenders, as the majority of studies have focused on convicted and imprisoned men, among whom one can expect to find the more serious offences, such as rape, over-represented (Mair, 1993). In addition, as the number of arrests for sex crimes may be a poor indicator of the actual frequency of such acts, it has

been suggested that self- reports, under appropriate conditions of confidentiality, may be a more accurate means of obtaining such data (Kaplan, Abel & Cunningham-Rathner, 1990). However, others have cautioned against the validity of self-reports (Fehrenbach, Smith, Monastersky & Deisher, 1986).

Thus it would appear that there are a number of studies that postulate a link between males traumatised in childhood and sexually aggressive behaviour in later life (e.g. Seghorn et al. 1987). Estimates of the number of offenders victimised during childhood range from 19 per cent to 80 per cent (Fehrenbach et al. 1986). Yet it should be noted that other factors, such as social skill deficits, situational factors and particular circumstances may also be involved. From this point of view, it would seem wise to accept the view of Finkelhor (1984), that it is not the majority of victimised children who go on to become perpetrators or parents of victims. However, among hospitalised paraphiliacs and incarcerated sex offenders, sexual and physical victimisation are common historical features by self-report. There appears to be some increased risk of perpetration by males who have been sexually victimised, and there are indications that those who do go forward into later perpetration are somehow different from those who do not (Russell, 1984). Unfortunately, clinically identifiable and verifiable variables which discriminate between these two groups remain elusive at this point in time.

For the male victim of childhood abuse, it appears that the impact can range from nominal to quite damaging, depending on a number of environmental and personal variables. The task for the clinician, therefore, is apparently twofold; accurately assess the nature of the abuse and its relative importance to the presenting problems, and, accordingly develop an effective treatment package.

1.4 *The present study*

In view of the above, the present study is an attempt to investigate male childhood trauma and dissociation in the realm of adult male offending behaviour, and more specifically, with reference to individuals who have committed rape. The rationale behind the present study includes the fact that paramount to the modern study and treatment of clinical dissociation is the need for valid and reliable measures to detect and quantify dissociation in research and

clinical study groups (Carlson, Putnam, Ross, Torem, Coons, Dill, Loewenstein & Braun, 1993). To date, the majority of estimates regarding the frequency of dissociative disorders have been derived mainly from the most severe manifestation - multiple personality disorder (Saxe et al. 1993). However, relatively few studies exist which have used rigorous epidemiological criteria in order to estimate the prevalence of dissociative disorders. These studies have tended to use the Dissociative Experiences Scale (Bernstein & Putnam, 1986), across a range of subjects, including female psychiatric in-patients (Chu & Dill, 1990); surveys of specific high-risk populations, such as patients with eating disorders (Demitrack, Putnam, Brewerton, Brandt & Gold, 1993); and general population surveys (Ross, Joshi & Currie, 1990). The present study will collect data to add to the evidence pertaining to the prevalence of dissociative disorders in two specific client groups: (i) a prison group of convicted rapists; and (ii) a general population group (control group).

Sanders, McRoberts & Tollefson (1989), recently found dissociation in college students to be positively related to stressful or abusive childhood experiences. One could therefore expect that a relationship between dissociation and trauma should exist across various other diagnostic groups. Sanders & Giolas (1991), point out that such an expectation is particularly true if multiple personality disorder is viewed as the extreme end of a dissociation continuum extending into the non-clinical population. If a positive relationship were to emerge between childhood trauma, dissociation and offending behaviour in the present study, this would indicate that therapists working with offenders should enquire about childhood trauma, be knowledgeable of dissociation and assess a client's dissociative abilities. Such findings could then be incorporated into the therapy process. The important implications if such a finding were to emerge increase if one considers the following points; a) the view that individuals with dissociative symptoms often present difficult clinical challenges, in that they may deny awareness of past experiences/actions (Saxe et al. 1993); and b) the suggestion that individuals whose dissociation is recognised and treated improve at far greater rates than those who receive no such recognition and treatment (Kluft, 1984).

The remaining reason for undertaking the present study is concerned with risk assessment. A large amount of risk assessment is based on clinical presentation, level of institutional

adjustment and perceived changes in personality, i.e. increased maturity. However, one of the problems with this is that secure environments are not a good analogue of the outside world, and it is therefore very difficult to know how an individual will manage stress outside the secure environment. If more was known about dissociation, including to what extent it does occur in some apparently well adjusted people, this would offer another important dimension for assessing risk potential. Norton, Ross & Novotny (1990), in a university sample, found that individuals who scored highly on the Dissociative Experiences Scale (Bernstein & Putnam, 1986), and presumably have strong dissociative tendencies, are more likely than those with lower scores to experience a number of effects. These included; a) experiencing intense anxiety and engaging in avoidance behaviour, b) experiencing high levels of anger, c) experiencing numerous bodily complaints, d) becoming imaginatively involved, and e) thinking in an irrational manner.

1.5 *Aims*

In view of the above, the present study was designed to:

i) provide a general description of the level of childhood trauma and dissociation in two different male population groups - a prison group comprised of convicted rapists, and a control (non-clinical) group;

ii) investigate any identified differences in the level of childhood trauma and dissociation between the prison and control group populations;

iii) investigate the relationship between dissociation and personality disorder in the prison and control groups.

Hypothesis 1

Dissociation should be greater in the prison population group, than in the general population group.

Hypothesis 2

Dissociation should positively correlate with childhood trauma in both the prison and general population groups.

Hypothesis 3

Dissociation should positively correlate with degree of personality disorder (as ascertained by The Special Hospitals Assessment of Personality and Socialisation (SHAPS) (Blackburn, 1982) in both the prison and general population groups.

1.6 *Ethical approval*

As the prison authority does not have a constituted ethical committee, the study was submitted, with approval from the prison governor, to the Research and Ethics Committee of another forensic establishment. Approval for the research was granted by this Ethical committee, following which permission was granted from the prison governor to undertake the present study.

2.0 Method

2.1 Design

The study was a correlational questionnaire design, involving two groups of subjects; i) a prison group of convicted rapists and ii) a control group.

2.2 Participants

The study involved two groups of participants; a prison and a control group, all of whom were adult males, i.e. aged between 18 and 65 years. This was a condition of participation in the study.

Group 1 consisted of 34 male prisoners, all of whom had been convicted of rape. The mean age for the men in this group was 31.35 years (SD = 7.31), with a range from 22 to 47 years.

Group 2 comprised the control group, of 45 males taken from the general i.e. non-clinical population. Subjects were members of the public, randomly selected from a public house. With the landlord's permission, every other adult male who entered the establishment between the hours of 2 p.m. and 6 p.m., over a period of four non-consecutive days, was approached to take part in the study. The mean age was 26.62 years (SD = 4.91), with a range from 20 to 42 years.

2.3 Measures and data collected

1) The Special Hospitals Assessment of Personality and Socialisation (SHAPS) (Blackburn, 1982).

The SHAPS is a self-administered 213-item questionnaire which was developed for use with British institutionalised populations (McDougall, Venables & Roger, 1991). A selection of scales was assembled, with items drawn mainly from the Minnesota Multiphasic Personality Inventory (MMPI) (Morey, Waugh & Blashfield, 1985). Items are related to aspects of emotional adjustment and interpersonal behaviour. The SHAPS includes 10 scales to assess lying (i.e. 'faking good'), anxiety, extroversion, hostility, introversion, depression, tension, psychopathic deviance, impulsivity and aggression. Normative data is British in origin.

The aim of the SHAPS is to measure personality traits rather than psychiatric symptoms, i.e. it is not diagnostic in terms of symptomatology or psychiatric category. However, it is intended to be useful in describing deviant tendencies, which may contribute to the identification of personality disorder. Traits are viewed as summary descriptions of average or typical behaviour across time and setting (including 'covert' reactions), and indicate the relative strength of particular patterns of behaving in an individual's repertoire.

The SHAPS does not provide an exhaustive sample of deviant tendencies, although in relation to the behaviours which seem important in mentally disordered offenders it appears to be fairly comprehensive. Due to the probable overlap between the mentally disordered offender population and prison populations, the SHAPS has been thought to be of value in the investigation of offenders generally.

For the purposes of the present study, the scale of psychopathic deviance (Pd) was used to assess level of personality disorder. Despite its psychometric shortcomings, this scale has consistently been shown to discriminate between criminal and non-criminal populations. It is most appropriately construed as a measure of under-socialisation or rejection of conventional standards (Blackburn, 1982). In DSM IV (American Psychiatric Association, 1994) the nearest equivalent to psychopathic is anti-social personality disorder, which is one of eleven categories of personality disorder. There is no single category of personality deviation exclusively associated with anti-social behaviour which would justify the notion of a

psychopathic personality, and offenders labelled in this way present with a wide range of inflexible and maladaptive traits. Nevertheless, Blackburn (1992) argues that it is a reasonable assumption that the socially deviant behaviour of many offenders is a function of personality disorder, and that clinical concern should focus on the modification of offenders inflexible and maladaptive traits.

2) The Dissociative Experiences Questionnaire (DES) (Bernstein & Putnam, 1986).

The DES was developed in America to offer a means of reliably measuring dissociation in both normal and clinical populations. This scale is a 28-item, self-report, visual analogue instrument that evaluates dissociative experiences and has been designed to screen for dissociative disorders, i.e. it is not a diagnostic tool. However, scores over 30 on the DES often indicate a dissociative disorder, and subjects with high scores often warrant further diagnostic assessment (Anderson, Yasenik & Ross, 1992). In addition, scores above 40 are considered to be strongly suggestive of multiple personality disorder (Bernstein & Putnam, 1986).

The DES has been described as the most thoroughly validated index of dissociative experiences (Sandberg & Lynn, 1992). It has a test-retest reliability ranging from 0.84 to 0.96 in previous studies (Pitblado & Sanders, 1991), and good split-half reliability. The DES has enabled discrimination between subjects with multiple personality disorder from other diagnostic groups and normal control subjects (Ross, Norton & Anderson, 1988). Items enquire about the frequency of different experiences of amnesia, depersonalisation, derealization, absorption, and imaginative involvement. Examples of questions regarding dissociative experiences include, having no memory for important events in life, being in a familiar place and finding it strange and unfamiliar, and feeling that your body does not belong to you.

3) The Social History Questionnaire (SHQ) (Hillbrand, Foster & Hirt, 1988).

The SHQ consists of 47 dichotomous items, surveying the areas of family background, social/developmental history, educational history, sexual marital history, criminal history and support systems. It was developed following debate over which types of data are most useful in the prediction of violence, and more specifically in view of the current thinking which

emphasises that violence is a multi-determined phenomenon that results from a number of situational and predisposing factors. For the purposes of the present study, the SHQ was employed in an attempt to minimise any arousal of anxiety related to the possibility of disclosing a history of abuse. Estimates of the prevalence of abuse were based on affirmative responses to both the SHQ familial-items of parents being physically abusive, parents being neglective, and parents being sexually abusive, and to the SHQ childhood-items of being physically or sexually abused (excluding parents). Thus in line with other studies, childhood abuse and trauma was classified as follows: none, physical, sexual, or multiple (e.g. Swett & Halpert, 1993).

4) All participants were requested to write their age on the front sheet provided.

2.4 Procedure (prison and control groups)

Informed consent was obtained from all subjects (see Appendix 1), and all participating individuals were provided with a written explanation ensuring them of confidentiality and anonymity (see Appendix 2). This was also used to inform subjects that they were free to withdraw at any point, and with regard to the prison group, that withdrawal would in no way affect any subsequent treatment. Finally, all subjects were requested not to confer with other participants whilst undertaking the study.

In line with the wishes of the prison, a liaison person was appointed, to whom the nature and aims of the present study were explained, with special emphasis regarding the distribution and collection of materials. This appointed person was then to distribute the necessary material to those prisoners committed of rape who were willing to comply with the study. Within the prison there were 72 men serving sentences for rape, of which 39 initially agreed to participate in the study. Completed data was received from 34 of these men, a response rate of 47.22 per cent. Sixty questionnaires were distributed for completion to the control group personally by the author and 45 were completed, a response rate of 75 per cent. All subjects received copies of the three questionnaires; SHAPS, DES, and SHQ. It was estimated that completion of the three questionnaires should take between 50 to 65 minutes. All subjects were provided with an envelope in which to place their completed data, in order to ensure confidentiality. Upon

completion, the prison group were to hand their material to the prison liaison person in the first instance, ready for collection by the author at an agreed date. The control group were provided with stamp addressed envelopes for data return.

Upon receipt of completed questionnaires, the SHAPS, DES and SHQ results were calculated for each subject. The mean age for both groups - prison and control, was also computed. Data was analysed using SPSS for Windows, and the differences between the prison and the general population groups were investigated using two-tailed t-tests (uncqual variance estimate), except in the case of the differences in DES scores which used one-tailed tests, due to the direction of the relationship being predicted. As the t-tests showed a significant difference between the two samples with regard to age, the differences between the two groups were re-tested using analysis of covariance (ANCOVA), with age as a covariate. As childhood abuse was coded in an ordinal fashion, the difference between the two groups regarding abuse history was tested using a Mann-Whitney (U) test. The relationship between abuse history and dissociation was tested using Spearman's Rho. The relationship between dissociation and personality disorder was tested using a Pearson's Correlation Coefficient (r). The correlations used one-tailed tests, as a direction in the relationships was assumed. Throughout the analyses, the following values of significance were employed; $p < .05$ = significant, and $p < .01$ = highly significant.

3.0 Results

3.1 *Age*

The mean age of the prison and control groups was 31.35 (SD = 7.31) and 26.62 years (SD = 4.91) respectively. A t-test (two-tailed) identified a significant difference between the age of the two groups ($t = 3.26$, $df = 54.60$, $p < .05$). In view of this being a potential problem, age was partialled out using analysis of covariance (ANCOVA) with age as a covariate.

3.2 *Childhood trauma*

In the prison sample, eighteen subjects (52.94%) had been victims of childhood abuse. Four (11.77%) of the prisoners reported physical abuse only, and a further 4 (11.77%) reported

sexual abuse only, with 10 (29.41%) reporting being subjected to multiple abuse. This was in comparison to the control group, in which only two subjects (4.44%) reported incidents of childhood abuse, both of which were of the physical category. A Mann-Whitney (U) test revealed the difference between the groups regarding reported level of childhood abuse to be statistically highly significant ($U = 380.0$, $z = -5.00$, $p < .01$).

3.3 *Dissociation*

Table 1 illustrates the mean and median dissociation scores for the overall sample and for the two groups separately. For the overall sample of 79 subjects, the mean and median DES scores were 10.38 (SD = 11.44) and 6.43 respectively, with a range from 1.07 to 63.93. Fifty subjects (63.29%) had DES scores in excess of 4.38, the median score of normal adults established by Bernstein & Putnam (1986). However, it should be noted that the DES norms are based on American samples. Regarding the prison group, 11 subjects (32.35%) scored above 20, (indicating the existence of a substantial number of dissociative experiences in an individual's life); six subjects (7.59%) obtained a score of 30 or more, (indicating a dissociative disorder); and 2 subjects (2.53%) scored at least 40, (strongly suggestive of multiple personality disorder). The range of scores for the group was 1.25 to 63.93. In comparison, all subjects in the control group scored below 20, with a range from 1.07 to 18.75.

Table 1. Mean and median DES scores for the overall sample, and each group separately

Group	Median	Mean	Standard Deviation
Overall (n = 79)	6.43	10.38	11.44
Prison (n = 34)	9.73	15.77	15.30
Control (n = 45)	5.36	6.31	4.10

3.4 *Personality variables*

The results of the SHAPS for both groups were initially compared using t-tests (two-tailed) and then re-tested using analysis of covariance with age as a covariate. Table 2 illustrates the difference between the two groups in mean personality trait scores obtained from the SHAPS.

Table 2. Mean scores (SD) obtained on the SHAPS for the prison and control groups.

SHAPS	Prison Group	Control Group
Psychopathic Deviate	25.00 (6.49)	18.02 (3.73)
Anxiety	17.00 (10.85)	12.13 (6.89)
Extroversion	22.32 (5.64)	26.71 (5.06)
Hostility	13.18 (7.88)	7.98 (4.62)
Introversion	5.50 (4.52)	5.02 (3.69)
Depression	6.62 (5.43)	4.73 (3.05)
Tension	8.00 (4.41)	5.93 (3.03)
Impulsivity	14.03 (5.37)	16.98 (4.71)
Aggression	13.85 (8.41)	12.71 (5.55)
Lie	5.65 (2.62)	3.29 (1.97)

Regarding the 10 scales of the SHAPS, the results after submission to analysis of covariance were as follows (unless otherwise stated, significant results relate to the prison group achieving the higher score, with higher scores equating to an individual displaying greater levels of that trait); age was found to have a highly significant effect on psychopathic deviance, but the between group difference remained highly significant $F(1,76) = 9.9$, $p < .01$; anxiety was also found to be related to age, but again the between group difference remained highly significant $F(1, 76) = 14.4$, $p < .01$; age was found to be having no significant effect on extroversion, and the between group difference remained significant, with the control group scoring as more extrovert $F(1, 76) = 10.5$, $p < .05$; age was found to be significantly related to hostility, although the between group difference remained highly significant $F(1, 76) = 19.0$, $p < .01$; introversion was found to be significantly related to age, but there was no significant difference found between the two groups on this trait $F(1, 76) = 1.88$, $p > .05$; depression was found to be significantly related to age, but this did not detract from the highly significant between group difference $F(1, 76) = 9.9$, $p < .01$; age was found to be significantly related to tension, but the between group difference was still highly significant $F(1, 76) = 10.7$, $p < .01$; impulsivity was found to be just significantly affected by age, but there was no between group difference found $F(1, 76) = 2.9$, $p > .05$; age was found to be significantly related to aggression, but it had not taken away the between group difference, which remained not significant $F(1, 76) = 3.7$ $p > .05$; the lie scale was found to be related to age, but this had not

taken away the between group difference, which remained highly significant F (1, 76) = 12.1, p < .01.

3.5 *Hypothesis 1: Dissociation*

A t-test (one-tailed) was conducted to compare the DES scores for the prison sample with those of the control sample, the result of which indicated a highly significant difference between the two groups (t = 3.51, df = 36.60, p < .01). When this result was re-tested using analysis of covariance with age as a covariate, age was found to be having no effect on the between group difference F(1,76) = 13.6 p < .01. Hypothesis 1, that dissociation should be greater in the prison population than in the general population is therefore supported.

3.6 *Hypothesis 2: Dissociation and childhood trauma*

Spearman's Rho (one-tailed) was used in order to test Hypothesis 2, that dissociation should positively correlate with childhood trauma in both the prison and general population groups. Taking the overall sample, a highly significant positive correlation was found (r = .47, p < .01). The degree of correlation between dissociation and abuse in the prison group was also found to be highly significant (r = .59, p < .01). The correlation for the control group revealed a non-significant result (r = .17, p > .05), although this may have been due to only two members of the control group having experienced childhood abuse. Thus partial support was obtained for Hypothesis 2.

3.7 *Hypothesis 3: Dissociation and personality disorder*

A Pearson's Correlation coefficient (one-tailed) was used to test the relationship between dissociation and personality disorder. For the overall sample a highly significant positive correlation was found (r = .33, p < .01). A positive correlation was also found for the prison group, although this was not statistically significant (r = .10, p > .05). The relationship between dissociation and personality disorder in the control group was found to be positively correlated at a significant level (r = .28, p < .05). Partial support was therefore gained for Hypothesis 3, which stated that dissociation should positively correlate with degree of personality disorder as ascertained by the SHAPS (Blackburn, 1982) in both the prison and the general population groups.

4.0 Discussion

This study was designed to examine childhood trauma and dissociation as factors affecting adult male sexual offending behaviour, by comparing two different male population groups, comprising a group of convicted rapists and a control group. The aims of the study were to provide a general description of the level of childhood trauma and dissociation in the two groups; to investigate any identified differences between the groups in the levels of childhood trauma and dissociation found; and to investigate the relationship between dissociation and personality disorder in the two groups.

4.1 *Childhood trauma*

The results revealed a fairly high rate of reported childhood abuse (52.94%) among the sample of convicted rapists, which was found to be significantly greater than that reported by the non-clinical control group (4.44%) ($U = 380$, $z = -5.00$, $p < .01$). This would seem to be in line with other studies that have examined the incidence of childhood physical and sexual abuse in the developmental histories of men who have committed serious sexual offences (e.g. Seghorn et al. 1987). Incident rates for adult sexual contact with female children in Britain have been estimated to stand at 12 per cent, and at 8 per cent with regard solely to male children (Baker & Duncan, 1985). Thus the figure in the present study exceeds the reported prevalence rates for child sexual abuse among men in the general population as discussed. In addition, it exceeds the equivalent abuse rates quoted for incarcerated rapists by Seghorn et al. (1987) of 23 per cent, and by Groth (1979) of 29 per cent. What may be regarded as even more alarming is the fact that in the Seghorn et al. (1987) study, the incidence of childhood sexual abuse reported by child molesters was found to be more than 2.5 times the incidence for rapists. Abel (1982, p. 32) noted that 'there is growing awareness that a number of perpetrators - around 40 per cent - have been victimised as children.' The incidence reported in this study for convicted rapists represents an increase on Abel's (1982) estimate by close to 20 per cent. It would therefore seem that the present study adds further support to the notion of an association existing between childhood abuse and sexual offending behaviour in adulthood. However, such results do not mean that all male victims of abuse become sexual abusers. At present it is not

clear which factors influence whether or not this transition from victim to perpetrator occurs, although the offenders need to dominate or control another person may be an important contributory factor to sexually assaultive behaviour. Such needs are thought to represent an attempt by the offender to master the helplessness and hurt of his own victimisation by re-enacting similar encounters with himself in the position of power, although many other factors no doubt also contribute to the sexually assaultive behaviour of men who were themselves abused in childhood (Finkelhor, 1986). The comparatively low rate of reported abusive experiences among the control group, appears to be more in line with previous estimates of prevalence as cited in the literature (e.g. Bagley & King, 1990).

It has been argued that assessment of convicted sexual offenders can be invalidated, due to them being frequently unrepresentative of the general population of sexual assaulters. This is due to the fact that an average of fewer than 15 per cent of sex crimes result in imprisonment, therefore the majority of sex offenders are not within the prison system, but 'on the street' (Abel & Rouleau, 1990). If, as suggested by Rogers & Terry (1984), it is the case that male victims of childhood abuse are reluctant to report their experiences, then the data in the present study may be somewhat skewed in that those men with histories of abuse may have been more unwilling to participate. If so, the overall prevalence of abuse would be underestimated. In addition, as pointed out by Chu & Dill (1990) individuals who dissociate abusive experiences might not recall such experiences while completing a questionnaire, which may also have led to an underestimation of the true prevalence of abuse for the men involved in the present study. An interview study, in which it would be possible to pursue clues concerning abuse, may yield more accurate data pertaining to the prevalence of abuse.

4.2 *Dissociation*

The present study revealed a significantly greater amount of dissociation to be occurring in the prison group as opposed to the control group ($t = 3.51$, $df = 36.60$, $p < .01$). The prison group revealed a very high variation in the DES scores obtained, ranging from 1.25 to 63.93, with a mean of 15.77. In addition, the difference between the prison and control groups with regard to the standard deviation of the DES scores was huge (15.30 and 4.10 respectively) which

suggests that even within the present, relatively small sample, the offenders achieved a much greater spread of scores than the control group. Overall 63.29 per cent of subjects scored in excess of the median score established for normal American adults by Bernstein & Putnam (1986) which suggests that dissociative experiences and disorders are a somewhat common occurrence within the British population.

Scores above 20 on the DES are considered to be indicative of a substantial number of dissociative experiences occurring in a person's life. The present study revealed that all subjects in the control group were below this level, compared to the prison group in which 32.35 per cent of subjects reached this level of score. In clinical studies, scores above 30 on the DES have been associated with a high likelihood of post traumatic stress disorder or multiple personality disorder (Ross, Norton & Anderson, 1988). In the present study, 10.12 per cent of the prison sample had scores of 30 or more. This result would seem to suggest that over 10 per cent of the convicted rapists involved in the present study have a psychiatric disorder. However, a high rate of mental disorder in offender populations does not establish a causal link between the disorder and criminal or violent acts. Studies of the prevalence of psychiatric disorder among convicted offenders are plagued by a lack of consistent diagnostic criteria across studies and over time, as well as by the filtering out of many disordered offenders at an early stage of the criminal justice procedure. Despite this it has been suggested that a third or more of prisoners show some form of mental disorder, but that this is mainly a reflection of high rates of alcohol and drug abuse and personality disorder (Blackburn, 1993). There are no reported studies that have used the DES to identify the prevalence of dissociative disorders among prisoners, however the present study would seem to be in line with the above view that a rather high amount of prisoners suffer from some sort of psychiatric disorder. The causal implications of such findings are uncertain, although as pointed out by Blackburn (1993) they nevertheless carry policy implications for provision of services to offenders. The extent of dissociation found among prisoners in the present study is somewhat less than that found in studies of psychiatric populations. For example Quimby & Putnam (1991) found 30 per cent of the patients in their study had high degrees of dissociation (score > 30). A general population study using the DES found that as many as 5 per cent of the respondents had

dissociation scores above 30 (Ross, Joshi & Currie, 1990), whereas in the present study there were no DES results above 20 for the general population group, with just 10 per cent of the prison group scoring over 30. Thus it would seem that in comparison to other studies, relatively low levels of DES scores were obtained in the present study across both subject groups. However it should be noted that the above cited studies were American and Canadian in origin, and it has been shown that place of birth can significantly effect DES scores, with persons born in Europe found to achieve lower scores than their United States counterparts (Ross, Joshi & Currie, 1990). It should also be remembered that the established norms for the DES are American, therefore the question arises as to whether the lower levels of dissociation achieved in the current study as compared to previous studies are due to cultural differences in response style or to a 'real' difference.

However, the results obtained offer a tentative prediction that dissociative disorders, including multiple personality disorder, may be a relatively common phenomenon, with a prevalence rate that may be in the range of 10 to 15 per cent among the sexual offender population of Britain. It would also seem that those dissociative experiences located towards the lower end of the dissociative continuum are a somewhat common occurrence among the UK adult male population.

The fact that dissociation was found to be significantly greater in the prison population than in the general population leads to the question of whether the greatly enhanced level of dissociation found among the offender group was a contributory factor in the perpetration of their crimes. Bower (1981) reported that an amnesia is present following violent crimes, such as assaults or murders, in approximately one third of cases. In a study of sexual criminality and hypnotizability Bliss & Larson (1985) reported anecdotal and inferential evidence that 'spontaneous self-hypnotic processes' (spontaneous dissociations) may promote or produce some male criminality. Bliss & Larson (1985) suggested that the altered state of self-hypnotic dissociation, which produces sensations such as a feeling of distance and unreality extending to amnesia, will allow an individual to perform acts which ordinarily would be taboo, i.e. the dissociated state makes the act possible. Thus in the present study it may be that dissociation facilitated sexual offending in some offenders, yet in comparison, the fact that other members

of the prison group did not report high levels of dissociation suggests that some sexual offenders do not have, or do not require, this mechanism in order to offend.

A possible conclusion is that although dissociation may play a role in some criminality, other factors, including childhood abuse as discussed previously, are also important. The pertinent question regarding the relative importance of dissociative symptoms/processes in the commission of rape therefore remains unanswered by the present study, especially when the number of other possible variables operating is considered.

The support found for hypothesis 1, that dissociation should be greater in the prison population than in the general population, has implications with regard to risk assessment and prediction of future dangerousness, especially when considering parole or release, as legal decision makers frequently rely on the judgements of mental health professionals. While understanding of clinical decision making remains limited, enough is known to indicate that it is highly fallible and could be improved (Blackburn, 1993). If the results of the present study, concerning the offenders significantly elevated dissociation scores in relation to the general population group, are considered in conjunction with; a) the suggestion of Kluft (1984) regarding the importance of recognising and treating dissociation, and b) the findings of Norton et al. (1990) regarding the effects associated with dissociation which include high levels of anger and thinking in an irrational manner, then it would seem that consideration of an offenders dissociative abilities would add a further dimension to the task of predicting dangerousness. If nothing else, it would aid the clinician in reaching a more informed judgement, which Mulvey & Lidz (1984) argue is the best that can be hoped for.

4.3 *Dissociation and childhood trauma*

Dissociation and childhood trauma were found to positively correlate with each other to a highly significant level, both for the overall sample ($r = .47$, $p < .01$) and in the prison sample ($r = .59$, $p < .01$). The relationship between these two variables was found to be non-significant ($r = .17$, $p > .05$) in the control group, in which significantly lower levels of both child abuse and dissociation were found as compared to the prison group. Thus partial support was obtained for Hypothesis 2, that dissociation should positively correlate with childhood

trauma in both the prison and the control groups. However, it is worth noting that in the control group with the low prevalence of childhood abuse, it is not particularly surprising that abuse was not significantly correlated to dissociative experiences.

The findings of the present study would seem to support the notion that traumatic experiences and disruptions in parental care play a major role in the development of dissociative symptoms (Kluft, 1991). There would also appear to be some support for the suggestion of a correlation between previous victimisation and aggressive sexual behaviour in the future. Further weight is also added to the contention that the deleterious effects of childhood abuse constitute a major health problem. A widely held belief is that dissociation is a defence mechanism employed to cope with overwhelming experiences (Spiegel, 1991) and that childhood trauma creates the fragmented sense of self that characterises these individuals. However, as mentioned previously, it is possible that dissociation increases the bias with which people remember and report their past (Chu & Dill, 1990). Saxe et al. (1993) have suggested that the only satisfactory way to deal with this methodological problem would seem to be to conduct prospective studies of traumatised children in order to determine subsequent rates of dissociation. Perhaps in this way interventions could be undertaken early enough to help avoid severe, and often chronic problems, such as engaging in sexually assaultive behaviour, developing in later life. A compounding problem is that individuals have frequently been found to 'hide' their dissociative symptoms for a wide variety of reasons (Putnam, 1989).

The finding that the criminal group reported significantly higher rates of both childhood abuse and dissociation has implications for clinical practice with such populations, in suggesting that therapists working with offenders should enquire about childhood trauma, and assess a client's dissociative abilities. Such findings could then be incorporated into the therapy process, and enable the therapist to assess the relative importance of the abuse and the dissociation in relation to the presenting offending behaviour. For example, if the difficulties experienced by those male offenders with histories of abuse are directly related to the abusive experiences, it seems clear that definitive treatment cannot occur without the acknowledgement of the reality of those experiences, which can profoundly shift the attitudes of both therapist and client. In addition, it is widely recognised that many sex offenders either deny their offence

or do not see it as a sexual problem, and as such do not readily become engaged in therapy (Maletzky, 1991). The fact that dissociative experiences/ symptoms may be playing a part in the development and maintenance of such behaviours has not been investigated, despite it being known that those with dissociative symptoms often deny awareness of past actions or experiences. Although such a link would not explain all criminality, it might be one factor, among many, promoting anti-social behaviour in some male offenders.

4.4 *Dissociation and personality disorder*

The present study also aimed to investigate the relationship between dissociation and personality disorder in the prison and control groups. This relationship was found to be significant both in the sample overall ($r = .33$, $p < .01$) and in the control group independently ($r = .28$, $p < .05$). However, the relationship between personality disorder and dissociation in the prison group, although found to be in a positive direction, was not statistically significant ($r = .10$, $p > .05$). This was despite the fact that the mean scores for the prison group were statistically higher than those of the control group both in terms of the Pd sub-scale, $F(1, 76) = 9.9$, $p < .01$, and the DES ($t = 3.51$, $df = 36.60$, $p < .01$) (one-tailed). Regarding the Pd scale, the standard deviation for the prison group was almost twice that of the control group, which indicates that there is no single pattern of personality disorder exclusively associated with anti-social behaviour (i.e. rape) into which offenders can be categorised. Some support was therefore gained for Hypothesis 3, that dissociation should positively correlate with degree of personality disorder as ascertained by the SHAPS in both the prison and the control groups.

There are a number of possible reasons which may account for the unexpected non-significant result for the prison group. These may include problems to do with the measure used to assess personality disorder, although several other studies have employed self-report inventories with Pd sub-scales in order to assess personality disorder (e.g. Langevin, Handy, Day & Russon, 1985). However, the use of such inventories for research purposes is considered to be problematic. For example, self-report scales are susceptible to malingering and impression management, a particular concern with individuals who may be skilled at deception and manipulation (Hare, Forth & Hart, 1989). Moreover, self-report scales designed to measure psychopathy seem to measure only the social deviance components and do not seem

to effectively measure the affective and interpersonal features of psychopathy (Hare, 1991). It should also be remembered that the nature of the SHAPS is to measure personality traits, which, after all, are descriptions of behaviour in the average person. Traits do not account for specific acts, such as rape, which require a situation as well as a person, and they do not explain why a person has their particular dispositions. Alternatively, it could be that the present sample was not representative of the sex offender population, as incarcerated offenders are thought to represent perhaps only 1 per cent of the total number of sex offenders.

The present results are somewhat surprising when one considers previous reports of strong associations between high DES scores and the existence of multiple personality disorder, which is regarded as a severe disorder of personality, and the most extreme and chronic of the dissociative disorders (e.g. Bernstein & Putnam, 1986). However, it may be as Blackburn (1992) suggests, that the statutory concept of psychopathic disorder has only limited correspondence with clinical concepts of psychopathic personality, and obscures the heterogeneity of personality disorder among the anti-social. The results of the present study seem to support the notion that not all of those who are socially deviant show the traits of personality disorder, nor do all those with personality disorder violate legal or ethical norms. In addition, although socially deviant behaviour may sometimes be a consequence of personality disorder and/or dissociation, it would appear that anti-social behaviour in itself cannot be used to define a personality disorder, or the existence of dissociative symptoms.

The findings of the present study are in line with those of comparison studies of rapists with other offenders on personality tests, which have not yielded consistent discrimination, suggesting that rapists may be characterised by criminality, but not by more specific personality characteristics (Koss & Leonard, 1984). On the other hand, MMPI studies of imprisoned rapists have indicated that this group tend to score highly on the Pd scale. Blackburn (1993) argues that while the most consistent finding is that rapists are poorly socialised, the MMPI data suggests that they are among the more personally deviant criminals.

Despite the non-significant correlation found between personality disorder and dissociation, it would seem that the diagnosis of personality disorder has implications for clinical interventions with offenders, which includes screening for, and awareness of, the possibility of

both dissociation and childhood trauma existing in such individuals. In addition, if deviant/personality disordered behaviour is, as Blackburn (1992) suggests, associated with an inflexible style due to distorted expectations, then the target of change with such individuals (a topic of some disagreement) is clearly the individual's dysfunctional belief system.

4.5 *Limitations*

The present study is possibly the first to examine dissociation using rigorous epidemiological criteria (DES) within the British male population. As such it is necessarily exploratory, with the intention of finding out general information regarding the prevalence of dissociative disorders in two specific client groups, convicted rapists and control. In addition, it has also attempted to provide a general description of the level of childhood trauma and personality disorder in the two study groups.

This study, like the majority of research on dissociation, is inherently limited by its reliance on retrospective self-reports of abuse. Nevertheless, the findings of the present study illustrate the importance of examining the correlates of dissociative experiences not only in offender populations, but also in non-clinical populations.

The correlational nature of the study prevents any conclusions being drawn regarding cause and effect in any of the relationships found to exist. However, detecting the existence of such a relationship is an important finding in its own right, especially if one considers that such findings may add another dimension to the treatment of offenders, which may reduce reoffending and ultimately save victims from the devastating effects that sexual assaults incur.

It was recognised that prisoners pose the problem of falsification of tests if some gain is implied or assumed. Such motivations seemed unlikely in the present study, as the prisoners had been sentenced, and there was no suggestion that their performance would affect their sentence.

A further consideration is how representative the non-clinical control group was of the UK adult male population, who were simply randomly selected from the males entering one public house in a northern suburb.

It should be noted that sexual offenders represent only a small and perhaps atypical segment of the criminal population. However, the considerable variability of the dissociation results (with a range from 1.25 to 63.93) observed among the prisoners in the present study, coupled with the fact that childhood abuse was found to be positively correlated with dissociation for the prison group ($r = .59$, $p < .01$) encourages the expectation that other subgroups of criminals, such as murderers, may contain individuals with high levels of dissociative experiences and childhood histories of traumata. Future research could address this issue by comparing levels of dissociation across various subgroups of offenders. A further suggestion for future studies (which was considered in the present study but was excluded due to procedural difficulties), would be to compare a specific group of convicted offenders with a corresponding group of personality disordered offenders detained within a special hospital. These are forensic psychiatric establishments for mentally disordered offenders, including the more serious violent and sexual offenders who additionally show personality disorder.

4.6 *Summary/conclusions*

This study involved the investigation of two groups of British adult men, which included a group of convicted rapists and a non-clinical group.

Basic epidemiological information relevant to both groups of participants was obtained. This information related to childhood trauma, dissociation and personality disorder. Of particular note was the high prevalence of childhood abuse reported in the prison group (52.94%), and the fact that 63.29 per cent of the men involved in the study scored in excess of the median score previously established for normal American adults (Bernstein & Putnam, 1986). As expected, the amount of personality disorder as established using the Pd scale of the SHAPS, was significantly greater in the prison as compared to the control group $F(1, 76) = 9.9$, $p < .01$.

Hypothesis 1

Dissociation was found to be greater in the prison group than in the control group to a highly significant degree.

Hypothesis 2

Dissociation was found to positively correlate with childhood trauma in both groups, although with regard to the control group this relationship did not reach statistical significance.

Hypothesis 3

Dissociation was found to positively correlate with degree of personality disorder in both groups, although this correlation did not reach statistical significance for the prison group.

It can be concluded from the present study that those working with sexual offenders should be knowledgeable about dissociation. The possibility of childhood abuse should also be borne in mind, especially if a client presents with dissociative experiences or personality disorder, even if the offender has no awareness of any traumatic experiences. The offender's dissociative strategies, including the possible role these may have played in an offence history, should be understood and taken into account in the planning of an intervention. However, it should not be forgotten that criminal behaviour, including rape, is a complex phenomenon of multifactorial origin.

Further research is needed to document the temporal and causal relationships between traumatic experiences and dissociative symptoms, including how they may affect criminality, the extent to which personality traits predispose a person to manifest a dissociative disorder, and the specific cognitive and emotional mechanisms that underlie dissociative phenomena.

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Appendix 1: Research consent form

Childhood Trauma and Dissociation as Factors Affecting Adult Male Sexual Offending Behaviour

To be signed and dated by all individual participants.

I ..... agree to be involved in the study carried out by Fiona Hislop (Trainee Clinical Psychologist). I am satisfied that the purpose and procedures of the study have been fully explained to me. 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 .....

Appendix 2: Written explanation of the study

Childhood Trauma and Dissociation as Factors Affecting Adult Male Sexual Offending Behaviour

The present study involves the completion of three questionnaires, in an attempt to investigate current symptoms and past life experiences, including possible experiences of abuse. The aim is to compare the questionnaire results of a sample of adult males taken from the general population, with a group of convicted prisoners. With regard to the prison group, the aim is to look at whether the above named factors are related to their offending behaviour.

In addition, please could you note down your age on the front page provided.

There is no risk or discomfort involved in participating in this study.

If you wish to withdraw at any point, please feel free to do so; this will in no way affect any subsequent treatment.

Please do not confer with other participants whilst completing the questionnaires.

All information is anonymous and strictly confidential.

Thank you for your help and co-operation.

Yours

Fiona Hislop
Trainee Clinical Psychologist

Appendix 3: Mann-Whitney (U) Test

SHQ by Group

Group	Mean Rank	Cases
1 (Prison)	51.32	34
2 (Control)	31.44	45

		79

Corrected for ties

U	W	z	2-Tailed P
380.0	1745.0	-5.00	.00

Appendix 4: T-tests and analysis of covariance for SHAPS data

T-tests

SHAPS	Prison Group Mean Score	Control Group Mean Score	t (df)
Psychopathic Deviate	25.00	18.02	5.60 (49.23)
Anxiety	17.00	12.13	2.29 (52.51)
Extroversion	22.32	26.71	-3.58 (66.79)
Hostility	13.18	7.98	3.43 (49.81)
Introversion	5.50	5.02	.50 (62.74)
Depression	6.62	4.73	1.82 (48.54)
Tension	8.00	5.93	2.35 (55.39)
Impulsivity	14.03	16.98	-2.55 (65.87)
Aggression	13.85	12.71	.69 (53.91)
Lie	5.65	3.29	4.40 (59.25)

Analysis of covariance by group with age

SHAPS	F	Sig of F		(df)
		Group	Age	
Psychopathic Deviate	49.62	.00	.00	(1, 76)
Anxiety	14.35	.00	.00	(1, 76)
Extroversion	10.53	.00	.75	(1, 76)
Hostility	19.00	.00	.02	(1, 76)
Introversion	1.89	.17	.02	(1, 76)
Depression	9.86	.00	.00	(1, 76)
Tension	10.69	.00	.02	(1, 76)
Impulsivity	2.98	.09	.05	(1, 76)
Aggression	3.65	.06	.00	(1, 76)
Lie	12.13	.00	.01	(1, 76)

Appendix 5: Full results of tests of hypotheses

Hypothesis 1
a) t-test

Variable	No. of cases	Mean(SD)
DES		
Prison	34	15.77
Control	45	6.31

Variance	t (df)	1-tailed sig.
Unequal	3.51	.00

b) Analysis of covariance: DES by group with age

F	Sig of F		(df)
	Age	Group	
13.57	.97	.00	(1, 76)

Hypothesis 2
Spearman correlation coefficients

i) Sample overall

DES .47
N (79)
Sig .00

SHQ

(Coefficient/ (Cases)/ 1-tailed significance)

ii) Prison group

SHQ .59
N (34)
Sig .00

(Coefficient/ (Cases)/ 1-tailed significance)

iii) Control group

SHQ .17
N (45)
Sig .14

(Coefficient/ (Cases)/ 1-tailed significance)

Hypothesis 3
Pearson's Correlation Coefficients

" . " is printed if a coefficient cannot be computed

i) Sample overall

	DES	Pd
DES	1.00 (79) p = .	.33 (79) p = .00
Pd	.33 (79) p = .00	1.00 (79) p = .

(Coefficient/ (Cases)/ 1-tailed significance)

ii) Prison group

	DES	Pd
DES	1.00 (34) p = .	.10 (34) p = .28
Pd	.10 (34) p = .28	1.00 (34) p = .

(Coefficient/ (Cases)/ 1-tailed significance)

iii) Control group

	DES	Pd
DES	1.00 (45) p = .03	.28 (45) p = .
Pd	.28 (45) p = .03	1.00 (45) p = .

(Coefficient/ (Cases)/ 1-tailed significance)

Placement: Learning Disabilities

A Study of Stress, Job Perception and Role in Staff Employed in Day Centres for People with Learning Disabilities

Word Count = 3336 (excluding references)

= 3898 (including references)

Abstract

The relationship between levels of stress, job perception and the percentage of time spent in type of direct client work (role) by 11 Day Centre staff was assessed by means of a postal survey. The estimated prevalence of psychological distress as measured by the General Health Questionnaire (GHQ) (Goldberg, 1978) was 45.4 per cent, which is higher than that reported in other studies. A statistically non-significant negative relationship was found between the GHQ and the job perception measure. This would seem to indicate that stress as measured by the GHQ, and job perception are largely independent dimensions of staffs' experiences. However, when examined as a separate group, a significant negative relationship was found between the below threshold level GHQ group and their job perception. The percentage of time spent in both physical care and leisure activities was found to have non-significant low positive correlations with the GHQ scores. Both categories of activity were also found to have a non-significant low negative correlation with job perception levels.

1.0 Introduction

The theme of the study was to examine staff stress and job satisfaction levels in relation to the type of work undertaken by staff in Day Centres. The role of Day Centres for people with learning disabilities will initially be examined, followed by a discussion of the general occupational stress literature. Studies looking at how various factors of direct care work are thought to be related to work stress and job satisfaction will then be discussed.

Day Centres for people with learning disabilities (previously known as Adult Training Centres) are seen as having a variety of roles. As cited in the Future Role of Day Centres document (Lancashire County Council, 1990), they are primarily viewed as offering daytime respite to parents and carers. In many cases they have been seen as the providers of education, work or leisure for the learning disabled adult population. Responsibility for the Day Centres lies with Social Services. The centres seek to provide a service for a very large group - from school leaving age (generally 19 years), to normal retiring age. The needs and abilities of the clients who attend the Day Centres show considerable variation, from those with profound and multiple disabilities who rely heavily on the centre's facilities, to those who require only minimal support in order to benefit from community activities outside the centre.

However, it has become increasingly apparent that problems prevail. For example, the service provision is often restricted due to problems such as low staffing levels and inadequate staff training. In addition, basing day services upon centres results in the unnecessary segregation of many people thus restricting opportunities for community participation. At the present time, services to people with learning disabilities are going through a process of considerable change and reorganisation. There are a number of reasons for this change, which are cited in the Lancashire County Council (1990) document. These include the recently increased expectations for learning disabled people; the government policy shift towards community as opposed to segregated services; the creation of closer links between Day Centres and local colleges of further education and leisure services; and the estimated increase in demand due to hospital closures. Changes in policy (both at County and centre level) with clear aims and objectives have had implications for the present role of staff. During such times of change investment in staff is increasingly necessary.

Joyce & Oliver (1984) note that the staff who work in Day Centres are usually not trained to work specifically with people with learning disabilities, and very rarely have any specialised knowledge of working with those clients who have profound and multiple handicaps. This can often lead to staff feeling de-skilled and stressed, as well as contributing to low morale and job satisfaction. Over the years, work related stress has received growing recognition, and occupational stress in the caring professions is now a well recognised phenomenon (Cherniss, 1987).

Menaghan & Merves (1984), in looking at individual coping strategies with problems in a variety of occupations, defined stress as 'a discrepancy between environmental demands and individual capabilities' (p. 408). Thus staff may be stressed if the demands made on them are too great, or if they are inadequately equipped for the task.

In his Dynamics of Work Stress Model (1988), Cooper points out that, regardless of how one job may compare to another in terms of stress, it is helpful to recognise that every job has potential stress agents. His model identifies five major categories of work stress, which to varying degrees may be causally linked to stress in each job. These five categories are: factors intrinsic to the job (e.g. work overload); role in the organisation (e.g. role ambiguity); relationships at work (e.g. rivalry); career development (e.g. lack of job security); and organisational structure and climate (e.g. no sense of belonging). (See Appendix 1 for diagram of the model).

In addition, Lazarus (1991) identifies the fact that many aspects of work such as time pressure, noise, work overload, lack of decisional control and role ambiguity are potential stressors for large numbers of workers. Likewise certain types of person, such as those with neuroticism or a tendency to depression, are likely to react with more frequent or intense stress than others. However, Lazarus (1991) continues that although such knowledge is valuable, it misses the central point which is that the sources of stress are always, to some extent, individual, as are the ways people cope with stress.

High levels of such stress have often been reported to lead to 'burnout', comprising emotional exhaustion, depersonalisation, low productivity and low achievement (Cherniss, 1987). In 1983, Cade wrote, 'the various helping professions are particularly at risk of burnout,

concerned as they are with different client groups and working frequently with inadequate resources and insufficient acknowledgement or support' (p. 9).

Sharrad (1992) states that those staff involved in direct client care are perhaps the most important employees within the Learning Disability Service. They usually have close daily contact with the clients, and as such play a vital role in the implementation of training, programming and general development packages. As such it would seem vital that this staff group is given the level of support necessary for them to work effectively. Thus, in addition to focusing on the impact of work related stress, the issue of job satisfaction/perception also needs to be addressed.

High levels of occupational stress have been reported as contributing to job dissatisfaction (Davis, 1974). Bersani & Heifetz (1985) suggest that work related stress and job satisfaction appear to be independent of each other and can coexist. George & Baumeister (1981) suggested that direct care staff have lower levels of measured job satisfaction compared with industrial workers, and that their greatest dissatisfaction is due to staffing shortages and low pay. Staff dissatisfaction has also been associated with extensive client contact, and perceived lack of client progress (Sarata, 1974). Conversely, interactions with clients has been identified as the main source of job satisfaction (Browner, Ellis, Ford, Silsby, Tampoya & Yee, 1987).

Several studies have cited the existence of violence and behaviour problems as reasons for dissatisfaction (e.g. Allen, Pahl & Quine, 1990). In their 1985 study, Bersani & Heifetz reported that client contact provided the greatest source of both stress and satisfaction for staff. In view of this they concluded by suggesting that 'greater degrees of impairment in clients are not associated with either higher levels of stress or lower levels of satisfaction of staff' (p. 295).

A number of studies identify staff turnover as an objective measure of job stress or dissatisfaction, (e.g. Zaharia & Baumeister, 1979). However, as indicated by Sharrad (1992), increased stress does not necessarily mean increased turnover, as one must establish whether an employee has left for reasons other than those related to stress.

To summarise the findings of the job stress and satisfaction studies, it would seem that the main point is that working directly with people with learning disabilities can either be

challenging and rewarding, or exhausting. Staff reactions will also vary depending on factors such as individual personalities and the philosophy of the service.

2.0 *Aims*

The purpose of the current study was to investigate the relationship between the percentage of time staff spend in various types of direct client contact, staff stress levels, and staff job perception levels (the term perception was used rather than satisfaction due to the data collection measure used). Direct client contact was divided into two distinct categories, that of physical care activities (such as feeding and toileting), and that of leisure activities (such as swimming and trampolining).

Hypothesis 1

There will be a negative correlation between the GHQ and the job perception questionnaire scores. For example, negative job perception will be associated with poor mental health.

Hypothesis 2

There will be a relationship between the GHQ scores and the percentage of time spent in type of activity, such that:

i) the percentage of time spent in physical care activities will be positively correlated with the GHQ scores.

ii) the percentage of time spent in leisure activities will be negatively correlated with the GHQ scores.

Hypothesis 3

There will be a relationship between the job perception scores and the percentage of time spent in type of activity, such that:

i) the percentage of time spent in physical care activities will be negatively correlated with job perception.

ii) the percentage of time spent in leisure activities will be positively correlated with job perception.

3.0 Method

3.1 Design

The study involved a survey comprising of two questionnaires and one time sheet, which were distributed to a total of 23 Day Centre staff.

3.2 Participants

The assessment measures were distributed to Social Services staff who were employed in the two Day Centres for people with learning disabilities in the district. At the time of the study, 23 such staff were employed, 11 of whom voluntarily completed the questionnaire (47.8% response rate). Details relating to age, sex, relevant qualifications and length of service were not collected, as is was thought that such information may infringe upon confidentiality given the relatively small sample size, and therefore affect the response rate.

3.3 Measures and data collected

1) The General Health Questionnaire GHQ-60 (Goldberg, 1978).

This 60-item questionnaire was used in order to obtain an indication of the respondent's stress level. It provides a measure of non-psychotic psychiatric disturbance namely general anxiety, depression and social dysfunction's. Although primarily a measure of psychological symptoms rather than a measure of stress per se, the GHQ has been used as a measure of general distress in other studies of occupational stress (e.g. Cushway, 1990). Items were scored using the GHQ method whereby items are scored as either 0 or 1 (maximum score 60). As suggested by Goldberg (1978) a cut off score of 11 was used to indicate caseness.

2) Job Perception Questionnaire (see Appendix 2).

This 11-item questionnaire was designed for the present study and aimed to collect information pertaining to the staff member's level of job perception. The items included were adapted from Coopers (1988) Dynamics of Work Stress model. As such, this measure is not standardised in terms of reliability and validity. Subjects were required to rate the intensity of their perceptions on a 5 point scale. A total perception score was obtained by calculating the sum of the ratings (maximum score 55). The mid point of the scale was used to distinguish between high and low levels of perception providing a cut off score of 33.

3) Recording Sheet (see Appendix 3).

The final part of the data collected involved the completion of an activity recording sheet for the duration of one week. The recording sheet was broken down into days and then into hours. For each hourly period, staff were required to note down the amount of time in minutes that they had spent involved in either physical or leisure activities. Examples of what constituted each type of activity were given on the front cover of the recording sheets. Only activities which involved direct client contact were to be recorded.

3.4 Procedure

Staff meetings were attended by the author during which the project was explained in detail to staff, and any queries or concerns they had were answered. It was at these meetings that the material was distributed. To ensure confidentiality staff were requested to return the completed questionnaires anonymously in the stamped addressed envelopes provided.

Upon receipt of the completed data, the GHQ and job perception scores were calculated for each subject. From the recording sheets, the total amount of time spent in direct client contact work for each subject was calculated as a percentage of the working week, as was the time spent in either leisure or physical care activities.

4.0 Results

4.1 *Descriptive Analysis*

GHQ

The mean GHQ score was calculated ($\overline{X}$ = 11, SD = 11.92). 45% of subjects (n=5) had scores of 11 or above, which is equivalent to the recommended threshold score for caseness. According to the GHQ manual, the threshold score for caseness reflects the concept of a 'just significant clinical disturbance.' This does not necessarily indicate that those scoring above the threshold require intervention (Goldberg,1978).

Job Perception Questionnaire

The mean job perception score was calculated ($\overline{X}$ = 29.82, SD = 8.58). 45% of staff members had scores which fell above the mid-point of the job perception scale (mid-point was taken as an indication of satisfaction).

Percentage of time

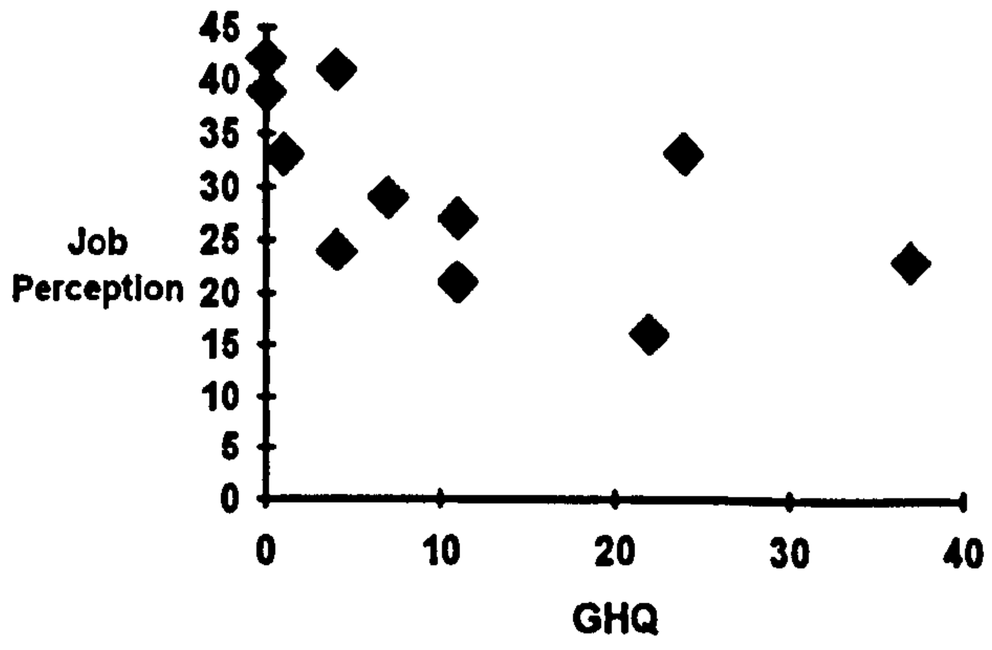
The mean total percentage of time spent involved in direct client contact work was calculated ($\overline{X}$ = 68.45%, SD = 14.14). The mean percentage of time spent involved in physical care activities (%P) was calculated ($\overline{X}$ = 23.65%, SD = 10.88). The mean percentage of time spent involved in leisure activities (%A) was calculated ($\overline{X}$ = 44.79%, SD = 15.43).

4.2 *Statistical Analysis*

Hypothesis 1

A Pearson's correlation coefficient was calculated using the GHQ and the job perception scores for the whole group. The results were found to be non significant at the 5% level ($r = -0.28$, $p > .05$) (see Fig. 1). The mean job perception score was calculated for the group who scored 11 or more (n=5) on the GHQ ($\overline{X}$ = 24, SD = 6.40). A t-test(one-tailed) (indicated there was no significant relationship between GHQ and job perception for this subgroup ($t = -0.54$, $p > .05$). In contrast, the group who scored less than 11 on the GHQ had a mean job perception score of $\overline{X}$ = 34.6 (SD = 7.23). This was found to be significant ($t = -10.16$, $p < .05$)

Figure 1. Scattergram to illustrate the relationship between GHQ and job perception scores.

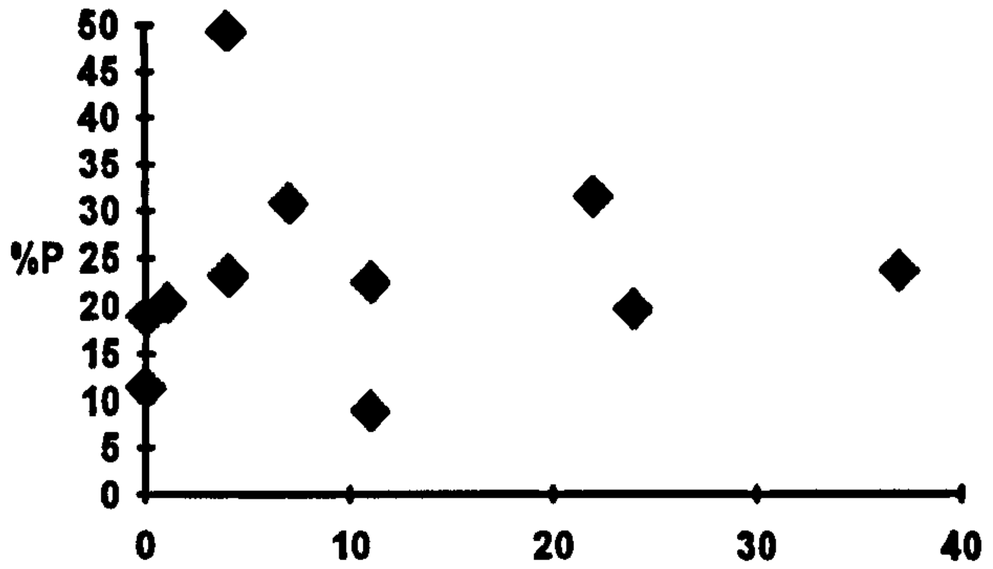


low negative correlation (not significant)

Hypothesis 2

i) A Pearson's correlation coefficient between the amount of time spent in physical care activities (%P) and GHQ scores revealed a non-significant result ($r = 0.12$, $p > .05$) (see Fig. 2).

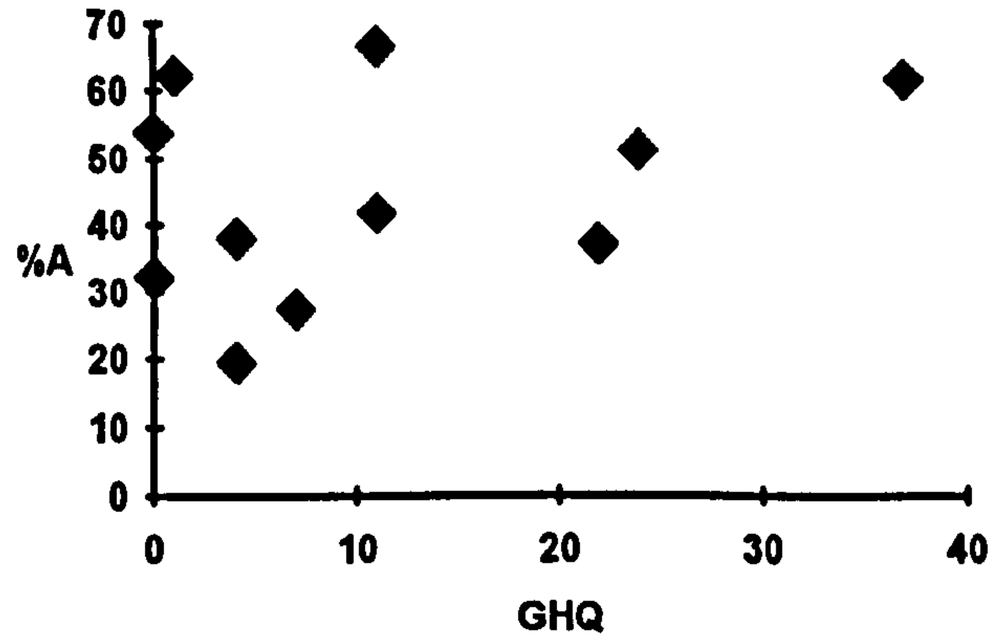
Figure 2. Scattergram to illustrate the relationship between %P and GHQ scores.



low positive correlation (not significant)

ii) A Pearson's correlation coefficient was calculated on the relationship between the amount of time spent in leisure activities (%A) and GHQ scores. This was found to be non-significant ($r = 0.33$, $p > .05$) (see Fig. 3).

Figure 3. Scattergram to illustrate the relationship between %A and GHQ scores.

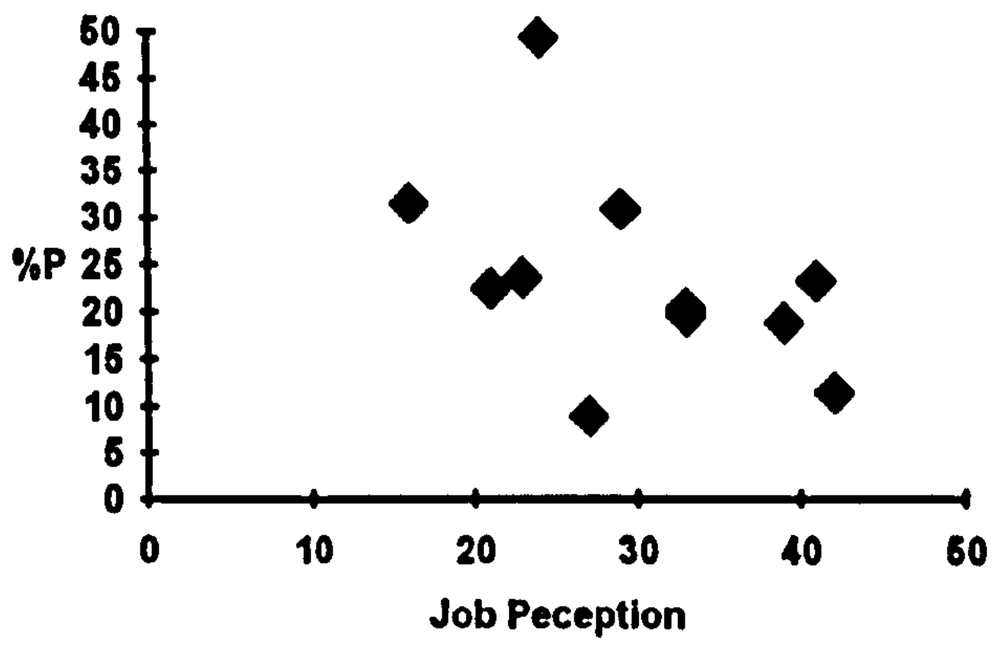


low positive correlation (not significant)

Hypothesis 3

i) A Pearson's correlation coefficient was calculated on the relationship between amount of time spent in physical care activities (%P) and job perception. This was found to be non-significant ($r = -0.46$, $p > .05$) (see Fig. 4).

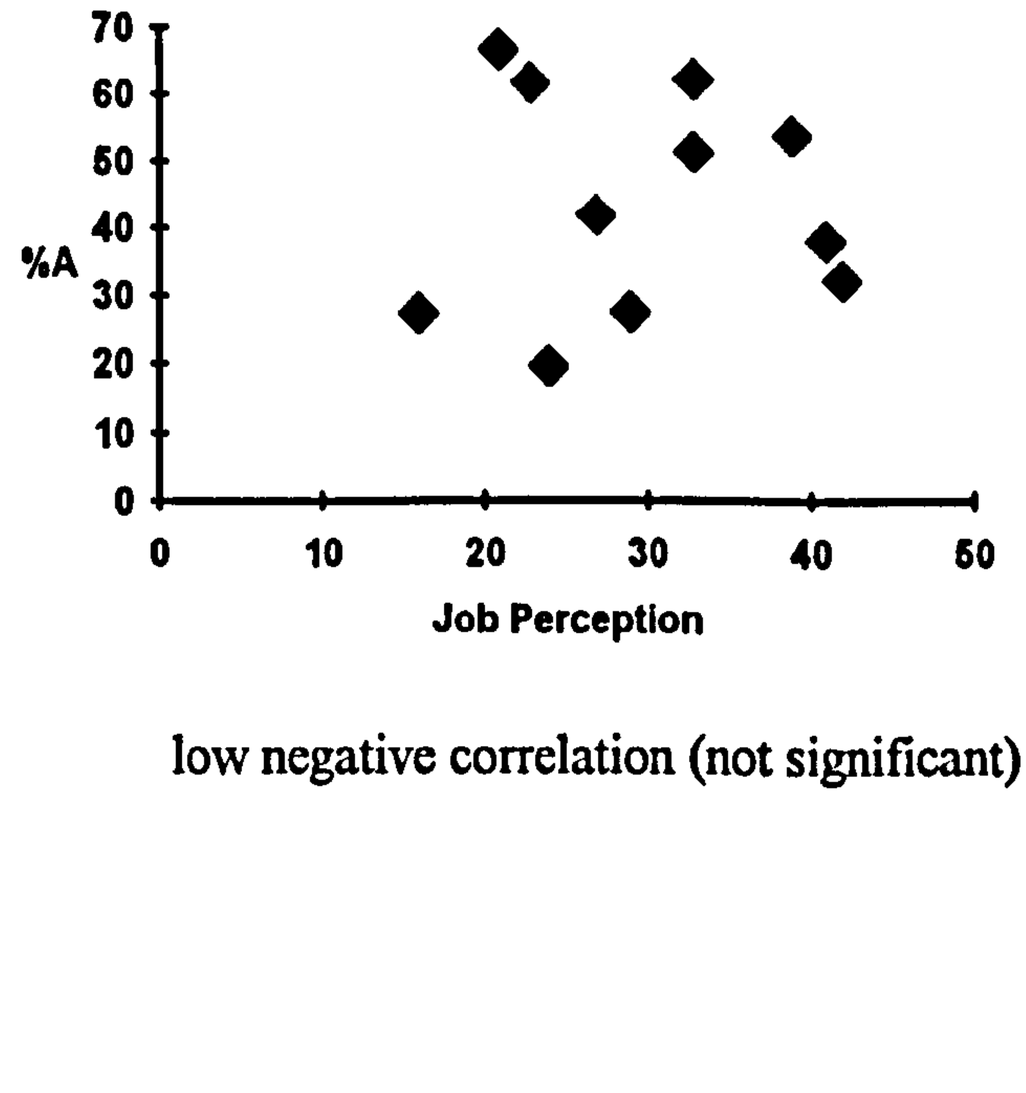
Figure 4. Scattergram to illustrate the relationship between %P and job perception scores.



low negative correlation (not significant)

ii) The relationship between amount of time spent in leisure activities (%A) and job perception scores was found to be non-significant using a Pearson's correlation coefficient ($r = -0.07$, $p > .05$) (see Fig.5).

Figure 5. Scattergram to illustrate the relationship between %A and job perception scores.



low negative correlation (not significant)

5.0 Discussion

Among the Day Centre staff who completed the questionnaire the prevalence of psychological symptoms was 45.5%. This prevalence rate of psychological symptoms is higher than that shown by comparable data using the GHQ, for both medical students, which yielded a prevalence rate of 30 per cent (Firth, 1986), and that for male and female executive civil

servants for which respective rates of 34 and 36 per cent were identified (Jenkins, 1985). The present sample would therefore seem to indicate that people working in Day Centres are a relatively highly stressed group of people.

The hypothesis that there would be a negative relationship between the GHQ and the job perception scores was not confirmed by statistical analysis. This would appear to be in line with the findings of Bersani and Heifetz (1985), who suggested that stress and satisfaction operate as independent factors. However, the group who scored below 11 on the GHQ had a statistically significant negative correlation between GHQ and job perception. This does not necessarily imply that there is a causal relationship between the two, since intervening variables may be involved.

The hypothesis that the percentage of time spent in physical care activities would be positively related to the GHQ score was not supported by the results. This was despite previous work which has suggested that lack of specialist knowledge in working with those individuals who are more profoundly and multipally handicapped, and therefore require a greater amount of physical care from staff, often leads to staff feeling stressed and de-skilled (e.g. Joyce & Oliver, 1984).

The correlation between GHQ scores and percentage of time spent in leisure activities was found to be non-significant at the 5% level. Thus the hypothesis that amount of time spent in leisure activities would be negatively related to GHQ scores was also not supported by the results. Discussions held with staff at the establishments involved in the study yielded support for this finding, as there seemed to be a general feeling amongst staff that integrated leisure activities (i.e. those which occur outside the centre) did result in increased levels of strain.

When considering the relationship between stress and amount of time spent in type of activity it should also be remembered, as pointed out by Lazarus (1991), that sources of stress are always individual to some degree, as are the ways people cope with stress.

Percentage of time spent in physical care activities was found to be not significantly related to job perception. This is in line with the findings of Zaharia and Baumeister (1979), who found that clients disabilities (i.e. the type and level of care clients require) are not related to

the job perceptions of staff. In addition, Browner et al. (1987) have identified interactions with clients as the main source of job satisfaction.

The hypothesis that the percentage of time spent in leisure activities would be positively related to job perception was not confirmed. In this instance, a negative correlation (non-significant) was found, which would seem to offer support to the null hypothesis that as percentage of time involved in leisure activities increases, job perception levels do not necessarily follow.

Unfortunately the present study has a number of methodological inadequacies. Firstly, the small sample size may increase the possibility of Type 2 errors occurring. It also makes it difficult to apply the results obtained from the current sample to the wider population of Day Centre staff. A larger sample size was anticipated, but a large number of staff were reluctant to participate in the study, citing reasons such as 'problems of morale and commitment.' Such feelings may be linked to the current reorganisation of Day Centres, as staff reported being unaware of the precise nature of these changes. As such, staff felt threatened and were worried about job security. It may therefore be useful to repeat the study during a more stable period, at which time a larger sample may be obtainable.

Secondly, the study relies on perceptions of subjective stress. This implies the use of a stress-strain model of stress, in which the effects of an external stressor results in stress as reported by the individual. However, a self-report survey was considered the most practicable way of carrying out a preliminary investigation, as well as being in line with most other studies of health employees (Cushway, 1992).

Thirdly, the Job Perception Questionnaire was devised specifically for use in this study. Although comprised of clinically significant factors, no empirical data in terms of reliability or validity exists. As such, the results concerning job perception should be treated with caution. However, after consultation, the Day Centre managers felt that the 72-item Job Descriptive Index (Smith, Kendall and Hulin, 1969) was too cumbersome for staff to complete, especially in the current climate of change.

Overall these results would seem to indicate, for these Day Centre staff at least, that the type of direct client contact activities (physical or leisure) staff spend the greater percentage of their

working week involved in is not significantly associated with their stress or job perception levels. An important area for further research would be to assess the level of strain and job perception of Day Centre staff once the current changes in the service have had an opportunity to become established.

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Appendix 1: Dynamics of Work Stress Model (Cooper, 1988)

Appendix 2: Job Perception Questionnaire

Appendix 3: Recording Sheet

Appendix 4: Hypothesis Testing Data

Hypothesis 1

Pearson's Correlation Coefficient

$\overline{X}$=11 Σxy = -284.96

$\overline{Y}$=29.82 r = -0.28

T-Tests

i)

	Mean	Standard Deviation	n
X	21	10.79	5
Y	24	6.40	5

T = -0.54 df = 8

Probability: 2 tail 2.31 1 tail 1.86

ii)

	Mean	Standard Deviation	n
X	2.67	2.81	6
Y	34.67	7.23	6

T = -10.16 df = 10

Probability: 2 tail 2.23 1 tail 1.81

Hypothesis 2

Pearson's Correlation Coefficients

i) $\overline{X}$ = 11 Σxy = 153.4
$\overline{Y}$ = 44.79 r = 0.12

ii) $\overline{X}$ = 11 Σxy = 599.3
$\overline{Y}$ = 44.79 r = 0.33

Hypothesis 3

Pearson's Correlation Coefficients

i) $\overline{X}$ = 29.82 Σxy = -432
$\overline{Y}$ = 23.65 r = -0.46

ii) $\overline{X}$ = 29.82 Σxy = -97.77
$\overline{Y}$ = 44.79 r = -0.07

Placement: Elderly

A Review of the Psychological Service Provision for Clients Aged Over Sixty Five In a Health District

Word Count = 3340 (excluding references)

= 3729 (including references)

Abstract

Due to impending Trust status as from 1 April 1994, a systematic review of the current psychological provision for the elderly population in the Health District (x) was considered necessary. Archival data was used, with the month of January 1994 taken as being representative in terms of case load. Information pertaining to two main areas of referral characteristics for the current caseload was gathered;

i) client characteristics including age, sex, source of referral both by agent and by area, and reason for referral.

ii) intervention criteria, including length of involvement and type of intervention offered.

The question of whether such characteristics varied depending on referring agent and area was also addressed. A very similar pattern of referral characteristics, independent of both referring agent and area, were found. A number of findings emerged which hopefully can be used to formulate proposals regarding future service provision and contracts. Tentative suggestions for future research are also included.

1.0 Introduction

Major developments have occurred within the Health Service over the past few years that have had significant implications for the organisation and delivery of services, including those of clinical psychologists. The recent separation between purchases and providers, along with the increasing emphasis on a sophisticated NHS management culture, has emphasised the requirement to identify and clarify the needs of the population being served (Stallard & Childs, 1993). Psychologists and psychology managers are also increasingly being required to define, measure and cost services in the contract culture of the current NHS (Cape, Pilling & Barker, 1993). With the 1992 re-election of the Conservative Party came a commitment to continue the move towards self-governing Trusts as the main NHS provider organisations. As the Partnerships in Health Care document (Guild Community Health Care, 1993) indicates, seeking NHS Trust status does not mean 'opting out' of the Health Service or becoming 'privatised'. Trusts are very much part of the NHS, and remain accountable to the people of Great Britain through Parliament and the Secretary of State for Health. Trusts operate within the regulations outlined in the NHS and Community Care Act (1990). They provide services for the NHS by entering into service contracts, which should provide for the full range of NHS services, with District Health Authorities or GP's. It is the money available from these service contracts within which the Trusts have to operate. As a result, both NHS purchasers and Trusts are concerned with achieving maximum value for money.

Health Authority (x) will be split into two Trusts - Acute Hospitals and Community Health Care Trust respectively, with effect from 1 April 1994. Psychological Services are to be located in the latter. In order to allow for a smooth transition form being a unit of a Health Authority to becoming an independent operation within the NHS, the Community Health Care Trust started to operate in shadow form on 1 November 1993 (Partnerships in Health Care, 1993).

The organisation has been reshaped into a Clinical Directorate model, with four directorates covering General Community and Professional Services, Mental Health Services, Learning Disability Services and Forensic Psychiatry. The principle behind the concept of service directorates is to place control over issues related to client care with those who directly

influence and provide that care. Thus clinical staff should have a major role in the management of the service directorates. Psychiatry of Old Age is located within the General Psychiatry Directorate. Clinical psychology provision for the elderly population of the district is based within the psychiatrically led multi-disciplinary team, yet remains accountable to the Head of the District Clinical Psychology Service. The elderly service team provides in-patient, out-patient, day-patient and community care for elderly people (over 65 years old) with both functional and organic mental health problems. The services for these clients are mainly purchased by Health Authority (x), and GP fundholders. In addition, bordering Health Authority (y) also purchases services. The service currently operates from a purpose built ESMI unit located to the north east of the town centre. The geographical area served is primarily urban in nature, with an estimated population of 128 000 (Office of Population Census, 1993).

The clinical psychology provision within the elderly speciality consists of one full time post and a half time assistant psychologist post. This is not an unusual scenario, as Howells (1992) suggests that for many psychologists, working with elderly people may mean working as the only clinical psychologist. Originally the psychological input was confined to providing a service aimed at the psychiatric component of work with older people. In 1988/9, initially on a trial basis, psychological input was extended to include provision to older people referred from the General Medical Services for the Elderly, which led to an increase in referrals. Therefore the psychology service provision has shifted from where the funding for the post was originally provided.

At present, four sessions are re-funded from the Acute Hospitals Trust to the Community Trust budget. With the introduction of contracting this may pose a significant problem, as from 1 April 1994 the number of sessions provided will have to be very closely allied to funding. A contract is 'a framework within which two parties reach and then monitor an agreement about what each will provide' (Øvretveit, 1992, p. 28). Contracts for therapy services make it possible for clinical directors and general managers to be sure of the psychology services they require. As Øvretveit (1991) points out, this offers them the control they need, as well as allowing psychology managers to maintain district departments and to

offer 'free standing' services. With a contract system that requires greater specificity, accurate records and information concerning existing services is essential (Øvretveit, 1993).

The Conway Community Information System has recently been introduced in order to provide client and staff based information for services. The system is used for collecting data to enable monitoring of activity, and to set new contracts with GP fundholders. However, it has been suggested that psychologists need more detailed data, and, in the long term, information regarding the number and types of cases categorised in terms of the time, level of skill required and the source of referral, will be considered to be particularly important (Øvretveit, 1992; Sage, 1993). Such detailed information may enable costings for purchasing by time or by 'type' of case, as well as for block contracts.

2.0 *Aims*

In view of the impending Trust status of Health Authority (x) and the associated changes this will incur, especially regarding the introduction of contracting, the need for a systematic review of the current psychological service provision to the elderly by the qualified staff member was deemed to be necessary. The information provided could be used for formulating proposals for future service provision/contracts. It could also be used as a baseline measure for future investigations regarding possible changes in the psychological provisionto the elderly once the Trust becomes formally operational.

A number of dimensions were targeted for exploration. In line with the suggestions detailed above by Øvretveit (1992) and Sage (1993), these were as follows:-

i) information relating to client characteristics, including the age and sex of the referred client, source of referral by agent and by area, plus reason for referral.

ii) intervention criteria, including the length of time over which the client is seen and the type of intervention offered.

It should be noted that the review was specifically focused on individual client work and that other aspects of psychological input to the elderly service (e.g. staff training) have not been included.

3.0 Method

3.1 Design

The study used archival data. The information required was obtained from the current psychology caseload which totalled 48 individual clients in January 1994, as registered on the Comway Community Information System. For the purpose of the study, the month of January was taken as a representative sample month with regard to the elderly psychological caseload pattern.

3.2 Data collected

i) Data relating to referral

All subjects were classified as having been referred from either Psychiatry, General Medicine for the Elderly, or a GP. This information was obtained from the individual referral letters, as was information concerning age and sex.

Using usual place of residence, all clients were classified as having been referred by source of area, e.g. (x) or (y) district.

Reason for referral was not always clear from the referral letter. This was therefore elicited from the psychological reports to the referring agent. These reports summarise in detail the psychological input offered over the intervention period for each individual client. A list of broad categories was devised in order to classify reason for referral (see Appendix 1 for list of categories).

ii) Data relating to intervention

Length of psychological involvement with individual clients was obtained by calculating the length of time between date of referral and January 1994.

Type of intervention offered was also deduced from the psychological reports directed to the referring agents. As with reason for referral, a broad list of categories was devised for the purpose of classifying each individual's type of intervention (see Appendix 2).

4.0 Results

4.1 *Data relating to referral:-*

i) Age and Sex

Of the 48 clients registered on the elderly psychology caseload for January 1994, 15 (31.25%) were male, and 33 (68.75%) female. Mean age overall was 77.48 years (SD = 5.77), with a range from 66 to 93 years. Mean age for males was 77.33 years (SD = 7.09), and for females 77.55 years (SD = 5.19).

ii) According to Agent

Of the total clients, 60.42 per cent had been referred by the General Medicine for the Elderly department, 20.83 per cent by GP's and 18.75 per cent by Psychiatry.

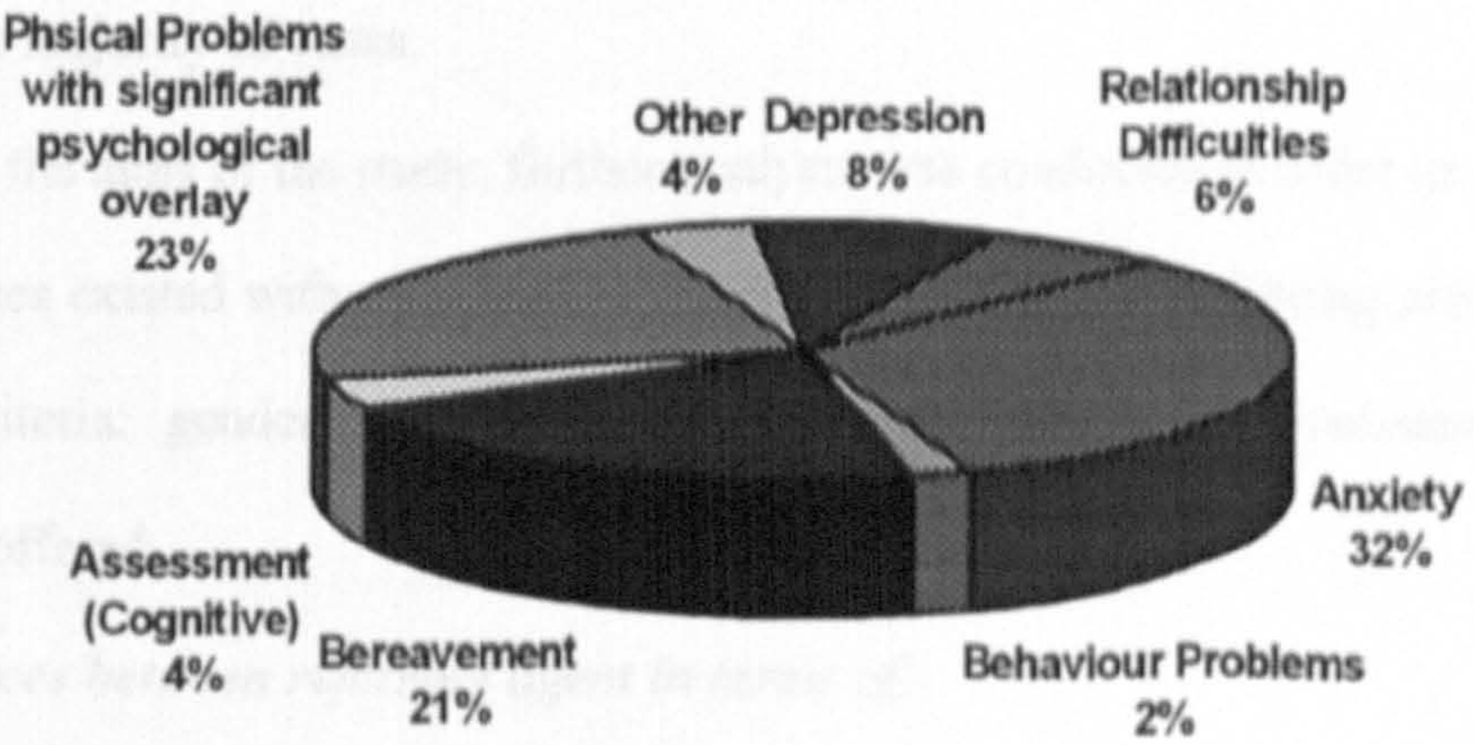
iii) According to Area

Regarding source of referrals by area, Health Authority (x) accounted for 72.92 per cent, and the bordering Health Authority (y) for 27.08 per cent of the total referrals.

iv) Reasons for referral

These were broadly categorised, and are represented in Fig 1.

Figure 1. A pie chart representing reasons for referral in percentages.



The pie chart highlights the fact that anxiety related disorders accounted for the largest percentage of referrals.

4.2 *Data relating to intervention:-*

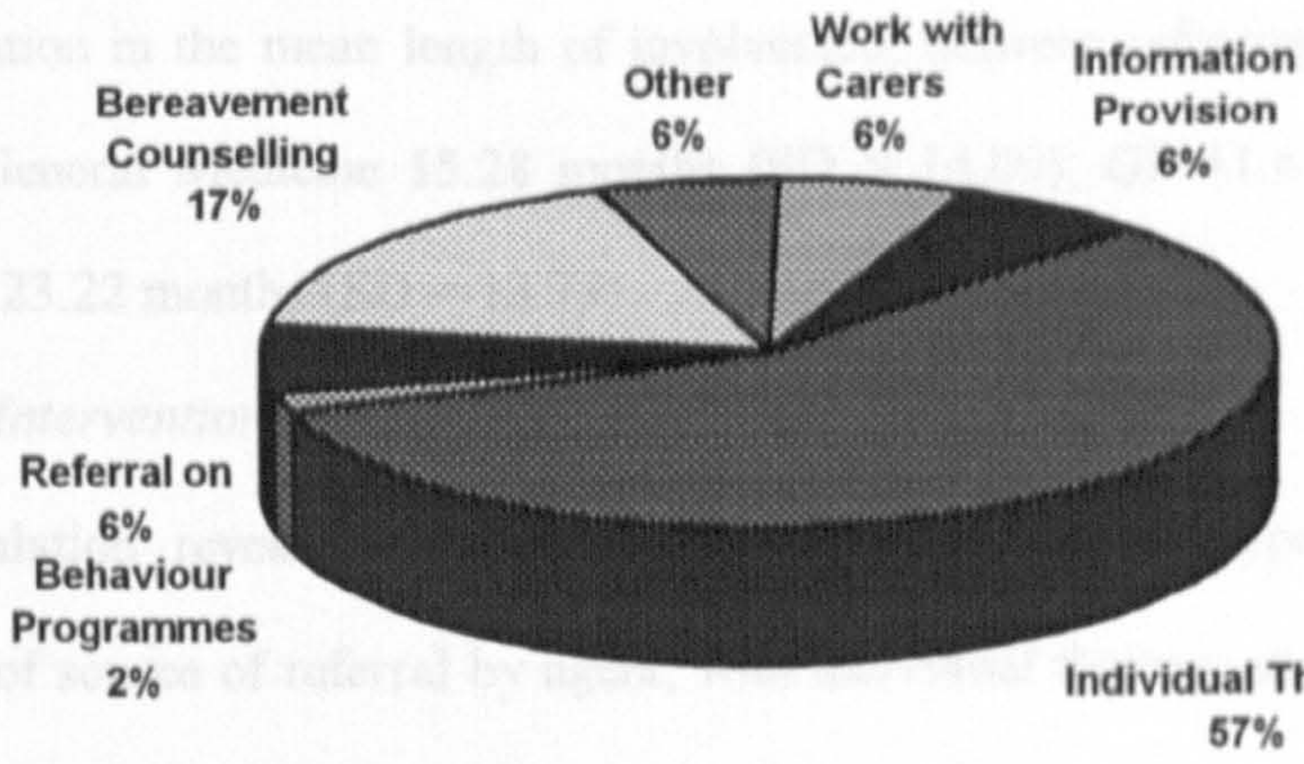
i) Length of involvement

The length of time over which clients had received psychological input ranged from one session to 3.5 years, with the mean length of involvement being 16 months (SD = 13.36). However, involvement was not necessarily on a continuing or regular basis for all clients.

ii) Type of intervention offered

Type of intervention offered was broadly categorised, and is represented in Fig. 2.

Figure 2. A pie chart representing type of intervention offered in percentages.



From the pie chart it would appear that individual therapy was the choice of intervention offered in the majority of cases.

In line with the aims of the study, further analysis was conducted in order to establish whether any differences existed with regard to a) referring agent, and b) referring area, in terms of the following criteria: gender; age; reason for referral; length of involvement and type of intervention offered.

4.3 *Differences between referring agent in terms of:-*

i) Gender

Cross tabulation of referring agents by gender (Appendix 3) showed a higher proportion of females than males were referred from all agents. Percentage of female referrals was 65.52, 70 and 77.78 for General Medicine, GP and Psychiatry respectively.

ii) Age

The mean age for those referred by GP and Psychiatry was 74 years (SD = 5.14 and 2.39 respectively). This was in contrast to the mean age of General Medicine referrals which was slightly higher, at 79.76 years (SD = 5.67).

iii) Reason for referral

Cross tabulation revealed that for each referring agent, anxiety, bereavement and physical problems with significant psychological overlay accounted for at least 50 per cent of referral reasons (Appendix 4).

iv) Length of involvement

Some variation in the mean length of involvement between referring agents was apparent, as follows: General Medicine 15.28 months (SD = 14.09), GP 11.6 months (SD = 8.3), and Psychiatry 23.22 months (SD = 13.79).

v) Type of Intervention

Cross tabulation revealed a very similar pattern regarding type of intervention offered regardless of source of referral by agent, with individual therapy and bereavement counselling accounting for the majority of interventions (Appendix 5).

4.4 *Differences between referring area in terms of:-*

i) Gender

Cross tabulation revealed that both districts (x) and (y) referred a higher proportion of females than males (Appendix 6). Females accounted for 74.29 per cent and 53.85 per cent of the total referrals for (x) and (y) districts respectively.

ii) Age

The mean age for referring areas was 77.89 years (SD = 5.40) for (x), and 76.38 years (SD = 6.78) for (y).

iii) Reason for referral

Cross tabulation revealed a similar pattern of referral reasons for both areas (x) and (y), with anxiety, bereavement and physical problems with significant psychological overlap accounting for the largest number of referrals in each area (Appendix 7).

iv) Length of involvement

Length of involvement was similar across both areas. The mean for (x) was 15.97 months (SD = 13.92), and for (y) 16.08 months (SD = 12.24).

v) Type of Intervention

Cross tabulation revealed no significant differences regarding type of intervention offered in terms of referring area (Appendix 8). Individual therapy and bereavement counselling accounted for the majority of interventions in both areas.

5.0 Discussion

In consideration of the impending Trust status of Health Authority (x), the present study was conducted in order to elicit more detailed information pertaining to the current psychological provision for the over 65's in the district. Investigation focused on two key areas of service provision, which will now be discussed in detail.

Firstly, information relating to a range of client characteristics was collected. It was found that within the district, a higher proportion of females than males were receiving psychological input. This seeming imbalance may of course be related to the fact that the elderly population across Great Britain comprises of a disproportionally higher number of women than men. This may also account for the slightly higher mean age for females than for males in the study. Due to a lack of comparative data, it is not known whether this pattern is typical of elderly departments in other districts.

Information regarding source of referral by both agent and area was also sought. As from 1 April 1994, when the Community Healthcare Trust will become formally operational, such information will be of increasing importance, especially within the contracting climate. Within this study, the majority of referrals (60.42%) had been received from the General Medical Services for the Elderly, followed in decreasing order by GP's (20.83%) and Psychiatry (18.75%).

Although the reasons for this pattern are unclear at this point in time, there may be service implications resulting from the relatively low number of referrals received from GP's and

Psychiatry in the current NHS climate. For example, with the growing number of GP fundholders, with increased flexibility and discretion regarding the services they wish to purchase, links with GP practices need to be reinforced.

A potential area for future investigation is GP's opinions and satisfaction with the service quality provided by the psychology service. It should be noted that other such surveys of GP's have proved favourable (Espie & White, 1986).

There may also be implications for the high proportion of Medicine referrals, in that at present only four sessions are refunded from the Acute Hospital Trust to the Community Trust budget. Analysis of source of referral by area, shows that for the month of January 1994, district (x) accounted for 72.92 per cent of total referrals, with district (y) accounting for the remaining 27.08 per cent. Such data may be inherently useful in negotiating the type of contract to offer neighbouring districts. For example as Øvretveit (1991) suggests, costings for purchasing by time or 'type' of case to be treated should be determined, as well as costings for block contracts.

It was noted that the largest percentage of referrals received was for anxiety related problems. This would seem to be in line with the work of Sallis & Lichstein (1982), who suggested that anxiety symptoms are more than twice as common in elderly people than in any other age group. Interestingly, depression accounted for only 8.33 per cent of referrals, despite suggestions by other studies that up to 50 per cent of elderly people living at home may suffer from some degree of depression (Hanley & Baikie, 1984). However, the particularly high suicide rates in the elderly population (Chaisson-Stewart, 1985) may mean that depression is more likely to be treated in conjunction with medication at the point of presentation. Alternatively, it may be that mild depressions are being effectively treated by GP's. Finally, anxiety and depression have been found to be the commonest of all emotional disorders across the adult population (Seligman, 1975). It may therefore be expected to follow such problems would account for the highest number of referrals to Psychology. Thus it would seem that in comparison the present study actually identified a surprisingly low number of such referrals in the sample.

The second area of enquiry included investigation into the length of time over which the client had received psychological input, which ranged from one session to 3.5 years. However, involvement was not necessarily on a continuing or regular basis for all clients. As such, it would have perhaps been preferable to measure involvement in terms of number of hours/appointments with each individual. Unfortunately, as case notes were not conducive to such data collection, this was not possible. Such difficulties would seem to highlight the necessity for client records to contain a front sheet, so that information regarding characteristics and patterns, such as number and length of appointments, is easily and clearly accessible. The provision of such information will be important not only for the contracting considerations but also in terms of future research, for example to investigate any changes that Trust status has incurred in service provision.

Finally, type of intervention offered was considered. Results indicated that individual therapy (56.25%) and bereavement counselling (16.67%) accounted for the majority of interventions. This focus on individual work will have financial implications in the developing organisational culture of the NHS, with its increasing emphasis on cost control and improved efficiency.

In view of the aims and objectives of the study, the above referral characteristics were also considered separately for both referral agent and area, in order to ascertain whether any differences existed in referral patterns.

A very similar pattern of referral characteristics emerged across both referral agents and referral areas. For example, all agents had referred a higher proportion of women than men, and mean ages were very similar. However, there was some difference concerning length of involvement, in that Psychiatric referrals had the longest mean involvement length. Perhaps a future study could address possible reasons for this.

The present study has provided a 'snapshot' of the current psychological service provided to the elderly in health district (x) at a particular point in time. The possibility of seasonal variations affecting results are acknowledged. Although archival studies offer the advantage of a 100 per cent response rate, methodological disadvantages do exist. For example, there is the question of how accurate data in case notes is, or alternatively, the form recorded data takes. Accuracy may have been increased if initial diagnoses had been available, rather than reason

for referral. However, no such data was available. In summary, it would seem there is an increased possibility of pertinent information being 'missed' in archival studies.

A number of findings have emerged which will be fed back to those concerned. Hopefully, the relevant results can be used for formulating proposals to the impending Trust Board regarding future service provision and contracts. The present study may also act as a basis on which to conduct future research, for example to investigate any changes arising regarding psychological provision to the elderly once the Trust has become formally established. As previously suggested, it may be useful for future work to investigate the perceptions and expectations of service quality by referral agents This may also enable future services to more adequately meet the needs of the consumers.

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Appendix 1: Reason for referral

- Assessment - BEHAVIOURAL
  - COGNITIVE
- Anxiety
- Depression
- Bereavement
- Dementia
- Behaviour problems
- Relationship difficulties
- Physical problems with significant psychological overlay
- Problems of adjustment
- Other

Appendix 2: Type of intervention offered

- Information Provision

- Assessment Only
  - BEHAVIOURAL
  - COGNITIVE

- Bereavement Counselling

- Individual psychological therapy (e.g. anxiety management/cognitive therapy)

- Setting up behavioural programmes

- Referral on to other services

- Work with carers

Appendix 3: Cross tabulation of gender by referring agent

Count	Female	Male	Row Total (%)
General Medicine	19	10	29 60.4
GP	7	3	10 20.8
Psychiatry	7	2	9 18.8
Column Total (%)	33 68.8	15 31.3	48 100.0

Number of Missing Observations: 0

Appendix 4: Cross tabulation of reason of referral by referring agent

	Reason								
Count	Ber 0	Anx 1	Phys 2	Dep 3	Beh 4	Other 5	A(c) 6	Rel D 7	Row Total (%)
Referral									
Gen Med	5	8	9	4	-	1	1	1	29 60.4
GP	4	4	-	-	-	-	-	2	10 20.8
Psych	1	3	2	-	1	1	1	-	9 18.8
Column Total (%)	10 20.8	15 31.3	11 22.9	4 8.3	1 2.1	2 4.2	2 4.2	3 6.3	48 100.0

Number of Missing Observations: 0

Appendix 5: Cross tabulation of type of intervention by referring agent

	Type							
Count	B.C.	B.P.	C	I	I.T.	Other	R.On	Row Total (%)
Referral								
Gen Med	3	-	1	3	17	3	2	29 60.4
GP	4	-	2	-	4	-	-	10 20.8
Psych	1	1	-	-	6	-	1	9 18.8
Column Total(%)	8 16.7	1 2.1	3 6.3	3 6.3	27 56.3	3 6.3	3 6.3	48 100.0

Number of Missing Observations: 0

Appendix 6: Cross tabulation of gender of referrals by referring area

Count	Female	Male	Row Total (%)
(x)	26	9	35 72.9
(y)	7	6	13 27.1
Column Total (%)	33 68.8	15 31.3	48 100.0

Number of Missing Observations: 0

Appendix 7: Cross tabulation of reason for referral by referring area

	Reason								
Count	Ber 0	Anx 1	Phys 2	Dep 3	Beh 4	Other 5	A(c) 6	Rel D 7	Row Total (%)
Area									
(x)	6	12	9	3	1	1	1	2	35 72.9
(y)	4	3	2	1	-	1	1	1	13 27.1
Column Total (%)	10 20.8	15 31.3	11 22.9	4 8.3	1 2.1	2 4.2	2 4.2	3 6.3	48 100.0

Number of Missing Observations: 0

Appendix 8: Cross tabulation of type of intervention by referring area

	Type							
Count	B.C.	B.P.	C	I	I.T.	Other	R.On	Row Total (%)
Area								
(x)	4	1	2	2	22	1	3	35 72.9
(y)	4	-	1	1	5	2	-	13 27.1
Column Total (%)	8 16.7	1 2.1	3 6.3	3 6.3	27 56.3	3 6.3	3 6.3	48 100.0

Number of Missing Observations: 0

Placement: Child

A Single Case Study Employing Graduated In-Vivo Exposure for a Child Displaying a Phobia of the Dark.

Word Count = 3061 (excluding references)

= 3692 (including references)

Abstract

This within series single case study examined the effects of introducing a programme of graduated in-vivo exposure for an eight year old boy with a phobia of the dark. The aims of the study were;

a) to reduce the perceived level of severity of anxiety relating to the dark, and

b) to consequently reduce the avoidance strategies employed to prevent having to go to sleep i) in the dark, and ii) alone.

Results indicate support for the hypotheses that;

1) His phobia was a learned reaction to a nightmare. Continual avoidance of the dark since this experience, coupled with reinforcement of his avoidance strategies by Mrs H. had maintained his fear.
2) Negative expectations regarding his ability to cope in the dark had resulted in the implementation of further avoidance strategies.
3) The resounding nature of his original nightmare meant he dreaded going to sleep in the dark.

At the point treatment was withdrawn, E.H. was able to go to sleep alone, in the dark, with his bedroom door shut, without feeling unduly anxious. Progress was maintained at follow up.

1.0 Introduction

It is generally accepted that many childhood fears are common and that they change with development, i.e. children tend to show particular patterns of fear at certain stages of development (Ollendick & King, 1991). For example, young infants are unaffected by events that will frighten them at a later time, whereas older children and adolescents are no longer affected by events such as separation from major attachment figures that would once have resulted in major distress for them.

Young children generally display many more fears than adults, and, like most childhood emotions, these fears are often more volatile and intense than in adults (Marks, 1987). Many fears are common, e.g. the ten most common fears in girls and boys aged between 8 and 16 years of age have been identified (Ollendick, Yule & Ollier, 1991). In addition, certain fears occur more frequently than others, such as fear of small animals, darkness and thunder (Marks, 1987).

Thus it is seemingly common for children to experience fear toward a number of stimuli. In fact, it is somewhat expected and has even been described as adaptive (Crewe, 1973). However, such fears are generally mild, age-specific and transitory (Ollendick, 1979). Excessive fears (phobias), which persist over time and result in considerable distress to the growing child are less common and are reported to probably occur in 3-8 per cent of the population (Ollendick, 1979).

A phobia can be defined as 'a persistent and excessive fear of an object or situation that is not in fact dangerous' (Butler, 1989, p. 97). This often results in a strong desire to avoid phobic situations, even though the individual may recognise that this is not rational. Unlike other fears, phobias are disabling and not adaptive, as they interfere with ordinary activities. They are generally considered to be learned fears.

Regarding the origins of such fears, although a majority of phobics attribute their fear acquisition to direct conditioning experiences, one half to one third of phobics do not attribute their phobias to such events (Ollendick & King, 1991). Rather, a significant minority report indirect paths of fear acquisition, which is consistent with Rachman's (1977) 'three pathways of fear' theory - direct conditioning, vicarious conditioning, and instruction/information.

However, Ollendick & King (1991) have suggested that Rachman's (1977) theory may not be independent, but interactive in the origins of childhood fears. Therefore, although fear can result from any one of these sources, it is more likely to occur when the effects of these sources are combined. Thus, fear can be said to be multipally determined.

Mack (1970) defined the nightmare as 'an anxiety dream in which fear is of such an intense degree as to be experienced as overwhelming by the dreamer and to force at least partial awakening' (p. 52). Studies have suggested that between 20 and 30 per cent of five to twelve year olds have at least one nightmare in a six month period (Terr, 1987).

The causes of nightmares in children are poorly understood (Hawkins & Williams, 1992). The most common parental causal attribution of nightmares in school children has been identified as 'over tiredness'. Parents did not rate 'stress' highly as a likely causal factor (Fisher & Wilson, 1987).

Several studies have identified significant correlation's between experiencing nightmares and being frequently either fearful of the dark or reluctant to go to sleep because of fears (e.g. Hawkins & Williams, 1992). Children have been found to exhibit a range of behaviours after experiencing nightmare(s). These include struggling to stay awake all night, refusing to sleep in their own beds and insisting that a parent sleep with them (Terr, 1987). Such findings may indicate either unclear verbal reports from child to carer, or equally, may represent a real fear, given that these children are likely to experience frightening events at night. Fisher & McGuire (1990) also found a significant relationship between bad dreams and being afraid of the dark. It has been suggested that parents are often unaware of the extent of their children's fears and worries at night (Richman, 1987).

2.0 *Aims*

The aims of this study were, in the case of an eight year old boy :-

a) to reduce the perceived level of severity of anxiety related to the dark; and

b) to consequently reduce the strategies currently employed so as to avoid having to go to sleep i) in the dark and ii) alone.

Following on from the early work on fear reduction, a programme of graduated in-vivo

exposure was implemented. Such techniques are still considered to be the most effective and consequently the most widely used treatments for children's fears (Yule, 1991). Additionally, Emmelkamp (1982) postulated that exposure in-vivo is the treatment of choice for simple phobias.

The hypotheses examined for the client under investigation were :-

1) The acquisition of the phobia was a learned reaction to experiencing a nightmare. It had been maintained since this time both by continual avoidance of the dark at bedtime, and by significant others reinforcing his avoidance strategies, e.g. Mrs H. going to bed with him.

2) Perceived self-efficacy levels had been lowered due to repeatedly finding himself unable to cope with being alone in the dark (Bandura, 1977). This had led to negative expectations regarding his coping skills in the dark, resulting in further avoidance strategies being implemented (e.g. leaving the light on; leaving the bedroom door wide open).

3) His original nightmare had had a resounding quality about it, such that he had dwelled on it during the days that had followed to the point that he now dreaded going to sleep in the dark because of the dream.

3.0 Method

3.1 Design

The design was a within series single case design, which took the form of an A B design with a follow up period. Baseline measures were collected over a 2 week period (A phase). A programme of graduated in-vivo exposure was introduced over a 9 week treatment period (B phase). A follow up period of 3 weeks was then arranged. Once weekly sessions were organised.

3.2 Client

E.H. was an eight year old boy who lived at home with his parents and his older sister. Excluding his fear of the dark, there were no reported difficulties at home or at school. E.H. presented as a very able and lively child. This opinion was seemingly shared by both his parents and his class teacher, all of whom spoke highly of him. He enjoyed a wide circle of

friends, and was involved in a number of extra curricular activities, e.g. Scouts and Chess Club.

3.3 Procedure

As it had been established that E.H. had no other difficulties, the purpose of implementing a programme of graduated in-vivo exposure was explained to both E.H. and Mrs H. The main guidelines for exposure were also emphasised, i.e. that for optimal effectiveness, exposure should be graduated, repeated and prolonged, and that wherever possible tasks should be clearly specified (Emmelkamp, 1982). The graded hierarchy was then constructed with E.H. Butler (1989) defines a graded hierarchy as 'an ordered list of phobic situations used to guide exposure' (p. 106). In the case of E.H., this resulted in a 12-item list of progressively anxiety provoking situations involving the dark (see Appendix 1 for the graded hierarchy).

Measures

Each item was rated by E.H. using the subjective unit of disturbance (S.U.D.) method. A scale of 0-100 was used according to the amount of perceived anxiety each item would evolve, with 0 representing 'not anxious at all', and 100 representing 'the most anxious I could possibly be'.

The hierarchy included items ranging from those perceived as being only mildly anxiety provoking, e.g. 'being alone in a dark room other than at bedtime' (S.U.D. = 5), to those perceived as provoking extreme levels of anxiety beyond his present range of perceived ability, e.g. 'being in bed and going to sleep alone in the dark with the bedroom door completely closed' (S.U.D. = 100).

Baseline

Prior to implementing the graded hierarchy, and as a means of establishing a baseline, E.H. was requested to keep a record over a 2 week period of the number of nights he went off to sleep with a) Mrs H. present, b) some illumination, and c) his bedroom door open. Throughout the baseline period he was also asked to rate his level of anxiety, using the above mentioned S.U.D. (0-100) scale.

Treatment

Apart from item 1 on the hierarchy, which was completed during a session, and for which very

little disturbance was shown, it was decided that the remaining hierarchy items should be worked through by E.H. (and Mrs H. where appropriate) at home, 'in-situ'. In order to evaluate progress as the hierarchy was worked through, E.H.. was asked to record his level of distress (S.U.D. 0-100) at the beginning of, and during, exposure to each item.

Weekly sessions were held in order to monitor and reinforce progress made. They also afforded the opportunity to discuss any difficulties that may have arisen during the previous week.

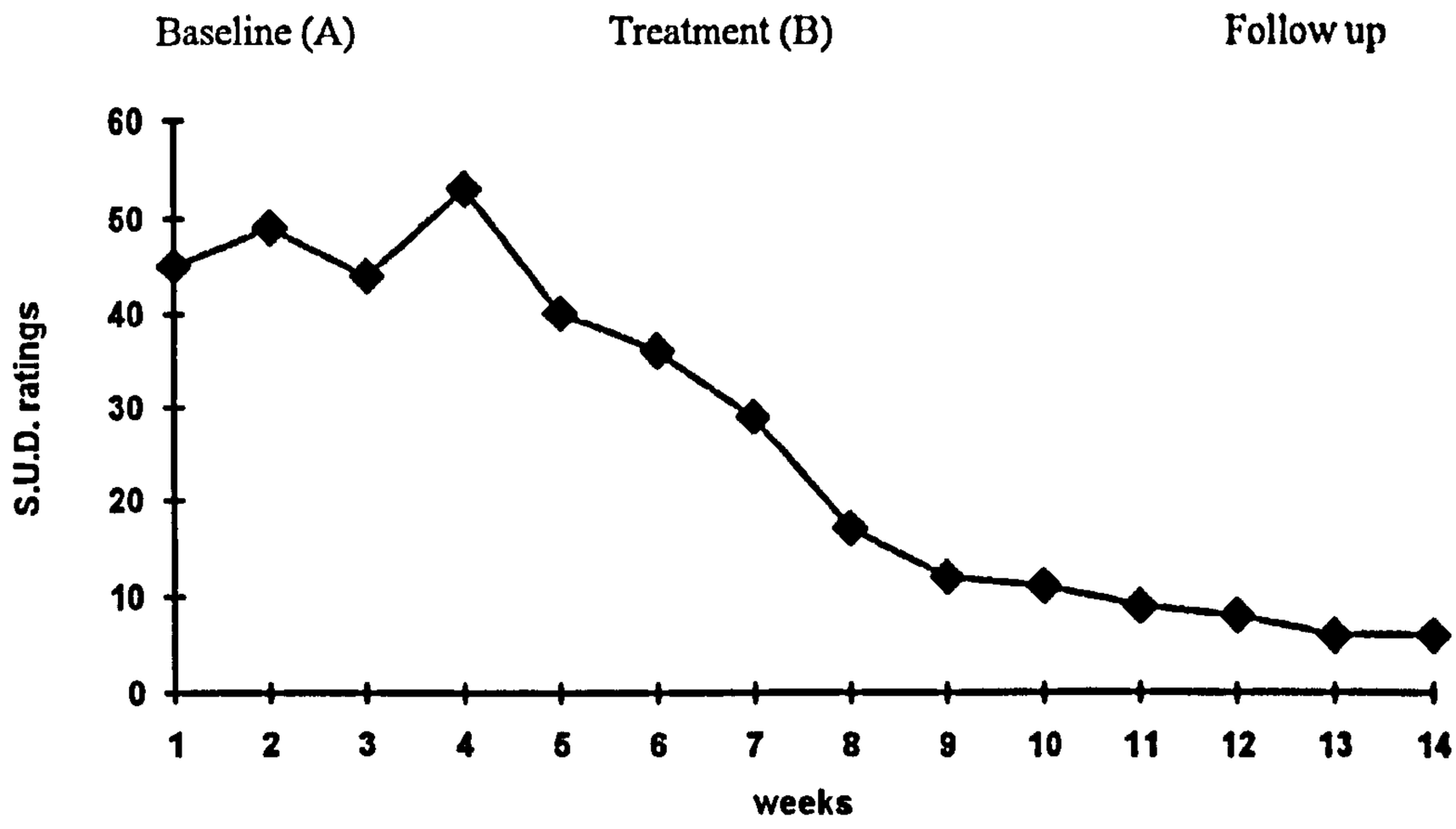
The final goal of treatment would involve E.H. being able to go to sleep on his own, in the dark, with his bedroom door closed, without feeling unduly anxious or fearful.

4.0 Results

The effects of the exposure in-vivo were that by treatment session nine, E.H. had successfully worked through all his hierarchy items. He now reported feeling able to go to sleep without Mrs H. being present, without any lights on, and with his bedroom door closed. More importantly, he was able to do so without feeling anxious/scared. Mrs H. confirmed this position. Thus it would appear that E.H.'s perceived severity of anxiety of the dark had dramatically decreased over the intervention period. In order to prevent any possible relapse, a short follow up period was organised for a further 3 week period, over which progress continued to be maintained.

Fig. 1. illustrates the effects that the graduated exposure in-vivo had on the S.U.D. anxiety ratings of E.H. with regard to his fear of the dark. The daily ratings of his anxiety relating to his movement through his hierarchy items were used as the main outcome measure.

Figure 1. Effects of graduated exposure in-vivo on the S.U.D. ratings of E.H. with regard to his phobia of the dark



(N.B. daily S.U.D. ratings were averaged)

5.0 Discussion

This study aimed to reduce the perceived severity of anxiety related to the dark, and consequently to reduce the strategies currently employed in order to avoid having to go to sleep, i) in the dark, and ii) alone, in one particular 8 year old boy.

The results of the study illustrate that the effects of the graduated exposure in-vivo led to a significant reduction of E.H.'s anxiety levels regarding the dark. As can be seen in Fig.1, very little variation in S.U.D. ratings occurred during the baseline period. This enables a reasonably confident assumption to be made that the reduction in S.U.D. ratings that occurred in the treatment period was not just part of the random variation displayed by the client.

E.H. progressed well through his hierarchy, with completion of one stage apparently influencing generalisation on to the next. In addition to reducing his anxiety levels by working through his hierarchy items, E.H. had eliminated his need to employ his various avoidance strategies. Thus he now felt comfortable in going to sleep, on his own, in the dark, and with his bedroom door shut.

E.H.'s confidence in his ability to progress through his hierarchy increased over the treatment

sessions, from being slightly wary at first to becoming extremely enthusiastic to attempt the later, more anxiety provoking items, and thus conquer his fear.

The results also offer support to the three suggested hypotheses in that;

1) His phobia was a learned reaction to having experienced a nightmare. Once acquired, his fear had been developed and maintained, both by his personal avoidance strategies, and by the considerable, albeit unintentional reinforcement received from Mrs H. As such it had remained unchallenged. Graded exposure had afforded the opportunity for E.H.'s learned fear to be unlearned and instead to be replaced, by learning more adaptive reactions (Wolpe, 1961). Thus by approaching instead of avoiding his fear relearning had occurred, so that he no longer perceived the dark as threatening or anxiety provoking. This relearning allowed Mrs H.'s presence at bedtime to be eliminated, which in turn meant she was no longer reinforcing his fear.

2) E.H.'s avoidance behaviour had resulted in the possibilities for naturally occurring fear reduction being limited. It had also limited his encounters with the dark to anxiety provoking events. As a result, he held negative expectations regarding his performance ability in the dark. By arousing his anxiety in a controlled way, and therefore enabling him to remain in the feared situation until his anxiety gradually reduced, his feelings of personal mastery and coping skills in the feared situation were able to increase. Bandura (1977) suggested that by raising expectations of personal mastery through performance based techniques (i.e. exposure), results in perceived self-efficacy levels being raised, eventually leading to the elimination of the 'defensive' behaviour.

3) As E.H. progressed through treatment, with his increases in confidence, feelings of personal mastery and ability to cope in the dark, he reported feeling relatively less aware of his thoughts regarding his original nightmare until he no longer feared going to sleep in the dark because of the dream. This would appear to be in line with the belief that exposure is a crucial component in reducing the attentional bias of phobic individuals (Lavy, Hout & Arntz, 1993).

To summarise, as E.H. worked through his hierarchy and his levels of avoidance regarding being in the dark reduced, his fear was being confronted. His confidence in his own coping skills increased and this was coupled with a marked reduction in his anxiety relating to being

alone in the dark. His heightened awareness relating to his original nightmare was also reduced.

Although single case methods provide a flexible and logical way of evaluating clinical activity (Morley, 1989), methodological disadvantages were noted. For example, there is the question of generality of results from single case research to other individuals. However, Johnston & Pennypacker (1980) argue that the most appropriate way to study behaviour is to identify and isolate the determinants of an individual's behaviour. As such, generalisation proceeds by replicating functional relationships across individuals.

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Appendix 1: A progressive hierarchy for a child with a phobia of the dark

Item No.	Hierarchy Item	Initial Perceived S.U.D. Rating
1	Being alone in a dark room other than at bedtime	5
2	Being in bed and going to sleep with mum lying on his bed until he falls asleep	10
3	Being in bed and going to sleep with mum sitting on the end of his bed until he falls asleep	15
4	Being in bed and going to sleep with mum standing at the doorway until he falls asleep	20
5	Being in bed and going to sleep with mum downstairs, but with bedroom and lounge doors open	40
6	Being in bed and going to sleep with mum downstairs, with lounge door closed	45
7	Being in bed alone and going to sleep alone with bedside lamp and hall light on and bedroom door open	55
8	Being in bed alone and going to sleep alone with only bedside lamp on, with bedroom door open	65
9	Being in bed and going to sleep alone, without bedside lamp being left on, with bedroom door open	80
10	Being in bed and going to sleep alone in the dark with bedroom door open	90
11	Being in bed and going to sleep alone in the dark with bedroom door half closed	95
12	Being in bed and going to sleep alone in the dark with bedroom door completely closed	100