Insight into Mental Illness and Its Relationship to Clinical Variables in Forensic Patients with Schizophrenia

by

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MAJOR RESEARCH PROJECT

Insight into mental illness and its relationship to clinical variables in forensic patients with schizophrenia

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INTRODUCTION – VOLUME ONE

Overview

This portfolio is made up of two volumes.

This is Volume One and contains the academic dossier, clinical dossier and research dossier.

Volume Two contains the extended clinical dossier which is comprised of the placement documentation from each of the placements and the five full case reports. Volume Two contains confidential clinical material and is held in the Clinical Psychology Department at the University of Surrey.
Overview

The academic dossier comprises essays from the four core client groups:

1. Adult Mental Health
2. People with Learning Disabilities
3. Children, Adolescents and Families
4. Older People
Psychotic experiences (e.g. auditory hallucinations and delusions) are not understandable or meaningful. Critically discuss this statement and any implications for treatment.
INTRODUCTION

Psychotic experiences include delusions, hallucinations and disorders of thought processes. A review of the literature revealed the majority of research has been conducted on delusions and hallucinations therefore there is an exclusive focus on these. It is also important to clarify how the term ‘understandable’ will be used. In the literature a distinction is made between explanation and understanding. People may give explanations for the cause of psychotic experiences but these will not be considered understandable if they cannot be seen to derive meaningfully from past history. The term understandable will be used in a way that is consistent with the literature. A distinction between understanding and meaning is not deemed necessary, (non) advocates of understandability are (non) believers of meaningfulness.

This essay will discuss the origins of the view that psychotic experiences are not understandable and meaningful and discuss the implications this view had in concentrating the search and interventions in the biological arena. It will challenge the influential view of Jaspers’s that psychotic experiences are incomprehensible and qualitatively distinct from normal experiences, by drawing on research which demonstrates a continuum of psychotic experiences from general to clinical populations. It will review briefly how people who believe in the understandability of psychotic experiences have attempted to explain them (i.e. the psychological view), concentrating on the most recent theories of cognitive biases. Psychoanalytical approaches have been mainly discredited and behavioural approaches have led to interventions (for example social skills training) that target functional difficulties, not actual psychotic experiences (Sellwood & Haddock, 1994), therefore these approaches will not be discussed. Finally a summary of the intervention possibilities arising from psychological research will be presented with a critical appraisal of the evidence-base for these.

The essay is structured to demonstrate how interventions have derived from theory. However this is not to deny the reciprocal relationship between theory and practice. The views of people who have psychotic experiences are remembered throughout and this is emphasised by drawing on their subjective accounts. It is acknowledged that pre-existing beliefs of the writer will influence the nature of the discussion and the chosen analysis.
within it. Nevertheless it is hoped the reader will be provided with a relatively balanced account and with significant insight into the views of others.

JASPERS AND THE BIOMEDICAL APPROACH TO PSYCHOTIC EXPERIENCES

Jaspers (1963) in his influential text 'General Psychopathology' clearly stated that psychotic experiences are 'ununderstandable', 'psychologically irreducible' and 'incorrigible'. Jaspers asserted that a distinction must be made between delusion-like ideas and delusions proper. Delusion-like ideas were considered to be either, only a tendency towards a false judgement of reality or a transient certainty. Jaspers regarded these phenomena as fully psychologically understandable arising comprehensibly from a person's personality, affect and history. However, in contrast, delusions proper were thought to be false judgements of reality held with absolute certainty and impervious to counterargument. He considered these to be the primary delusional experience and as surface symptoms of an underlying disease process, insisting they arise from a break in the continuum of personality development. The content of delusions proper was dismissed as accidental, rudimentary and beyond our understanding. Jaspers's argument presents a problem for this debate on whether psychotic experiences are understandable or not. According to Jaspers, a delusion can only be a delusion if it is ununderstandable; once it is understandable it is no longer a delusion, but a 'delusion-like idea'. Thus psychotic experiences are not understandable or meaningful; if they were they would not be 'true' psychotic experiences. In order to make progress on the present debate, one must leave the intricacies of Jaspers's argument and move to a definition of delusions (and psychotic experiences in general) that does not have inherent within it an ability to be understood. In fact Bentall, Corcoran, Howard, Blackwood and Kinderman (2001) suggest that existing definitions of delusions have done just that. The emphasis is on Jaspers's more general criteria because of difficulties in operationalising ununderstandability. For example the definition of a delusion in the DSM IV is:

A false personal belief based on incorrect inference about external reality that is firmly sustained in spite of what almost everyone else believes and in spite

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of what usually constitutes incontrovertible and obvious proof or evidence to
the contrary. The belief is not one ordinarily accepted by other members of
the person's culture or subculture (e.g. it is not an article of religious faith)

Jaspers arguments have greatly influenced how delusions and hallucinations have been
conceptualised within the traditional and dominant medical paradigm. His assertions have
led to the construction of two main assumptions. Firstly, that psychotic experiences are
meaningless reflections of an underlying biological dysfunction. A view also derived
from Kraepelin's (1896) (as cited in Bentall, Jackson & Pilgrim, 1988) conceptualisation
of a syndrome (dementia praecox, later termed schizophrenia by Bleuler (1911), as cited in
Bentall et al., 1988) which has an underlying biological cause and for which delusions and
hallucinations are simply surface symptoms, although Kraepelin should not be accused
falsely of ignoring the influence of personality and experience.

There is an interplay of forces at work: the nervous system of the affected
individual, the deficits inherited from past generations and his own personal
history...the general desires of such people are reflected in these delusions...
the key to the understanding [is] primarily in characteristics of the individual

Secondly, Jaspers's views led to the categorical, all-or-nothing notion of psychotic
experiences where they are seen to differ qualitatively from ordinary beliefs and in this
respect cannot be understandable in the way normal beliefs are.

BIOLOGICAL EXPLANATIONS OF PSYCHOTIC EXPERIENCES
In their advocation of the ununderstandability of psychotic experiences, researchers have
searched for a biomedical explanation for the cause of the syndrome. Often it is believed
there is one explanation for the discontinuity between normal and psychotic experiences
(British Psychological Society (BPS), 2000). The role of genetic factors has been
extensively researched and some evidence for its importance has been yielded. A critique
is presented by the BPS (2000). One study (Gottesman, 1991: cited in BPS, 2000) concluded that as the biological relationship became closer the risk of receiving a diagnosis of schizophrenia increased. The risk was 46% for a child with two parents with a diagnosis of schizophrenia, 13% if only one parent had a diagnosis and 9% for siblings. The risk for the general population is 1%. However, separating the effects of genetics and environment is fraught with difficulties and often a conclusion needs to be drawn that genetic factors, although likely to be implicated, do not provide the full causal explanation (BPS, 2000).

Recently, findings that new ‘atypical’ neuroleptics (acting on serotonin levels) can have the dramatic effect of alleviating psychotic experiences where ‘typical’ neuroleptics have failed, has led to the suggestion that serotonin plays a role in causing psychotic experiences (BPS, 2000; Laws & McKenna, 1997). The reciprocal relationship between theory and practice is demonstrated; clinical intervention through pharmacology has informed biochemical explanations (Russell, 2002). Abnormalities in brain structure have also been investigated, but both this research and the research into biochemical abnormalities are hounded by difficulties in proving the direction of the cause-effect relationship and by the presence of third variables (BPS, 2000; Laws & McKenna, 1997). For example, psychotic experiences may lead to biochemical or structural change, not the reverse, and psychosocial experiences may leave physical traces on the brain, which then lead to psychotic experiences. In addition, the participants in this type of research are often in long-term receipt of medication and the biological effects of this are not always taken into account (BPS, 2000).

In line with the view that psychotic experiences reflect biological deficits, psychological research previously focused on cognitive deficits (Bentall, 1996), assuming they were either necessary or sufficient to create psychotic experiences. Laws and McKenna (1997) discuss studies and provide evidence, through two single case studies, which demonstrates a dissociation between cognitive deficits and psychotic experiences. Cognitive deficits can continue to exist while psychotic symptoms cease to, therefore deficits may be an enduring aspect of the disorder but are not a sufficient condition for psychotic experiences, a counterintuitive finding for psychiatry (Laws & McKenna, 1997).
There are no conclusive findings to support the notion that psychotic experiences are not understandable and meaningful because they are symptoms of an underlying biological cause and are conceptually and aetiologically different to normal experiences.

**IMPLICATIONS FOR INTERVENTION FROM THE BIOMEDICAL APPROACH**

The assumption that psychotic experiences are not understandable or meaningful has massive implications for intervention and beyond. If the view held is that psychotic experiences are caused by an organic dysfunction the assumption is that these experiences will only be amenable to biological intervention. Antipsychotic medication is the most common and preferred (medical) treatment (BPS, 2000; Dawkins, Lieberman, Lebowitz & Hsiao, 1999). These treatments do have advantages for many; their experiences can be made less intense and distressing. However, they are also problematic in terms of serious side effects leaving a fine balance between the risks and the benefits of medication (Dawkins et al., 1999; Mann, 1999). The consequences of this can be a cycle of non-compliance, relapse and rehospitalisation (Dawkins et al., 1999). They can also lack long-term positive effects and are not universally effective; some people are resistant to medication (BPS, 2000; Dawkins et al., 1999). Importantly, the assumption that psychotic experiences are not understandable and meaningful has led to widespread use of medical interventions *at the expense of psychosocial approaches* (Bentall, 1993).

An important, but perhaps less obvious, implication of the view of a discontinuity between normal and psychotic experiences is that it encourages an 'us-and-them' distinction (Bentall, 1993). Such a distinction may influence the approach one has towards a person with psychotic experiences.
The psychiatrists I've seen they're just quite dismissive and they just expect me, because they are authority...just to...think...oh that can't be, my psychiatrist says that just couldn't be happening (Messari & Hallam, 2003, p.178). 

This account demonstrates how it can empower the professional and instil powerlessness in the person with psychotic experiences. The assumption held by the medical model has contributed towards an unempathetic approach, assumptions of chronicity and incurability, and lack of individualised care. Other serious, although unintended, effects of this approach are the social exclusion and discrimination of people with psychotic experiences (BPS, 2000; Wahl, 1999); a culture from which society is trying to move away (Aschebrock, Gavey, McCreanor & Tippett, 2003; BPS, 2000; Fowler, Garety & Kuipers, 1998; Wahl, 1999). The medical model, however, has not entirely failed its users, as Bentall (1993) believes.

For me the disease model in action, with its inference of hardware disorder, although of questionable validity in isolating necessary causal factors thus far has, in a general sense, nonetheless been protective and practically helpful rather than condemnatory and confusing (Chadwick, 1993, from his personal experience, p.249).

In conclusion the long-term advocation of this approach has impeded the development of adequate accounts of psychotic behaviour and the pursuit of other types of intervention. An alteration in perspective, that psychotic experiences might be understandable and meaningful is important otherwise the route to finding an explanation for these experiences remains too narrow. Neither theory nor clinical practice is served by the belief that normal and psychotic experiences are qualitatively distinct (Jones, Delespaul & van Os, 2003). The fact that the clinical decision to treat is dichotomous is not evidence for how these conditions exist in nature (Johns & van Os, 2001).

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1 Not only the theoretical and professional orientation but the personal empathy of the clinician implicated in these situations will influence the experience the client has of the medical approach. It is the presence of a diversity of beliefs between the clinician and client that will produce an unsatisfactory experience.
DIMENSIONAL APPROACH TO PSYCHOTIC EXPERIENCES

The alternative perspective approaches psychotic experiences in two fundamentally different ways to the pathological model. Firstly, the focus is on the psychological phenomena (delusions and hallucinations) (the 'symptom approach') rather than on the syndrome. Secondly, it assumes psychotic experiences are on a continuum with normal beliefs and that if they are they will be understandable in terms of ordinary psychological processes. If this view is valid, hallucinations and delusions should to some degree be present in the general population.

Strauss (1969) (as cited in van Os, Hanssen, Bijl & Ravelli, 2000) was one of the first to demonstrate psychotic experiences in clinical populations to be 'points on continua of function'. More recently this continuity has been shown to exist between the general and clinical populations. Van Os et al. (2000), in a random sample of 7076 people, found 17.5% had psychotic-like experiences, 4.2% presented with delusions and hallucinations but only 2.1% had a diagnosis meeting the DSM-III-R criteria for psychosis. Therefore, psychotic experiences may be 50 times more prevalent than is found if the narrower medical definition of psychosis is used (van Os et al., 2000). Tien (1991) found 10% to 15% of the general population had experienced hallucinations. The prevalence rates of psychotic-like experience will reflect to some degree the assessment measure used (Johns & van Os, 2001) but it seems clear that people not part of a clinical population do have psychotic experiences. Van Os et al. (1999) studied 680 people who were either in the general population, had depression or anxiety, or psychosis. They found a pattern of psychotic experiences that increased in severity from normality through depressive states to clinical psychosis. The higher presentation of psychotic experiences in those with a diagnosis of depression or anxiety, compared with the general population, was not a result of a few individuals scoring highly, suggesting there is a continuum (van Os et al., 1999).

People with spiritual or religious beliefs also have experiences similar to psychotic experiences. Peters, Day, McKenna and Orbach (1999) explored the level of delusional ideation in members of new religious movements (NRMs) and people with clinical psychosis. Interestingly, members of the NRMs could not be differentiated from the clinical sample by their score on the Peters et al. delusion inventory or level of conviction,
even though both groups showed a diversion from mainstream beliefs. The cultural context has a strong influence on whether experiences are characterised as normal or signs of a mental health problem (BPS, 2000; Johns & van Os, 2001; Peters, Day, McKenna & Orbach, 1999).

The main difficulty for the prevalence studies is that they are cross-sectional in nature and therefore cannot provide unquestionable evidence against a discontinuity between normal and psychotic beliefs. Surely Jaspers would argue that although similar experiences have been found to be present in normal and clinical samples, are the experiences for the former group not delusion-like ideas and for the later delusions proper? However, an association between demographic risk factors for clinical psychosis and those for psychotic experiences in the general population has been found (van Os et al., 2000). The risk factors, including higher levels of urbanicity and unemployment, could be argued to be the results of a premorbid drift rather than causes of psychotic experiences (van Os et al., 2000) but it cannot be denied that the similarity in risk factors adds further weight to the argument of a continuum.

Longitudinal studies would provide compelling support for the dimensional approach. In a birth cohort study Poulton et al. (2000) found a considerable proportion of children aged 11 years in the general population who presented with psychotic-like symptoms, had a schizophreniform disorder aged 26 years. Chapman, Chapman, Kwapil, Eckblad and Zinser (1994) found psychosis-like experiences in students predicted onset of psychotic illness ten years later. Such findings make it very difficult to argue against the dimensional view and contend that psychotic-like ideas are qualitatively different from true delusions in the same people (Jones et al., 2003), they would be better thought of as a risk factor for florid psychosis (Johns & van Os, 2001).

Findings such as those from Peters, Joseph and Garety (1999) now need to be considered. Nearly 10% of their sample of the ordinary population had more delusional experiences than their clinical sample. What is differentiating healthy individuals and those who suffer from their experiences? Peters, Day, McKenna and Orbach (1999) who compared NRM and a clinical sample found the clinical sample was significantly more distressed and
preoccupied with their experiences. This indicates it is the level of distress rather than the nature of the belief that is important. Chadwick and Birchwood's (1994) exploration of hallucinatory experiences identified that the behavioural and affective consequences of the experience were highly associated with the belief the person held about the voices, not the content of that voice. People who believed the voice to be benevolent engaged with the voice and were less distressed than those who believed the voice to be malevolent. Close and Garety (1998), in a close replication of this study, found less evidence of beliefs of omnipotence but found other beliefs about experiences were important. To understand psychotic experiences one must attend to both the type and content of the event and the person's evaluation of that event.

Strong, empirical support emerges for the view that delusional beliefs are on a continuum with normal beliefs and that psychotic experiences are multidimensional in nature. When confronted with this evidence it seems difficult to argue that psychotic experiences are not understandable or meaningful. In fact it is the understanding the client has assigned to the experience which is important in explaining their affective and behavioural responses.

It is this belief that psychotic experiences are understandable which drove psychological exploration into how the quantitative variation between normal and psychotic experiences may be explained. The question now becomes, how can we understand psychotic experiences? A summary of the proposed psychosocial theories follows with the focus on cognitive theories and most recent proposals.

PSYCHOSOCIAL UNDERSTANDING OF PSYCHOTIC EXPERIENCES
Since the mid 1980s psychological accounts of delusions have flourished, with the emphasis on the contributory role in psychosis of cognitive biases, not deficits. Theoretical accounts of hallucinations have also been proposed². However, unitary accounts are likely to be inadequate and only aspects of each theory receive support (Bentall, 1990; Garety & Freeman, 1999). The complexity of psychotic experiences

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² A detailed critique of the individual theoretical accounts of delusions is presented by Garety and Freeman (1999) and of hallucinations by Bentall (1990).
demands a multifactorial conceptualisation (Garety & Freeman, 1999). Such a cognitive model of psychotic experiences has been proposed by Garety, Kuipers, Fowler, Freeman and Bebbington (2001).

Garety et al. (2001) present their conceptualisation within a stress-vulnerability model which proposes that, vulnerability, which may arise from biological, psychological or social factors, will only result in difficulties in the presence of environmental stresses. The hypothesis is that under these circumstances cognitive styles of 'jumping-to-conclusions', external attributional biases for negative events and dysfunctions in theory of mind (the ability to understand the mental state of others) will be exaggerated. These are all theories previously presented as unitary theories to account for delusions (see Garety & Freeman, 1999). This model also posits a central role for emotion, specifically anxiety. It proposes that disturbed affect triggered by environmental stressors will lead to the occurrence of cognitive processes known to be associated with anxiety. These include selective attention to threat-related material, confirmatory bias and safety behaviours. If these processes are present they will also exert an influence on the formation and maintenance of psychotic experiences.

Social factors, known to be implicated in psychotic experiences, are also integrated into the model. For example, prevalence rates of schizophrenia and non-clinical psychotic experiences are known to be higher in minority populations, specifically British Afro-Carribbeans (BPS, 2000; Russell, 2002; van Os & McGuffin, 2003). These same rates are not found where people are in the majority population (for example in the Caribbean) and the effect size is modified by the size of the minority group in the wider social environment (Russell, 2002; van Os & McGuffin, 2003). The findings do appear to be linked to social marginalisation and not genetic or biological factors (BPS, 2000; Garety et al., 2001; Russell, 2002; van Os & McGuffin, 2003). The family environment is also considered important. Although current evidence indicates families are unlikely to be implicated in causing psychotic experiences, against a popular theory in the 1960s (Laing, 1964: cited in Forrest, 1975), their attitudes are believed to be important in affecting recovery. People with psychotic experiences in families with high expressed emotion (extreme emotional overinvolvement or critical attitudes) show a poorer outcome (BPS,
2000). Garety et al. (2001) believe unsupportive family environments, social exclusion and traumatic experiences may exert indirect effects by contributing to the formation of negative, dysfunctional schemas about the self and world which in turn facilitate external attributions and low self-esteem. Overall, this model is appealing, however it must be remembered that it is speculative and as a whole model is not yet grounded within empirical evidence.

The exact processes implicated in the formation and maintenance of psychotic experiences continue to be debated. What is unquestionably evident is that psychotic experiences are not irreducible, ununderstandable and meaningless, but can be increasingly understood to be a function of the same complex factors that affect normal experiences (Chadwick, Birchwood & Trower, 1996; Garety et al., 2001; Jones et al., 2003). Psychotic experiences have a multifactorial aetiology, involving cognitive, affective, social and biological factors, all of which are distributed in the general population along a continuum (Garety et al., 2001; Jones et al., 2003). Psychological models of individual symptoms have the implication of allowing the development of psychological interventions and a final move away from biological exclusivity.

IMPLICATIONS FOR INTERVENTION FROM THE PSYCHOLOGICAL AND DIMENSIONAL APPROACH
Two main interventions have arisen from psychological theoretical findings; family psychoeducation, an indirect approach, and cognitive-behaviour therapy (CBT) for psychosis, which aims to act directly on an individual’s psychological processes, for example changing people’s attributions and biased reasoning and exploring alternative explanations for experiences. The normalising approach in CBT derives from the dimensional view of psychosis and is less stigmatising than the medical approach. Clients are not seen as categorically different from the general population (Johns and van Os, 2001).
As far as the hallucinations themselves go…he’s [the psychologist’s] going into detail of how…not only schizophrenics see things, there’s a whole scale of people... people under stress can hear things...he doesn’t start with hallucinations, just telling me it’s not real (Messari & Hallam, 2003, p.177).

When I see the psychologist, it’s as though they’re responding to the human being that’s in his own dilemma (Messari & Hallam, 2003, p.179).

Another aspect of the cognitive-behavioural approach in stark contrast to the approach of the biomedical model is that attention is given to the content, not only the form of psychotic experiences (Aschebrock et al., 2003; Bentall, 1996). A recent international survey (Aschebrock et al., 2003) indicated clinicians do believe considering the content of these phenomena can substantially benefit therapeutic intervention.

Evidence of the multidimensionality of psychotic experiences demonstrated that how a person evaluates their experience, not just the type and content of the experience, should be addressed in intervention. If attention is not paid to the subjective experience of the client, as it is often not within psychiatry, the behavioural response of the person will appear incongruous to the experience (Chadwick & Birchwood, 1994). Therapeutically it is the client’s explanations of experiences that are explored and clients are facilitated to construct alternative meanings. It is this that is important in reducing distress not necessarily the removal of the actual psychotic experience as is the aim of pharmacotherapy (Chadwick & Birchwood, 1994). CBT has demonstrated that beliefs can be changed and are not always unresponsive to reason; such findings challenge the view held by Jaspers that true delusions are held with total conviction (Chadwick et al., 1996). Also therapeutic work is often conducted within a client’s delusional system (Sellwood & Haddock, 1994) (i.e. no attempt is made to correct the delusional belief) and attention is paid to the relationship a client has with, for example, the voices they hear. Some people have a good relationship with their voices; to remove them would be more distressing. The cognitive-behavioural approach views the client’s subjective perspective as all important. An implication of findings of the complexity and multifactorial aetiology of
psychotic experiences means CBT must occur within the context of an individualised formulation and in collaboration with the client (Fowler et al., 1998).

A further clinical implication arises from the findings from longitudinal studies (Poulton et al., 2000; Chapman et al., 1994). Early intervention for children with psychosis-like symptoms is proposed given that such symptoms have been demonstrated to be predictive of adult psychosis (BPS, 2000; Johns & van Os, 2001; Peters, Joseph & Garety, 1999; Poulton et al., 2000). However, the presence of false positives (children believed to be at risk who will never develop florid psychosis) must always be a consideration. Johns and van Os (2001) argue early intervention should be psychological and not pharmacological, given the side effects of medication.

All the research that has led to the development of the range of cognitive-behavioural interventions has only been conducted because of a belief that psychotic experiences are understandable and meaningful. The range of therapeutic opportunities this belief has afforded is very evident. The consideration now is whether these opportunities are supported by empirical evidence. If psychotic experiences lie on a continuum with normal beliefs they should be treatable by CBT.

**Efficacy and effectiveness of CBT**

Despite wanting to believe in the proven effectiveness of CBT, it is difficult to argue against recent points made by McKenna (Turkington & McKenna, 2003) that challenge the methodology and subsequently the conclusions of the main trials of CBT. The London-East Anglia trial (Kuipers, et al., 1997) found only 50% of the treatment group responded to CBT and they did not use a control intervention or blind evaluations. Sensky et al.'s (2000) randomised control trial found CBT showed no immediate significant advantage over a befriending intervention, however CBT had improved on its gains at the nine month follow-up while the effects of befriending had dissipated. Drury, Birchwood and Cochrane (2000) in their five year follow-up of a comparison of CBT and recreational activities could no longer claim the advantage CBT demonstrated at nine months. A meta-analysis of 13 trials of CBT (Cormac, Jones, Campbell & Silveire de Mota Neto, 2002), where all trials showed a moderate risk of bias, again found no compelling evidence of an
effect in the longer term and had to state that trial-based data supporting the use of CBT is far from conclusive.

The finding from clinical trials of CBT that not all clients respond to psychological intervention has an important implication for this debate, it begs the question 'what prevents therapeutic change along the dimensions of belief in non-responsive patients?' (Jones, et al., 2003, p.285). Jones (Jones et al., 2003) proposes that it may mean Jaspers's view is in the end correct. However, Jones (Jones et al., 2003) draws upon arguments already challenged by empirical findings for example that delusions are impervious to counterargument (Chadwick et al., 1996) and that psychosis-like symptoms in non-clinical populations may not share the same mechanism as true delusions (see longitudinal studies). While not denying findings that CBT is yet to be proven universally effective, other researchers remain optimistic; CBT is the only psychological intervention which maintains effects in the short-term and its collaborative approach means it is well-liked by service users (BPS, 2000; Messari & Hallam, 2003; Turkington in Turkington & McKenna, 2003). NICE (2002) recommend CBT be available as a treatment option.

CONCLUSION
It appears unjustified to conclude that people with psychotic experiences function in a psychologically distinct way to the general population and therefore that their experiences are not understandable or meaningful. There is strong support, particularly from longitudinal studies, for a dimensional approach to psychotic experiences and support for the multidimensionality of these experiences. Delusions and hallucinations can be (for many) understood using a multifactorial conceptualisation and by listening to the subjective experience of the client. Research has not yielded findings that can exclusively implicate biological deficits in the causation of psychotic experiences.

The belief, promoted by Jaspers, that psychotic experiences are not understandable or meaningful has been prominent for too long and has clearly retarded attempts at understanding these experiences and impeded the development of important therapeutic interventions (for example CBT). It is small wonder that psychosocial theories and
psychological interventions are in their earlier stages of development relative to medical approaches and therefore one has to disagree with McKenna's (Turkington & McKenna, 2003) insinuation that CBT should be consigned to history. Further development of psychological models and methodologically sound evaluation of psychological therapy is needed. However, the underlying belief which drove psychological research, that psychotic experiences are understandable and lie on a continuum with normal beliefs, has afforded many more therapeutic opportunities than the biological approach, with the belief that psychotic experiences are meaningless surface expressions of an underlying organic dysfunction. One main contribution of the psychological, dimensional approach has to be its individualised, collaborative and normalising approach, able to take into account the diverse experiences of clients.

However, an anti-psychiatric perspective is not being advocated here. Psychotic experiences can and do lead to severe suffering and impairment for a number of people for whom medical intervention may be the most appropriate management, but it must be provided within an empathetic service. Empathy is yielded from an attempt to understand a person's experiences. Whatever one's theoretical beliefs, therapeutically it must be the beliefs of the clients and the meaning they assign to their experiences that are all important. The earlier quote from Chadwick (1993) demonstrates the medical approach is right for some people. If there is diversity in the beliefs of the client and professional these must be acknowledged and respected.
REFERENCES


What role do clinical psychologists have in the assessment and treatment of people with learning disabilities who have been sexually abused? How can they assist with the prevention of such abuse?
INTRODUCTION
Historically people with learning disabilities have been denied a sexuality, but a paradigm shift in the 1970s and 1980s led to greater acknowledgement that they, like everybody else, have sexual needs and should have the right to sexual expression. Unfortunately the reality is that in their sexual lives people with learning disabilities are extremely vulnerable to exploitation and abuse (Brown, 1993). Sexual abuse is broadly defined as 'sexual acts performed on, or with, someone who is either unwilling or unable to consent to those acts' (Brown & Turk, 1992, p.46). The most comprehensive surveys to date (Brown, Stein & Turk, 1995; Turk & Brown, 1993) found that women and men are victims; perpetrators are usually male, familiar to the victim and in positions of trust; perpetrators are from four main groups, staff, family, trusted adults in the community and a significant proportion are other people with learning disabilities. These surveys alarmingly revealed 109 and 119 newly reported cases of sexual abuse in the south-east of England in two two-year periods and estimated from these incidence figures that there could be 950 new cases of sexual abuse of adults with learning disabilities in the United Kingdom each year. A clear stimulus exists for clinical psychology to consider its role in this area and contribution by psychology will be required; Beail and Warden (1995) found that 25% of people with a learning disability referred to a psychology service had been sexually abused and Turk and Brown (1993) report that clinical psychologists are the second most frequent professional, after social workers, to become involved after an allegation of sexual abuse.

This essay will explore the roles of clinical psychologists in assessment, treatment and prevention. There is no inherent assumption that psychologists will be the only professionals competent to fulfil the roles but as Risin and McNamara (1989, p.178) argue clinical psychologists have 'intensive, broad-based theoretical, clinical, and assessment training’ enabling them to develop skills in interviewing, behavioural observations and administration and interpretation of psychometric instruments, and abilities in appraising cognitive and emotional development, treating psychological problems and training other health professionals. However, contemplation also needs to be, and will be, given to the specific issues and competencies that will be required if psychologists are to fulfil their roles successfully in this area. This essay will focus on adults with learning disabilities to
enable the extra dynamic this creates to be considered; adults, unlike children, do have a legal and moral right to sexual lives.

ASSESSMENT
A number of roles for clinical psychologists exist in assessment. These include firstly, to determine whether or not a person has been sexually abused which may include assessing a person's capacity to consent to sexual relationships; secondly, to validate allegations of abuse which may include gathering evidence for legal 'proof' of abuse; thirdly, to assess the effects of sexual abuse on the victim and the implications for the service in which the abuse occurred, which may include providing risk estimates of future abuse. As an assessment can serve several purposes psychologists must be clear about the objectives; these will determine the type of assessment and their role at any one time (Babiker & Herbert, 1998).

Diagnosing sexual abuse
One role for clinical psychologists is to assess if sexual abuse has occurred. Central to fulfilling this role successfully is a thorough understanding of what constitutes sexual abuse. One definition is:

... when a perpetrator exposes his/her genitals or looks at or touches certain parts of a victim’s body (breasts, buttocks, thighs, mouth, genital or anal areas) or requires the victim to perform sexual acts, for the purpose of gratifying or satisfying the needs of the first person and when one or more of the following apply:

1) The second person withholds their consent.
2) The second person is unable to give their consent because the severity or nature of their learning disability severely affects their understanding of the basic elements of sexual behaviour.
3) Some other barrier to consent is present for the victim which means that they are unduly pressured in this particular situation including:
• the presence of parental, familial, caretaking or other authority relationship between the persons involved;
• the use of force, a weapon or the threat of injury or punishment by the first person;
• the abuse of a power relationship which precludes consent by the weaker person

In determining if an act was, by definition, abusive, psychologists must firstly recognise that abuse can take the form of contact (penetrative and non-penetrative) and non-contact sexual acts but secondly and more crucially must give thorough consideration to the circumstances in which the act occurred and the consent issues involved; did the person consent and/or could the person consent (Brown & Turk, 1992)?

This latter question requires psychologists to use their skills in administering psychometric instruments to evaluate a person’s intellectual abilities to determine whether the person has capacity to consent and whether there was sufficient understanding of sexual behaviour and its consequences to enable meaningful consent (Brown & Turk, 1992). Psychologists may also need to assess for the presence of behavioural indicators of consent and mutuality; for example, did both parties seek to spend time together? (Brown & Turk, 1992). Legal restrictions must also be considered; people cannot consent if under 16 years of age or in an incestuous relationship. However, a person with severe learning disabilities is now not automatically deemed unable to consent to any sexual relationship (The Stationary Office: Sexual Offences Act, 2000) and a ‘functional approach’ to assessment, which judges the person’s capacity to consent to the specific act in question at the time the decision had to be made, should be taken; no blanket decisions on capacity should be made (Green, 2001).

Where there is not an obvious factor precluding consent, the issues faced by psychologists in this role are much more complex; they are required to determine if there was ‘an abuse of a power relationship which precluded consent by the weaker person’ (Turk & Brown, 1993, p.197). When concerning vulnerable adults, the rights of people with learning
disabilities to engage in sexual relationships must be balanced with the duty to protect them from exploitation. Brown and Turk (1992) warn that professionals and carers while believing they are promoting choice and applying the principle of normalisation can fail to acknowledge unequal power relationships and therefore fail to act in cases of sexual abuse. A psychologist must negotiate this tension.

Decisions, about whether or not sexual abuse has occurred, are frequently ‘muddled’ by professionals’ judgements about the perceived outcome for the victim, the perceived intentions of the perpetrator and who should define the act as abusive (Brown & Turk, 1992). Subjective experiences on the part of the victim will vary; the victim may have positive feelings about the perpetrator or may not find the abusive acts disturbing (McCarthy & Thompson, 1997). Also the perpetrator may not have intended to ‘abuse’ or both the abuser and the victim may have believed they were engaging in a consensual relationship (Brown & Turk, 1992). Such dynamics are likely because perpetrators are often other people with learning disabilities (Brown et al., 1995; Turk & Brown, 1993). However, the psychologist must be clear about which role they are fulfilling at any one time. If the aim is to assess whether or not sexual abuse occurred then the question to be answered is did or could the victim consent? Subjective experiences on the part of the victim or perpetrator should not be considered (Brown & Turk, 1992; McCarthy & Thompson, 1997). However, clinically, the situation will always be much more complex and as therapeutically-orientated professionals psychologists should consider such issues as the effects of the abuse on the victim.

Validating allegations of sexual abuse
The validation of sexual abuse allegations is likely to be another important role; in the majority of cases it is the victim who discloses abuse but in many cases is not believed (Beail & Warden, 1995; McCarthy & Thompson, 1997; Turk & Brown, 1993).

The effects of sexual abuse
The role of a psychologist in a validation assessment is to determine whether the ‘characteristics of the abusive experience are concordant with what is known about the nature and course of sexual abuse’ (Risin & McNamara, 1989, p.178). Unfortunately,
there is little factual knowledge regarding the effects of sexual abuse on people with learning disabilities and considerable methodological difficulties with studies that do exist, for example most are retrospective meaning vulnerability factors cannot be differentiated from effects (Fenwick, 1994a; Matich-Maroney, 2003; Sequeira, Howlin, & Hollins, 2003). Existing research does counter previous beliefs that this population is less affected than others (Moss, 1999) and indicates that they experience similar difficulties as people without disabilities including post-traumatic stress disorder (PTSD), higher levels of depression and aggressive behaviour, low self-esteem, feelings of shame and guilt, self-injury and sexually maladaptive behaviours (Beail & Warden, 1995; Matich-Maroney, 2003; Sequeira & Hollins, 2003; Sequeira, et al., 2003).

Most of these studies fail to discuss if the diversity within their sample, in terms of gender, severity of disability, cultural background and type of abuse, contributed towards different presentations. It seems highly unlikely that the heterogeneous groups presented will have homogenous responses. Psychologists must be cautious not to make this mistake at a clinical level or abuse cases may be missed. Psychologists must also be careful if supplementing their knowledge with research on people without disabilities (Moss, 1999). In a person with a learning disability, effects of abuse may be compounded because of an already existing poor self image (Fenwick, 1994a) and cognitive impairment may mediate the impact and produce reactions not found in the general population (Sequeira & Hollins, 2003). Any assessment must see victims in the context of their whole life and consider how abuse may compound existing feelings of disempowerment because of gender, culture or disability (Bernard, 1999; Kenny & McEachern, 2000) and will necessitate psychologists to see beyond their own experiences, for example, as a white, non-disabled woman.

**Interviewing**

The role of psychologists may be to interview the victim and their interviewing skills can ensure an approach that is facilitative without being leading (Babiker & Herbert, 1998). This challenge is greatest with a client who is non-verbal and there is a dearth of well-standardised instruments to facilitate this work. The current tools used, such as anatomically correct dolls and drawings and the object relations test, have no standardised
formats and no norms. The interpretation is therefore very subjective and may be leading and these tests may not be able to discriminate between victims and non-victims (Babiker & Herbert, 1998; Risin & McNamara, 1989; Valenti-Hein, 2002). One small study (Valenti-Hein, 2002) also demonstrated that people with learning disabilities may lack the cognitive abilities to generalise from the tool to themselves. The consensus appears to be that these techniques can be utilised in conjunction with other types of assessment to aid communication but not to diagnose abuse (Babiker & Herbert, 1998; Risin & McNamara, 1989).

**Behavioural observations**

Psychologists are also well-placed through their training and as ‘external’ professionals to conduct direct observations of the victim to ascertain if there are any behavioural or emotional signs that may be indicative of abuse (Babiker & Herbert, 1998; Beail & Warden, 1995; Risin & McNamara, 1989). It is imperative that psychologists ask staff specifically about the presence of such behaviours; staff often lack competence to recognise sexual abuse where there are behavioural, rather than verbal, manifestations (Beail & Warden, 1995). Often behaviours are considered to be integral to the person’s learning disability (Brown, 1994). Thus staff need to be educated about behavioural signs (Risin & McNamara, 1989), a further role for psychologists.

Psychologists also have a responsibility to be mindful of the possibility of abuse when the referral is for another problem, for example ‘challenging behaviour’. However, behavioural signs should not be used as conclusive evidence; certain behaviours can be related to a person’s learning disability or can be present in people who have not been abused (Babiker & Herbert, 1998; Risin & McNamara, 1989; Sequeira & Hollins, 2003). Fenwick (1994b) highlights the need to assess, symptoms indicative of a traumatic experience in general, symptoms more specifically indicative of sexual abuse, normal behaviour and functioning for the person, and the situational and developmental context; an adolescent male with learning disabilities and emerging sexuality may exhibit sexual behaviour in inappropriate contexts.
Evidence from interviews and behavioural observations can only strengthen a conclusion of sexual abuse when other indicators are present (Babiker & Herbert, 1998; Sinason, 2002).

TREATMENT

Direct intervention
The wide ranging emotional, psychological and behavioural effects of sexual abuse make treatment an obvious role for a psychologist. Treatment may arise not only from a referral but also from the disclosure of abuse in psychotherapy for another reason (Beail & Warden, 1995; Sinason, 1994). Unfortunately, there is limited systematic research on the most effective treatment for this population; most discussions draw on case studies or extrapolate from research conducted with non-disabled victims (Fenwick, 1994a; Moss, 1999). However, it is now recognised that people with learning disabilities are able to benefit from psychotherapeutic approaches; a view not held historically (Cooke, 2003). The main approaches are psychoanalytic psychotherapy and cognitive-behavioural therapy. Individual therapy is probably the most appropriate form of treatment but group therapy can be a valuable complement (Sullivan & Scanlan, 1990).

Psychologists can fulfil a number of therapeutic roles. One of the most important is to help clients develop the capacity to form trusting interpersonal relationships. The client-therapist relationship provides clients with a chance to experience a trusting and intimate relationship that is neither overwhelming nor self-serving (Cooke, 2003; Tharinger, Horton & Millea, 1990) and can be an important starting point. However, relationships can mirror the dynamics of an abusive relationship and to prevent this psychologists need to acknowledge emotions that can be provoked and be sensitive to the power differentials and countertransference inherent in a client-therapist relationship (Cooke, 2003; Moss, 1999; Short, 1996).

Other therapeutic roles will depend on the client’s individual needs (Moss, 1999) and may include helping clients develop a vocabulary for expressing their emotions and resolve
these in appropriate ways (for example anger, loss and guilt); treating mental health problems (such as depression and PTSD), or any secondary behavioural difficulties; helping clients improve their self-esteem and reduce self-destructive responses; or facilitating the development of knowledge and skills (for example assertiveness) to prevent future abuse (Moss, 1999; Sullivan & Scanlan, 1990). Needs will vary depending not only on the person's abusive experiences but also on their existing beliefs, their ability to understand their experiences (Moss, 1999) and their personal identity (defined by their gender, culture and sexuality). Cambridge and Mellan (2000) and Brown and Turk (1994) highlight the need to be sensitive to gender issues. Men may have greater difficulty disclosing their experience and sexual abuse may raise sexual identity issues, as the majority of perpetrators are also men. For women, power differences play an important role.

In fulfilling these roles a number of therapeutic approaches can be utilised. Cognitive-behavioural strategies include guided visualisation to facilitate 'safe' recall of the abuse, distraction and cognitive restructuring to cope with flashbacks, and systematic desensitisation to overcome anxiety provoked by stimuli related to the abuse (Davidson, Clare, Georgiades, Divall & Holland, 1994; Moss, 1999). Davidson et al. (1994) describe the effective use of these techniques in treating PTSD after sexual abuse in a client with borderline disabilities. Cooke (2003) also discusses the benefits of solution-focused therapy, because of its structured and practical approach, although this therapy is yet to be empirically validated for use with the learning disabled population.

Sinason (1988; 1994) has discussed, in the context of a number of single case studies, the use of individual and group psychoanalytical psychotherapy with children and adults with severe learning disabilities. These clients often have considerable communication difficulties which are responded to by using a range of concrete objects to facilitate expression, including magazines, photographs, drawings and dolls. Free symbolic play is used to encourage clients to express their thoughts and feelings, through which the emergence of explicit and distressing sexualised play and language is seen in both child and adult clients (Sinason, 1988; Sinason, 1994). The role of the therapist is to interpret the behaviour and the transference and countertransference (Sinason, 2002).
Psychotherapy can enable clients to acknowledge their often confusing experiences; distress from the hurt caused but also a sense of missing the abuse because part of the experience was physically pleasurable (Sinason, 1988; Sinason, 1994). Sinason's accounts, more than any, highlight that psychologists fulfilling a therapeutic role will need the ability to tolerate high levels of distress on the part of the victim and will need to be supported through supervision (ARC/NAPSAC, 1993; Moss, 1999).

**Indirect intervention**

The role of the clinical psychologist will go beyond direct intervention. The needs of staff, family and other service users, who may have witnessed abuse or been victims themselves, will need to be met (ARC/NAPSAC, 1993; Moss, 1999). Psychologists have a responsibility to help carers understand why a victim may present as they do and to help them 'hear' non-verbal communication. Carers must understand the process of recovery so victims are receiving the correct support in their daily lives (Moss, 1999).

This discussion shows that there are a number of psychological treatments available. However, too few staff take up these treatment opportunities on behalf of victims. McCarthy and Thompson (1997) in their study found only 47% of the victims received any form of support after the abuse and although Turk and Brown (1993) found in the first Kent study that 71% were offered therapeutic services, these were minimal and usually offered by a carer already working closely with the victim. Also, an aspect Turk and Brown (1993) failed to consider, is what the quality of this support would be, given that a proportion of those receiving support were not actually regarded to have suffered any trauma. Another dimension is that only half the people who had been sexually abused by other service users were believed to have been traumatised compared with 88% of the people abused by non-disabled perpetrators (Brown & Stein, 1997). Therefore the role of psychologists must also be to promote their therapeutic services, informally and through formal staff training programmes, and ensure an understanding that even if the perpetrator also has learning disabilities this does not reduce the effects of the abuse for the victim. The second Kent study (Brown et al., 1995) was conducted after staff training and offers some support for its effectiveness; 71% of the victims compared to 51% in the first study.
were considered to have suffered trauma and therapeutic services, which now consisted of multiple sources of help including psychological therapy, were offered to 96%.

PREVENTION
The primary aim for all professionals should be to prevent sexual abuse (Department of Health (DoH), 2000).

There are multiple risk factors that render people with learning disabilities extremely vulnerable to sexual abuse and these need to be addressed. Vulnerabilities include physical and emotional dependence on others; relative powerlessness in society and the acquiescence and compliance this has created; lack of knowledge about sexuality, relationships, abuse and issues of consent and power; and difficulties with comprehension and communication making them vulnerable to suggestion and impairing their ability to assert themselves (Tharinger, et al., 1990; Turk & Brown, 1993). These vulnerabilities may also be compounded by the culture and provision of services in which they reside (Brown, 1997; McCarthy & Thompson, 1996; White, Holland, Marsland & Oakes, 2003).

There are three levels of prevention; primary prevention, preventing the initial occurrence of abuse; secondary prevention, identifying early potential or actual abuse; and tertiary prevention, responding to abuse to reduce it in the future (White et al., 2003). Clinical psychologists have roles at all three levels.

Direct education and training

Sex education
It is imperative that services intervene to address deficits in social-sexual knowledge and skills; if people are unprepared and unsupported in their sexual lives they risk being sexually abused or becoming an abuser of others (Brown & Cambridge, 1997). Clinical psychologists can address this limited social-sexual knowledge by providing education on sexual abuse and sexuality, for example on appropriate and inappropriate sexual relationships. Before conducting sex education, however, psychologists must undertake a
thorough assessment of the kinds of sexual activities in which the individual is engaged (McCarthy, 1992). For example, many men with learning disabilities have sex with both men and women, even if only their relationships with women are made public (McCarthy, 1996). Psychologists must not define ‘normality’ otherwise their own gender, cultural and sexual identity may prevent the most appropriate form of education reaching their client and people engaging in behaviours considered ‘taboo’ will continue to be unsupported (Cambridge & Mellan, 2000; Davidson-Paine & Corbett, 1995; Malhotra & Mellan, 1996). Psychologists will also need to use their sensitivity; some cultures condemn discussions about sex in general, for example Hispanic (Kenny & McEachern, 2000) and Muslim cultures (Miles, 1996), or forbid certain behaviours such as same-sex relationships, for example fundamentalist Christian, Muslim and Jewish religions (Cambridge & Mellan, 2000). To prevent abuse, psychologists must educate and support, or find someone who can meaningfully support, the person to enable them to take up socially valued roles within their own subculture (Davidson-Paine & Corbett, 1995).

**Self-protection training**

Sex education must be complemented with training in self-protection and assertiveness skills which people with learning disabilities can acquire (Lumley, Miltenberger, Long, Rapp & Roberts, 1998; Miltenberger et al., 1999; Singer, 1996). Behavioural skills training is the most effective (Davis & Gidycz, 2000) and does not create adverse effects (Haseltine & Miltenberger, 1990; Lumley et al., 1998). Clinical psychologists can provide this type of training which involves teaching clients how to respond to and report abuse using a three component response: verbal refusal of a sexual solicitation, leaving the situation, and reporting the incident to a trusted adult (Lumley et al., 1998; Miltenberger et al., 1999). In clinical practice, psychologists will need to utilise an assessment that demonstrates increases in *actual behaviour*, not only knowledge (Lumley & Miltenberger, 1997). Verbal reports do not correspond with how people behave in role-play (Singer, 1996) and behaviour in role-play is not as reliable as performance in naturalistic (in-situ) assessments (Lumley et al., 1998; Miltenberger et al., 1999). However, psychologists need to be aware that even with in-situ training there are difficulties with the generalisation and maintenance of skills (Miltenberger, et al. 1999; Singer, 1996). Another important problem is that none of the above studies have examined the effects of
the programmes on the prevalence of abuse. Therefore it is unknown whether sex education and self-protection training actually reduces the amount of abuse (Davis & Gidycz, 2000), the ultimate aim of prevention work.

Education and training of parents and staff groups

*Sex education*

Direct education work will need to be continually reinforced in the daily lives of people with learning disabilities (McCarthy & Thompson, 1997). Clinical psychologists therefore also have a role in working with parents (Blakey, Frankland, Dix & Farrell, 1996) and care staff to facilitate them to develop a positive and proactive attitude to this type of work (White et al., 2003).

*Education and training on effective recognition of and response to abuse*

The recognition of sexual abuse is critical to preventing it; if services deny the potential for abuse they will fail to respond or introduce preventative strategies (Brown, 1994; White et al., 2003). Promisingly, staff do recognise that people with learning disabilities are at a high risk (Allington, 1992; Brown, Hunt & Stein, 1994; Hames, 1996) but there is a discrepancy between this recognition and the amount of discussion about sexual abuse in the workplace; Allington (1992) found nearly one third of staff never discussed these issues. Also some staff are unaware of the patterns of abuse; Hames (1996) found staff feel the risks to men are less than research has demonstrated. In working towards prevention there is a clear need for staff training; something staff themselves have identified (Brown et al., 1994; McConkey & Ryan, 2001). Clinical psychologists can play a role in this training; they can disseminate research findings to direct workers and can facilitate staff, and other service users (Baum & Sheppard, 2001), to recognise, respond and report abuse effectively (Turk & Brown, 1993). Crucially, psychologists in this role also need to seek to change attitudes and work cultures that militate against the prevention of abuse. Responses to abuse can be driven by staff members' own attitudes and opinions, which may not necessarily be in the best interests of the client, unless opinions are acknowledged and reflected upon (Allington, 1992; Brown et al., 1994; McConkey & Ryan, 2001). Staff members also need training on issues of confidentiality because they
may not report abuse if a victim wishes their disclosure to be confidential; a dilemma that also affects psychologists (Short, 1996); however ‘confidentiality should not be confused with secrecy’ (DoH, 2000, p.6). Unfortunately research has questioned the effectiveness of training in achieving staff attitudinal and behavioural change (Hames, 1996; White et al., 2003). Hames (1996) concludes that to ensure training influences practice ‘more varied and imaginative’ strategies are needed but Hames fails to suggest what these might be.

To achieve a consistent approach and to assist staff in negotiating the ‘complex issues of choice, consent, and the interface between them’ (White et al., 2003, p.7) sexual abuse training is required for all members of staff (including purchasers, managers, supervisors and direct care and administrative staff) (DoH, 2000; Furey & Keharhahn, 2000; McCarthy & Thompson, 1996) and supported by policies and guidelines (Brown, 1994; DoH, 2000), to which clinical psychologists can also contribute. In addition, while psychologists are able to educate other staff they too have a direct role in ensuring that they recognise, respond to and report abuse effectively and set appropriate standards and attitudes within services.

Multi-agency training
Multi-agency training programmes are also vital; cases of abuse against people with learning disabilities resulting in prosecution is very low (McCarthy & Thompson, 1997; Turk & Brown, 1993) and Keilty and Connelly (2001) found police officers showed confusion about what constitutes a learning disability and some held myths about women with learning disabilities, for example, that they were promiscuous. Stein and Brown (1995) found training could change attitudes; after training the police believed people with learning disabilities could be supported to provide the quality of evidence they required for a conviction. It is imperative that police education is provided if perpetrators are to be convicted of their crime and future abuse prevented.

Treating perpetrators of sexual abuse
In prevention, equally important as securing a conviction, is the effort to offer perpetrators treatment and support. Psychologists can play a role by developing treatment services for
perpetrators with learning disabilities but coupled with the type of staff training already described. Studies show that there is a consistent failure by services to recognise the behaviour of these perpetrators as abusive, rather it is considered unintentional or a misunderstanding, and unfortunately this lack of recognition leads to inaction, which precludes any clinical or legal intervention; a costly mistake because repeat offences by these perpetrators are frequent (Brown & Stein, 1997).

Successful treatment for victims of abuse may also serve as a preventative strategy because, although evidence shows the move from victim to perpetrator is not a simplistic process (Thompson, 1997), it may serve to break the victim-perpetrator cycle.

CONCLUSION
Psychologists clearly have the knowledge, skills and qualities that enable them to fulfil roles in the area of sexual abuse. They are able to assess a person’s capacity to consent to sexual relationships, determine if sexual abuse has occurred, establish if allegations are valid and assess the effects of abuse. Psychologists can also provide therapeutic interventions, increase clients’ knowledge of sexuality and help them develop self-protection skills. They are also well placed to educate and train parents and staff groups so victims and perpetrators are provided with the correct support and, crucially, can also facilitate staff groups to provide a service and culture that will successfully prevent abuse. To be most effective, psychologists must always consider the complex issues of consent, take into account the current, historical and cultural context of the person and seek not to impose their own beliefs and experiences. Psychologists must recognise that they have a dual obligation to facilitate the rights of people with learning disabilities and to protect them from abuse. Acknowledgement must also be made that work will occur within a socio-cultural context and therefore will be influenced by the costs encountered by failing to diagnose, treat or prevent abuse or conversely by misclassifying abuse and causing unnecessary intervention (Babiker & Herbert, 1998). Psychologists must incorporate effective multidisciplinary communication and collaboration into their role (DoH, 2000).
It will be a challenge for psychologists to fulfil these roles successfully where there is limited theoretical knowledge, sound research and empirically-based assessment and treatment methods. Specifically there are too few studies including people with severe learning and communication difficulties therefore the treatment and direct prevention work described here may not be applicable to this group. More systematic and broad research is required, another obvious role for clinical psychologists, but a lack of access to research participants means it is crucial that partnerships are established between researchers and clinical services (Babiker & Herbert, 1998; Matich-Marony, 2003).

While there are clearly a vast number of roles that psychologists can fulfil, it is important to recognise that some are mutually exclusive; the perspective adopted will depend on the role, for example when investigating the accuracy of an allegation the aim is to discover the 'truth' but when working in a therapeutic capacity it is to validate the client's experiences (Moss, 1999). On every occasion psychologists must be clear of their role and mindful of the issues involved, then they will be capable of making a very valuable contribution.
REFERENCES


"Divorce is bad for children". Critically discuss with reference to the literature on the psychological effects on children of divorce and parental conflict

December 2004

Year 2
INTRODUCTION
There is a plethora of research into the effects of divorce on children which began in the 1970s when there was a sharp rise in the number of divorces (Braver & Cookston, 2003). Continued interest in this area is stimulated not only by the rising divorce rate, which means that 4 in 10 children in the United Kingdom (UK) will experience a parental divorce by aged 16 (Office for National Statistics, 2002), but perhaps also by the fact that family life is common, and therefore of interest, to us all. It is therefore important for me¹ to acknowledge that my experiences as a white female with married parents from a middle-income family with pro-marriage attitudes and no generational history of divorce, and a belief that this family structure has positively contributed to my own psychological adjustment, will influence my construction of the debate about whether or not divorce is bad for children.

Research has consistently shown that divorce does have short-term effects on children's psychological well-being. In the first years following divorce most children, compared with children from non-divorced families, show greater behavioural problems, antisocial behaviours, anxiety and depression, and lower school performance (Hetherington, Cox & Cox, 1985; Kelly & Emery, 2003). However, I believe that in considering whether or not divorce is inherently bad for children, it is important to look beyond the initial 'crisis' period and whether or not there are long-term effects of divorce. I agree with many researchers that this is the 'overarching, critical question' (Braver & Cookston, 2003; Wallerstein & Lewis, 1998). It is only relatively recently that the long-term effects of divorce on children have been, and could be, studied as the cohorts whose parents divorced in and after the 1970s entered adolescence and young adulthood (Braver & Cookston, 2003; Chase-Landsdale, Cherlin & Kiernan, 1995). Throughout the discussion the word 'children' will be used relative to parents rather than referring to developmental status (Boney, 2003).

I will begin by providing an overview of the general findings of longitudinal studies, then proceed to consider how research has informed thinking about a more complex relationship between divorce and psychological effects in children. Firstly I will take

¹ This discussion is written in the first person to facilitate the reader's understanding of the trainee clinical psychologist's viewpoint.
each researcher's own definition of 'bad'; that is when divorce creates negative effects. However, in the latter stages I will critically discuss what each researcher's construction of 'bad' means for an overall conclusion of whether or not 'divorce is bad for children'. The major aspect of this discussion will be an in depth critique of some of the familial, cultural and societal factors and research perspectives that can interact and confound discussions on whether or not divorce is actually bad. It is my intention not to argue one position over another and to make clear in the following discussion why this is the case.

LONGITUDINAL STUDIES

Wallerstein's clinical studies

One longitudinal study in the literature that has sparked considerable debate is the Californian Children of Divorce Study conducted by Wallerstein and colleagues. In 1971, 131 children, aged 3 to 18 years old, from 60 families were studied using clinical interviews. These children were followed up at 18 months, 5, 10 and 25 years (when the children were aged 28 to 43 years old) post-divorce (Wallerstein & Lewis, 2004).

In the 25-year study, Wallerstein and Lewis (1998) report finding that, although some of their participants had adjusted well in childhood and adolescence, many entered adulthood worried, self-deprecating and fearful they would be abandoned by any partner. One of Wallerstein’s central claims is that divorce negatively influences relationship formation and maintenance, with the effects of divorce on a child possibly not arising until the developmental stages of late adolescence or young adulthood when issues of relationship formation become salient. Wallerstein and Lewis (2004, p.368) state that:

...sad memories of the past and observations from the present build to a dramatic crescendo as young people from divorced homes confront the issues of love, sex and lasting commitment.

To an uncritical reader, Wallerstein’s work portrays, through the use of very emotive language, that divorce is most definitely bad for children. However, her work has, rightly,
come under heavy criticism from other researchers. Her conclusions were based on a small and unrepresentative sample; all participants were from white, well-educated middle class families and were offered counselling in exchange for participation, thus her sample may disproportionately comprise families adjusting poorly to divorce (Amato, 2003; Boney, 2003; Elliott, Ochiltree, Richards, Sinclair & Tasker, 1990). She adopted a clinical, qualitative approach and relied on interpretative interviews rather than standardised, quantitative measures or statistical analyses (Amato, 2003; Braver & Cookston, 2003). Wallerstein makes conclusions and generalisations beyond her own evidence and beyond that which her methodology allows (Amato, 2003; Elliott et al., 1990). She condemns all children to the 'legacy of divorce', including those presenting with no difficulties; ‘...many of the children who are able to traverse earlier stages successfully, go under at a later developmental stage when their resources have been depleted’ (Wallerstein & Lewis, 1998, p.381), and children from intact families; ‘the shadow of divorce profoundly affects even those children of marriages that are considered stable and enduring’ (Wallerstein, 1991, p.351). Crucially, no control group of children from non-divorced families was included, until later research (possibly in reaction to such criticisms). Walker (2003) argues, that her lack of control group ‘allowed’ her to attribute the negative aspects of a child’s life to divorce rather than other life circumstances.

Large-scale, quantitative studies

There is a clear need to contrast these findings from small scale, clinical studies with large-scale research that includes a control group of children with married parents. These studies enable us to consider how many children in the general population, if any, are harmed by divorce (Amato, 2003) and include the Virginia Longitudinal Study of Divorce and Remarriage (VLSDR) (Hetherington, Cox & Cox, 1985), the Marital Instability Over the Life-Course Study (MIOLC) (Amato, 2003), the National Child Development Study (NCDS) (Chase-Landsdale, Cherlin & Kieman, 1995) and the National Survey of Children (NSC) (Zill, Morrison & Coiro, 1993).

The MIOLC study began in 1980 and in 1997 followed up 691 adult children of whom 147 parents had divorced. It found that 1 in 10 children with divorced parents reached adulthood with lower psychological well-being than children whose parents remained
married, leading Amato (2003) to conclude that the long-term effects of divorce are not trivial. The NSC (Zill, Morrison & Coiro, 1993) support this finding; the young adults from divorced families were twice as likely to have poor parental relationships, high levels of emotional distress and behavioural problems, and to have used psychological services. In adulthood, Hetherington and Kelly (2002) (as cited in Amato, 2003) found 25% of the children with divorced parents compared with 10% of the children from intact families had serious social, emotional or psychological difficulties. The NCDS showed that, at age 23, there was a 39% increase in the risk of clinical levels of mental health problems in children with divorced parents and that these problems were predicted from scores at age 16; confirming that serious problems can persist into adulthood (Chase-Lansdale, Cherlin & Kiernan, 1995).

Given that these large-scale studies demonstrate that children with divorced parents are more, perhaps twice as likely, than children with married parents to experience psychological or interpersonal problems in young adulthood (Amato, 1993; Kelly & Emery, 2003; Zill, Morrison & Coiro, 1993) it could be concluded that, 'yes', divorce for children, in the populations studied, was bad. However, if the results are phrased differently, most children with divorced parents, 90% (Amato, 2003), cannot be differentiated on measures of psychological well-being from children from intact families and an average of 88% of children from divorced families score below the clinical cutoff on a mental health measure (Chase-Lansdale, Cherlin & Kiernan, 1995). A meta-analysis of studies conducted between 1950 and 1980 revealed that children with divorced parents do score lower than children with married parents on measures of well-being but only by one tenth to one fifteenth of a standard deviation. Differences in well-being are weak to moderate (Amato & Keith, 1991).

The long-term effects of divorce, although possible and real, are not as pervasive and strong as Wallerstein claimed, with many children circumventing the ‘inevitable pathology’ she described (Amato, 2003; Coltrane & Adams, 2003; Kelly & Emery, 2003). Without a control group Wallerstein failed to detect, as these large-scale studies have, that while a number of children with divorced parents have psychological difficulties in adulthood, so too do children from intact families. The consensus among researchers of
quantitative studies appears to be that divorce is a risk factor for psychological problems in adulthood, not to be minimised, but that the relationship between divorce and adjustment is unlikely to be simple or direct, given the diversity of children’s experiences in pre-divorce, post-divorce and intact families (Amato, 2003; Hetherington, Cox & Cox, 1985; Zill, Morrison & Coiro, 1993). It is likely to be confounded and mediated by other variables. The key question is under what conditions is divorce bad for children?

FACTORS INFLUENCING THE RELATIONSHIP BETWEEN DIVORCE AND PSYCHOLOGICAL EFFECTS IN CHILDREN

There is an enormous number of mediating variables; there are factors inherent to the child (for example age at time of divorce (Chase-Lansdale, Cherlin & Kiernan, 1995; Zill, Morrison & Coiro, 1993), gender (Hetherington, Cox & Cox, 1985) and pre-divorce adjustment (Cherlin, Chase-Lansdale & Kiernan, 1998)), pre- and post-divorce family process variables (such as parent-child relationships, parental adjustment, quality of parenting, interparental conflict and parental remarriage) and cultural and societal factors that influence the relationship between divorce and psychological effects on children. Interactions between variables are also possible: for example child gender can interact with the effect of remarriage; the presence of a step-parent can be beneficial for a step-child of the same gender (although these children are not overall as well adjusted as children from non-divorced families), but be detrimental, or have no effect, on the psychological adjustment of a step-child of the opposite gender (Amato, 1993; Hetherington, Cox & Cox, 1985).

In the following discussion it will be clear that there are different types of moderating factors; those that actually influence whether or not divorce is bad for children (for example age at time of divorce and ethnicity) and those that affect whether or not one perceives divorce as producing negative psychological effects. In the latter case, a third variable may lead to both divorce and psychological difficulties but if this variable is not investigated, divorce may appear as if it is related to psychological problems. For example, Amato (2003) suggests the association between divorce and child adjustment could be spurious with both being related to parental maladjustment; parents with
psychological difficulties are more likely to create adjustment difficulties for their children and more likely to have a marriage that ends in divorce. In addition, research methodologies and approaches could influence one’s perception of whether or not divorce is ‘bad’.

I think it is most crucial to raise these issues in a truly critical discussion of whether or not divorce is bad; it is not enough just to collate the vast amount of research findings on the effects of divorce and conduct a superficial methodological critique. The following discussion will focus on how interparental conflict, parent-child relationships, cultural factors, societal factors, and research perspectives and methodologies interact with one another and impact on the conclusions that can be drawn about whether or not divorce is bad for children.

Interparental conflict
The relationship between divorce and psychological adjustment is easily confounded by interparental conflict; marital conflict is widely accepted to affect the psychological adjustment of children and parents with high marital conflict are more likely to divorce (Amato, 2003; Amato & Sobolewski, 2001; Gohm, Oishi, Darlington & Diener, 1998; Kelly & Emery, 2003; Morrison & Coiro, 1999).

Dunlop and Burns (1995) and O’Connor, Thorpe, Dunn, and Golding (1999) found that it is interparental conflict, not divorce, that places children at risk of long-term adjustment difficulties. However, the NCDS, controlled for family variables (conflict, parental psychopathology and quality of parenting) at age 7 when all parents were still married, then assessed how divorce was related to mental health in young adulthood (age 23) and found that controlling for pre-divorce factors did depress the main effect of divorce but a relationship between divorce and adult mental health still remained. Also, Schmidtgall, King, Zarski and Cooper (2000) found that interparental conflict only explained 6% of the variance in depression scores of adult women with divorced parents and Hetherington (2003), in the VLSDR, studying marital instability in adult children found there were still ‘striking’ differences in stability between children with divorced parents and children from intact families, in the low-conflict families.
The varied findings may reflect differences in the measures of conflict used or the failure of some studies to control for different types of conflict or conflict resolution (Kelly & Emery, 2003; Schmidtgall et al., 2000) but while interparental conflict may account for more of the variance in psychological adjustment than divorce, there is more in the divorce experience that creates negative psychological effects (Amato & Sobolewski, 2001). Riggio (2004) found parental conflict had negative effects on the level of emotional support and affective quality that parents provided in their relationships with their children, therefore, like divorce, the relationship between interparental conflict and children’s psychological difficulties may be mediated by other variables such as quality of parenting and parental adjustment (Kelly & Emery, 2003).

An interactional effect between marital conflict and divorce on children’s psychological well-being has been found. In families with low marital discord, children whose parents divorce generally show poorer adjustment than children with married parents. However children from families in which there is high conflict, have been shown to be no worse off, or in some cases have greater well-being, than children whose parents remain married (Amato 1993; Hanson, 1999; Jekielek, 1998; Gohm et al., 1998). Divorce may actually benefit children from high-conflict families (Amato, 2003). This interaction between interparental conflict and divorce may also influence the average effects of divorce on children. Amato (2001) compared the effects of divorce found in studies conducted from the 1950s to the 1980s with effects found in studies conducted in the 1990s. A continuing and slightly larger gap existed in well-being between children with divorced and children with married parents. He considers that this could, in part, be attributed to the reduction over the decades, as divorce as become more acceptable, in the level of discord occurring prior to divorce. The marital dissolutions that children find most disruptive (those from low-conflict families) may be increasing in proportion (Amato, 2001). Societal views about the acceptance of divorce can therefore indirectly influence the average size of the effect of divorce and thus whether or not divorce is perceived as ‘bad’. At a population level, divorce may be worse for children now, and could become worse as more people divorce, if, as Amato believes, this means more people from low-conflict families are divorcing.
Parent-child relationships

This is one of the main variables mediating between divorce and psychological effects in children. The quality of parent-child relationships is related to children’s psychological well-being (Amato, 1993; Dunlop & Burns, 1995; Zill, Morrison & Coiro, 1993) and some studies show it is more crucial to well-being than family structure (Dunlop & Burns, 1995; Kelly & Emery, 2003). Quality must be contrasted with the quantity of contact with parents. Parental absence alone does not account for poor psychological adjustment; children with divorced parents show poorer adjustment than children who whose parents have died (Amato, 1993; O’Connor et al., 1999).

The relatively few studies that have asked children about their experiences confirm that the important factor is not divorce, but whether or not they have good relationships with the significant adults in their lives (Fabricius, 2003; Kelly & Emery, 2003; Moxnes, 2003). Even though family forms are changing, it is the intimate relationships within families that remain the salient influence on psychological well-being (Bengtson, 2003; Hetherington, Cox & Cox, 1985; Riggio, 2004). Moxnes (2003) commented that divorce is only an important influence on children if it results in a negative change in the quality of parent-child relationships. Unfortunately, divorce can often result in poorer parent-child relationships (Amato & Keith, 1991; Zill, Morrison & Coiro, 1993), particularly father-child relationships (Amato, 2003; Kelly & Emery, 2003; Lauman-Billings & Emery, 2000; Riggio, 2004). Whether the relationship between divorce and well-being is direct or indirect, is of intellectual interest and prevents generalisations about divorce effects, but surely it is of much less relevance to a child who has experienced divorce, poorer parental relationships and then reduction in psychological well-being. For this child it is divorce that started this chain of events. I am not forgetting that a child whose parents remain married may also have a poor parental relationship or that a child whose parents have divorced may have a good or better post-divorce parental relationship (Moxnes, 2003; Riggio, 2004), but it still remains that divorce can place a child at greater risk of a poorer relationship. The same argument can be applied to other post-divorce effects, for example, the MIOLC study found that as the number of family transitions increased, child psychological well-being declined, suggesting that any negative effects witnessed post-
divorce may not be a result of the marital dissolution but the subsequent family transitions (Amato & Sobolewski, 2001). However these events would not have occurred without divorce.

It is also important to note that Moxnes (2003) interviewed children in Norway where the political goal over the last ten years has been to facilitate the relationship of children with both parents (Moxnes, 2003), a contrast to the UK (Walker, 2003) and United States of America (USA) where children do not always have (frequent) contact with their non-custodial parent (usually the father) (Riggio, 2004); Kelly and Emery (2003) state that between 35% and 40% of children in USA have weekly contacts with their fathers. If the involvement of fathers changes in the UK will this reduce effects of divorce on children?

**Cultural and societal factors**

It is important to consider to what extent the published research, based on parents divorcing in the 1970s and 1980s in the UK and USA, can really inform our thinking about whether or not divorce has negative effects on children in a multicultural UK, in the 21st Century (Fabricius, 2003). Divorce takes place within wider society therefore the effects of divorce will be influenced by societal and political factors.

Gohm et al. (1998) have demonstrated how cultural and societal variables moderate the impact of divorce on children’s psychological well-being. They conducted a study, with 6,820 individuals from 39 countries, and found that marital status and conflict were related to children’s life satisfaction differently in individualist and collectivist cultures and differently depending on the country’s divorce rate. The negative effect of divorce was smaller, and the benefit of divorce for children from high-conflict families was greater, in collectivist cultures and in countries with a low divorce rate. Therefore research conducted in individualist cultures and countries with a high divorce rate, such as the USA and UK, may find greater the effect of divorce and less important the influence of conflict than research conducted in other countries (Amato, 2001; Gohm et al., 1998). Amato and Sobolewski (2001, p.918) further state that:
...the result of this trend [the rise in the rate of parental separation] may be a gradual weakening of the bonds between generations and a decline in the mean psychological well-being of the population.

A clear statement in favour of the argument that divorce is, and could become more, detrimental to the well-being of children. Others (Allen, 1993; Bengtson, 2001; Boney, 2003; Walker, 2003) counter this 'family decline' hypothesis and challenge researchers, such as Amato and Wallerstein, on their unacknowledged bias towards the traditional, nuclear family and belief that any other structure, such as single-parent or step-families, is deficient in comparison. Bengtson (2001) highlights that the increased longevity of family members will create a resource for children in divorced families, as extended families do in collectivist cultures (Gohm et al., 1998). Therefore while divorce may be detrimental to children in a nuclear family it may not be so detrimental in future family types. A change in family form, in the USA and UK, may counteract any increased effects of divorce that may occur as more (low-conflict) families divorce.

RESEARCH METHODOLOGIES AND PERSPECTIVES

The research approach could influence one's perception of whether or not divorce is bad. This influence is overt in research such as Wallerstein's but there are more subtle influences in larger-scale studies. For example, whether or not researchers find psychological effects of divorce will depend on the outcome measures used, when samples are assessed and how psychological effects of divorce actually present; the last could be general psychological adjustment, clinical symptoms, behaviour in relationships with family, peers or partners, or more specifically children's functioning in their own marital relationships (Wallerstein, 1991). Boney (2003) argues that the majority of research is devised in such a way so as to perpetuate the deficit view of post-divorce families. Most research is problem focused; focusing on the negative consequences of divorce through the questions asked and the outcome measures used (Boney, 2003). For example the dependent variables studied by Zill, Morrison and Coiro, (1993) include depressive symptoms, delinquent behaviour and if psychological help was sought. Of the studies mentioned in my discussion only one talked about the positive effects of divorce unrelated
to high-conflict families, that divorce could lead to a better mother-child relationship and greater independence and self-reliance in adulthood (Riggio, 2004).

Researchers’ beliefs about what constitutes a ‘bad’ effect will also infiltrate their conclusions. A number of studies found that divorce can be related to pre-marital cohabitation and extramarital births in adult children (Dunlop & Burns, 1995; Wallerstein & Lewis, 2004). Cherlin, Kiernan and Chase-Lansdale (1995) state that this connection between divorce and cohabitation may weaken as cohabitation becomes more morally accepted, but more importantly it is a biased research view that treats these outcomes as evidence of deviance (Dunlop & Burns, 1995). Boney (2003) highlights that normal development in non-traditional family forms is not researched; the psychological development of children in nuclear families creates the norm by which children’s development in variant family structures is compared; if this continues, children raised in other family forms may always appear ‘worse off’.

The populations utilised in many studies are white, middle class children from western society. Wallerstein and Lewis (1998) stated that they used such a sample in order to study divorce ‘under the best circumstances’, but they make an inherent assumption that children in the majority population in a western society will fare best from divorce. However, a number of studies have in different ways shown this is not the case. Perhaps counterintuitively, children from high-conflict compared to low-conflict families (Amato, 2003; Gohm et al., 1998; Hanson, 1999; Jekielek, 1998), lower compared to middle socioeconomic class (Laumann-Billings & Emery, 2000), collectivist compared to individualist cultures (Gohm et al., 1998), children with poor compared to good pre-divorce adjustment (Chase-Lansdale, Cherlin & Kiernan, 1995), are African-American compared to Caucasian, (Amato & Keith, 1991) and are raised in a country with a low compared with a high divorce rate (Gohm et al., 1998) are less affected by divorce. Reasons for these findings will vary but perhaps for children from low-conflict families or with good pre-divorce adjustment, divorce comes as a greater shock (Chase-Lansdale, Cherlin & Kiernan, 1995); for children in low-income families divorce may be a less salient concern than poverty and deprivation, it may be the central life challenge and create more socioeconomic change for children from more privileged backgrounds.
(Laumann-Billings & Emery, 2000); and the greater involvement of family and community members in individuals' lives in collectivist, and African-American, cultures may provide greater social and emotional support to children experiencing divorce (Gohm et al., 1998). The majority of research may therefore be showing divorce under the worst circumstances.

Any method used or conclusions drawn will be influenced by the views and attitudes of the research team, and reader, about the effects of divorce on children and as Coltrane and Adams (2003) and Walker (2003) argue people's views about divorce in general will also colour objective interpretations of the consequences of divorce; researchers who have negative views of divorce are more likely to find pathological effects arising from it (Amato, 2003; Braver & Cookston, 2003). Unfortunately, mainstream media are eager to embrace bad news stories in order to promote the institution of marriage (Boney, 2003; Walker, 2003). In a recent television documentary, Bob Geldolf (2004) states:

...somebody should be doing something new about this, the cost to society and the state is so great, that somehow the state needs to begin to show its disapproval of divorce...the truth of every study is clear, dual-parent upbringing produces healthier, better educated children, that’s it.

But, as this discussion hopefully demonstrates, a critical interpretation of the research shows, that is not 'it'

These points raised about research are important; misinterpretations of research and the imposition of personal views, from researchers and those interpreting research, are creating negative expectations for children from divorced families (Kelly & Emery, 2003). Despite clear difficulties in interpreting research on the impact of divorce, because of the interrelation of factors at individual, cultural and societal levels, problem-focussed research, particularly that of Wallerstein’s, continues to be the standard by which society evaluates the effects of divorce (Boney, 2003). Boney (2003) advocates that it is time for a new paradigm of research, postmodernism, that promotes the legitimacy of multiple family contexts for successful child development, considers the competencies and positive
experiences of children from divorced families and focuses on the similarities between and within groups of children from different family forms. Allen (1993) believes research teams should include researchers from divorced families to prevent researchers misconstruing participants' experiences. Unfortunately this also assumes that all children from divorced families experience events in similar ways. I agree with Coltrane and Adams (2003) that family values can never be 'inherently neutral or scientifically objective'; it seems more appropriate for all researchers to be aware of, make explicit, and therefore guard against, as best they can, the influence of their biases, agendas and theoretical perspectives when interpreting findings (Walker, 2003).

Finally I return to the idea that it is researchers' or readers' constructions of what constitutes a 'bad' effect that will influence whether or not they perceive divorce as bad for children. Laumann-Billings and Emery (2000) found adults with divorced parents scored in the normal range on depression and anxiety scales but did report more distress about their childhoods than those with married parents. They state that a distinction needs to be made between the presence of a psychological disorder and more subtle psychological distress and pain. Researchers, such as Wallerstein, need to be clear that painful memories are not evidence of pathology or poor psychological adjustment, but equally, absence of a psychological disorder (the standard by which most larger-scale studies judge the presence of negative effects) does not mean that an individual may not have experienced psychological distress and therefore perceived divorce to have been 'bad' (Kelly & Emery, 2003; Lauman-Billings & Emery, 2000). In a therapeutic setting, a clinical psychologist needs to be driven by clients' beliefs about whether or not parental divorce for was bad for them.

CONCLUSION
The aim of this discussion has been, not to support or deny the statement 'divorce is bad for children', but to highlight the complexity of the relationship between divorce and psychological effects in children and demonstrate the range of issues any reader of research or practising psychologist must consider before drawing any conclusions.
The complex and different forms of interactions between age at time of divorce, pre-divorce adjustment, interparental conflict, parent-child relationships, culture and many other risk and protective factors confound any effort to clarify the effects of divorce and consider whether or not divorce is 'bad' for children. In addition, conclusions drawn can only be as good as the research currently available (Amato, 1993). Overall, research suggests that diversity in family life before, during and after divorce means that for some children divorce in the longer term is bad, even if only through the additional risk experiences that divorce can lead to or select for (for example poor parent-child relationships and multiple family transitions), but most children can adjust to the experience of divorce (Amato, 2003; Chase-Lansdale, Cherlin & Kieman, 1995; Zill, Morrison & Coiro, 1993) and divorce may in fact create positive change (Riggio, 2004), especially in high-conflict families (Amato, 2004). While we should not underestimate the effect that divorce can have on psychological adjustment (Amato, 2001; Walker, 2003), Zill, Morrison and Coiro (1993, p.101) helpfully state that 'the fact that a young person comes from a divorced family does not in itself tell us a great deal about how he or she is faring in embarking into adulthood'.

We must also be mindful that societal influences, such as political agendas to facilitate the involvement of parents in children's post-divorce life, the national divorce rate and rates of behaviours (for example cohabitation) in the general population, may influence the difference between children with divorced and children with married parents at a population level. Also, attitudes and moral, religious and political agendas of researchers and interpreters of research may add bias to findings and further complicate attempts to decide whether or not divorce is 'bad'. An overall conclusion has to be that it is not possible to generalise to 'children'; group averages are not useful for predicting how a particular child will adjust to divorce (Amato, 2003), as practitioners we must be mindful of the complexity involved and consider 'was divorce bad for that child?'.
REFERENCES


Discuss how psychological theory and therapy can make a contribution to working with issues of loss and bereavement in relation to older people. To what extent do they accommodate emotional and social context and issues of cultural difference and diversity?
INTRODUCTION

The consideration of how psychological theory and therapy can contribute to working with issues of loss and bereavement specifically in older people is entirely appropriate; older people will necessarily experience loss and bereavement more than any other social group (Costello & Kendrick, 2000). Despite this increased incidence of bereavement, research and theoretical papers are surprisingly balanced in favour of the loss experiences of younger people (Costello & Kendrick, 2000; Rubinstein, 1995), perhaps a reflection of the value placed on older people in Western society in which most theories have developed (Rubinstein, 1995; Walter, 1999). Older people can experience a multitude of losses (Holman, Meyer & Cotter, 2004); a, if not the, most significant of which can be considered loss through death. This discussion will draw on different types of loss but the main focus will be on death-loss. It will also be noticeable that the majority of research conducted with older people has especially considered conjugal bereavement (Rodgers, 2004).

After a literature review it was easy to agree with Walter (1999) that the bereavement discipline is in turmoil; introducing a challenge to this discussion. Therefore I start by providing an overview and critique of traditional bereavement theory and discuss three aspects of current literature most relevant to older people that highlight the necessity for theory and therapy to move forward in the 21st Century. I then look at the current state of theory on loss and bereavement by discussing two approaches in detail. Each receives a critique of their ability to contribute to work with older people and accommodate issues of emotional, social and cultural context. I draw out further discussion on social context and cultural diversity as I believe these areas are most in need of further consideration. In the conclusion I offer a summary of the contributions of theory and their therapeutic implications for work with older people, after hopefully overcoming some of the chaos in the literature and the problem of the proportionately small amount of research with older people.

1 This discussion is written in the first person to facilitate the reader’s understanding of the trainee clinical psychologist’s viewpoint.
TRADITIONAL THEORIES OF GRIEF

Historically, the first significant contribution from psychological theory towards the understanding of loss and bereavement was Freud's grief work model (1917); this remained the guiding paradigm for much of the 20th century (Bradbury, 2001; Russac, Steighner & Canto, 2002; Walter, 1999). Freud stated that to achieve normal mourning individuals needed to withdraw libido from the lost object so energy could be reinvested in new objects and relationships. Failure to detach from the deceased was perceived as indicative of pathological grief (as cited in Kato & Mann, 1999).

A second influential theory was Parkes's (1965) phase theory, based on Bowlby's (1969) attachment theory (as cited in Parkes, 2002). Parkes acknowledged that losing a person through death is the most extreme form of relationship deprivation. Parkes extended Bowlby's stage theory of childhood separation and described four stages of grief; numbness, yearning and searching, disorganisation and despair, and reorganisation; involving emotional detachment from the attachment figure (the deceased) (Parkes, 2002). Central to this theory is the proposition that the security of the bereaved's attachment to the deceased will affect the ability to relinquish the relationship and adapt to the loss, thus different patterns of attachment could explain individual patterns of response to loss (Noppe, 2000; Parkes, 2002).

Therapy based on these traditional models aimed to assist the bereaved to 'work through' their grief, alleviate the intense emotions produced after loss, and ultimately detach from the deceased to achieve resolution and acceptance (Kato & Mann, 1999).

These theories have made significant contributions to working with issues of bereavement, and attachment theory still features in recent research (Fraley & Bonnano, 2004; Noppe, 2000; Stroebe, Shut & Stroebe, 2005), however they, and the resultant therapeutic approaches, have been heavily criticised. They focus exclusively on the emotional and intrapersonal context of grief (Malkinson, 2001), thus excluding social context (Stroebe & Shut, 1999), and contain unforgiving judgements about the constitution of 'normal' and 'pathological' grief. For example, an exaggerated or absent emotional response and/or failure to relinquish emotional ties to the deceased was perceived as indicative of
‘complicated’ or ‘unresolved’ grief (Corwin, 1995; Malkinson, 2001). A review of the literature which discusses bereavement experiences across cultural groups exposes cultural differences that cannot be accommodated within these traditional models; for example extended lengths of mourning, conservation of emotional expression and continuing relationships with the deceased (Irish, Lundquist & Nelson, 1993; Rodgers, 2004). Also, the variability of normal, healthy responses to loss, even within the Western culture from which the theories derived, were not acknowledged; thus there are inherent difficulties with the accommodation of cultural and individual diversity. A landmark paper by Wortman and Silver in 1989 brought the assumptions of these traditional theories to the fore presenting empirical data, on loss through death and permanent disability, that demonstrated that: neither distress nor depression are inevitable following loss, loss does not have to be ‘worked through’, absence of an emotional response is not necessarily indicative of pathology, and ‘recovery’ is not a necessary outcome.

PARADIGM CHANGE
Currently many researchers are calling for a paradigm shift in understanding the process of loss and bereavement (Malkinson, 2001; Neimeyer, 2000; Russac et al., 2002). For older people, three areas were to me persuasive of this need for theory to develop beyond the traditional approaches to ensure psychology makes an effective, and sensitive, contribution:

Continuing bonds
An important tenet in the contemporary literature is the challenge to the idea that grief can only be resolved by relinquishing relationships with the deceased. Proponents of an alternative approach argue that it is not maladaptive for the bereaved to allow a ‘continuation of a bond’. Death creates the redefining and restructuring of a relationship, not the end to one (Neimeyer, 2000; Russac et al., 2002; Walter, 1999). Walter (1999) argues that theory and therapy need to allow ‘continuing bonds’ to become a major theme. Bennett and Bennett (2001) interviewed widows in later life and found many were uncomfortable with pathologising lasting grief and felt ‘recovery’ was an insensitive aim; reflected in the statement ‘you can’t spend years with someone and then just cast them aside’ (Mrs C., p.248). Walter (1999) believes that the desire for older people to retain a
relationship with their deceased spouse, given their age, possible length of marriage, and lack of availability of replacement partners, has to be perceived as entirely rationale. I agree.

The Changing Lives of Older Couples Study (Bonnano, Wortman & Nesse, 2004)
A prospective, longitudinal study by Bonnano et al. (2004) offers important insights into understanding bereavement experiences of older people and challenges previous assumptions. An important feature is the account of pre-loss functioning, and therefore the acknowledgement of the emotional context of bereavement.

The researchers distinguished five trajectories of bereavement outcome; common grief, chronic grief, chronic depression, depression followed by improvement, and resilience. Common grief, characterised by the traditionally assumed ‘normal’ grief reaction (described by the phase theory), was displayed by only 10.7% of the older people. Over half (56.1%) actually presented with an absence of, or low, distress and Bonnano et al. (2004) found no evidence that these reactions were indicative of denial, maladjustment or lack of attachment to the deceased. Instead these older people presented with high scores on several measures indicative of genuine resilience. The researchers distinguished two subtypes; ‘resilience’ and ‘depression followed by improvement’. By taking emotional context into account, Bonnano et al. (2004) revealed that there were some who exhibited psychological improvement following loss, because they had been highly depressed pre-loss. Bonnano et al. (2004) hypothesised that for these people death of their spouse may have represented the end of chronic stress.

Bonnano et al. (2004) also made distinctions between the outcome trajectories ‘chronic grief’ and ‘chronic depression’. These two groups both presented with depression following loss but were qualitatively distinct in ways that have important implications for treatment (Bonnano et al., 2004). Those experiencing ‘chronic grief’ became depressed after the loss and remained depressed; they had exhibited excessive dependency on their usually healthy spouse, the likely ‘caregiver’. The trajectory ‘chronic depression’ was also characterised by continuing depression after loss however these people had emotional difficulties prior to loss and were more likely to have been the carers themselves,
experiencing high caregiver strain. These findings reveal that older people may have particular emotional or social contexts that influence loss reactions.

**Grief therapy**

Also contributing to my alliance with those advocating for a change in theoretical approach are three recent reviews of outcome studies that present a sobering account of the effectiveness of grief therapy, yielding small effect sizes (Allumbaugh & Hoyt, 1999; Kato & Mann, 1999; Neimeyer, 2000) and contradictory findings. After their meta-analyses, Kato and Mann (1999) and Allumbaugh and Hoyt (1999) both toy with the conclusion that grief interventions are not effective, but finally conclude that the problems are with the methodology; stating that most studies failed to control for important variables such as type of loss and gender of the bereaved. Neimeyer (2000) found, after his meta-analysis, that 38%, an unacceptably high percentage, of people would have had **better outcomes without** treatment; with the deterioration effect worse for older people. Further analysis revealed it was those with normal bereavement reactions who were most negatively affected by treatment; leading Neimeyer (2000) to a different conclusion from the other reviewers, and one with which I am more comfortable; ‘grief therapy is appropriately offered to...protracted, traumatic or complicated grief reactions...grief therapy for normal bereavement is difficult to justify’ (p.546). Frustratingly, for clinicians, is the problem of universal definitions for ‘protracted’ and ‘normal’ grief reactions. Corwin (1995) states that each therapist must ensure that the standards of normal and pathological grief employed are not discordant with the norms of the client. Bonnanno et al. (2004) found no evidence for the existence of delayed grief and therefore state there is a high probability that individuals presenting with relatively little distress or depression are coping well and not in need of intervention.

Despite theoretical challenges to the traditional models, grief therapy is often still based on their simplistic notions, such as the presence of linear stages of grief (Holman et al., 2004; Kato & Mann, 1999; Neimeyer, 2000; Stroebe & Shut, 1999). Alaszewski, Alaszewski and Potter (2004) explored professionals’ use of bereavement models in managing the rehabilitation of stroke survivors and state
...[bereavement] models outline the normal process or stages which grieving individuals go through to adjust to their new and changed status...they can be used in counselling to help individuals adjust to their loss (p.1068).

This demonstrates that similar assumptions contained within death-loss literature are being repeated in studies exploring other types of loss. With a theoretical change in understanding the process of loss and bereavement there needs to be a change in the psychological therapy of grief (Malkinson, 2001). Neimeyer (2000) also adds that outcome, by researchers and practitioners, continues to be assessed on general physical and psychological symptomatology (a legacy of the traditional theories) and not on features distinctive to bereavement. Acknowledgement is required of the varied effects of loss on, for example, roles and identities, meaning-making, and social contexts; and that there can be positive as well as negative emotional outcomes (Neimeyer, 2000; Stroebe & Shut, 1999).

These three specific areas made it clear to me why there is dissatisfaction with the psychoanalytic and attachment models of grief. But where now? Currently two theories are vying for attention in the bereavement literature; the dual-process model, based within cognitive-stress theory, (Strobe & Shut, 1999) and meaning reconstruction (Neimeyer, 2000). Crucial to this discussion is how these new theories can contribute to working with issues of loss with older people and whether or not they can succeed, where traditional theories have failed, in accommodating the emotional and social context of loss and issues of cultural diversity.

**DUAL-PROCESS MODEL OF COPING** (Stroebe & Shut, 1999)
This stressor-specific model of coping with bereavement identifies two types of stressors occurring after loss. Loss-orientated stressors relate directly to the loss experience (for example ending of the physical relationship, loss of social support from the deceased, and disintegration of future plans). Reactions to these include the emotional reactions associated with the traditional theories but also the possibility of reactions of pleasurable reminiscing and a continued relationship with the deceased. Restoration-orientated
stressors were not made explicit in (traditional) bereavement research and are those secondary to the loss (financial stressors, a new identity from ‘spouse’ to ‘widow’, and the possible need to master new tasks/roles). Central to this theory is that adaptive bereavement involves an individual ‘oscillating’ between avoiding and confronting the two types of stressors (Stroebe & Shut, 1999); a concept that captures the difficult to reconcile aspects of mourning, the need to move forward and the desire to remain connected to the deceased (Servaty-Seib, 2004). Stroebe and Shut (1999) identify that pathological forms of grieving are disturbances in oscillation; chronic grief is the absence of restoration-orientated coping and inhibited grief the absence of loss-orientated coping. The therapeutic implications are that interventions should challenge individuals to concentrate on the coping orientation to which they are less accustomed, thereby encouraging clients towards a more balanced way of coping.

This model contributes significantly to working with loss issues with older people as evidenced by two studies by Costello and Kendrick (2000) and Norris and Murrell (1990). Costello and Kendrick (2000) examined the experiences of twelve older people. They revealed that more significant for the bereaved than the emotional aspect of the loss was the necessary psychosocial transition after spousal loss to life as a single person. Norris and Murrell (1990), interviewed 130 older people and found those who had lost a spouse experienced more prolonged depression that those who lost a child or parent; leading them to conclude that in older people ‘the transition to widowhood is more aetiologically significant than is bereavement per se’ (p.435). The significant losses, are not of attachment, but of role and status, associated activities, and self-identity. I believe the dual-process model is important in raising the profile of such stressors, which may be particularly salient for older people, who through spousal loss may loose their emotional and instrumental support, at the time when they most need it; when physical, cognitive and financial losses may make independent living more difficult and when there may be other losses of social support (Bonnano et al., 2004; Fry, 2001). Both studies (Costello & Kendrick, 2000; Norris & Murrell, 1990) are however likely to have reduced generalisability to more collectivist cultures, where the availability of support may be different (Rodgers, 2004) and/or the value on identity as a ‘spouse’ less.
Stroebe and Shut (1999) identify the strengths of their dual-process model as its ability to accommodate social context and cultural diversity. They state that two people or different cultures may vary along the loss-orientation or restoration-orientated dimensions and therefore provide descriptions of different types of bereavement coping, without privileging one over the other (Neimeyer, 2000), and allow for individual variation without judgement. To acknowledge cultural diversity, Stroebe and Shut (1999) state that Muslims in Bali show little expression of grief and therefore could be described as more restoration-orientated. But, the authors also state that 'pathological forms of grieving can be seen as disturbances of oscillation' (p.217). No discussion is made of whether this means Muslims in Bali demonstrate 'pathological grief' or whether oscillation (the 'central component of the model' (p.215)) does not apply in that cultural context. This leads me to question whether or not this model can really 'account for cultural differences' (p.219) as the authors claim. It appears they are still imposing a model of coping with loss devised in western culture onto other cultural contexts.

Overall, the dual-process model has enhanced theoretical understanding and accommodates individual emotional variations in coping, and issues of bereavement and loss particularly important for older people. A particular development could be abandoning the judgement that failure to oscillate is indicative of pathological grief and acceptance that different combinations of loss- and restoration-orientated coping may be normative in different emotional, social, and cultural contexts. The authors have acknowledged that comprehensive empirical support for the model is not yet available (Stroebe, Shut & Stroebe, 2005).

MEANING MAKING AND MEANING RECONSTRUCTION
A number of theorists perceive the significant effect of loss (both death and non-death related) to be the disruption to, and undermining of, personally- and socially-constructed narratives, beliefs and assumptions about the world, and personal identity (Neimeyer, 2000; Servaty-Seib, 2004). The central process faced by individuals experiencing a loss is conceptualised as one of 'meaning reconstruction'; individuals are charged with adapting, or integrating, pre-loss beliefs, assumptions and identities into their new reality (Neimeyer, 2000). This theory acknowledges the cognitive, as well as the emotional
aspects of loss (Malkinson, 2001). There is not recovery or a return to pre-loss psychological functioning; meaning is not a product that is searched for and found, rather meaning-making is a process that can be on-going with meanings continuously revised (Neimeyer, 2000).

The search for meaning is a process experienced by a significant majority of people following loss (Davis, Nolen-Hoeksema, Larson, 1998; Davis, Wortman, Lehman & Silver, 2000). ‘Making sense of the loss’ and ‘finding benefit in the (loss) experience’ are two types of meaning-making, distinguishable in their content and relation to adjustment (Davis et al., 1998). The first is the attempt to make sense of the loss either within existing belief systems or through the revision of one’s present beliefs. Existing religious and spiritual beliefs, hitherto not considered as salient influences on the well-being of older adults after loss, can be important resources for meaning-making among older people (Fry, 2001; Golsworthy & Coyle, 1999; Rodgers, 2004). Fry (2001) found that existential factors such as personal meaning, optimism and importance of religion were sounder predictors of well-being in older people following spousal loss, than demographic variables, social resources and physical health. Golsworthy and Coyle (1999) hypothesise that religious beliefs may become particularly significant as people themselves move closer to death. As someone without religious beliefs, I wonder if the importance of religion is a function of cohort effects, rather than ageing; neither study ponders this question and this needs to be borne in mind as different cohorts meet eligibility for older people services. The second type of meaning-making ‘finding benefit in the loss’ was found by Davis et al. (1998) to be more significant than ‘making sense of the loss’ to longer term adjustment. However, the relationship between finding benefit and adjustment was inversely correlated with age, therefore it is unclear how benefit-finding may be operative among older people (Bonnano et al., 2004).

Importantly, Davis et al. (2000) exposed a significant minority of people (20% to 30%) who did not engage in a process of seeking meaning after loss and actually adapted better than those who searched for but did not find meaning; a useful corrective to the assumption that meaning must be sought if loss is to be resolved (Neimeyer, 2000). Implications for practice are that therapists must be cautious about initiating meaning-
making in clients who do not spontaneously engage in this process (Neimeyer, 2000). Bonnano et al. (2004) found that those older people showing ‘resilience’ and ‘depression with improvement’ showed little searching for meaning and demonstrated good adjustment; highlighting that caution needs to be taken in generalising Davis et al. (1998) results to older people. The individuals who Bonnano et al. (2004) believe would benefit from intervention are those showing ‘chronic grief’ or ‘chronic depression’. ‘Chronic grief’ was associated with a search for, and finding of, meaning, therefore these people would benefit from assistance with constructing new meaning around the loss. However those with ‘chronic depression’ did not engage in a search for meaning and therefore Bonnano et al. (2004) consider they would be most likely to benefit from intervention focusing on self-esteem and pragmatic issues.

Corwin (1995) argues that a focus on the search for personal meaning following loss is an approach congruent with cross-cultural practice. It allows clients to consider the cultural standards or normative ways of dealing with loss that may shape their personal meanings and I would argue also allows people to acknowledge any emotional or social contextual factors that may affect their personal meanings and ways of coping. Older people who have migrated to Britain may experience additional stressors at times of loss if they are unable to comply with Britain’s prescriptions of mourning (Corwin, 1995), this approach allows individuals to acknowledge the influence of being detached from their culture of origin. The meaning-making approach captures the idiosyncratic nature of loss experiences more than any other model or approach (Bennett & Bennett, 2001; Malkinson, 2001; Servaty-Seib, 2004) and is important in both death and non-death related losses. It can accommodate emotional, social and cultural contexts, however like other approaches, caution is needed, as the response to loss may not always be as it describes.

SOCIAL CONTEXT

Overall, the literature on loss and bereavement focuses on individuals’ private grief reactions and mostly fails to acknowledge that loss and grief occur within social contexts (Walter, 1996). Redressing this imbalance are researchers who adopt a constructivist view of grief and highlight that the meanings individuals assign to loss, and the reconstruction
of beliefs disrupted by loss, are negotiated within a social context (Gilbert, 1996; Neimeyer, 2000; Walter, 1996).

Walter (1996) views the influence of social context on grief not as the availability of social support for an intrinsically intrapersonal grief process, but as intrinsic to the process; grief is conceptualised as an interpersonal process. Through his own experience, Walter (1996) believes that the social context enables individuals to construct a durable biography of the deceased and integrate the deceased into their ongoing lives by conducting conversations with others also experiencing the bereavement. His implications are that therapists are a ‘poor substitute for those who actually knew [the deceased]’ (p.17), therefore therapists should encourage the bereaved to make contact with others who knew the deceased. The criticism of Walter (1996) is that it is now the intrapersonal process of grief that is being ignored (Stroebe, 1997). Bennett and Bennett (2001) however did find that older people rejected the need for intervention and instead wanted companionship from people who shared their experience. Unfortunately, this could be difficult for older people if they have a contracted social world or because of longevity are mourning a very different person to the one others are grieving (Walter, 1996). Walter (1999) states that particularly in Western society social groupings are becoming larger and more geographically distant which forces bereavement into being a individual psychological experience rather than the shared experience of a group; a process that is perhaps accentuated in older people. Crucially, social and historical contexts are as important to bereavement reactions as individual psychology (Walter, 1999).

Gilbert (1996) speaks about the social, relational context of the family and describes ‘differential grief’; the tendency of family members to be at different points in their grief, dealing with different issues, in different ways, and that there is an interaction between individual members’ grief, with each person affecting and being affected by another’s reaction. Loss can disrupt interpersonal processes in a family system, particularly if there are assumptions that the same physical loss will create the same grief reaction (Gilbert, 1996). Different generations of a family may have diverse ways of coping (Gilbert, 1996) and there will be influences on older people’s reactions (for example the World Wars) that are out of the social experience of younger relatives (Walter, 1999). Corwin (1995) raises
the same point in relation to culture and argues that older people from a non-majority culture may experience additional stressors at a time of loss if differing levels of acculturisation within a family result in different generations having contrasting grief reactions.

CULTURAL DIVERSITY
A growing concern in the literature is that the processes of loss and bereavement have been culturally stereotyped and thus there is recognition that for culturally diverse clinical populations theories and therapies need to be reassessed (Corwin, 1995; Irish et al., 1993; Rodgers, 2004). We must no longer ignore the impact of cultural heritage on bereavement (Rodgers, 2004). Klass (1999) argues that a cross-cultural model of grief would be a model with a set of concepts that would allow an understanding of different cultural experiences of loss. However, when theorists such as Walter (1999) place the experience of loss and bereavement in socio-historical contexts, and demonstrate the need for models and theories to adapt to changing societal and historical contexts even within cultures, it leads me to question whether theories and therapies can ever successfully accommodate full cultural diversity. Throughout this discussion I have stated, by mainly drawing on Walter’s (1999) arguments, that the theories and research are reflections of the values and assumptions of the Western culture in which they were derived, including the meaning-making approach (which is the most able to accommodate diversity) because even within this culture there are people who do not engage in meaning-making following loss. Contemporary bereavement literature with the current detraditionalisation and message that ‘everyone grieves differently’ (Walter, 1999), and indeed the title of this discussion, lures you to criticise theories and approaches that do not accommodate all aspects of cultural diversity, but is such a theory possible? Theories and therapies will always be a product of the culture from which they are derived and as Walter (1999) argues no culture before has abandoned all recommendations on how to mourn. Should theories be abandoned instead? Stroebe (1997) does not agree. She believes there is still a place for analyses at a grand theory level; as scientists the task is to search for patterns and general rules rather than demonstrate diversity. It is difficult to extract culture from theories of loss and bereavement and thus make them cross-culturally applicable therefore we must be
critical of any theory’s ability to apply to people from diverse backgrounds; cultural or otherwise.

CONCLUSION

A number of contributions have been made to the understanding of loss and bereavement in older people; many older people are resilient to loss and those presenting with little distress after loss are unlikely to need therapeutic intervention (Bonanno et al., 2004), which in cases of ‘normal’ bereavement could be harmful (Neimeyer, 2000). Allowing people to retain a relationship with the deceased is often important (Walter, 1999). The pre-loss emotional contexts and social roles can potentially influence the grief response (Bonanno et al., 2004) and in conjugal bereavement the restoration-orientated stressors and changes in role and identity created by the loss can be as, if not more, significant than emotional loss (Costello & Kendrick, 2000; Norris & Murrell, 1990). Meaning-making, and particularly using religious beliefs to make sense of loss, may be important to older people (Fry, 2001; Golsworthy & Coyle, 1999) but equally many may not engage in the process of meaning-reconstruction (Bonanno et al., 2004). Finally, older people may, because of their particular social, historical and cultural contexts, face additional stressors at a time of loss, and a particular challenge may be finding people with whom they can construct a meaningful understanding of their loss (Corwin, 1995; Gilbert, 1996; Walter, 1999). None of the theories and their therapeutic implications are fully able to accommodate emotional, social and cultural contexts; some capture the individual emotional aspects and others the social and interactional aspects to loss and bereavement. Interestingly, Holman et al. (2004) who reviewed studies of loss in older people in continuing care institutions also found this division. It is also clear that theories cannot always be generalised to older people, perhaps because they have been developed within a contemporary Western culture that gives older people a low status (Rubinstein, 1995; Walter, 1999) or because research is influenced by researchers’ experiences and biases; loss is a universal human experience (Silverman, 2000) but most researchers are unlikely to have experienced it as an older person. To be informed by theory and research is vital but individual differences in reactions to loss and bereavement must also be acknowledged.
It could be argued that this discussion has fallen into the same trap as much research in the field of loss in older people in assuming death-loss to be the primary loss. Older people experience a multitude of losses, only one of which is the death of people around them. Older people can experience loss of physical or psychological health, employment, home and local community, the anticipatory loss of others and their own life, and frequently all of these (Harvey & Miller, 1998; Holman et al., 2004). In addition, individuals from minority cultures may be grieving for significant losses on a chronic basis (including loss of cultural traditions and language) (Irish et al., 1993). Holman et al. (2004) believe there is a continual failure of research to reflect the complexity, multiplicity and temporal chronicity of losses in later life, resulting in a fragmentation of the loss experience.

Harvey and Miller (1998) argue for a 'psychology of loss' to bridge fields such as thanatology, traumatology and gerontology so the understanding of diverse loss experiences can be integrated. Commonalities exist in different loss experiences; the perception of loss by the individual and the reduction in physical, psychological or symbolic resources (Harvey & Miller, 1998). However, the diverse nature of loss experiences and multitude of potential contexts and variables (for example culture, social context and personal history) that influence bereavement reactions is too overwhelming to accurately portray in one discussion. My reaction has been to write about one main loss experience (within which there is still considerable variability) in order to understand this in some detail and offer a critique of the theories currently available, but much insight can also been gained from this discussion about the overall loss experience for older people.
REFERENCES


Gilbert, K. (1996). “We’ve had the same loss, why don’t we have the same grief?”. Loss and differential grief in families. *Death Studies, 20,* 269-283.


Older People Essay
Overview

The clinical dossier comprises:

1. A summary of each of the four core placements and two specialist placements.
2. Summaries of the five case reports written at the end of the first five placements: the four core placements and the forensic specialist placement.

The extended clinical dossier is in Volume Two of the portfolio and contains all the documents from each of the placements completed during training and the five full case reports.
Core Adult Mental Health Placement
Placement Details

Dates: October 2003 to March 2004
Region: South West London and St George’s Mental Health NHS Trust

Summary of placement experience
This placement provided me with experience of working within a Community Mental Health Team and in a Primary Care Psychology Service, and I was able to observe clinical work carried out on an adult inpatient unit. My clinical work was formulated and conducted within a cognitive behavioural framework. My clinical experience included assessment for treatment interviews, assessment for the suitability for group work, cognitive assessments and shorter term psychological interventions. I observed clinical work conducted by my supervisor and other clinical psychologists, and completed work by myself on an individual basis. I also observed and provided some co-facilitation to a Stress Management Group; a structured therapeutic group conducted within Primary Care by a clinical psychologist. All the clients I worked with lived in the community. Clients were aged from 22 years to 59 years, were a mixture of male and female, and were mostly from a white British background.

Clinical skills and experience
The presenting problems of the clients I worked with included: depression, generalised anxiety, panic attacks, anger problems, borderline personality disorder, marital relationship difficulties, and decline in cognitive functioning. The group I observed and to which I provided some co-facilitation was for individuals with mild to moderate levels of depression and anxiety. The assessment tools I used on placement were the Beck Depression Inventory, the Beck Anxiety Inventory, the Hospital Anxiety and Depression Scale, the General Health Questionnaire, the Anxious Thoughts Inventory, the Wechsler Adult Intelligence Scale, and the Wechsler Test of Adult Reading.
Meetings, seminars, visits and research
I attended the Community Mental Health Team's weekly team meeting, where client referrals and progress were discussed, and the weekly business meeting, where local and trust-wide organisational issues were discussed. I had the opportunity to meet with the team manager and with the lead psychologist for the borough to discuss the role of psychology within teams, and to meet with and observe clinical work conducted by the team consultant psychiatrist, community psychiatric nurse, social worker and occupational therapist to develop my understanding of their roles and working practices. I also attended the bimonthly adult mental health clinical psychology speciality meetings and attended a group for mental health workers with a specialist interest in Asperger's Syndrome. I observed a teaching session run by clinical psychologists for nursing staff on the inpatient wards. The training events that I attended were: a one-day course on child protection and risk assessment and management, and two workshops on dialectical behavioural therapy.

I completed my Service Related Research Project on this placement, which was entitled 'An audit of clients' views of the therapeutic relationship between themselves and their psychologist'. This project involved the four psychologists working in each of the Community Mental Health Teams in the borough and I fed back the findings to these clinical psychologists at their speciality meeting.
Case Report Summary

COGNITIVE BEHAVIOURAL THERAPY WITH A 34 YEAR OLD MAN PRESENTING WITH GENERALISED ANXIETY

All names and other details have been changed to preserve the client's anonymity

Referral
Chris, a 34 year old, white, British man, for whom English was his first language, was referred by his G.P. because he was experiencing anxiety and low mood.

Assessment process
The assessment was conducted across two, fifty minute sessions. Information was also gathered from the referral letter, case notes, a timeline produced by Chris, and three self-report outcome measures; the Beck Anxiety Inventory (Beck, Epstein, Brown & Steer, 1988), the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983) and the Anxious Thoughts Inventory (Wells, 1994).

Presenting problems
Chris described his difficulty as longstanding, diffuse anxiety which fluctuated in severity. Chris focused on his physical symptoms of anxiety but also gave an account of three other current difficulties; his excessive concern over other people's perceptions of him, his high anxiety around interpersonal confrontation, and his constant rumination about his decision to be a novelist and his inability to be honest to other people about this. Chris was unable to control his worrying thoughts and mental images about these issues and believed he was missing out on his current life.

Formulation
Chris's difficulties were formulated within the cognitive theory of generalised anxiety by Beck, Emery and Greenberg (1985) which posits that the anxious individual has 'danger
schemas' which are core beliefs and assumptions that contain themes about danger and threat, and one's vulnerability and diminished ability to cope. Once a danger schema is activated, events are interpreted in ways that are consistent with these beliefs about danger and reduced ability to cope. It was formulated that Chris had a global view of himself as vulnerable and a view of the world and others as dangerous, through their ability to take advantage of him and to reject him. It was felt that these beliefs were maintained through his pattern of thinking (for example his cognitive biases of catastrophising and 'mind-reading') and avoidance behaviours; Chris avoided all situations that contained possible confrontation or rejection and this prevented the disconfirmation of his danger-themed thoughts. For example, Chris could not discover if people would reject him for being a novelist because he did not disclose this when asked. It was also hypothesised that Chris's anxiety was maintained by his poor social skills, because these could lead to 'real' rejection from peers, and by his tendency to form single friendships, because whilst these protected him from vulnerability they also prevented disconfirmation of his belief that he could not cope alone. Chris was also very sensitive to any bodily changes he experienced and it was felt that this maintained his anxiety because he frequently interpreted bodily feelings as anxiety symptoms.

**Intervention**

I met with Chris for eleven sessions of cognitive behavioural therapy conducted in accordance with Beck et al.'s (1985) cognitive model of anxiety. I socialised Chris to the cognitive behavioural model and discussed with him the formulation of his difficulties. Intervention was then aimed at identifying and challenging Chris's anxious cognitions and cognitive biases and increasing his interpersonal effectiveness skills and assertiveness. Education around anxiety management was also completed and Chris was provided with self-help material. During the intervention it was apparent that Chris was reluctant to engage in self-exploration and there were difficulties in forming a therapeutic relationship. However towards the end of the therapy Chris felt able to discuss his early experiences which revealed the important theme of shame in Chris's life. Chris had had difficulty ending relationships in the past and so the ending of therapy was carefully planned.
Outcome

Chris's subjective accounts and my observations of Chris suggested the intervention did facilitate change. Chris reported finding the sessions helpful, particularly with respect to learning how to challenge his thoughts and worries, and it was evident from Chris's accounts that he was keenly applying techniques to challenge his thoughts. Scores on the formal measures also showed that at the end of therapy Chris was not depressed and his level of anxiety in all domains had reduced. It was felt however that the changes were small beginnings of a much greater process of change because Chris was experiencing longstanding and complex generalised anxiety.

Reformulation

Discovering the importance of the theme of shame towards the end of therapy enabled reflection on the therapeutic relationship and helped explain why Chris had found engagement and self-exploration difficult. Chris particularly experienced shame around his working class background and it was felt that the diversity in affluence between Chris and myself may have made it hard for him to disclose difficult childhood memories which were related to the issue of social class and were still very important to him.

Critical evaluation

The major learning from this piece of work was recognising that the therapeutic relationship is not only a vital source of information for understanding client difficulties but also a medium for working through problems, even within a cognitive behavioural intervention. Had I facilitated a dialogue with Chris about the therapeutic relationship, the issues of shame and rejection, which later became pertinent in understanding his difficulties, would have become apparent earlier. In addition, it would have been useful to ensure that the goals Chris had set for therapy were specific and measurable because failing to do this made it difficult at the end of therapy to ascertain exactly how much progress Chris had made in relation to his own therapeutic goals.
References


Core People with Learning Disabilities Placement
**Placement Details**

**Dates:** April 2004 to September 2004  
**Region:** Surrey Oaklands NHS Trust

**Summary of placement experience**

This placement provided me with experience of working within a Community Team for People with Learning Disabilities. My clinical work was formulated and conducted within behavioural and cognitive behavioural frameworks. My clinical experience included assessment for treatment interviews, extended assessments, cognitive assessments and shorter term psychological interventions, and involved direct work with people with learning disabilities and work with formal carers and parents of individuals with learning disabilities. I completed clinical work by myself on an individual basis and had the opportunity to conduct joint work with both a child community nurse and with a community nurse working with people with severe and challenging needs. I also observed clinical work conducted by my supervisor. I co-devised and co-facilitated a therapeutic group for adults with mild learning disability, which focused on developing friendship skills. This involved joint work with an assistant clinical psychologist, community nurse, and support worker. All the clients I worked with lived in the community and I had the opportunity to work with clients in their community housing, in day services, and in their family homes. I worked with children and adults (client ages ranged from 10 years to 45 years) and worked with people with mild to profound learning disabilities. Clients were a mixture of male and female, and were from a white British or Black African background.

**Clinical skills and experience**

The presenting problems of the clients I worked with included: challenging behaviour, sexual abuse, issues around self-identity, anger problems, communication difficulties, pica, autistic spectrum disorder, Down’s Syndrome, cerebral palsy, and dementia. The assessments conducted on placement drew on a number of data sources including: formal observations, information from carers, family members and day services, recording charts,
the Leiter International Performance Scale, the Hampshire Assessment for Living with Others, a dementia assessment, the British Picture Vocabulary Scale, the Wechsler Adult Intelligence Scale, and techniques for assessing facilitated communication.

Meetings, seminars, visits and research
I regularly attended the Community Team for People with Learning Disabilities' fortnightly team meeting and monthly business meeting. I attended a Surrey Oaklands Trust psychology meeting to gain an understanding of the broader psychology service in the trust. I also attended multidisciplinary meetings for the children with learning disabilities service and for the service for severe and challenging needs to gain an understanding of these specialist services. I also had the opportunity to meet with a care manager, to attend an interdisciplinary review meeting, and a meeting with the Audit Commission to gain an understanding of professional working between health and social care. I met with and observed clinical work conducted by the community nurse working with children and the team support worker to develop my understanding of their roles and working practices, and made visits to day centres and the last hospital in the region that has people with learning disabilities as residents. I was involved in three psychology seminars that discussed issues pertinent to working with people with learning disabilities, for example, capacity to consent and the new Mental Incapacity Bill. I was also involved in two pieces of audit on this placement. I was involved in the audit of clinical psychologists' case notes and in the feedback of the results of this audit to the psychologists in the service, and in the development of an audit tool to assess clients' views of the learning disabilities service.
Case Report Summary

BEHAVIOURAL ASSESSMENT AND MANAGEMENT OF A 41 YEAR OLD MAN WITH DOWN'S SYNDROME PRESENTING WITH PLAY FIGHTING BEHAVIOUR

All names and other details have been changed to preserve the clients' anonymity

Referral
Geoffrey, a white, 41 year old, British man with Down's syndrome, whose first language is English, was referred by his care manager following a vulnerable adult's investigation. Geoffrey had accused a staff member at his residential home of pushing him, however the investigation found the incident had occurred in the context of play fighting and Geoffrey had misunderstood the actions of the staff member. Geoffrey was referred for individual work to help him understand issues around play and real fighting.

Presenting problem
Geoffrey enjoyed engaging in play fighting and this behaviour had not been a problem until Geoffrey's accusation. Following this, staff at his residential home wished to manage the behaviour and minimise the risk of future injuries or misunderstandings but were unsure how to do this.

Assessment process
The assessment was conducted in two stages. The initial assessment took two sessions and involved an interview with the manager of Geoffrey's residential home, a meeting with Geoffrey, and an assessment of Geoffrey's cognitive abilities using the Leiter International Performance Scale (Leiter, 1945). Geoffrey had expressive and receptive communication difficulties and on the cognitive test Geoffrey could not complete the subtests requiring skills normally developed by age 7 and 8 years. This revealed Geoffrey did not have the cognitive abilities needed to achieve the goals from individual work the
staff were anticipating. Further assessment was therefore completed over another five sessions to determine the most appropriate intervention. This involved interviews with Geoffrey's key workers at his residential home and two day centres, observation of his behaviour at the day centres, providing staff with recording charts to record the frequency, severity and function of his play behaviour, and consulting his case notes. The assessment revealed that the play fighting only occurred at his residential home and not at the day centres, although no play fighting occurred during the observations.

Formulation
The formulation was guided by behavioural principles. It was felt that Geoffrey's play fighting may have originated in childhood as part of normal development but that it did not diminish for developmental and environmental reasons. It was hypothesised that the impairments associated with Geoffrey's severe learning disability and his experience of institutional care may have meant that in adulthood he had difficulty replacing play with more sophisticated and appropriate forms of interaction (Emerson, 2004; Pellegrini, 1993). It was felt that his play fighting was then maintained through positive reinforcement (staff engaging in the behaviour with him), his home environment (an all male environment), the reduced amount of quality time he had with staff, and the staff members' overestimation of his cognitive and communicative abilities.

Intervention
Consideration was given to whether or not an intervention was ethically appropriate but it was decided that an indirect, behavioural approach would be a suitable intervention. This was implemented over three sessions. Behavioural guidelines that aimed to stop the play fighting without effecting Geoffrey's social interactions were devised. These comprised an extinction procedure (communicating to Geoffrey in simple forms of communication that his play fighting was not appropriate), functional displacement (staff were encouraged to help Geoffrey develop other more appropriate, fun, social interactions), environmental enrichment (providing more one-to-one social opportunities) and a referral to Speech and Language Therapy for functional communication training (to help Geoffrey develop alternative behaviours). The assessment, guidelines and rationale underpinning the guidelines were then fed back to staff at Geoffrey's residential home and day centres. It
was planned that support would be given to staff during the implementation of the
guidelines and that the guidelines would be reviewed. Unfortunately this could not be
completed before the end of placement and so this work was referred to my supervisor.

Reformulation
It was necessary to formulate around staff beliefs to inform what level of support the staff
would require to implement the guidelines. After feeding back the guidelines, it was
found that staff found it difficult to understand that it was important to provide Geoffrey
with alternative interactions and not just stop the play fighting. It was hypothesised that
these beliefs may have reflected a poor understanding of behavioural theory or an
attribution error whereby staff over attributed the cause of play fighting to Geoffrey’s
personality and underestimated the importance of external factors.

Outcome
It was planned that my supervisor would evaluate the outcome because it was not possible
to complete the intervention before the end of placement. Evaluation of the intervention
would need to consider frequency of the play fighting and the impact of the intervention
on Geoffrey and the staff. It was recognised that it would be difficult to objectively assess
change because the infrequency of the play fighting meant no detailed baseline recordings
of the behaviour could be made.

Critical evaluation
This work provided me with greater insight into staff-client relationships and presented
two main challenges in working with care staff; firstly, assisting staff to appreciate the
cognitive and communicative limitations of a person with severe learning disabilities and
secondly, helping staff understand the need to alter their practices to ensure clients’ needs
are fulfilled. The staff were older and more experienced than myself and I feel this may
have influenced the staff response to my proposals and reduced my confidence in
challenging their lack of understanding about the behaviour. Geoffrey’s cognitive
limitations suggested he was unable to give informed consent, therefore, to ensure this
work was an ethical process, it was important that I carefully considered my rationale for
conducting the intervention.
References


Placement Details

Dates: October 2004 to March 2005
Region: South London and Maudsley NHS Trust

Summary of placement experience
This placement provided me with experience of working within a Child and Family Special Needs Clinical Psychology Service, and I was also able to work with one young person from the Child and Adolescent Mental Health Service and observe clinical work carried out in Primary Care. My clinical work was mainly formulated and conducted within behavioural and cognitive behavioural frameworks, although I also had the opportunity to use systemic ideas. My clinical experience included assessment for treatment interviews, extended assessments, cognitive assessments, and shorter term psychological interventions, and involved direct work with children and adolescents and work with parents, siblings, and teachers. I completed clinical work by myself on an individual basis and had the opportunity to conduct joint work with my supervisor. All the clients I worked with lived in the community and I had the opportunity to work with clients in an outpatient setting, in their family homes, and at school. Clients were aged from 2 years to 16 years, were a mixture of male and female, and although I worked with clients from a white British background, the majority of the clients either had a mixed ethnic background or were from a minority ethnic group.

Clinical skills and experience
The presenting problems of the clients I worked with included: behavioural difficulties, social communication difficulties including autism and Asperger’s Syndrome, family relationship difficulties, and anxiety. The assessments conducted on placement drew on a number of data sources including: formal observations at home and at school, information from family members and schools, the Wechsler Intelligence Scale for Children and the Wechsler Preschool and Primary Scale of Intelligence.
Meetings, seminars, visits and research

I regularly attended the special needs fortnightly team meeting and the South London and Maudsley child psychology meeting and also attended a half-day meeting with a facilitator on redeveloping the special needs service. I had the opportunity to meet with the psychologists working in primary care and the psychologists working in Sure Start to discuss the role of psychology in these services. I also met with and observed clinical work conducted by an educational psychologist and an occupational therapist to develop my understanding of their roles and working practices. I visited a secondary special needs school for half a day, visited an autistic unit for children of primary school age, and visited the toy library which provided the opportunity to play with young children and observe parents playing with their children. I was able to observe my supervisor carry out direct clinical work and also observe her conduct a session at an autistic unit with a member of teaching staff. I conducted a teaching session for parents on managing children's challenging behaviour. The training events that I attended were: a seminar about the diagnosis and assessment of social communication disorders which focused on the Autism Diagnostic Observational Schedule, a CPD event for clinical psychologists on risk assessment, and a one-day training course on Equality, Diversity and Child Protection run by Social Services.
Case Report Summary

THE EXTENDED ASSESSMENT OF A 9 YEAR OLD BOY PRESENTING WITH BEHAVIOURAL PROBLEMS AND DEVELOPMENTAL LANGUAGE DELAY

All names and other details have been changed to preserve the clients' anonymity

Referral
Ali, a black, 9 year old, British boy was referred by his school doctor to the Special Needs Psychology Service. His mother, Ms Hasan, had concerns about his behaviour at home and required help managing his behaviour. The paediatrician also raised concerns about social difficulties and language delay that had been noticed at an early age.

Initial assessment
The initial assessment was conducted over three sessions. Information was gathered from interviews with Ali and his mother, the referral letter, case notes and behavioural recording charts.

The family's first language was Somalian however Ms Hasan spoke English and Somalian, and Ali communicated in English. Ms Hasan declined the need for an interpreter.

Presenting problems
Ms Hasan described a multitude of problem behaviours. Ali could become angry and destructive of things at home. He had little understanding of danger and behaved inappropriately in the toilet (playing with the toilet water and smearing faeces). Ali lied, had poor concentration (for example on age-appropriate television) and often would not do what Ms Hasan asked. She was concerned that Ali had difficulty playing with other children. Ali's communication difficulties were apparent in the interviews; he did not use
appropriate eye contact and often gave tangential responses to questions. Ms Hasan could not understand Ali’s behaviour.

**Initial formulation**

The initial assessment revealed Ali was experiencing behavioural problems at home and peer relationship difficulties. It was formulated that Ali’s receptive and expressive language difficulties could be predisposing him to behavioural and relationships difficulties but it was also hypothesised that he had difficulties in social communication. Ms Hasan’s descriptions suggested difficulties in problem solving, ability to respond to social cues and ability to perceive another’s perspective. It was also hypothesised that some of the behaviours were maintained by Ms Hasan’s and the school’s poor understanding of Ali’s difficulties, and Ms Hasan’s permissive parenting style, inconsistent discipline, and construction of Ali as ‘the problem’. A main consideration was that Ali might have an autistic spectrum disorder (ASD).

**Action plan**

There were a number of possible pieces of work, however restricted resources and the high demand for the service, meant only a few could be conducted. I prioritised further assessment of Ali’s social communication difficulties and emotional well-being, and further exploration of Ms Hasan’s and the school’s understanding of Ali’s difficulties, although part of five sessions were used to help Ms Hasan develop behavioural management strategies and parenting skills based on techniques described by Webster-Stratton (1992).

**Extended assessment**

This had four components. I observed Ali’s behaviour, communication and social interaction in the school classroom and playground, and considered the triad of impairments found in ASD (communication, social interaction and play/imagination) (Carr, 1999). I also assessed the school’s perceptions of Ali’s difficulties by liaising with the Special Educational Needs Co-ordinator. I assessed Ali’s intellectual functioning using the Wechsler Intelligence Scale for Children – Third Edition (Wechsler, 1991). Ali’s performance was consistent with the presence of borderline verbal learning
difficulties. I assessed, over two sessions with Ali, his a) perceptions of his behaviour and interpersonal difficulties b) current emotional well-being and c) ability to perceive and regulate his emotions, and over part of five sessions I discussed with Ms Hasan her perceptions of Ali’s difficulties and her cultural beliefs in relation to children and parenting.

I did not aim to achieve a diagnosis for Ali; I recognised the importance of multi-agency assessment when diagnosing ASD (National Initiative for Autism Screening and Assessment, 2003), however I aimed to consider the appropriateness and necessity of a referral for a full ASD assessment and develop recommendations for his school and mother.

Extended formulation
The extended assessment demonstrated that Ali had receptive and expressive language difficulties, poor social understanding, and significant organisational and attentional difficulties and it was formulated that these had a negative impact on his peer and sibling interactions. Ali’s difficulties were maintained by his developmental problems but crucial maintaining factors were also the lack of support he received from school, peers and his mother, because of poor understanding of his social communication difficulties. Ms Hasan had not been given adequate support and opportunities by professionals to understand Ali’s problems. The assessment findings intensified the hypothesis that Ali had an ASD.

Recommendations
Written recommendations were provided for Ms Hasan, the school and other professionals and aimed to increase the level of support Ali received given his language difficulties and difficulties with attention, organisation and social understanding. I also recommended an increase in parent-professional collaboration and that Ali be referred for a full ASD assessment. I aimed to follow-up the assessment with verbal feedback but unfortunately Ms Hasan did not attend several appointments and I then completed my placement. This work was referred to the school doctor.
Critical evaluation
This work provided the valuable experience of working with a family from a different cultural (ethnic and socioeconomic) background to myself and the challenges of working with a combination of cultural factors and special needs. I also had the opportunity to reflect on issues such as the mainstream inclusion of children with special needs and the importance or not of a formal ASD diagnosis for children and their families. This family required intervention work however, upon leaving the service, limited service resources meant it was not possible to refer to another psychologist. This highlighted the ethical dilemma facing under resourced and highly demanded services; the necessity to balance the needs of one family (who have received some intervention) against another family (still on the 18 month waiting list).

References


Core Older People Placement
**Placement Details**

**Dates:** April 2005 to September 2005  
**Region:** Surrey and Borders Partnership NHS Trust

**Summary of placement experience**

This placement provided me with the experience of working within a Community Mental Health Team for Older People. My clinical work was formulated and conducted within a cognitive behavioural framework and I also had the opportunity to complete a piece of Schema Focused Therapy. My clinical experience included assessment for treatment interviews, cognitive assessments, and shorter term psychological interventions, and involved direct work with older people and consultation with professionals in the team around the management of clients. I completed clinical work by myself on an individual basis and had the opportunity to conduct joint work with my supervisor and with another trainee clinical psychologist. All the clients I worked with lived in the community and I had the opportunity to work with clients in an outpatient setting, in their homes and in a residential home setting. Clients were aged from 54 years to 92 years, were a mixture of male and female, and were mostly from a white British background.

**Clinical skills and experience**

I had the opportunity to work with clients presenting with organic and functional difficulties. The presenting problems of the clients I worked with included: depression, bereavement, family relationship difficulties, end of life issues, anxiety, personality disorder and splitting within the professional team, general deterioration in cognitive functioning and memory difficulties. The assessment tools I used on placement were: the Young Schema Questionnaire, the Geriatric Depression Scale, the Hospital Anxiety and Depression Scale, the Repeatable Battery for the Assessment of Neurological Status, the Wechsler Test of Adult Reading, the Wechsler Abbreviated Scale of Intelligence, the Wechsler Memory Scale, the Behavioural Assessment of Dysexecutive Syndrome, the Hating and Brixton Tests, and the Graded Naming Test.
Meetings, seminars, visits and research

I attended the Community Mental Health Team’s weekly team meeting, where client referrals and progress were discussed, and the weekly business meeting, where local and trust-wide organisational issues were discussed. I had the opportunity to meet with the team manager to gain an understanding of organisational issues within the team, wider directorate and the trust, and to meet with and observe clinical work conducted by a team psychiatrist, community psychiatric nurse, and occupational therapist to develop my understanding of their roles and working practices. I visited a small NHS day centre, a day centre run by the Alzheimer’s Society, the older people’s inpatient unit, and joined a carer’s group social lunch (for carers of people with dementia) to gain an understanding of their experiences. I also attended a meeting on copying correspondence to clients. I attended two teaching sessions run by my supervisor on the clinical psychologist’s role in neuropsychological testing and by another trainee clinical psychologist on schema-focused therapy for other professionals in the team. I also gave a presentation to the clinical team on a neuropsychological assessment I had conducted on placement and had my work observed by a community psychiatric nurse to increase her understanding of neuropsychological assessments conducted by clinical psychologists.
Case Report Summary

THE NEUROPSYCHOLOGICAL ASSESSMENT OF A 54 YEAR OLD MAN PRESENTING WITH CONCERNS ABOUT MEMORY PROBLEMS

All names and other details have been changed to preserve the client's anonymity

Referral
Richard, a 54 year old, white British gentleman, English first language, was referred by his G.P. after presenting with memory concerns.

Initial screening assessment
This was conducted in one, two hour session with Richard and his partner to gain an understanding of Richard's presenting problems and background history, and to assess Richard's premorbid intellectual functioning, using the Wechsler Test of Adult Reading (Wechsler, 2001), and current neuropsychological functioning, using the Repeatable Battery for the Assessment of Neurocognitive Status (RBANS; Randolph, 1998).

Presenting problems
Richard had had some worrying experiences; periods of acute confusion, not recognising familiar roads when driving, making a cup of tea but forgetting to add water, problems remembering things, experiencing 'vacant periods', and difficulty carrying out complex sequences. Richard felt his difficulties could fluctuate day-to-day but described an overall deterioration in functioning and felt he had to compensate for his difficulties. Richard presented with no problems with long-term autobiographical memory, general knowledge, production of speech, or word finding. Richard had no physical or mental health problems. There was no family history of memory impairment.

The initial assessment showed Richard's premorbid functioning was in the high average range and suggested a decline in functioning because he performed in the low average to
average range on the assessment of current functioning. He showed particular difficulties with delayed recall (but no problems with delayed recognition memory).

**Hypotheses**
These were developed in the context of Richard’s presenting problems, history, screening assessment, and the literature on cognitive profiles and symptoms associated with cortical and subcortical dementias of neurodegenerative and vascular aetiology and other potential causes of cognitive deficits, for example brain tumours and major depression.

It was hypothesised that further assessment would produce a cognitive profile consistent with organic and not functional difficulties, and with subcortical problems or possibly vascular-related impairments but not with Alzheimer’s Disease. It was hypothesised Richard would show difficulties with verbal recall but intact recognition memory, difficulties with attention, visuoconstructional tasks and executive functioning, but preserved language function.

**Further neuropsychological assessment**
This was conducted in two, two hour sessions. I assessed current intellectual functioning (Wechsler Abbreviated Scale of Intelligence (WASI); Psychological Corporation, 1999), memory and learning (Wechsler Memory Scale—Third Edition; Wechsler, 1998), attention (RBANS), language and semantic functioning (Graded Naming Scale, McKenna & Warrington, 1983; RBANS; WASI), perceptual organisation and visuoconstructional functioning (RBANS; WASI), and executive functioning (Behavioural Assessment of the Dysexecutive Syndrome, the Key Search and Zoo Map Tests; Wilson, Alderman, Burgess, Emslie & Evans, 1997). After the first assessment Richard reported an unusual experience; during a telephone conversation he had repeatedly called his friend by the wrong name and been unable to inhibit his verbal responses. Perseveration and ability to suppress responses were therefore assessed (Hayling and Brixton Tests; Burgess & Shallice, 1997).
Assessment findings
Richard was highly motivated during the assessment and maintained high levels of concentration. The findings demonstrated that Richard had not experienced a significant decline in general intellectual functioning but did have discrete cognitive difficulties. Results suggested difficulties with verbal retrieval, particularly of recently learned information, but adequate learning and storage abilities although he needed repeated exposure of material to learn. The hypothesis that Richard would demonstrate difficulties with verbal recall but show intact verbal recognition memory was confirmed. The hypothesis of preserved language function was supported. However, hypotheses that there would be deficits in visuoconstructional functioning, attention and executive functioning were not so well supported. Richard did demonstrate possible problems with suppressing verbal responses and/or perseveration of speech but it was difficult to determine the exact nature of the problem as it only occurred twice.

Conclusions and recommendations
Tentative conclusions were that the findings were suggestive of organic changes and not a functional disorder and that Richard’s cognitive profile was suggestive of subcortical problems with frontal system involvement. His profile was also consistent with profiles associated with early vascular-related changes. However, Richard’s profile and medical history were not entirely consistent with the presence of subcortical, frontal or vascular problems.

My supervisor and I met with Richard for one hour to feedback the results. Richard felt the findings had captured his subjective feelings of change and felt relieved there was confirmation of his perceptions. We highlighted that the nature of his difficulties meant that, because he could learn and store new information, he could use compensatory strategies to cue recognition and support his memory. We emphasised that, unfortunately, the results were not conclusive and that the assessment mainly represented a baseline against which change could be measured. We recommended further neuropsychological testing be carried out in 8-10 months but stated that the results did suggest possible organic change and supported the need for medical investigations. Richard was referred to a psychiatrist and neurologist.
Critical evaluation

This assessment provided evidence to support the conduction of important medical investigations that could lead to appropriate intervention and such recommendations may not have occurred if an assessment of this detail had not been conducted. However, there were limitations to the assessment and in future I would not use the WASI to assess global intellectual functioning because it did not allow the assessment of important cognitive functions such as processing speed.

References


Placement Details

**Dates:**  October 2005 to March 2006  
**Region:**  West London Mental Health NHS Trust

**Summary of placement experience**

This placement provided me with experience of working within a high-security special hospital. My clinical work was formulated and conducted within both cognitive behavioural and dialectical behavioural frameworks, and I had the opportunity to complete a piece of solution-focused therapy. My clinical experience included assessment for treatment interviews, assessment for the suitability of group work, a risk assessment, cognitive assessments, an admission assessment, and shorter term psychological intervention. I completed clinical work by myself on an individual basis and had the opportunity to conduct joint work with my supervisor. I also co-devised, co-designed and co-facilitated a structured therapeutic coping skills group delivered within the dialectical behavioural model of therapy, and this involved joint work with another trainee clinical psychologist, a senior house officer, and member of nursing staff. I also had the opportunity to observe my supervisor conduct criminal and civil court assessments outside the high-security hospital, and this included a visit to a maximum-security prison. All the clients I worked with were patients in the high-security hospital. Clients were aged from 20 years to 65 years, were a mixture of male and female, and were mostly from a white British background. I completed one piece of work with a patient who did not speak English and this work was conducted through an interpreter.

**Clinical skills and experience**

I had the opportunity to work with clients with severe mental illness and personality disorder. The presenting problems of the clients I worked with included: schizophrenia, schizoaffective disorder, self-harm, violent and sexual fantasies, difficulties with emotion regulation, anger problems, mild mental impairment, deafness, and narcissistic, borderline, antisocial and mixed personality disorder. All the clients had committed a criminal
offence and presented with a risk of violence. The assessment tools I used on placement were: the Historical, Clinical and Risk Management Guide (HCR-20), the Hare Psychopathy Checklist-Short Version, the Blackbury Circle, the Social Problem Solving Inventory-Revised, the Coping Responses Inventory, the Inventory of Altered Self-Capacities, the National Adult Reading Test, the Adult Memory and Information Processing Battery, Memory for Designs, the Camden Memory Tests, the Behavioural Assessment of the Dysexecutive Syndrome, the FAS, the Stroop Test, the Hayling and Brixton Tests, the Classical Weigl Task, the Modified De Renzi Token Test, and the Digit Copy Test (Kendrick Battery). I also observed the use of the Impact of Events Scale, the Gudjonsson Suggestibility Scale, the Gudjonsson Compliance Scale, the Culture-Free Self-Esteem Inventory, the Beck Depression Inventory, the Beck Anxiety Inventory, the State and Trait Anger Inventory, the Rathus Assertion Scale, the Wechsler Adult Intelligence Scale, the Wechsler Memory Scale, the Complex Figure Test, and the Sentence Completion and Spot the Word Test.

Meetings, seminars, visits and research
I attended clinical team meetings on the male admission ward, male rehabilitation ward for older and vulnerable patients, the rehabilitation ward for young men with personality disorders, and a female rehabilitation ward. I also attended three CPAs (one on the male high dependency ward, and two on the male rehabilitation ward for older and vulnerable patients) and I attended patient community meetings on the male admission ward to gain an understanding of the patients’ experience of being in the hospital. I attended two multidisciplinary admission panel meetings to increase my understanding around the reasons why patients are or are not admitted to high-security hospitals. I also attended the psychology group supervision on risk assessment. I visited all the wards in the hospital. I met with an occupational therapist to discuss her role within the hospital and observed an occupational therapy session. At the start of the placement I completed a seven-day induction programme and this covered training on: diversity, the Mental Health Act (1983), patient advocacy, the patient experience, maintaining boundaries with patients, child protection, risk assessment and security procedures. I also completed breakaway training and CPR training. I attended academic seminars on: the association between violent behaviour and startle response in people with antisocial personality disorder and
schizophrenia, transsexualism in high-security settings, the use of electro-convulsive therapy in high-security hospitals, and research conducted into therapeutic relationships within high-security hospitals. I also attended the trust research and development day, which had presentations on different research projects conducted through-out the trust.

I completed my Major Research Project on this placement, which was entitled ‘Insight into mental illness and its relationship to clinical variables in forensic patients with schizophrenia’. This included direct contact with 59 patients from the hospital with a diagnosis of schizophrenia.
Case Report Summary

A COPING SKILLS GROUP INFORMED BY THE DIALECTICAL BEHAVIOURAL MODEL OF THERAPY WITH MEN WITH PERSONALITY DISORDER IN A HIGH SECURITY HOSPITAL

All names and other details have been changed to preserve the clients' anonymity

Overview of and rationale for the group
The Coping Skills Group was a short-term, ward-based intervention informed by dialectical behavioural principles. It was a shorter adaptation of the Dialectical Behaviour Therapy (DBT) skills training and was adapted from the Skills Training Manual for Treating Borderline Personality Disorder (Linehan, 1993a). The group was conducted over eleven weeks, with one, ninety-minute session, per week. The group was conducted as a pilot to inform the ward clinical team of the usefulness of this therapeutic approach for their client group. It was not intended as an alternative to DBT.

Theoretical framework: Dialectical Behaviour Therapy
DBT is based on the biosocial theory of Borderline Personality Disorder and is a comprehensive treatment that integrates cognitive-behavioural approaches with Eastern (Zen) psychological practices (Linehan, 1993b). In recent years, the application of DBT to forensic populations and people with antisocial personality disorder has increased (Linehan, 2000) although it was acknowledged that our shorter, Coping Skills Group, delivered without concurrent individual therapy, could not be placed within an established evidence base and was developed in response to clinical need.

Group members
The clinical team referred seven patients to the group. The patients were white, British men between the ages of 20 and 31 years detained under the Mental Health Act 1983. All had been convicted of violent interpersonal offences and had clinical diagnoses of mixed
personality disorder. The patients’ difficulties were broadly characterised by low self-confidence, flat affect and/or emotional instability, problems with the management of anger, the tendency to act impulsively, problems in interpersonal relationships, and the presence of intrusive thoughts of violence and/or homicidal or sexual violent fantasies. An outcome measure (the Inventory of Altered Self-Capacities, Briere, 2000) was completed prior to the start of the group.

**Formulation**

The formulation was developed in accordance with the biosocial theory, which proposes that emotional dysregulation and an invalidating environment in childhood lead to affective instability (characterised by vacillation between inhibition of emotions and disinhibition of emotions) and that this in turn leads to behavioural and interpersonal chaos, problems with identity development, and cognitive instability. These patterns of instability can then develop further as individuals attempt to use them to regulate their emotions. Emotion dysregulation becomes ‘both the problem the individual is trying to solve and the source of additional problems’ (Linehan, 1993a, p.59).

**Intervention**

The group was facilitated by two trainee clinical psychologists. A male senior house officer and staff nurse were also present to facilitate aspects of the group and adhere to hospital policy around risk management.

The group aimed to help group members develop a better understanding of their thoughts, emotions and behaviours, and develop a core set of strategies for coping with painful, unhelpful or inappropriate emotions, thoughts and situations (specifically the experience of being in a high-security hospital). The group covered four main areas: mindfulness, radical acceptance, emotion regulation, and interpersonal effectiveness, and involved a combination of didactic presentations and large and small group exercises. Patients were also asked to complete written or reflective tasks between sessions, which were discussed at the beginning of each group.
The concept of dialectics was extremely useful for understanding and addressing a number of difficult themes that emerged during the group, and there were three themes for which the conceptualisation of these as 'dialectical dilemmas' was instrumental in moving the group forward from a potentially damaging, 'stuck' position. These were the validation of the 'self' versus the validation of the 'system', the experience of violent thoughts as 'evil' versus 'justified', and the dilemma of 'inhibiting' versus 'acting impulsively' in response to emotions. In addressing each of these difficult dilemmas, our dominant therapeutic stance was one in which dialectical dilemmas were attended to and validated but where we also utilised change strategies to help group members move towards a position of synthesis. A crucial element of the intervention was the negotiation of the core dialectic between acceptance and change; the need for the patients, and us as therapists, to accept the patients as they were in the moment and to accept the need for change.

Outcome
The final evaluation revealed that the group experience had been very different for the different group members. Six completed the group; two felt that they had not gained from the experience but four felt that the process had led to increased self-understanding and honesty, increased awareness of the patterns between thoughts, feelings and behaviours, and stated that learning the principle of 'radical acceptance' had been the most helpful process. The short-term nature of the group and complexity of the concepts did appear to reduce the patients' abilities to fully acquire the coping skills and on conclusion of the group this was a remaining need for the members.

Conclusion: professional and ethical issues
One of the main difficulties during the group was the seeping of wider ward issues into the group process; including staff-patient conflict, pressure from the patient who left the group on the continuing members not to attend, and tension between group members as a result of incidents that had occurred outside the group. The situation of our group within the larger group (the ward) also raised our awareness of the possible negative impact of the group on the patients' relationships with ward staff and it was invaluable having a member of the ward staff present during the group to begin a process of disseminating the principles of dialectical behaviour therapy to other staff.
References


Specialist Adolescent Systemic Placement
Placement Details

Dates: April 2006 to October 2006
Region: South West London and St. George’s Mental Health NHS Trust

Summary of placement experience
This placement provided me with the experience of working within a child and adolescent mental health team and in a youth offending team which provided experience of working as a mental health professional in a non-mental health, local authority context. My clinical work was formulated and conducted within systemic, family therapy, and cognitive behavioural frameworks. My clinical experience included assessment for treatment interviews, shorter term psychological intervention, working as part of a family therapy reflecting team, and working as part of a team providing consultation to non-mental health professionals from the youth offending team. I completed clinical work by myself on an individual basis and had the opportunity to conduct joint work with my supervisor. My clinical work involved individual work with adolescents and work with adolescents and their families. All the clients I worked with lived in the community and I had the opportunity to work with clients in an outpatient setting and with a family in their home. Clients were aged from 11 years to 17 years, were a mixture of male and female, and were mostly from a white British background.

Clinical skills and experience
The presenting problems of the clients I worked with included: a phobia, obsessive compulsive disorder, substance misuse, school refusal, anxiety, family and peer relationship difficulties, domestic violence, self-harm, low self-esteem, difficulties managing feelings of anger, and offending behaviour. The assessment tools I used on placement were the Strengths and Difficulties Questionnaire, the Spence Children’s Anxiety Scale and the Children’s Depression Inventory, and the assessments conducted drew on a number of data sources including recording charts, information from family members, and information from teachers and other professionals.
Meetings, seminars, visits and research

I attended the Child and Adolescent Mental Health Team’s weekly meeting, where cases and business issues were discussed, the team’s Starter Clinics where referrals and cases were discussed, and the bimonthly psychology team meetings. I had the opportunity to meet with and/or observe clinical work conducted by the team consultant psychiatrist, registrar, child psychotherapist, social worker, dietician, teacher, and family therapist to develop my understanding of their roles and working practices. I also met with a clinical psychologist trained in family therapy for four consultation sessions on systemic therapy and with a family therapist to receive consultation around one of my clinical cases to discuss theory-practice links. I also attended a CAMHS re-development day, seminars on clinical psychology in youth offending teams and on music therapy, a meeting with magistrates to discuss the youth offending team progress and future directions, a meeting for mental health professionals working in youth offending teams, and a meeting on how to increase service user involvement in the child and adolescent mental health service. I also visited a youth magistrates court for a day. The training event I attended was a conference on anti-social behaviour in adolescents.
Overview

The research dossier comprises:

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2. The Service Related Research Project
3. The Major Research Project
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*Administering questionnaires only*
15 Negotiating access to study participants in applied NHS settings ✓
16 Setting up a data file ✓
17 Conducting statistical data analysis using SPSS ✓
18 Choosing appropriate statistical analyses ✓
19 Preparing quantitative data for analysis ✓
20 Choosing appropriate quantitative data analysis ✓
21 Summarising results in figures and tables ✓
22 Conducting semi-structured interviews ✓
23 Transcribing and analysing interview data using qualitative methods ✓
24 Choosing appropriate qualitative analyses ✓
25 Interpreting results from quantitative and qualitative data analysis ✓
26 Presenting research findings in a variety of contexts ✓
27 Producing a written report on a research project ✓
28 Defending own research decisions and analyses ✓
29 Submitting research reports for publication in peer-reviewed journals or edited book -
30 Applying research findings to clinical practice ✓
An audit of clients’ views of the therapeutic relationship between themselves and their psychologist

June 2004

Year 1
ABSTRACT

**Title:** An audit of clients' views of the therapeutic relationship between themselves and their psychologist. **Objective:** To assess, within the local psychology service, the clients' perceptions of the quality of the therapeutic relationship. The influence on the alliance of client demographic characteristics, client presenting problem and client-therapist demographic variable combinations were also assessed. **Design:** This was a cross-sectional survey using a self-report questionnaire. **Setting:** The audit was conducted for a psychology service, in an Adult Mental Health Directorate, which comprised four clinical psychologists working in community mental health teams. **Participants:** There were 30 participants, 20 female and 10 male, aged between 22 and 58 years, the majority were white British and most presented with depression and/or anxiety. All were clients of the community teams and had completed three or more psychology sessions. **Main Outcome Measure:** This was the Working Alliance Inventory Short Form (Tracey & Kokotovic, 1989). **Results:** The audit demonstrated the service is forming good alliances with their clients and that no client demographic characteristics and no client-psychologist demographic variable combinations influenced the alliance. Type of presenting problem and time of alliance measurement were observed to have some influence. **Conclusions:** The limitations of the study, such as a small and unrepresentative sample and possible positive response bias, prevent firm conclusions and mean the results cannot be generalised. However the project raised the importance of the therapeutic alliance and provided the service with a method with which to assess this alliance in the future.
ACKNOWLEDGEMENTS

I would like to thank the local psychology service, the clients and my placement and university supervisors for their contribution to this project.
INTRODUCTION
The clinical psychologist's ability to form a therapeutic relationship is a core competency (Division of Clinical Psychology (DCP), 2001). The Department of Health Evidence-Based Clinical Practice Guidelines (Department of Health (DoH), 2001) recommend attention is paid to the therapeutic alliance because it is reliably related to outcome in all forms of therapy; meta-analyses have found overall effect sizes of 0.26 (Horvath & Symonds, 1991) and 0.23 (Martin, Garske & Davis, 2000). The importance of the alliance led the local psychology service to decide to explore clients' perceptions of the alliance and to integrate these views into psychologists' appraisals.

Operational definition and alliance measurement
The therapeutic alliance has been operationalised in different ways (Horvath & Luborsky, 1993) but currently the definition by Bordin (1979) is most frequently used (Cook & Doyle, 2002; Kokotovic & Tracey, 1990). He defined the 'working alliance' as comprising three related components: (a) goals; client and therapist agreement on therapy goals, (b) tasks; agreement on the tasks to achieve these goals, and (c) bond; the development of a personal bond between client and therapist.

There were three reasons why the clients' perception of the alliance was assessed. Firstly, research has shown it is clients', rather than psychologists' or observers', perception of the alliance that is most reliably related to clinical improvement (Burns & Auerbach, 1996; Horvath & Symonds, 1991; Martin et al., 2000). Secondly, research on the appraisal process has highlighted the subjectivity of self-reports and proposes the use of the multi-source assessment (360-degree appraisal); collecting appraisals from supervisors, peers, subordinates and customers. This process should ensure a behaviour is evaluated by the person in the best position to observe that behaviour (van der Heijden & Nijhof, 2004). This service decided clients are in the best position to evaluate the therapeutic relationship. Finally, service users should be involved in assessing services to ensure they are provided in a way that best meets their needs (DoH, 2001).
Variables influencing the therapeutic alliance

Client variables and client-therapist variable combinations can influence the alliance and the DCP (2001) state that psychologists should take account of any ethnic, gender or age inequalities that could compound the power dynamic in therapeutic relationships. Research has studied ethnic (Erdur, Rude, Barón, Draper & Shankar, 2000) and other similarities or differences between clients and therapists (Vera, Speight, Mildner & Carlson, 1999) and type of presenting problem (Cook & Doyle, 2002; Horvath & Luborsky, 1993), but overall the only variable appearing to have a significant negative impact on the alliance is client difficulty in developing interpersonal relationships (Horvath & Luborsky, 1993; Klein et al., 2003; Martin et al., 2000). However, some studies have been based on small and unrepresentative samples therefore still little is known about which variables are influential (Horvath & Luborsky, 1993; Zuroff et al., 2000).

Aim

The aim was to assess, within the local psychology service, the clients’ perceptions of the quality of the therapeutic relationship between themselves and their psychologist.

This project was situated at the initial stage of the audit cycle (Barker, Pistrang & Elliott, 2002) by observing and comparing practice against an existing guideline (DoH, 2001); ‘the psychologist should be able to achieve as best as possible a therapeutic relationship with the client...’ (DCP, 2001).

Research question and hypotheses

One research question was proposed:

Are the psychologists forming positive therapeutic relationships with their clients?
Four two-tailed experimental hypotheses were generated:

1. The therapeutic relationship will be influenced by client:
   i) age
   ii) gender
   iii) ethnicity
   iv) presenting problem.

Three one-tailed hypotheses were generated:

2. The therapeutic relationship will be stronger when client and psychologist are similar rather than different in:
   i) age
   ii) gender
   iii) ethnicity.

**METHOD**

**Design**

This was a cross-sectional survey assessing strength of therapeutic alliance, measured by the score on the Working Alliance Inventory Short Form (WAI-S).

The independent variables were; gender, age, ethnicity, presenting problem and client-psychologist gender, age and ethnic combinations. Data was also collected on stage of therapy at the time of measurement because this could not be standardised.

**Participants**

All participants were clients of one of four adult community mental health teams (CMHTs). All had completed three or more psychology sessions, to ensure a valid assessment of the alliance (Horvath & Greenberg, 1989; Kokotovic & Tracey, 1990). Clients who had finished therapy in the past four months were also asked to participate. These CMHTs serve a mainly urban, white, relatively affluent population.
The psychology service comprised four qualified clinical psychologists whose main theoretical orientation is cognitive-behavioural; one male and three female, aged 32 to 42 years. Two described their ethnicity as white British, one as white Irish and one as any other white.

**Measures**

Martin et al. (2000) state that given the diversity of alliance measures no more should be developed. They recommend the Californian Psychotherapy Alliance Scales (CALPAS), Vanderbilt Scales or Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989) because these have received most empirical scrutiny. In a consultation with the psychologists the WAI was deemed the most appropriate; it measures the three components of Bordin's (1979) working alliance, the Vanderbilt Scales do not include a client version and the CALPAS language was too American for the target population. The WAI short version was considered most suitable for its ease of completion.

*Working Alliance Inventory Short Form (WAI-S)* (appendix 1)

The WAI-S client version is a 12-item questionnaire (Tracey & Kokotovic, 1989). It measures a general alliance factor and Bordin's (1979) three constructs; goals, tasks and bonds, four questions for each. Each item is rated on a 7-point Likert scale, ranging from never (1) to always (7). The items are summed and total scores range from 12 to 84; a higher score indicates a stronger alliance. The WAI-S has good reliability; internal consistency estimates of alpha are 0.98 for the overall score and subscale alphas range from 0.90 to 0.92 (Tracey & Kokotovic, 1989). The reliability coefficient for the overall score from the current study was 0.81. The WAI has good validity (Horvath & Greenberg, 1986) and Bussari and Tyler (2003) have demonstrated equivalent psychometric results and interchangeability of the WAI and WAI-S.

The psychologists made minor changes to the WAI-S language to make it more appropriate for the target sample; 'therapist' was substituted by 'psychologist' and 'therapy' by 'psychology sessions'.
Demographics Questionnaire (appendix 2)
This asked participants their gender, age and ethnicity.

Psychologist Information Sheet (appendix 3)
This asked psychologists their gender, age, ethnicity, theoretical orientation, each client’s presenting problem and number of sessions completed with each client.

Procedure
The psychologists administered the WAI-S, demographics questionnaire and a covering letter (appendix 4) to clients in a session. These were posted to clients who had completed therapy. Clients were told why they were being asked to participate, to enable informed consent, and were assured of confidentiality (Fitzpatrick, 1991a) (appendix 4). Clients were asked to return the questionnaire to the trainee clinical psychologist to ensure responses were confidential from the psychologist, preventing any negative effects on the on-going therapy and maximising the honesty of responses (Fitzpatrick, 1991a). To facilitate response rates, clients were provided with a stamped addressed envelope and clients who failed to return the questionnaire after two weeks were sent a reminder letter (appendix 5). Clients were followed up only once and were assigned a number to enable this (Fitzpatrick, 1991a).

RESULTS

Response rate
Forty people were approached and 30 agreed to participate; a response rate of 75%. Initially 19 returned their questionnaires (45%), after reminders a further 11 out of 20 responded (55%). Data were not collected on the non-responders to respect their choice not to be included.

Descriptive data
Table 1 shows the participants’ demographic characteristics.
Table 1: Number of clients in each demographic category

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>Group</th>
<th>Number of Clients (percentage)</th>
<th>Mean (standard deviation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>10 (33%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>20 (67%)</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White British</td>
<td>22 (73%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any other White</td>
<td>5 (17%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any other Background</td>
<td>3 (10%)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-</td>
<td>30</td>
<td>39.47 (8.89)</td>
</tr>
<tr>
<td>Presenting Problem</td>
<td>Mood Disorder</td>
<td>11 (37%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anxiety Disorder</td>
<td>5 (17%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mood and Anxiety Disorder</td>
<td>5 (17%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Schizophrenia or other</td>
<td>4 (13%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychotic Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personality Disorder</td>
<td>3 (10%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2 (6%)</td>
<td></td>
</tr>
<tr>
<td>Gender of client and</td>
<td>Match</td>
<td>19 (63%)</td>
<td></td>
</tr>
<tr>
<td>psychologist</td>
<td>Not Match</td>
<td>11 (37%)</td>
<td></td>
</tr>
<tr>
<td>Age of client and</td>
<td>Match</td>
<td>3 (10%)</td>
<td></td>
</tr>
<tr>
<td>psychologist</td>
<td>Not Match</td>
<td>27 (90%)</td>
<td></td>
</tr>
<tr>
<td>Ethnicity of client and</td>
<td>Match</td>
<td>10 (33%)</td>
<td></td>
</tr>
<tr>
<td>psychologist</td>
<td>Not Match</td>
<td>20 (67%)</td>
<td></td>
</tr>
<tr>
<td>Stage of Therapy</td>
<td>Early</td>
<td>15 (50%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3-6 sessions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Middle</td>
<td>8 (27%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(7-14 sessions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Late</td>
<td>5 (17%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(15+ sessions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Completed sessions</td>
<td>2 (6%)</td>
<td></td>
</tr>
</tbody>
</table>

1 The data were collapsed across ethnicity and presenting problem categories into those described in table 1 to protect the anonymity of the clients by having more than one client in each category.
2 Clients and psychologists were matched for age using five year age ranges (for example 30-34 or 35-39) and for ethnicity using more specific categories (see appendix 2) than the three groups in table 1.
Method of analysis

The descriptive statistics of mean, median and range are provided. This data includes outliers therefore the median is the most useful measure of central tendency because, unlike the mean, it is not affected by extreme scores (Gravetter & Wallnau, 2000). Large differences between the mean and median can be seen in most of the data.

Non-parametric tests were used because, although the scores are normally distributed (Kolmogorov-Smirnov test was not significant, p>0.05), the data is ordinal and the sample sizes small.

Analysis of the scores for the total sample

Table 2 shows a high median total score of 71 out of 84 and demonstrates that this score is comprised of equally high scores on all three subscales. There is a large variation in the scores, demonstrated by the large range (46.61) and standard deviation (sd) (8.75), however this has been affected by the response of one client whose low rating of the alliance (37.39) is an exception (see box plot in appendix 6). It is a valid response however so has not been omitted from any analyses.

Table 2: Descriptive statistics for the total and subscale scores on the WAI-S for the total sample (n=30)

<table>
<thead>
<tr>
<th>WAI-S</th>
<th>Mean (sd)</th>
<th>Median</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score on WAI-S</td>
<td>69.03</td>
<td>71.00</td>
<td>37.39</td>
<td>84.00</td>
</tr>
<tr>
<td>(maximum total=84)</td>
<td>(8.75)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bond Subscale Score</td>
<td>22.54</td>
<td>23.00</td>
<td>13.26</td>
<td>28.00</td>
</tr>
<tr>
<td>(maximum total=28)</td>
<td>(3.49)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal Subscale Score</td>
<td>22.70</td>
<td>24.00</td>
<td>12.13</td>
<td>28.00</td>
</tr>
<tr>
<td>(maximum total=28)</td>
<td>(3.91)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task Subscale Score</td>
<td>23.79</td>
<td>24.00</td>
<td>12.00</td>
<td>28.00</td>
</tr>
<tr>
<td>(maximum total=28)</td>
<td>(3.64)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Analysis of the hypotheses

From the seven hypotheses it was not valid to investigate three; the influence of ethnicity (hypothesis liii), presenting problem (liv), or client-psychologist age combination (2ii), significance tests would not yield meaningful results because of small sample sizes and large variability between group sample sizes.

Analyses in this section were limited to the general working alliance; the most meaningful results are yielded from the total rather than the subscale scores because there is a large overlap between the goal and task constructs (Hatcher & Barends, 1996; Tracey & Kokotovic, 1989).

Demographic Characteristics (Hypotheses li, lii, liii)

Figure 1 shows the relationship between age and WAI-S. It demonstrates there is not a linear relationship between these two variables.

Figure 1: Relationship between age and total score on the WAI-S
Tables 3 and 4 show the descriptive statistics for gender and ethnicity respectively. These descriptive statistics are presented graphically in appendix 7.

Table 3: Descriptive statistics and the Mann-Whitney U-test statistic for the total score on the WAI-S for males and females

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number of Clients</th>
<th>Total Score on the WAI-S</th>
<th>Mann-Whitney U Test Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean (sd)</td>
<td>Median</td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>64.61 (12.15)</td>
<td>65.00</td>
</tr>
<tr>
<td>Female</td>
<td>20</td>
<td>71.24 (5.61)</td>
<td>71.50</td>
</tr>
</tbody>
</table>

Table 4: Descriptive statistics for the total score on the WAI-S for the three ethnic categories

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number of Clients</th>
<th>Total Score on the WAI-S</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean (sd)</td>
<td>Median</td>
</tr>
<tr>
<td>White British</td>
<td>22</td>
<td>69.36 (6.51)</td>
<td>71.00</td>
</tr>
<tr>
<td>Any other White</td>
<td>5</td>
<td>66.40 (11.62)</td>
<td>67.00</td>
</tr>
<tr>
<td>Any other</td>
<td>3</td>
<td>71.00 (7.12)</td>
<td>74.00</td>
</tr>
</tbody>
</table>

Overall, none of the demographic characteristics influenced the alliance. A Spearman’s Rank Order Test ($r(30)=-0.15$, $p=0.42$, 2-tailed) showed client age was not significantly correlated with strength of alliance ($p>0.05$), table 3 shows women rated their relationship as stronger than men but a Mann-Whitney U test indicated this was not a significant difference ($p>0.05$) and table 4 shows each ethnic group similarly rated the alliance.
Type of Presenting Problem (Hypothesis Iiv)

Table 5: Descriptive statistics for the total score on the WAI-S for the different types of presenting problems

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Number of Clients</th>
<th>Mean (sd)</th>
<th>Median</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorder</td>
<td>11</td>
<td>68.36 (5.52)</td>
<td>70.00</td>
<td>58.00</td>
<td>75.00</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>5</td>
<td>77.78 (7.24)</td>
<td>81.82</td>
<td>68.09</td>
<td>84.00</td>
</tr>
<tr>
<td>Mood and Anxiety Disorder</td>
<td>5</td>
<td>68.18 (5.25)</td>
<td>70.91</td>
<td>62.00</td>
<td>73.00</td>
</tr>
<tr>
<td>Schizophrenia or other Psychotic Disorder</td>
<td>4</td>
<td>65.93 (4.91)</td>
<td>66.37</td>
<td>60.00</td>
<td>71.00</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>3</td>
<td>61.13 (20.58)</td>
<td>72.00</td>
<td>37.39</td>
<td>74.00</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>71.00 (7.07)</td>
<td>71.00</td>
<td>66.00</td>
<td>76.00</td>
</tr>
</tbody>
</table>

These descriptive statistics are presented graphically in appendix 7.

Table 5 demonstrates that clients with anxiety gave the highest rating and clients with schizophrenia and other psychotic disorders gave the lowest rating on the WAI-S.
**Client-Psychologist Variable Combinations (Hypotheses 2i, 2ii, 2iii)**

Table 6: Descriptive statistics and Mann-Whitney U-test statistics for the total score on the WAI-S for the different client-psychologist variable combinations

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th>Number of Clients</th>
<th>Total Score on the WAI-S</th>
<th>Mann-Whitney U Test Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mean (sd)</td>
<td>Median</td>
</tr>
<tr>
<td>Age of client and psychologist</td>
<td>Match</td>
<td>3</td>
<td>66.97 (7.79)</td>
<td>70.91</td>
</tr>
<tr>
<td></td>
<td>Not Match</td>
<td>27</td>
<td>69.26 (8.95)</td>
<td>71.00</td>
</tr>
<tr>
<td>Gender of client and psychologist</td>
<td>Match</td>
<td>19</td>
<td>70.52 (6.46)</td>
<td>71.00</td>
</tr>
<tr>
<td></td>
<td>Not Match</td>
<td>11</td>
<td>66.47 (11.63)</td>
<td>67.00</td>
</tr>
<tr>
<td>Ethnicity of client and psychologist</td>
<td>Match</td>
<td>10</td>
<td>70.75 (5.42)</td>
<td>71.46</td>
</tr>
<tr>
<td></td>
<td>Not Match</td>
<td>20</td>
<td>68.17 (10.03)</td>
<td>69.55</td>
</tr>
</tbody>
</table>

No client-psychologist variable combinations influenced the alliance. The median scores in table 6 suggest the alliance was not rated differently by the clients who did and those who did not match their psychologist on age. No significant differences (p>0.05) in the rating of the alliance were found between clients with the same or different gender or ethnicity.
**Stage of Therapy**

Table 7: Descriptive statistics for the total score on the WAI-S for the different stages of therapy

<table>
<thead>
<tr>
<th>Stage of Therapy</th>
<th>Number of Clients</th>
<th>Total Score on the WAI-S</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean (sd)</td>
</tr>
<tr>
<td>Early (3-6 sessions)</td>
<td>15</td>
<td>67.82 (9.72)</td>
</tr>
<tr>
<td>Middle (7-14 sessions)</td>
<td>8</td>
<td>71.86 (7.47)</td>
</tr>
<tr>
<td>Late (15+ sessions)</td>
<td>5</td>
<td>65.55 (5.73)</td>
</tr>
<tr>
<td>Completed sessions</td>
<td>2</td>
<td>75.50 (12.02)</td>
</tr>
</tbody>
</table>

These descriptive statistics are presented graphically in appendix 7.

Table 7 shows the alliance was rated highest by people who had completed therapy and lowest by those in the late stages.

**Analysis of individual psychologists' scores**

Individual feedback sheets, in appendix 8, give the ratings of the alliance for each psychologist. These are not included here because it was not the aim to compare relationships across psychologists.
DISCUSSION

Main findings
The aim was achieved; clients’ perceptions of the quality of the therapeutic relationship were assessed. The results showed a high median total score of 71.00 out of 84 on the WAI-S which demonstrates the psychology service is forming good alliances with their clients and is meeting the guideline “the psychologist should be able to achieve as best as possible a therapeutic relationship with the client…” (DCP, 2001). In addition, similar scores on each WAI-S subscale were found, indicating that all three aspects of Bordin’s (1979) working alliance are equally strong; the psychologists are forming good agreements on therapy goals and tasks and are developing good personal bonds with clients.

Seven experimental hypotheses regarding the influence of a number of variables on the alliance were proposed however small sample sizes prevented investigation of three of these. The results did not support the four hypotheses investigated and therefore overall the results indicated that none of the client demographic characteristics and none of the client-psychologist variable combinations (gender, age and ethnicity) influenced the alliance. This indicates some support for previous research (Erdur et al., 2000; Vera et al., 1999) and suggests the psychologists are acknowledging client diversity and managing the power dynamic so it is not damaging the alliance. Although it must be considered that the variables and combinations studied are not ideal, for example ethnic similarity does not necessarily equal cultural similarity (Erdur et al., 2000).

The results suggest two variables might have some influence on the alliance; client presenting problem and stage of therapy. Previous research has found no influence of presenting problem on alliance (Cook & Doyle, 2002; Horvath & Luborsky, 1993) and the result in this study, that clients with schizophrenia and other psychotic disorders rated the alliance as weaker than clients with other presenting problems, could be a function of the finding that people with difficulties developing interpersonal relationships find it difficult to form therapeutic alliances (Horvath & Luborsky, 1993; Klein et al., 2003; Martin et al., 2000). However the group most linked to finding interpersonal relationships difficult;
people with personality disorders (Linehan, 1993), did not as a group rate the alliance very low, although the lowest rating in the entire sample was from a client with personality disorder. Implications are that although the psychologists may find it more challenging to form good alliances with clients with more complex disorders this difficulty may be a function of the clients', not the psychologists', difficulty with relationships. In addition, the median total score on the WAI-S from people with schizophrenia was 66.37, still demonstrating a good alliance and in this project the categories for presenting problem were relatively crude and mostly did not take account of co-morbidity.

The stage of the therapy appeared to exert some influence; those in the late stages rated the alliance lower than those at other stages, suggesting the relationship might be perceived differently at different times in therapy (Horvath & Luborsky, 1993). In future, time of alliance measurement should be held constant if results are to be comparable across clients. It should be assessed after the third session (Horvath & Greenberg, 1989).

Methodological critique and future recommendations

All the conclusions are tentative because the analyses are based on a small sample size and did not take account of interactions between the variables or the confounding influence of other variables, for example problem severity or client and psychologist diversity in social class. Any differences observed may not be significant or conversely there could be significant differences between groups but the small sample size prevented these being detected (type 2 error). The sample is not likely to be representative of all clients and this affects the generalisation of the results to other clients. Psychologists still need to be vigilant that they are forming good relationships with all client groups.

The results could show a positive bias; those with a good alliance are perhaps more likely to respond, leading to an oversampling of this group, and demand characteristics, such as acquiescence, may make it difficult for service users to report negative views (Fitzpatrick, 1991b). However, attempts were made to minimise this positive bias; assurance of anonymity, neutrality of person gathering the data (Fitzpatrick, 1991a) and the successful implementation of methods to increase response rate, which was reasonable at 75%.
A useful method for measuring client perception of the alliance was found; the WAI-S is easy to complete and quick to analyse. The high response rate also suggests that psychologists handing out the WAI-S was better than posting; this method should be used in future. Rephrasing question four (see appendix 1) positively rather than negatively could increase validity; a number of responders answered this question in a way that was at variance with their other responses suggesting misinterpretation. Also in future, clients should have the opportunity to report qualitatively on the alliance allowing the service to consider in more detail why a particular alliance rating is reported.

**Implications for the service**

This project has been valuable in making explicit the importance of the therapeutic relationship and the psychologist's ability to form a positive alliance with all clients regardless of gender, age or ethnicity (DCP, 2001). It has started the audit process by comparing practice against the DCP guideline and the next stage, identifying change, can now be employed by the service. A possible area for consideration is how psychologists could build stronger alliances with clients with complex problems. The appraisal process could provide the forum in which this could be considered and the alliances with these client groups re-audited. It is also recommended that through the appraisal process the service continues to assure this skill is being retained; it is such an important component of therapeutic effectiveness (DoH, 2001) and this project was not able to represent all client groups. Appraisal research demonstrates that the validity of self-assessments is greater if individuals expect their appraisal to be validated against external criteria (van der Heijden & Nijhof, 2004); this project showed that client responses on the WAI-S can provide this criteria, but should be gathered after the third session. Similar services should consider the benefits of this model of working.

The findings and recommendations were fed back to the local psychology service (appendix 9).
REFERENCES


Appendix 1: Working Alliance Inventory Short Form (Tracey & Kokotovic, 1989)

Below is a list of statements about your psychology sessions. Please consider each item carefully and indicate your level of agreement for each of the following items by circling the appropriate number.

1. My psychologist and I agree about the things I will need to do in my psychology sessions to help improve my situation.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

2. What I am doing in my psychology sessions gives me new ways of looking at my problem.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

3. I believe my psychologist likes me.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

4. My psychologist does not understand what I am trying to accomplish in my psychology sessions.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

5. I am confident in my psychologist’s ability to help me.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
6. My psychologist and I are working towards mutually agreed upon goals.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Always</td>
</tr>
</tbody>
</table>

7. I feel that my psychologist appreciates me.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Always</td>
</tr>
</tbody>
</table>

8. We agree on what is important for me to work on.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Always</td>
</tr>
</tbody>
</table>

9. My psychologist and I trust one another.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Always</td>
</tr>
</tbody>
</table>

10. My psychologist and I have different ideas on what my problems are.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Always</td>
</tr>
</tbody>
</table>

11. We have established a good understanding of the kind of changes that would be good for me.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Always</td>
</tr>
</tbody>
</table>

12. I believe the way we are working with my problem was correct.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Always</td>
</tr>
</tbody>
</table>
Appendix 2: Demographic Questionnaire

It would be helpful for us to know your age, gender and ethnicity. Please complete this before filling in the questionnaire.

1. Please state your gender by ticking the appropriate box.

Male □ Female □

2. Please state your age.


3. Please state your ethnicity by ticking the appropriate box.

White British □
White Irish □
Any Other White □
White and Black African □
White and Black Caribbean □
White and Asian □
Any Other Mixed Background □
Indian □
Pakistani □
Bangladeshi □
Any Other Asian Background □
Black Caribbean □
Black African □

Any Other Black Background □

Chinese □

Any Other Ethnic Group □
Appendix 3: Psychologist Information Sheet

Psychologist 1:

Please hand out the questionnaire to all clients you have seen for 3 or more sessions (including assessment). Please encourage clients to fill in the questionnaire after a session in a waiting area and post it in the local post box, if you feel this is appropriate.

Please list, in the table below, the name of the client, his/her presenting problem and the session number in which you gave out the questionnaire.

All questionnaires are numbered so please correspond the number on the questionnaire with this list.

Please also state your own:

Gender: __________

Age: __________

Ethnicity: __________

Main Theoretical Orientation: ______________________

<table>
<thead>
<tr>
<th>Name of Client</th>
<th>Presenting Problem</th>
<th>Session Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Numbers on the Information sheet for Psychologist 2 ranged from 11 to 20 and so on)
Dear Sir/Madam,

This psychology service is currently thinking of ways in which client feedback can be used in psychologists’ appraisals (this is a review of the psychologist’s work). You are therefore being asked to contribute to a small pilot project asking about your views on your psychology sessions and the psychologist which can be used anonymously as part of the psychologist’s appraisal. Your views would be very helpful.

Attached to this letter is a short questionnaire asking about your views on your psychology sessions. I would be very grateful if you could fill in this questionnaire, it should take no more than 5 minutes. However if you do not wish to complete the questionnaire you do not have to and if you decide not to reply this will not affect any aspect of your care. Your answers will be confidential and the psychologist will only be given general feedback, they will not know who has given individual answers.

Please answer the questions as honestly as you can and return the questionnaire in the stamped addressed envelope which is attached. If I do not receive your questionnaire within the next two weeks I will send you a reminder, however you do not have to reply. If you have any questions please do not hesitate to contact me on the number below.

I thank you for your co-operation.
Appendix 5: Reminder Letter

Dear Sir/Madam,

You will have received a request from your psychologist to complete a questionnaire asking about your views on your psychology sessions and to return this questionnaire in the stamped addressed envelope that was provided. I have not received this questionnaire from you and therefore I am writing to ask again if you would be willing to complete the questionnaire. I would really appreciate your response, however if you do not wish to reply you do not have to and this will be the last time I send you a reminder.

(Information in the original covering letter was then repeated).
Appendix 6: Box Plot of the Total Scores Showing the Outlier

Figure i: Distributions of the total score on the WAI-S for the total sample
Appendix 7: Graphical Presentation of the Descriptive Statistics for the Variables Gender, Ethnicity, Type of Presenting Problem and Stage of Therapy

Figure ii: Median total scores on the WAI-S for males and females
Figure iii: Median total scores on the WAI-S for the three ethnic groups

Figure iv: Median total score on the WAI-S for the different presenting problems
Figure v: Median total score on the WAI-S for the four stages of therapy
Appendix 8: Individual Psychologists Feedback Forms

INDIVIDUAL PSYCHOLOGISTS FEEDBACK FORM - Introduction

The aim of this form is to provide a descriptive summary of your clients’ perception of their therapeutic relationship and is intended to be read in conjunction with the full report.

It shows the total score on the working alliance inventory short form (WAI-S) and the score on each of the three subscales; goals, tasks and bond (Bordin, 1979).

These scores are shown for the total group of your clients and according to certain grouping variables. To ensure anonymity of clients, the number of clients in each category and the range of scores are not presented and where there was only one person in a group this group has either been omitted or combined with another group. No significance tests have been conducted; these would not yield meaningful results because of small sample sizes and large variability between group sample sizes.

Psychologists should bear in mind that the scores presented are based on a small number of clients and therefore will not be representative of all clients’ views. In addition the summary does not take account of interactions between variables or the confounding influence of other variables on the scores. Therefore there is no discussion of the reasons for certain scores; individual psychologists and their managers can take account of the psychologist’s work context and therefore are best placed to consider the meaning of the scores.
INDIVIDUAL PSYCHOLOGISTS FEEDBACK FORM - Psychologist 1

**Total Scores**

Table 1: Median total and subscale scores on the WAI-S for the total sample for Psychologist 1 (n=5)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th>Median Total Score on WAI-S 84</th>
<th>Median Bond Subscale Score 28</th>
<th>Median Goal Subscale Score 28</th>
<th>Median Task Subscale Score 28</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Maximum total=84 (range)</td>
<td>Maximum total=28 (range)</td>
<td>Maximum total=28 (range)</td>
<td>Maximum total=28 (range)</td>
</tr>
<tr>
<td></td>
<td>61.00 (17.00)</td>
<td>23.00 (4.00)</td>
<td>21.00 (11.00)</td>
<td>21.00 (8.00)</td>
<td></td>
</tr>
</tbody>
</table>

The median total score is 61 out of 84 as shown in table 1. An evaluation of the questionnaires demonstrates that this result is comprised of most clients rating between 4 and 6 out of 7 on the Likert scale for each item. The median values for each subscale are similar which indicates that all three aspects of Bordin's (1979) working alliance are being attended to equally. The ranges demonstrate that most clients agree on the bond subscale rating but that the clients are more variable in their views on the goal and task subscales.

**Demographic Characteristics and Client-Psychologist Variable Combinations**

Table 2: Median total and subscale scores on the WAI-S for males and females and for client-psychologist gender combinations

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th>Median Total Score on WAI-S 84</th>
<th>Median Bond Subscale Score 28</th>
<th>Median Goal Subscale Score 28</th>
<th>Median Task Subscale Score 28</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Maximum total=84 (range)</td>
<td>Maximum total=28 (range)</td>
<td>Maximum total=28 (range)</td>
<td>Maximum total=28 (range)</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>59.00</td>
<td>22.50</td>
<td>17.50</td>
<td>19.00</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>67.00</td>
<td>23.00</td>
<td>21.00</td>
<td>23.00</td>
</tr>
<tr>
<td>Gender of client and</td>
<td>Match</td>
<td>59.00</td>
<td>22.50</td>
<td>17.50</td>
<td>19.00</td>
</tr>
<tr>
<td>psychologist</td>
<td>Not Match</td>
<td>67.00</td>
<td>23.00</td>
<td>21.00</td>
<td>23.00</td>
</tr>
</tbody>
</table>

Table 2 shows that the females, who do not match the psychologist in gender (table 3), have tended to rate the working alliance higher than the males particularly on the goal and task subscales.
**Stage of Therapy**

Table 3: Median total and subscale scores on the WAI-S for the different stages of therapy

<table>
<thead>
<tr>
<th>Stage of Therapy</th>
<th>Median Total Score on WAI-S (Maximum total=84)</th>
<th>Median Bond Subscale Score (Maximum total=28)</th>
<th>Median Goal Subscale Score (Maximum total=28)</th>
<th>Median Task Subscale Score (Maximum total=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early (3-6 sessions)</td>
<td>67.00</td>
<td>23.00</td>
<td>21.00</td>
<td>23.00</td>
</tr>
<tr>
<td>Middle (7-14 sessions)</td>
<td>61.00</td>
<td>20.00</td>
<td>21.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Late (15+ sessions)</td>
<td>60.00</td>
<td>23.00</td>
<td>20.00</td>
<td>17.00</td>
</tr>
</tbody>
</table>

Table 3 shows that overall the therapeutic relationship has been rated highest by those in the early stages of therapy and shows that the greatest change in the ratings from the early to late stages is on the task subscale.
INDIVIDUAL PSYCHOLOGISTS FEEDBACK FORM - Psychologist 2

Total Scores

Table 1: Median total and subscale scores on the WAI-S for the total sample for Psychologist 2 (n=8)

<table>
<thead>
<tr>
<th>Median Total Score on WAI-S Maximum total=84 (range)</th>
<th>Median Bond Subscale Score Maximum total=28 (range)</th>
<th>Median Goal Subscale Score Maximum total=28 (range)</th>
<th>Median Task Subscale Score Maximum total=28 (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>72.00 (12.00)</td>
<td>24.50 (9.00)</td>
<td>22.00 (11.00)</td>
<td>24.50 (7.27)</td>
</tr>
</tbody>
</table>

The median total score of 72 out of 84, shown in table 1, is high which demonstrates that overall good working alliances are being formed. The median values for each subscale are similar which indicates that all three aspects of Bordin’s (1979) working alliance are equally strong. The ranges show that there is some variation between the views of the different clients.

Demographic Characteristics and Client-Psychologist Variable Combinations

Table 2: Median total and subscale scores on the WAI-S for the variables gender, age and ethnicity

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>Group</th>
<th>Median Total Score on WAI-S Maximum total=84</th>
<th>Median Bond Subscale Score Maximum total=28</th>
<th>Median Goal Subscale Score Maximum total=28</th>
<th>Median Task Subscale Score Maximum total=28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>66.37</td>
<td>22.50</td>
<td>22.00</td>
<td>21.87</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>73.00</td>
<td>25.00</td>
<td>23.00</td>
<td>26.00</td>
</tr>
<tr>
<td>Age</td>
<td>20-29</td>
<td>74.00</td>
<td>27.00</td>
<td>22.00</td>
<td>25.00</td>
</tr>
<tr>
<td></td>
<td>30-39</td>
<td>64.00</td>
<td>19.00</td>
<td>22.00</td>
<td>23.00</td>
</tr>
<tr>
<td></td>
<td>40-49</td>
<td>73.00</td>
<td>21.50</td>
<td>26.00</td>
<td>25.50</td>
</tr>
<tr>
<td></td>
<td>50-59</td>
<td>68.00</td>
<td>24.50</td>
<td>19.00</td>
<td>24.50</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White British</td>
<td>72.00</td>
<td>23.00</td>
<td>22.00</td>
<td>24.00</td>
</tr>
<tr>
<td></td>
<td>Any Other White</td>
<td>64.00</td>
<td>19.00</td>
<td>22.00</td>
<td>23.00</td>
</tr>
<tr>
<td></td>
<td>Any Other Background</td>
<td>75.00</td>
<td>27.50</td>
<td>21.50</td>
<td>26.00</td>
</tr>
</tbody>
</table>
Table 3: Median total and subscale scores on the WAI-S for the different client-pyschologist variable combinations

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th>Median Total Score on WAI-S</th>
<th>Median Bond Subscale Score</th>
<th>Median Goal Subscale Score</th>
<th>Median Task Subscale Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Maximum total=84</td>
<td>Maximum total=28</td>
<td>Maximum total=28</td>
<td>Maximum total=28</td>
</tr>
<tr>
<td>Gender of client and psychologist</td>
<td>Match</td>
<td>73.00</td>
<td>25.00</td>
<td>23.00</td>
<td>26.00</td>
</tr>
<tr>
<td></td>
<td>Not Match</td>
<td>66.37</td>
<td>22.50</td>
<td>22.00</td>
<td>21.87</td>
</tr>
<tr>
<td>Age of client and psychologist</td>
<td>Match</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Not Match</td>
<td>72.00</td>
<td>24.50</td>
<td>22.00</td>
<td>24.50</td>
</tr>
<tr>
<td>Ethnicity of client and psychologist</td>
<td>Match</td>
<td>72.00</td>
<td>23.00</td>
<td>22.00</td>
<td>24.00</td>
</tr>
<tr>
<td></td>
<td>Not Match</td>
<td>74.00</td>
<td>27.00</td>
<td>22.00</td>
<td>25.00</td>
</tr>
</tbody>
</table>

Table 2 shows that the females have tended to rate the working alliance higher than the males particularly on the bond and task subscales. This could be influenced by the psychologist being female and therefore there being a difference between the gender of the male clients and the psychologist (table 3).

The alliance rating fluctuates between age ranges (table 2). This fluctuation is most evident in the bond and goal subscales; the task subscale is rated consistently by clients of all ages represented. None of the clients matched the psychologist on age (table 3); therefore this does not appear to be an influence.

Table 3 shows that there is only a small difference between the total ratings from the clients who did and those who did not match the psychologist in ethnicity. However, those with a different ethnicity rated the bond as higher than those from the same ethnic background as the psychologist.
**Type of Presenting Problem**

Table 4: Median total and subscale scores on the WAI-S for the different types of presenting problems

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Median Total Score on WAI-S Maximum total=84</th>
<th>Median Bond Subscale Score Maximum total=28</th>
<th>Median Goal Subscale Score Maximum total=28</th>
<th>Median Task Subscale Score Maximum total=28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>69.00</td>
<td>20.50</td>
<td>24.50</td>
<td>24.00</td>
</tr>
<tr>
<td>Anxiety</td>
<td>72.00</td>
<td>28.00</td>
<td>16.00</td>
<td>28.00</td>
</tr>
<tr>
<td>Anxiety and DepressionSchizophrenia</td>
<td>66.37</td>
<td>22.50</td>
<td>22.00</td>
<td>21.87</td>
</tr>
<tr>
<td>Other</td>
<td>76.00</td>
<td>27.00</td>
<td>24.00</td>
<td>25.00</td>
</tr>
</tbody>
</table>

Table 4 shows that the clients with schizophrenia rated the relationship as less strong than the clients with other problems.

**Stage of Therapy**

Table 5: Median total and subscale scores on the WAI-S for the different stages of therapy

<table>
<thead>
<tr>
<th>Stage of Therapy</th>
<th>Median Total Score on WAI-S Maximum total=84</th>
<th>Median Bond Subscale Score Maximum total=28</th>
<th>Median Goal Subscale Score Maximum total=28</th>
<th>Median Task Subscale Score Maximum total=28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early (3-6 sessions)</td>
<td>72.00</td>
<td>21.00</td>
<td>24.00</td>
<td>24.00</td>
</tr>
<tr>
<td>Middle (7-14 sessions)</td>
<td>72.00</td>
<td>28.00</td>
<td>16.00</td>
<td>28.00</td>
</tr>
<tr>
<td>Late (15+ sessions)</td>
<td>71.37</td>
<td>27.00</td>
<td>20.50</td>
<td>23.87</td>
</tr>
</tbody>
</table>

Table 5 shows that overall the therapeutic relationship is rated consistently through the different stages of therapy. However, it suggests that the bond is perceived as stronger as therapy progresses and that in the later stages there is perhaps less agreement on the tasks, and to some extent the goals, of therapy.
INDIVIDUAL PSYCHOLOGISTS FEEDBACK FORM - Psychologist 3

Total Scores

Table 1: Median total and subscale scores on the WAI-S for the total sample for Psychologist 3 (n=10)

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>Group</th>
<th>Median Total Score on WAI-S Maximum total=84 (range)</th>
<th>Median Bond Subscale Score Maximum total=28 (range)</th>
<th>Median Goal Subscale Score Maximum total=28 (range)</th>
<th>Median Task Subscale Score Maximum total=28 (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>71.00 (46.61)</td>
<td>23.00 (14.74)</td>
<td>24.00 (15.87)</td>
<td>26.00 (16.00)</td>
</tr>
</tbody>
</table>

The median total score of 71 out of 84, shown in table 1, is high which demonstrates that overall good working alliances are being formed. The median values for each subscale indicate that all three aspects of Bordin's (1979) working alliance are strong and show that the ratings on the task subscale are particularly high. The range is large on all subscales showing that there is variation between the views of the different clients.

Demographic Characteristics and Client-Psychologist Variable Combinations

Table 2: Median total and subscale scores on the WAI-S for the variables gender, age and ethnicity

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>Group</th>
<th>Median Total Score on WAI-S Maximum total=84</th>
<th>Median Bond Subscale Score Maximum total=28</th>
<th>Median Goal Subscale Score Maximum total=28</th>
<th>Median Task Subscale Score Maximum total=28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>72.00</td>
<td>23.00</td>
<td>21.00</td>
<td>6.00</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>70.50</td>
<td>22.50</td>
<td>24.50</td>
<td>26.00</td>
</tr>
<tr>
<td>Age</td>
<td>20-29</td>
<td>70.00</td>
<td>19.00</td>
<td>25.00</td>
<td>26.00</td>
</tr>
<tr>
<td></td>
<td>30-39</td>
<td>73.00</td>
<td>23.00</td>
<td>24.00</td>
<td>26.00</td>
</tr>
<tr>
<td></td>
<td>40-49</td>
<td>72.00</td>
<td>24.00</td>
<td>21.00</td>
<td>27.00</td>
</tr>
<tr>
<td></td>
<td>50-59</td>
<td>68.09</td>
<td>23.09</td>
<td>21.00</td>
<td>24.00</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White British</td>
<td>71.00</td>
<td>23.00</td>
<td>24.00</td>
<td>26.00</td>
</tr>
<tr>
<td></td>
<td>Any Other White</td>
<td>68.50</td>
<td>21.00</td>
<td>21.50</td>
<td>26.00</td>
</tr>
</tbody>
</table>

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Table 3: Median total and subscale scores on the WAI-S for the different client-psychologist variable combinations

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th>Median Total Score on WAI-S</th>
<th>Median Bond Subscale Score</th>
<th>Median Goal Subscale Score</th>
<th>Median Task Subscale Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Maximum total=84</td>
<td>Maximum total=28</td>
<td>Maximum total=28</td>
<td>Maximum total=28</td>
</tr>
<tr>
<td>Gender of client and psychologist</td>
<td>Match</td>
<td>70.50</td>
<td>25.50</td>
<td>24.50</td>
<td>26.00</td>
</tr>
<tr>
<td></td>
<td>Not Match</td>
<td>72.00</td>
<td>23.00</td>
<td>21.00</td>
<td>26.00</td>
</tr>
<tr>
<td>Age of client and psychologist</td>
<td>Match</td>
<td>71.00</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Not Match</td>
<td>71.00</td>
<td>23.00</td>
<td>24.00</td>
<td>26.00</td>
</tr>
<tr>
<td>Ethnicity of client and psychologist</td>
<td>Match</td>
<td>70.00</td>
<td>19.00</td>
<td>25.00</td>
<td>26.00</td>
</tr>
<tr>
<td></td>
<td>Not Match</td>
<td>71.00</td>
<td>23.00</td>
<td>25.50</td>
<td>26.00</td>
</tr>
</tbody>
</table>

Table 2 shows that there is little difference in the overall rating of the alliance between males and females and therefore similarity or difference in gender between client and psychologist does not appear to have influenced the therapeutic relationship (table 3).

Clients in the younger (20-29 years) and older (50-59 years) age ranges rated the alliance as slightly lower than the clients in the middle age ranges (table 2). None of the clients matched the psychologist on age (table 3); therefore this does not appear to be an influence.

Clients who were not white British rated the alliance lower than those who were, particularly on the bond and goal subscales (table 2), and table 3 shows that it was the clients who matched the psychologist on ethnicity who gave lower ratings on the bond subscale.
Type of Presenting Problem

Table 4: Median total and subscale scores on the WAI-S for the different types of presenting problems

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Median Total Score on WAI-S Maximum total=84</th>
<th>Median Bond Subscale Score Maximum total=28</th>
<th>Median Goal Subscale Score Maximum total=28</th>
<th>Median Task Subscale Score Maximum total=28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>70.50</td>
<td>22.00</td>
<td>22.50</td>
<td>26.00</td>
</tr>
<tr>
<td>Anxiety</td>
<td>83.00</td>
<td>27.00</td>
<td>28.00</td>
<td>28.00</td>
</tr>
<tr>
<td>Anxiety and Depression</td>
<td>73.00</td>
<td>21.00</td>
<td>26.00</td>
<td>26.00</td>
</tr>
<tr>
<td>Schizophrenia/other</td>
<td>71.00</td>
<td>22.00</td>
<td>25.00</td>
<td>24.00</td>
</tr>
<tr>
<td>Personality Disorder /Other</td>
<td>51.00</td>
<td>18.13</td>
<td>16.57</td>
<td>17.00</td>
</tr>
</tbody>
</table>

Table 4 shows that clients with anxiety gave the highest rating and clients with personality disorder gave the lowest rating on the WAI-S.

Stage of Therapy

Table 5: Median total and subscale scores on the WAI-S for the different stages of therapy

<table>
<thead>
<tr>
<th>Stage of Therapy</th>
<th>Median Total Score on WAI-S Maximum total=84</th>
<th>Median Bond Subscale Score Maximum total=28</th>
<th>Median Goal Subscale Score Maximum total=28</th>
<th>Median Task Subscale Score Maximum total=28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early (3-6 sessions)</td>
<td>70.50</td>
<td>20.00</td>
<td>24.50</td>
<td>26.00</td>
</tr>
<tr>
<td>Middle (7-14 sessions)</td>
<td>71.00</td>
<td>23.09</td>
<td>21.00</td>
<td>24.00</td>
</tr>
<tr>
<td>Late (15+ sessions)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Completed</td>
<td>75.50</td>
<td>25.50</td>
<td>23.00</td>
<td>27.00</td>
</tr>
</tbody>
</table>

Table 5 shows that the lowest rating of the alliance is given by clients in the early stages of therapy and the highest rating by those who have completed therapy.
Total Scores

Table 1: Median total and subscale scores on the WAI-S for the total sample for Psychologist 4 (n=6)

<table>
<thead>
<tr>
<th>Median Total Score on WAI-S Maximum total=84 (range)</th>
<th>Median Bond Subscale Score Maximum total=28 (range)</th>
<th>Median Goal Subscale Score Maximum total=28 (range)</th>
<th>Median Task Subscale Score Maximum total=28 (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>71.46 (19.82)</td>
<td>21.46 (9.82)</td>
<td>25.00 (4.00)</td>
<td>24.00 (9.00)</td>
</tr>
</tbody>
</table>

The median total score of 71.46 out of 84, shown in table 1, is high which demonstrates that overall good working alliances are being formed. Table 1 also shows that the ratings for the goal and task aspects of the working alliance are higher than those for the bond aspect. The ranges show that there is some variation between the views of the different clients.

Demographic Characteristics and Client-Psychologist Variable Combinations

Table 2: Median total and subscale scores on the WAI-S for the variables age and ethnicity and for the different client-psychologist variable combinations

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th>Median Total Score on WAI-S Maximum total=84</th>
<th>Median Bond Subscale Score Maximum total=28</th>
<th>Median Goal Subscale Score Maximum total=28</th>
<th>Median Task Subscale Score Maximum total=28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>20-29</td>
<td>72.41</td>
<td>20.91</td>
<td>26.50</td>
<td>25.00</td>
</tr>
<tr>
<td></td>
<td>30-39</td>
<td>68.30</td>
<td>20.33</td>
<td>24.67</td>
<td>23.00</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White British</td>
<td>71.46</td>
<td>21.46</td>
<td>25.00</td>
<td>25.00</td>
</tr>
<tr>
<td></td>
<td>Any Other Background</td>
<td>68.00</td>
<td>20.00</td>
<td>25.00</td>
<td>23.00</td>
</tr>
<tr>
<td>Age of client and psychologist</td>
<td>Match</td>
<td>71.46</td>
<td>21.46</td>
<td>25.00</td>
<td>25.00</td>
</tr>
<tr>
<td></td>
<td>Not Match</td>
<td>68.00</td>
<td>21.50</td>
<td>25.00</td>
<td>23.00</td>
</tr>
<tr>
<td>Ethnicity of client and psychologist</td>
<td>Match</td>
<td>71.46</td>
<td>21.46</td>
<td>25.00</td>
<td>25.00</td>
</tr>
<tr>
<td></td>
<td>Not Match</td>
<td>68.00</td>
<td>20.00</td>
<td>25.00</td>
<td>23.00</td>
</tr>
</tbody>
</table>
Table 2 shows that those in the younger age range and those who are white British have rated the alliance the highest and that client and psychologist matching in age and ethnicity could be an influence on these ratings.

**Stage of Therapy**

**Table 3: Median total and subscale scores on the WAI-S for the different stages of therapy**

<table>
<thead>
<tr>
<th>Stage of Therapy</th>
<th>Median Total Score on WAI-S (Maximum total=84)</th>
<th>Median Bond Subscale Score (Maximum total=28)</th>
<th>Median Goal Subscale Score (Maximum total=28)</th>
<th>Median Task Subscale Score (Maximum total=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early (3-6 sessions)</td>
<td>72.00</td>
<td>22.91</td>
<td>25.00</td>
<td>24.00</td>
</tr>
<tr>
<td>Middle (7-14 sessions)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Late (15+ sessions)</td>
<td>62.50</td>
<td>17.50</td>
<td>24.50</td>
<td>20.50</td>
</tr>
</tbody>
</table>

Table 3 shows that clients in the early stages of therapy have rated the alliance higher than those in the later stages, particularly on the bond and task subscales.
Appendix 9: Service Acknowledgement of Feedback

Alison Christie
5 Haven Court
Berrylands
Sutton
Surrey KT5 8JF

Dear Alison

I am writing to thank you for coming to the adult mental health meeting this afternoon to present the results of the audit on patient’s perception of alliance with their psychologist. It was interesting and informative and very clearly presented. We hope that the results will be used in our appraisals this year.

With best wishes

Yours sincerely

Chartered Clinical Psychologist
Insight into mental illness and its relationship to clinical variables
in forensic patients with schizophrenia

July 2006

Year 3
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</tr>
<tr>
<td><strong>Mood</strong></td>
<td>221</td>
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<tr>
<td><strong>Cognitive functioning</strong></td>
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<td><strong>Understanding of cognitive functioning</strong></td>
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</tr>
<tr>
<td><strong>Insight and demographic variables</strong></td>
<td>226</td>
</tr>
<tr>
<td><strong>Insight and psychopathology</strong></td>
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</tr>
<tr>
<td><strong>Insight and mood</strong></td>
<td>227</td>
</tr>
<tr>
<td><strong>Insight and cognitive functioning</strong></td>
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</tr>
<tr>
<td><strong>Insight and understanding of cognitive functioning</strong></td>
<td>229</td>
</tr>
<tr>
<td><strong>Summary</strong></td>
<td>231</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td>232</td>
</tr>
<tr>
<td>The relationships between insight and clinical variables</td>
<td>232</td>
</tr>
<tr>
<td><strong>Insight and psychopathology</strong></td>
<td>232</td>
</tr>
<tr>
<td><strong>Insight and mood</strong></td>
<td>234</td>
</tr>
<tr>
<td><strong>Insight and cognitive functioning</strong></td>
<td>237</td>
</tr>
<tr>
<td><strong>Insight and understanding of cognitive functioning</strong></td>
<td>239</td>
</tr>
<tr>
<td>Study limitations</td>
<td>240</td>
</tr>
<tr>
<td>Conclusions and implications for practice</td>
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</tr>
<tr>
<td>What were the clinical correlates of insight?</td>
<td>241</td>
</tr>
<tr>
<td>Were there differential relationships between the components of insight and the clinical variables?</td>
<td>243</td>
</tr>
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<td>Further implications and future directions</td>
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<td>244</td>
</tr>
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<td>The utility of the concept of insight: the importance of clinical state</td>
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</tr>
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<td>247</td>
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<tr>
<td>References</td>
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</tr>
<tr>
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</tr>
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<td>Appendix 3: Summary of studies investigating the relationship between insight and cognitive functioning</td>
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</tr>
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</tr>
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</tr>
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</table>
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Appendix 18: Mean percentage scores on the SAI-E compared with mean percentage insight scores from samples from published studies
Appendix 19: Descriptive and inferential statistics for Positive and Negative Syndrome Scale scores between the two raters
ABSTRACT

This research aimed to develop the understanding of the concept of insight in forensic patients with schizophrenia by considering how insight relates to other clinical variables (psychopathology, mood, cognitive functioning and understanding of cognitive functioning), given the frequent consideration of insight in everyday clinical and risk decision-making and in legal discharge proceedings. This was a cross-sectional study with a correlational design and was conducted at a high-security mental health hospital. There were 29 participants. All participants were patients in the hospital, had a DSM-IV diagnosis of schizophrenia and a history of violent behaviour. Insight was assessed using the Schedule for the Assessment of Insight-Expanded Version (Kemp & David, 1997). Greater awareness of the need for treatment was associated with lower levels of positive symptomatology and general psychopathology, and greater recognition of mental illness and ability to relabel psychotic phenomena as signs of illness were associated with higher anxiety. Insight was not related to negative symptomatology, depression or cognitive functioning. The different aspects of insight appeared to have different aetiologies, and there appeared to be a dissociation between awareness of the need for treatment and the other two aspects of insight; however no aspect of insight was adequately explained by clinical factors. Consideration is given to the limitations of the study that restrict generalisation of the findings, for example, the small sample size and the relative clinical stability of the sample, and finally the implication of the results for the utility of the concept of insight in a forensic setting.
ACKNOWLEDGEMENTS

I would like to thank all the participants who agreed to take part in this research project. I am extremely grateful as the project would simply not have been possible without their agreement to give their time and patience. I would also like to thank all the RMOs and clinical staff at Broadmoor Hospital for their time and help and I would especially like to thank Dr Tina Irani and Dr Fernanda Garcia for completing the assessments of psychopathology, again the project would not have been possible without their collaboration.

Thank you also to my field supervisor Dr Mary Hill, Consultant Clinical Psychologist, and Dr Vicky Senior, my university supervisor, for all their help and support. I have really appreciated and valued their input.

Thank you.
INTRODUCTION

1.0 OVERVIEW OF INTRODUCTION
In forensic settings, insight into mental illness is frequently considered in everyday clinical and risk decision-making and in legal discharge proceedings, but despite the use of the concept at a clinical level there is actually a surprising paucity of research that has examined this concept in forensic populations. The aim of this research is to develop the understanding of the concept of insight in forensic patients with schizophrenia by considering how insight relates to other clinical variables in this population. This introduction firstly considers schizophrenia, violence and insight, in broad terms, and provides a definition of the concept of insight. Then research that has studied insight in people with schizophrenia who have committed acts of violence is considered and the reasons for exploring the concept of insight in this population are presented. The introduction then moves to discuss and review studies that have investigated the aetiology of insight in people with schizophrenia without a history of violence, and finally, the research, ideas and concepts appraised throughout the introduction are integrated to inform the research questions and hypotheses.

2.0 SCHIZOPHRENIA AND VIOLENCE

2.1 Prevalence and diagnostic characteristics of schizophrenia
The lifetime prevalence rate of receiving a diagnosis of schizophrenia is approximately 1% (one person in one hundred). At any one time in the United Kingdom there are likely to be between 100,000 and 500,000 people with a diagnosis of schizophrenia (British Psychological Society, 2000).

Schizophrenia is one of a number of psychotic disorders and has characteristic signs and symptoms, broadly divided into positive and negative symptoms. Positive symptoms are additional to normal functioning and include distortions or exaggerations of beliefs and experiences (delusions; e.g. persecutory, religious, grandiose), perceptions (hallucinations; e.g. auditory, visual, olfactory), language and communication (disorganised speech) and
behaviour (grossly disorganised or catatonic behaviour). Negative symptoms reflect a loss or reduction in normal functioning and include a reduction in emotional expression, fluency of thought and speech, and initiation of behaviour (American Psychiatric Association (APA), 1994). Schizophrenia can also be divided into subtypes: paranoid, disorganised, catatonic, undifferentiated and residual types (APA, 1994) (full diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) are shown in appendix 1).

2.2 Prevalence of violence in people with schizophrenia

Epidemiological research over the last two decades has shown that people with mental illness, particularly those suffering from schizophrenia, do present with an increased risk of committing violence towards others (Angermeyer, 1998). Swanson et al. (1990) looked at the prevalence of schizophrenia and violence among community samples and found that people with schizophrenia had a four-fold increase in violence risk. Wessely et al. (1994) assessed the prevalence of violence (criminal convictions) among incident cases of schizophrenia (n=538) and a representative sample of people with other non-psychotic mental disorders, in the London Borough of Camberwell between 1964 and 1984. Women with schizophrenia had an increased likelihood of being convicted of a criminal offence (3.3 rate ratio) and men with schizophrenia were more likely to be convicted of a violent offence (3.8 rate ratio). Psychotic mental disorder is an independent risk factor for violent behaviour, however it is important to place this in context and highlight that it is a weaker contributor to risk than, for example, age, gender, substance abuse and antisocial personality disorder (Angermeyer, 1998; Eronen et al., 1998) and the actual proportion of community violence attributable to people with schizophrenia is very small (Walsh et al., 2002). Swanson et al. (1990) found people with schizophrenia committed only 3% of societal violence.

With these caveats in place it is possible to reiterate that schizophrenia is a risk factor for violence and this violence does have important societal and clinical implications (Krakowski, 2005). It is therefore important to understand what clinical factors increase the risk of violence in people with schizophrenia (Arango et al., 1999; Yen et al., 2002).
2.3 Clinical factors associated with violence in people with schizophrenia

Eronen et al. (1998) highlight that the presence of a psychotic disorder leads to a greater risk of violence, than the presence of a non-psychotic disorder, raising the possibility that the clinical features of schizophrenia are important in leading people to commit violent acts, and research has supported an association between violence and positive symptoms (Angermeyer, 2000; Cheung et al., 1997; Krakowski, 2005; Link et al., 1998; Swanson et al., 1990; Taylor, 1998). However, it is not entirely clear which specific symptoms are risk factors for violence (Cheung et al., 1997) and why some individuals with the same symptoms are violent and others are not (Heads et al., 1997). Taylor (1998) highlights that there is likely to be an interrelationship between symptoms and other factors. Three other main factors discussed within the literature are substance misuse (Angermeyer, 2000; Foley et al., 2005; Swanson et al., 1990; Swartz et al., 1998; Walsh et al., 2002), neurological impairment (Brower & Price, 2001; Golden et al., 1996; Krakowski, 2005; Morgan & Lilienfeld, 2000; Spaletta et al., 2001), and lack of insight into mental illness (Arango et al., 1999; Krakowski 2005; Torrey, 2004). It is the last factor that is expanded upon here.

To provide a context, the concept and assessment of insight in schizophrenia in general is first considered and then the specific research investigating insight and violence is reviewed.

3.0 INSIGHT INTO MENTAL ILLNESS IN SCHIZOPHRENIA

3.1 Prevalence of lack of insight in schizophrenia

Lack of insight is considered a salient feature of schizophrenia. For example an International Pilot Study of Schizophrenia conducted by the World Health Organisation observed that 97% of people with schizophrenia believed that they did not have a mental illness (as cited in Kim et al., 1997). Amador et al. (1994) examined awareness of illness in 412 people with either schizophrenia, schizoaffective disorder or major depression and found nearly 60% of those with schizophrenia showed a moderate to severe lack of insight
and had more severe and pervasive self-awareness deficits than people with other diagnoses.

### 3.2 Definition and characteristics of insight

Much of the research into insight has been conducted over the last 20 years and over that time conceptualisations and operational definitions of insight have changed, becoming more sophisticated (Mintz et al., 2003). Insight is currently conceptualised as a complex, multidimensional construct rather than an all-or-nothing phenomenon or unitary concept. The implication is that people can vary in their level of insight and differ in their insight into different (but overlapping) aspects of mental illness (Amador & Kronengold, 2004; Mintz et al., 2003).

David in 1990 proposed that insight composed i) awareness of illness, ii) capacity to relabel psychotic experiences as abnormal, and iii) awareness of the need for treatment. Amador et al. (1993) conceptualised that insight includes i) awareness of having a mental disorder, ii) awareness of specific signs and symptoms, iii) attributions of the symptoms to the disorder, iv) understanding of the social consequences of the disorder, and v) awareness of the need for treatment. The definition by David (1990) is used in this study for largely pragmatic reasons; this is explained in more detail in the method (section 3.1.3).

The need to distinguish different aspects of insight has been emphasised because, for example, people may be aware of symptoms but not attribute the cause of these to mental illness but rather to, for example, supernatural influences or physical illness (Johnson & Orrell, 1995). Similarly, awareness of the presence of mental illness does not inevitably lead to the acceptance of treatment; acceptance of treatment is not necessarily associated with the awareness of illness (Kemp & David, 1997); and acceptance of the need for treatment does not automatically lead to actual compliance. A number of steps and influences occur from awareness, through attribution, to action (David, 2004). It is
considered most meaningful to consider the components of insight as well as overall insight into mental illness\(^1\) (David, 2004).

### 3.3 Assessment of insight

There is a wide range of standardised instruments designed to measure insight (Amador & Seckinger, 1997; Sanz et al., 1998). There are researcher-rated (Schedule for the Assessment of Insight, SAI, David, 1990; Scale to Assess Unawareness of Mental Disorder, SUMD, Amador et al., 1993; Insight and Treatment Attitudes Questionnaire, ITAQ, McEvoy et al., 1981) and self-report insight scales (Insight Scale, Birchwood et al., 1994; Self-Appraisal of Illness Questionnaire, Marks et al., 2000). Some assess insight as a multidimensional construct (SAI and SUMD) and others as a unitary construct (the Positive and Negative Syndrome Scale (PANSS) Insight Item, Kay et al., 1988; ITAQ). Overall, the various instruments do measure similar constructs (Sanz et al., 1998).

The most contemporary, reliable and widely used method for assessing insight is via the use of a standardised, semi-structured interview that scores responses according to a systematic rating system (Swartz, 1998). Two instruments utilise this method and enable insight to be assessed as a multidimensional, continuous (and not dichotomous) construct; these are the SAI (David, 1990) and its expanded version (SAI-E; Kemp & David, 1997) and the SUMD (Amador et al., 1993). Acceptable levels of reliability and validity of these scales have been reported (Amador et al., 1993; David, 1990; David et al., 1992; Sanz et al., 1998).

It is crucial to recognise that in order to judge and measure, for example, awareness of a mental disorder or awareness of specific signs and symptoms, decisions on what a ‘mental disorder’ is or what constitutes a ‘symptom’ are made and these decisions will incorporate biases based on social, cultural and theoretical constructions of mental illness. Kirmayer et al. (2004, p.206) argue:

> ..who or what authority...establishes standards or criteria? The “correct” attitude toward an illness depends on changing medical concepts of

\(^1\) The term ‘insight’ is used throughout to refer to the overall concept of insight into mental illness. The term ‘awareness of mental illness’ is used to refer to one component of insight.
illness...insight then is manifested by specific attitudes and attributions that are contingent on changing knowledge and practice.

It is important to acknowledge that the concept of schizophrenia is contested within the literature. Bentall (1993) challenges the concept of schizophrenia because its presence assumes that psychotic disorders can be usefully divided into categories (like ‘schizophrenia’), it encourages a focus on a ‘syndrome’ rather than individual psychotic experiences (Bentall advocates a ‘symptom-orientated approach’), and fails to acknowledge that psychotic experiences are on a continuum with normal experiences and thus can be understood in terms of ordinary psychological processes; and these criticisms are supported by others (for example, Garety et al., 2001). It is therefore important to highlight that the definitions of insight presented are current Western medical definitions and contain assumptions about the nature of mental illness (and more specifically the nature of schizophrenia) that are based on the current Western medical, professional framework (that which is reflected in the DSM-IV, APA, 1994) which is challenged within the psychological literature. The definitions of insight do not reflect other broader (Frese, 2004) or more socially (Kirmayer et al., 2004) or psychoanalytically based conceptualisations of insight. The rationale for this is made clear through the course of the introduction.

4.0 (LACK OF) INSIGHT IN PEOPLE WITH SCHIZOPHRENIA WHO ARE VIOLENT
Torrey (2004) states that:

"...accumulating evidence clearly indicates that impaired insight and medication noncompliance are important contributors to violent behaviour committed by individuals with severe psychiatric disorders (p.250)."

and that:
two of the most important consequences of impaired insight are increased violent behaviour by some individuals with severe psychiatric disorders and its inevitable sequel, increased stigma against all individuals with psychiatric illness (p.243).

In support of the idea that insight is important to violence, insight is often considered by clinicians in the assessment of risk. For example, the Historical Clinical Risk Management Guide (HCR-20; Webster et al., 1997) a frequently used, structured clinical approach to assessing static and dynamic risk factors for violence includes insight as one of the ‘clinical’ factors, and a study that looked at clinical decision-making found that clinicians emphasised lack of insight as one of five factors important in violence risk assessment (Sturidsson et al., 2004). Diesfeld (2003) also highlights that, in the face of uncertainty about risk, lack of insight is commonly presented in Mental Health Review Tribunals as an extra-legislative rationale for the continued compulsory care of people detained under mental health legislation. Several authors have reasonably postulated that lack of insight may be important in leading to violence because as psychotic symptoms are associated with violence it seems logical to suggest that poorer insight into these symptoms would exacerbate this relationship. In addition, individuals may be more likely to act upon delusions and hallucinations that they perceive are based in reality (Arango et al., 1999) or lack of insight could make an individual more likely to misinterpret malevolence in other people’s motivations and actions (Krakowski, 2005). Lack of insight could also increase the risk of violence indirectly through noncompliance with treatment (Arango et al., 1999; Krakowski, 2005; Torrey, 2004) because poorer insight has been shown to be associated with poorer treatment adherence (Lacro et al., 2002; MacPhearson et al., 1996; McEvoy, 2004) and poorer adherence has been related to violence (Swartz et al., 1998) because it increases the risk of relapse (Arango et al., 1999; Torrey, 2004).

However, while insight as a predictor is receiving increased attention there is actually a surprising paucity of research in this area. Carroll et al. (2004) highlight that Torrey (2004) is mainly hypothesising that people with schizophrenia who are violent are ‘a subgroup characterised by poor insight, poor compliance, neuropsychological deficits, and substance abuse’ (Carroll et al., 2004, p.170). There is little research that has examined
the relationship between insight and violence if one contrasts this with the amount of
literature on insight in general, and scarcely any research that has examined insight in
forensic patients with schizophrenia who have committed serious criminal offences; there
have only been three very recent studies (Buckley et al., 2004; Carroll et al., 2004;
Goodman et al., 2005), conducted in the United States of America, Australia and Israel
respectively.

Two areas of research need to be considered: i) research investigating the relationship
between insight and violence in people with a psychotic mental illness, and ii) research
considering insight in forensic patients with a psychotic mental illness where ‘forensic
patients’ are defined in this research as ‘people who have committed a criminal offence
and are patients in a secure mental health facility because they are thought to present
sufficient risk to others to require compulsory detention’.

4.1 The relationship between insight and violence – findings from studies with
community samples
In 1999, Arango et al. conducted a prospective study to assess which factors predicted
violence in 63 inpatients with schizophrenia or schizoaffective disorder. They found that
those who were violent, compared with those who were not violent, demonstrated
significantly less insight (on the SUMD) into their delusions and a trend towards
significantly less insight into their hallucinations. The authors also found that the violent
patients continued to have poorer insight at discharge, despite other clinical improvement.
Furthermore, the factor that was the best single predictor of violence (correctly classifying
79.4% of patients as violent or not violent), the best at correctly classifying patients as
high or low risk, and the best at accurately predicting the likelihood of violence in
identified high risk patients, was insight. Arango et al. (1999) were the first to show that
poor insight is a predictor of violence and concluded that:

..the fact that violence in patients with schizophrenia...is correlated with
certain symptoms and a concomitant lack of insight into them poses the
interesting possibility that violence is not the direct result of the
pathophysiological process of these disorders (p.499).
That is, it is the lack of insight into the symptoms, not just the symptoms, that predicts violence. However, during their study only 16 patients committed violence, 47 did not. Foley et al. (2005) examined correlates of aggression and violence in 157 individuals with first episode psychosis (not exclusively schizophrenia) and found lack of insight was associated with increased violence but that this relationship was limited to violence occurring after inpatient admission.

Yen et al. (2002), in a one-year prospective study, investigated insight (using the SAI-E) and violence in 74 people with schizophrenia in remission but failed to demonstrate the value of poor insight as a predictor of future violence. They hypothesise that the difference between their and Arango et al.'s (1999) findings may be because, in contrast to Arango et al.'s sample, the individuals in their study were not involuntarily admitted to hospital; and admission status has been shown to be related to insight (see 5.1: David et al., 1992; Sanz et al., 1998).

4.2 Insight in forensic patients with schizophrenia
Carroll et al. (2004) were one of the first to quantify level of insight in individuals with schizophrenia who were, or had been, detained in a high-security hospital. In a sample of 28 forensic patients, with a mean duration of illness of 12.4 years and a mean time elapsed since index offence of 97.6 months, insight (on the SAI) was no different to previously published levels of insight in general psychiatric patients with schizophrenia and there was no difference in level of insight in patients with, and those without, a history of violence prior to their index offence. The authors highlight that such findings are 'at odds with the notion that violence in psychosis is largely attributable to a particularly insightless subgroup of patients' (p.171) and that 'the notion of insight as predictive in forensic patients is likely to appeal to courts and tribunals and has intuitive appeal, but lacks empirical basis' (p.172). However the authors are tentative with their conclusions because of methodological reasons, such as the small sample size and fact that their participants were assessed some time after their index offences. Since then Buckley et al. (2004) have found support for the assertions that poor insight is more pronounced in the subgroup of individuals who are violent. They assessed individuals with schizophrenia or
schizoaffective disorder and compared 115 with a history of violence, and currently in jail or in a court psychiatric clinic, with 111 individuals living in the community with no history of violence. No details on time elapsed since the offence are given. They found the violent individuals had more marked deficits in insight (on the SUMD) compared with the non-violent individuals. In addition, in 2005, Goodman et al. assessed 35 forensic patients and found poorer insight (on the SUMD) correlated with a greater number of previously recorded violent incidents. Unfortunately little further detail on their sample is provided.

4.3 Conclusions on research into insight, schizophrenia and violence
Despite the prevalent consideration of insight in clinical and risk decision-making, both in everyday practice and in legal discharge proceedings, insight in individuals with schizophrenia who are violent is underresearched (Buckley et al., 2004). The body of research in this area remains small because researchers are often deterred by the difficulties inherent in accessing, obtaining informed consent and conducting rigorous research with this population (Buckley et al., 2004; Taylor et al., 1998; Torrey, 1994). In addition, the specific nature of the group of interest (individuals with schizophrenia and a history of violence) means that the number of potential participants is necessarily small (Carroll et al., 2004; Taylor et al., 1998). More research is undoubtedly needed if there is to be an advancement in the understanding of this concept of 'insight into mental illness' as it is currently employed in practice in a forensic setting.

So what is known about insight from studies of individuals with schizophrenia living in the community that could inform the direction of research into insight in forensic patients with schizophrenia?

5.0 THE AETIOLOGY OF INSIGHT – FINDINGS FROM STUDIES WITH COMMUNITY SAMPLES
The vast majority of research has been dedicated to investigating the aetiology of insight by analysing its clinical correlates, and over the years three main theories have emerged; the lack of insight as: 1) directly related to the psychopathology of schizophrenia and thus
intimately linked with other symptoms; 2) a defence mechanism, conceptualised either within a psychodynamic framework or a cognitive model of coping with and attributions about illness; 3) a result of neuropsychological deficits (Carroll et al., 1999).

5.1 Poor insight as a form of psychopathology: the relationship of insight to symptoms of schizophrenia (see appendix 2)

An important question is: does insight increase as symptoms improve? Unfortunately, research examining correlations between insight and symptoms demonstrate that these are complex, far from straightforward, relationships.

Studies investigating the relationship between insight and positive symptoms have generally found modest inverse correlations (Collins et al., 1997; Kim et al., 1997; Rossell et al., 2003; Smith et al., 2000). For example Amador et al. (1994) found that symptoms of delusions, thought disorder and disorganised behaviour were modestly associated with poorer awareness of mental disorder and social consequences, and this was supported by Sevy et al. (2004), who demonstrated an inverse relationship between positive symptoms and awareness of mental illness, symptoms and social consequences. Carroll et al. (1999) studied patients at discharge from hospital or day care and found a correlation at baseline, but at 12 weeks, an improvement in insight was not related to change in positive symptoms. Other studies have failed to find any relationships (Nakano et al., 2004; Smith et al., 1998). It is important to consider severity of illness as a moderator of the relationship. Mintz et al. (2003), in their meta-analysis of 40 published papers, discovered 88.1% of the variance in the relationship between insight and positive symptoms was accounted for by the percentage of acutely ill individuals in the study samples; that is, in samples of stable patients, the relationship between positive symptoms and insight appeared weaker, and may, for example, explain the lack of relationship found in Nakano et al.’s (2004) study (Nakano et al., 2004). However, other studies have revealed that insight does not always improve as symptoms resolve (Carroll et al., 1999; McEvoy et al., 1989), thus the poor insight found in individuals who are not actively psychotic needs a different explanation (Carroll et al., 1999).
Fewer studies have looked at how insight relates to the presence of negative symptoms (Mintz et al., 2003). Amador et al. (1994) found that negative symptoms were not significantly correlated with insight in schizophrenia, a finding supported in other research (Kim et al., 1997; Smith et al., 1998). Yet others have found negative symptoms to have a modest inverse correlation with insight (Nakano et al., 2004; Rossell et al., 2003; Smith et al., 2000). Nakano et al. (2004), in their study of 37 inpatients with chronic schizophrenia, found fewer negative symptoms were significantly correlated with greater overall insight, awareness of illness and need for treatment, although there was no association of negative symptoms with the aspect of insight – ability to relabel psychotic phenomena as signs of mental illness. Collins et al. (1997) found that although there were modest correlations between insight and negative symptoms, only positive symptoms predicted insight in a multiple regression analysis.

It is apparent throughout the research that there are divergent and inconsistent findings. Unfortunately it is very difficult to compare studies because of cohort and methodological differences; for example differences in the operational definition of insight and the differential study of hospitalised and outpatients, and stable and acutely ill patients. Smith et al. (1998) argue that insight may be fundamentally different in hospitalised (particularly involuntary) patients compared with outpatients because issues around medication compliance are substantially different. In addition, messages promoting the medical model of schizophrenia could be considered to be more prominent in a hospital setting. Smith et al. (1998) suggest that people in hospital are therefore more likely to have greater insight into their mental illness, however, hospitalised patients could be considered to be more acutely ill and, as previously mentioned, the presence of acute positive symptoms has been found to be related to decreased insight (Mintz et al., 2003). Therefore there is an argument that hospitalised patients may have poorer insight, particularly those with an involuntary admission; for example Weiler et al. (2000) found a strong relationship between involuntary hospitalisation and poor insight, and both Sanz et al. (1998) and David et al. (1992) have found voluntary patients to have greater insight compared with those who had been hospitalised involuntarily (even when controlling for severity of illness).
Methodological problems also limit the research findings (Mintz et al., 2003). For example, in some studies the same interviewer has rated both insight and symptoms, therefore the heuristic that 'sicker patients have worse insight' could bias the results (Amador et al., 1994; Sevy et al., 2004).

Overall, it appears insight is related to psychopathology to some degree, thus is influenced by clinical state, however correlations are moderate and Mintz et al. (2003) demonstrated that only 3% to 7% of the variance in insight could be accounted for by severity of symptoms. These findings suggest insight must be regarded as more than just another manifestation of psychopathology (Amador & Kronengold, 2004; David, 2004).

5.2 Poor insight as a psychological defence mechanism
This conceptualisation of insight suggests that at some level individuals are aware of their illness but that there is denial of the illness to preserve self-esteem (Startup, 1996); that is, lack of insight can be seen as a protective cognitive strategy (Mintz et al., 2003). It is reasonable to suggest, as a number of researchers do (Beck-Sander, 1998; Johnson & Orrell, 1995), that it is the stigma attached to mental illness that prevents the acknowledgement of mental illness as people try to preserve a positive self-concept and social identity. These ideas gain some support from research that demonstrates a relationship between insight and depression (see appendix 2) with the vast majority of studies finding that individuals with greater insight have higher levels of depression (Amador et al., 1994; Carroll et al., 1999; Iqbal et al., 2000; Mintz et al., 2003; Moore et al., 1999; Rathod et al., 2005; Sanz et al., 1998; Schwartz, 2001; Smith et al., 1998; Smith et al., 2000). There were only two studies from those reviewed that found an inverse relationship between insight and depression (Buckley et al., 2001; Collins et al., 1997) and both have limitations; Buckley et al. (2001) did not use a standardised measure of depression and two-thirds of Collins et al.'s sample (1997) were rated as not depressed or minimally depressed which is likely to have influenced their findings (Smith et al., 2000). Therefore there does appear to be a relationship between depression and insight, but the research is less clear on the direction of causality in this relationship.
Those who view poor insight as a psychological defence mechanism would argue that it is an increase in insight that leads to increased depression. It is reasonable to hypothesise that self-awareness into one's illness and its potential consequences of functional limitations, limited future potential and stigmatisation, could cause a sense of loss, demoralisation and helplessness, leading to low self-esteem and feelings of depression (Rathod et al., 2005; Schwartz, 2001). In fact Moore et al. (1999) found higher levels of depression were related particularly to greater awareness of the social consequences of having a mental illness, and Lysaker et al. (2003), who studied insight and coping styles, found that the individuals who showed least insight into the consequences of having a mental illness were those who demonstrated an escape-avoidance coping style. Carroll et al. (1999) argue that the psychodynamic concept of 'denial' is not required to explain these relationships; it could merely be that, prior to developing a mental illness, patients are not aware of the medical explanation for their experiences and its implied long-term morbidity. Once they are, they became depressed about it.

In 2000, Iqbal et al. conducted a study, which shed important light on the processes that link insight and depression. They studied 105 individuals following an acute episode of psychosis and evaluated insight, depression and appraisals of psychosis (beliefs about psychosis and its implications for self) over 12 months. What is interesting, is that in the pre-depression stage, there was no difference in insight between the individuals who later developed depression and those who did not, but later when they became depressed, those with post-psychotic depression reported greater insight into awareness of illness, labelling of symptoms and need for treatment, compared with those who did not develop depression. Increases in insight did not precede the development of low mood, what did were particular appraisals of psychosis: stronger perceptions of humiliation and loss of social rank, perceived decreases in autonomy and valued roles, stronger beliefs that the cause of psychosis should be attributed to self rather than an externalised illness, and greater feelings of entrapment (by their illness). As David (2004) highlights, it is conceivable that lowered mood leads to a more self-critical attitude that may bring about greater insight through a more realistic appraisal of the world, rather than vice versa.
The predominant focus of the relationship between affective experiences and insight has been between insight and depression. A recent study (Freudenreich et al., 2004) however also considered the association between anxiety and insight in 122 outpatients with schizophrenia and found that while depression and anxiety were significantly related to unawareness of symptoms (on the SUMD), it was anxiety and not depression that was the significant predictor in a multiple regression analysis. Smith et al. (1998) found greater anxiety to be associated with greater past awareness of symptoms.

In conclusion, a psychological process of defence as an explanation of poor insight, at least as evidenced by a relationship between insight and depression, does not appear to be satisfactorily supported by research that has investigated causal processes. However, in any investigation of insight, depression and possibly anxiety appear important clinical variables for consideration.

5.3 Poor insight as a neuropsychological deficit (see appendix 3)
Amador et al. in 1991 noted that there were similarities between poor insight and anosognosia, the unawareness of illness in individuals with neurological disorders, and hypothesised that lack of insight in psychotic disorders may result from a neuropsychological deficit. Since then a substantial body of research that considers poor insight as arising from neurocognitive deficits has developed, with the majority focusing on the hypothesis that lack of insight in schizophrenia results, at least in part, from neurocognitive deficits in the frontal regions of the brain. There are three main reasons for this focus:

Firstly, neuroimaging studies with healthy samples have demonstrated that the frontal lobes are involved in processes that can be considered aspects of self-awareness, for example:

1. Self-evaluation, ‘the ability to think about and make judgements regarding one’s own cognitive, personality, physical, and emotional characteristics’ (Flashman & Roth, 2004, p. 163) and;
2. Self-monitoring, 'the capacity to accurately monitor one’s ongoing thoughts, emotions and behaviours...and ensure that they are attributed to oneself and not to an external agent' (Flashman & Roth, 2004, p.165).

Secondly, as Laroi et al. (2004) discuss, frontal lobe damage is known to lead to disorders in self-awareness in individuals with brain damage and thirdly, many individuals with schizophrenia demonstrate cognitive impairment and the main areas of impairment have been found to be those related to frontal and prefrontal areas of the brain, for example executive function, working memory, attention and verbal fluency (Elvevåg & Goldberg, 2000; Heinrichs & Zakzanis, 1998; Laroi et al., 2004).

One of the first studies to investigate the insight-cognition association was conducted by Young et al. in 1993. They assessed 31 individuals with chronic schizophrenia on the Wisconsin Card Sort Test (WCST) (a measure of executive functioning) and the SUMD, and found that neuropsychological deficits were significantly related to poor current awareness and attribution of symptoms and could discriminate 'high' and 'low' awareness groups.

Since then other researchers have also found significant relationships between insight and frontal, neurocognitive functioning (Buckley et al., 2001; McEvoy et al., 1996; Lysaker & Bell, 1995; Lysaker et al., 2003; Marks et al., 2000; Mohamed et al., 1999; Subotnik et al., 2005). However, others have failed to support these findings (Collins et al., 1997; Freudenreich et al., 2004; Kim et al., 2003; Koren et al., 2004; Nakano et al., 2004; Sanz et al., 1998), or find only partial support; as some measures correlated with insight but others did not (Drake & Lewis, 2003), or relationships were found but regression equations demonstrated that the neurocognitive variables did not contribute as much to the variation in insight as other variables (for example symptoms and depression) (Rossell et al., 2003). These studies have tended to investigate a variety of frontal, cognitive processes, particularly the areas of set-shifting and attention.
1. Set-shifting

The most common relationship found in research investigating the insight-cognition association is between poor insight and perseveration (commonly measured by the WCST) (Drake & Lewis, 2003; Morgan & David, 2004). Perseveration reflects an impairment in the executive function: ‘...the ability to shift from one cognitive element to another’ (Laroi et al., 2004, p.128). Therefore lack of insight is thought to possibly reflect difficulties in the ability to self-assess, self-monitor, and alter responses after feedback (Drake & Lewis, 2003), and this idea receives support from Mohamed et al. (1999) who have found significant correlations between insight and verbal fluency. Fluency in part assesses executive function because it tests the initiation and control of the retrieval of words and the ability to shift concepts (van Beilen et al., 2004). The role of a deficit in set-shifting in lack of insight is not unequivocal however as, despite it being the most consistent finding, many studies have failed to find significant relationships between perseveration and insight (Arudini et al., 2003; Collins et al., 1997; Freudenreich et al., 2004; Kim et al., 2003; Nakano et al., 2004; Sanz et al., 1998) or been unable to demonstrate a fluency-insight association (Freudenreich et al., 2004; Kemp & David, 1996; Kim et al., 2003; Smith et al., 2000; Young et al., 1993).

2. Attention

Deficits in attention are one of the main cognitive dysfunctions associated with schizophrenia particularly deficits in selective attention; the ability to focus on a desired stimulus while inhibiting and ignoring non-relevant stimuli (Brebion et al., 1996; Elvevåg & Goldberg, 2000; Jones et al., 2001).

Fewer studies have investigated the relationship between attention and insight than between insight and executive functioning. However, Laroi et al. (2004) explain that poor perceptual input can lead to:

..[the] relative weakening of the experience of perceptual stimuli compared to internally generated images...[which] may render the process of making distinctions between internally and externally generated information more difficult (p.139).
And that insight, at least in part, involves 'the ability to be aware of what is part of the self and distinguish it from what is not' (p.142). Therefore it seems reasonable to believe that deficits in attention could be related to poor insight.

An attention-insight relationship could also be hypothesised because poor attention leads to a reduction in information processing. Restricted visual search strategies found in individuals with schizophrenia can lead to the extraction of less information from a stimuli and a reduction both in the processing of salient information and the ability to discriminate relevant and non-relevant information. Ultimately it can lead to a restricted and inflexible response to a complex environment (Lussier & Stip, 2001; Minassian et al., 2005; Roitman et al., 1997).

Subotnik et al. (2005) found a significant relationship between insight (on the SUMD) and attention (on the Continuous Performance Test) in 52 individuals with recent onset schizophrenia or schizoaffective disorder; supporting findings by Walker and Rossiter (1989), Lysaker and Bell (1995), Voruganti et al. (1997) and Marks et al. (2000). In contrast Rossell et al. (2003) correlated performance on the Continuous Performance Test with insight (on the SAI-E) in 78 individuals with chronic schizophrenia and failed to find a relationship.

Even reviewing these two areas of cognitive functioning separately it is apparent that there are still varied and contradictory findings and these may relate to diversity in the study samples, for example in terms of diagnostic classification (schizophrenia and schizoaffective disorder), illness severity (inpatients and outpatients) and duration of illness (chronic and recent onset) (Morgan & David, 2004), and the latter two are felt to be particularly important. Many researchers have concluded that it is only in individuals with chronic, persistent lack of insight that neurological dysfunction and insight are related (Amador & Kronengold, 2004; Collins et al., 1997; Sanz et al., 1998; Subotnik et al., 2005; Weiler et al., 2000).
5.3.1 Understanding of cognitive functioning

One group of researchers has recently responded to the lack of consistent findings concerning the relationship between insight and cognitive functioning by considering whether the insight-cognition relationship is not direct but mediated by another aspect of self awareness - understanding of cognitive functioning. Koren et al. (2004) assessed 30 individuals with first-episode schizophrenia on their insight (on the SUMD), cognitive functioning (on the WCST), and metacognition; defined as 'a person’s awareness or knowledge regarding [his/her cognitive] abilities' (p.196) that may be unrelated to cognitive functioning per se. They found that the metacognitive measures showed moderate to large correlations with insight (0.30<r<0.67) and accounted for a moderate to large proportion of the variance in insight (56% of general insight). In contrast, cognitive functioning had, at best, low correlations with insight and accounted for only a small proportion of insight variance (10% of general insight). They concluded that individuals’ understanding of their cognitive functioning may be more relevant to insight than their actual cognitive deficits (Koren et al., 2004).

Another group of researchers (Medalia & Lim, 2004) assessed understanding of cognitive functioning, but not insight, in individuals with schizophrenia, and finding it was impaired concluded their results were ‘consistent with what is known about awareness of psychotic symptoms’ and ‘suggest[s] that lack of insight is a fairly pervasive characteristic of the disease’ (p.336). There is an assumption in these statements however that insight into mental illness and understanding of cognitive functioning are similar forms of self-awareness. David (2004) sensibly speculates that this may not be the case; ‘awareness of cognitive deficits’ that are ‘demonstrable objectively and relatively easily quantified’ may be different from ‘awareness of behaviours which are abnormal by virtue of violation of social rules, or indeed, purely subjective experiences or mental states (beliefs, perceptions, hallucinations etc.)’ (p.361). Little is known about which of these authors is correct. Further research is needed in this area (Drake & Lewis, 2003; Koren et al., 2004).
6.0 SUMMARY AND RESEARCH AIMS

There can be considerable implications for forensic patients' autonomy and liberty if it is considered that they 'lack insight' into their mental illness (Diesfeld, 2003) and current literature suggests to clinicians that insight is a factor important to consider in violence risk assessments (Arango et al., 1999; Buckley et al., 2004; Goodman et al., 2005; Krakowski, 2005; Torrey, 2004; Webster et al., 1997). It is therefore imperative that professionals delivering such messages understand what 'lack of insight' reflects in forensic patients. Research that has looked at the aetiology of insight in individuals with schizophrenia living in the community suggests there are four main questions and associated implications that arise for the concept of insight in forensic patients.

*Is insight an integral aspect of mental illness? Therefore something that will fluctuate with its course and be 'treatable' along with other signs and symptoms?*

*Is insight related to depression or anxiety levels? Therefore does the focus need to be more on psychological factors that may lead to or arise from insight into mental illness?*

*Is insight associated with a neuropsychological deficit? Begging the question: how is a patient to gain the insight that might be deemed necessary to be discharged from detention under mental health legislation? Lack of insight related to cognitive functioning deficits is likely to be more resistant to pharmacological or psychosocial interventions (Carroll et al., 1999; Young et al., 1993).*

New developments hint that it is possible that insight is not related to cognitive functioning but is related to understanding of cognitive functioning. *Is insight related to an aspect of self-awareness that involves knowledge about a concrete and relatively objective aspect of one's self or does it appear to be a different phenomenon?*

The aim of this research is to develop the understanding of the concept of 'insight' in forensic patients with schizophrenia by considering which clinical variables most relate to insight in this population. By doing so it will offer more critical consideration to current
views that the concept of insight, as it is used and defined in current practice, is important in this population.

In this research, insight will be treated as a multidimensional phenomenon with the components of insight being studied separately as well as insight as a whole. The clinical correlates of the different components of insight may vary: researchers propose that the component of insight – ability to relabel psychotic phenomena as signs of mental illness – is most likely to be related to clinical variables and awareness of the need for treatment is least likely to be related to clinical variables because it is more likely to be influenced by sociocultural factors (Beck Sander, 1998; David, 2004; Drake & Lewis, 2003; McEvoy et al., 1996; Freudenreich et al., 2004; Johnson & Orrell, 1995; Lysaker et al., 2003; Rossell et al., 2003).

The research questions and hypotheses are stated below.

7.0 RESEARCH QUESTIONS AND HYPOTHESES

1. What are the clinical correlates of insight into mental illness in forensic patients with schizophrenia?

It is hypothesised that greater levels of insight will be significantly associated with:

a) Lower levels of positive and negative symptomatic and psychopathology in general;

b) Higher levels of depression and anxiety;

c) Higher levels of executive functioning and attentional abilities;

d) Greater understanding of cognitive functioning.

Given the dearth of research investigating understanding of cognitive functioning in people with schizophrenia, this research will also draw on research that has looked at self-awareness of cognitive deficits in people with neurological impairments to inform the method of assessment of this clinical factor.
2. Are there differential relationships between the components of insight (recognition of illness, capacity to relabel psychotic experiences as signs of mental illness, and awareness of the need for treatment) and the above clinical factors?

It is hypothesised that the ability to relabel psychotic phenomena as signs of mental illness is the component of insight most likely to be significantly related to psychopathology and cognitive functioning. This hypothesis is more exploratory because previous research findings around this are not clear.
METHOD

1.0 DESIGN
This study is cross-sectional in nature and has a correlational design.

2.0 PARTICIPANTS
Participants were recruited from Broadmoor Special Hospital, one of three high-security psychiatric hospitals in England, providing treatment for people with major mental disorders who are thought to present sufficient risk to others to require compulsory detention under either the Mental Health Act (MHA) 1983 or the Criminal Procedure (Insanity and Unfitness to Plead) Act (CPIA) 1991. Participants were recruited from this hospital because ‘...the concentration of unequivocal and serious violence among people in special hospitals is not seen in other psychiatric samples...[therefore] these people are central to the exercise of trying to improve knowledge about the relationship between mental disorder and violence’ (Taylor et al., 1998, p.218).

Participants were sought whose clinical presentation met criteria for a DSM-IV diagnosis of schizophrenia (regardless of any dual diagnosis) as determined by each participant’s Responsible Medical Officer (RMO). The exclusion criteria were: an acutely unstable mental state that precluded a patient’s participation in the study (determined by the patient’s clinical team), an inability or unwillingness to give informed consent, poor intellectual functioning (defined as an IQ of less than 80), inadequate English language skills, known history of significant closed head injury or other neurological condition, and prior receipt of the cognitive measures used in the study.

Fifty-nine patients were identified by their RMOs for inclusion. All were approached and 30 agreed to participate. One patient was excluded because he had a history of epilepsy. Therefore the sample was comprised of 29 patients.
3.0 MEASURES

3.1 Insight into mental illness
This was assessed using the Schedule for the Assessment of Insight-Expanded Version (SAI-E) (Kemp & David, 1997) (appendix 4). This is a brief, standardised, semi-structured interview and items are researcher-rated according to a standardised scoring system.

3.1.1 Administration and scoring
The SAI-E yields a total score (10 items; score 0 to 24) and three subscale scores: a recognition of illness score (five items; score 0 to 10), a relabelling of psychotic phenomena score (two items; score 0 to 8), and an awareness of the need for treatment score (three items; score 0 to 6). A higher score represents greater insight. The SAI-E takes 10 to 15 minutes to administer.

3.1.2 Psychometric properties
The SAI-E was developed from the Schedule for the Assessment of Insight (SAI), devised by David (1990). Both have three subscales that measure the three independent, but overlapping components of insight: ‘awareness of having a mental illness’, ‘acceptance of the need for treatment’ and ‘ability to relabel unusual psychotic phenomena as signs of mental illness’ (David, 1990). A strong correlation between the SAI and the SAI-E has been demonstrated (Sanz et al., 1998) and a principle-component analysis of the SAI-E produced a three-factor solution that matched the three dimensions of insight proposed by David (1990) (David et al., 2003). All three components correlate significantly (coefficients range from .41 to .56) (David, et al., 2003).

David et al. in 1992 assessed 91 inpatients, aged between 18 and 65 years, with psychotic illness and found the SAI yielded normally distributed scores and had good inter-rater reliability (intraclass correlation coefficient= .72). Concurrent validity of the SAI and SAI-E has been confirmed by Sanz et al. (1998) who found strong correlations between the SAI/SAI-E and the Insight and Treatment Attitudes Questionnaire (ITAQ; McEvoy, et al., 1981) and the insight item on the Positive and Negative Syndrome Scale (PANSS; Kay et
al., 1988). Studies conducted with clinical populations in the UK and across the world have demonstrated consistency among the SAI/SAI-E ratings (David, 2004).

In this study, to ensure reliability of the assessments, inter-rater reliability was determined for a quarter of the assessments. Eight patients were assessed by two raters: the researcher and an assistant psychologist. Each rater scored the assessment independently. Any discrepancies between the ratings were discussed by the two raters and a score for each question agreed. Overall inter-rater reliability was checked for acceptability. The obtained Cohen's Kappa was .81 demonstrating highly significant agreement between the two raters (p < .0001).

3.1.3 Rationale for choice
The SAI-E is one of only two instruments, alongside the SUMD, that measures the multidimensionality of insight. However, unlike the SUMD, it is a British developed scale and has been used in many UK based studies. The SAI and the expanded version have frequently been used in studies assessing insight in non-forensic patients (Collins et al. 1997; Drake & Lewis, 2003; Rathod et al., 2005; Rossell et al., 2003; Yen et al., 2002) and the SAI was used in one of the studies with forensic patients (Carroll et al., 2004). It would therefore be possible to compare data yielded in this study with previously published data. In addition, the SAI/SAI-E was developed for use with patients in hospital (two items on adherence to treatment are rated by the patient's primary nurse).

3.2 Mood
This was assessed using the Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983) (appendix 5), a self-report instrument measuring severity of anxiety and depression in individuals aged 16 to 65 years.

3.2.1 Administration and scoring
The HADS consists of 14 items (seven each for assessing depression and anxiety) each rated on a scale from 0 to 3. Respondents are asked to rate each item according to 'how they have been feeling in the last week'. The HADS yields three scores: a total (from 0 to
42), depression (0 to 21) and anxiety score (0 to 21). A higher score indicates greater anxiety or depression. It takes approximately five minutes to complete.

3.2.2 Psychometric properties
The HADS has been demonstrated to be a reliable and valid scale (Zigmond & Snaith, 1983) and in this study the internal consistency of the items was good, demonstrated by an alpha co-efficient of .85 for the anxiety items and .78 for the depression items. Correlations between the HADS scores and ratings based on a psychiatric interview are .70 (p<.001) for depression and .74 (p<.001) for anxiety (Zigmond & Snaith, 1983).

3.2.3 Rationale for choice
The HADS enables both depression and anxiety to be measured in one short instrument and therefore burden on participants was kept to a minimum.

3.3 Cognitive functioning

3.3.1 The Homophone Meaning Generation Test (HMGT) (appendix 6)
The HMGT is a measure of executive function and verbal fluency (Crawford & Warrington, 2002; Warrington, 2000). It consists of eight homophones with multiple high frequency meanings: four with the same spelling (form, slip, tick, tip) and four with different spellings (bear, cent, right, bored), for example cent-scent-sent. The high frequency of the meanings reduces confounding effects of poor vocabulary and comprehension (Warrington, 2000).

Administration and scoring
The eight homophones are presented orally and participants are asked to give as many different meanings of each word as they can either verbally or by gesturing. There is no time limit. One point is awarded for each distinct meaning and the scores of the eight homophones are summed to obtain a raw score. The raw score can be converted into a scale score and a percentile score (Crawford & Warrington, 2002; Warrington, 2000) (appendix 7). A higher score represents greater verbal fluency. The test is administered in 10 to 15 minutes.
Psychometric properties

Normative data for the HMGT have developed from a UK standardisation sample of 170 English speaking adults, aged between 19 and 74 years (Crawford & Warrington, 2002; Warrington, 2000). The HMGT has clinical validity; Crawford and Warrington (2002) demonstrated that it can correctly classify 74.8% of cases as controls or anterior lesion cases, and that there is a significant correlation between neurological status and HMGT performance (p<.001). In addition, it has adequate internal consistency (Cronbach’s Coefficient Alpha=.82; Crawford & Warrington, 2002).

Rationale for choice

1. It is a test of executive, frontal lobe functioning.

Verbal fluency tasks assess two components: clustering ('generating words within a semantic or phonemic subcategory'; Warrington, 2000, p.647) which is a temporal lobe function (Troyer et al., 1998); and switching ('the ability to switch between clusters'; Warrington, 2000, p.647), which is a frontal lobe function (Troyer et al., 1998). The HMGT assesses the ability to generate and switch between multiple verbal concepts and thus maximises the switching, executive functioning component of the verbal fluency task.

Warrington (2000) demonstrated in a validation study that the HMGT can identify executive problems and frontal lobe impairment. Seventy-one patients with unilateral anterior or posterior cerebral lesions were assessed on the HMGT and Modified WCST. Those with anterior lesions performed significantly worse on the HMGT than those with posterior lesions (p<.0001) and the same number of patients failed both the Modified WCST and HMGT (Warrington, 2000).

2. It is pragmatic.

The HMGT has been used less frequently at Broadmoor Hospital than more conventional tests of fluency and executive function, thus reducing the likelihood that patients would need to be excluded because of practice effects due to prior receipt of the measure. The HMGT has a short administration time that would minimise burden on participants and in

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comparison to tests such as the WCST is a more straightforward, and therefore suitable, task for participants with a broader range of functioning.

3.3.2 The Visual Search and Attention Test (VSAT) (appendix 8)

The Visual Search and Attention Test (VSAT) (Trenerry et al., 1990) was used to assess attention.

Administration and scoring

The VSAT consists of four, 60 second, visual cancellation tasks where participants are asked, according to standardised instructions, to cross through all symbols in a grid that match a target symbol. Tasks one and two are practice trials and tasks three and four are scored to obtain the final score; these latter tasks provide the most sensitive discrimination between normal and brain-damaged individuals (Trenerry et al., 1990). The raw score is calculated by adding the total number of correctly crossed out symbols. This is then converted into an age-adjusted percentile score. A higher score represents better attention. The VSAT takes six minutes to administer.

Psychometric properties

Normative data for the VSAT have been developed from a sample of 272 adults aged from 18 to 85 years. Age was found to have a significant effect on performance and percentile scores are adjusted to account for this effect. Test-retest reliability is .95. The VSAT accurately and reliably discriminates normal individuals and adults with neurological damage; Trenerry et al. (1990) found that the number of correct targets identified by the two groups was significantly different (p<.01), and that the VSAT correctly classified 84 out of 100 people as normal or brain-damaged.

Rational for choice

1. It is a measure of sustained and selective attention (Trenerry et al., 1990).
2. It is pragmatic.

The VSAT is not frequently used in clinical practice, unlike for example the Stroop Test that is also used to assess selective attention (Barch & Carter, 1998; Brebion et al., 1996; Elvevåg & Goldberg, 2000), therefore the likelihood that patients would need to be
excluded due to prior receipt of the VSAT was reduced. It has a short administration time that would minimise burden on participants.

3.4 Understanding of cognitive functioning
This was assessed using a report-performance comparison method where the patient’s perception of his/her performance is compared with his/her actual performance (Goverover, 2004; Schlund, 1999; Sherer et al., 1998). The assessment was developed specifically for this study.

3.4.1 Administration and scoring
The understanding of cognitive functioning scores were achieved in two stages:

1. Patients’ perception of their performance on the VSAT and HGMT (appendix 9)
Participants were asked to predict how well they believed they would perform on the test (VSAT only) and then after administration of the test to evaluate how well they believed they did perform on the test (VSAT or HGMT). At both the prediction and evaluation stages, participants were asked to rate themselves i) relative to someone their own age in the general population and ii) relative to the population of Broadmoor Hospital. Therefore, participants were asked to make two predictions (VSAT only) and four evaluations (two each for the VSAT and HGMT). These predictions and evaluations were rated on a seven-point Likert scale (ranging from 1 ‘extremely poor’ to 7 ‘extremely good’), anchored with qualitative descriptions.

2. Report-performance comparison
The actual performance scores on the VSAT and HGMT were then allocated a score from 1 to 7 according to the percentile score achieved: 1: <5th, 2: 5th-10th, 3: 11th-25th, 4: 26th-50th, 5: 51st-75th, 6: 76th-90th and 7: >90th percentile. Report-performance differences were then calculated by subtracting the performance score (percentile category rating) from the self-rating (self-rating - performance) to give an understanding of cognitive functioning score between +6 (overestimate of cognitive ability) and -6 (underestimate of cognitive ability). A score of 0 represented a fully accurate estimate of ability (total understanding of cognitive functioning).
This stage was conducted after the completion of data collection for all participants and in the end it was not possible to calculate understanding of cognitive functioning scores from participants' predictions and estimations made relative to the population of Broadmoor Hospital (see appendix 10 for a full explanation), therefore three understanding of cognitive functioning scores were calculated:

1. Understanding of homophone generation
Participants' HMGT percentile category rating subtracted from their evaluation rating; how well they perceived they performed on the HMGT compared to someone their own age in the general population.

2. Understanding of attention 1
Participants' VSAT percentile category rating subtracted from their prediction rating; how well they believed they would perform on the VSAT relative to someone their own age in the general population.

3. Understanding of attention 2
Participants' VSAT percentile category rating subtracted from their evaluation rating; how well they perceived they performed on the VSAT relative to someone their own age in the general population.

3.4.2 Rationale for choice
1. The method used is a common method for assessing understanding of cognitive functioning (Schlund, 1999; Sherer et al., 1998).

2. It is more advantageous than report-report methods, that compare self-report ratings with ratings of a patient's cognitive functioning provided by a health professional or family member, because it produces a direct measure of cognitive functioning (it requires the administration of a cognitive test) and therefore is not affected by the potential lack of reliability of a clinician's or a family member's rating (Medalia & Lim, 2004; Schlund, 1999).

3. It takes account of the fact that self-awareness is influenced by two dimensions; task characteristics and prior experience (Goverover, 2004). Firstly, participants need prior experience to make a self-assessment therefore the prediction rating was only completed
on the VSAT because it includes practice items. Evaluation ratings (completed after the
tasks) were completed on the VSAT and the HMGT as participants then had experience on
which to base their ratings. Secondly, because prior experience can influence performance
and ratings of self-awareness the VSAT and HMGT tests were chosen because they were
unlikely to have been administered to the participants prior to this study.
4. This assessment of understanding of cognitive functioning does not effect the
standardisation of the test or the participant's test performance (Koren et al., 2004).

3.5 Psychopathology (clinical ratings of symptoms)
This was assessed using the Positive and Negative Syndrome Scale (PANSS) (Kay et al.,
1988; Kay et al., 2000) (appendix 11) by one of two Senior House Officers (SHOs) trained
in psychiatric interviewing.

3.5.1 Administration and scoring
The PANSS has 30 items; each rated on a seven-point scale ranging from 1 (absent) to 7
(extreme psychopathology) based on findings from a semi-structured interview and other
available information (for example reports from hospital staff). Ratings are based on
information from the preceding week. Five scores are produced: a total score, a positive
symptom score, a negative symptom score, a general psychopathology score and a
composite score (positive symptom score minus the negative symptom score), which
enables individuals to be classified as suffering from the positive (composite score > 0) or
negative (composite score < 0) subtype of schizophrenia (Kay et al., 2000). Separate
scores for depression and insight can also be calculated. A higher score indicates higher
symptom severity. The PANSS takes 30 to 40 minutes to administer.

3.5.2 Psychometric properties
Kay et al. (1987) demonstrated the PANSS's high internal reliability (alpha co-efficients
ranging from .73 to .83), high test-retest reliability and temporal stability over a three to
six month interval (co-efficients ranging from .77 to .89). The inter-rater reliability is
good, ranging from .83 to .87, and criterion, discriminant and convergent validity have
been demonstrated (Kay et al., 1988). Normative data have been developed from a sample
of 240 medicated individuals with schizophrenia (Kay et al., 1987).
3.5.3 Rationale for choice

The PANSS was developed to assess positive and negative symptom severity in schizophrenia (Kay et al., 1987) and is widely used in research studies (Sajatovic & Ramirez, 2001), including a number of the key studies investigating insight. This allows the comparison of the severity of psychopathology in the individuals in this study with that of individuals in other studies.

4.0 PROCEDURE

4.1 Identification of participants

Potential participants were identified by their RMOs. The researcher contacted all twenty RMOs at Broadmoor Hospital by letter (appendix 12) informing them about the nature and purpose of the research and asking them to identify patients who meet the sample criteria and whom the clinical team would allow to be approached. RMOs who did not respond were followed up twice, once by letter and then by email.

4.2 Obtaining consent

Following identification of potential participants, an initial meeting with each was arranged via the ward staff, this ensured patients were appropriately mentally stable to take part. Patients who were willing to meet were introduced to the research, given an information sheet (appendix 13) and consent form2 (appendix 14), and provided with the opportunity to ask questions. If the patient expressed a willingness to take part, the researcher arranged to return and conduct the research interview. This was arranged for within two weeks of, and at least 24 hours after, this initial contact to ensure patients were given time to fully consider whether or not they would like to participate. The researcher then attended for the research interview and if patients were still willing to take part they were asked to provide written, informed consent.

2 At this stage, the consent form was given for information purposes only. Patients were not asked to consent to take part in the research during this initial meeting.
4.3 Interviews and medical record review

The research was conducted in three parts: the main interview, the assessment of psychopathology and the medical records review.

The main interview commenced immediately after informed consent had been obtained. It took a maximum of 50 minutes and assessed insight, mood, cognitive functioning and understanding of cognitive functioning, in this standardised order. Insight was assessed first to ensure it was assessed blind to all other assessments. This made certain the researcher did not unwittingly influence the assessment of insight; a difficulty critiqued in previous research (Sevy et al., 2004).

The assessment of psychopathology was completed by one of the two SHOs between two and six weeks after the main interview and was assessed blind to the findings from the main interview.

The main interview and assessment of psychopathology were conducted in an interview room on the patient’s ward. No members of the clinical team were present during the interviews to preserve confidentiality. The team were made aware that one of their patients had taken part and of anything disclosed during the research that raised concerns about the patient’s safety or the safety of others. Patients were always informed if, and what, information was passed on to the clinical team.

Following completion of the main interview and assessment of psychopathology, the researcher conducted a review of each participant’s medical records. Information was collected on: age, ethnicity, legal classification, MHA 1983/CPIA 1991 classification, pathway into and length of stay at Broadmoor Hospital, current ward, diagnosis, duration of illness, nature of any dual diagnosis, nature of and length of time since index offence, history of previous offences, current medication, type of current or past therapeutic intervention, history of treatment with ECT, full scale IQ, and history of closed head injury or other neurological condition.
5.0 ETHICAL APPROVAL

Ethical approval was obtained from the Ethics and Research and Development Committees of the West London Mental Health NHS Trust, and the University of Surrey Ethics Committee (appendices 15 to 17).

6.0 POWER CALCULATION

An a priori power calculation using the computer package G*Power demonstrated that to detect an effect size of $r=0.3$, one-tailed, alpha .05 with a statistical power of 0.8, 64 participants would be required.

7.0 DATA ANALYSIS

The Statistical Package for Social Sciences for Windows version 13.0 was used to analyse the data. The demographic and clinical characteristics for the categorical variables are described with frequencies and percentages, and for the continuous variables with the median, mean and standard deviation. The median is provided because the majority of the data is ordinal and the difference between the median and mean provides a useful indication of the distribution of the data. To examine relationships between variables, non-parametric, Spearman’s Rank bivariate correlations were used because the data in relation to insight, psychopathology, mood and understanding of cognitive functioning is ordinal and the sample size is small. For comparison tests, where data was on an interval scale and met assumptions of normality (Kolmogorov-Smirnov test: $p<.05$ for non-transformed or transformed data$^3$), parametric, $t$-tests were utilised. Where data was ordinal, non-parametric Mann-Whitney $U$-tests were used and for categorical data the Chi-Square test for goodness of fit was used. Correlations and differences were deemed statistically significant if the $p$-value was <.05 and considered a non-significant trend if the $p$-value was <.10. Corrections for multiple correlations were not made because the variables were selected to test specific hypotheses.

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$^3$ Data that were not normally distributed and were transformed were: length of stay in the hospital (sample and remaining patients in the hospital with a diagnosis of mental illness) and age (remaining patients only).
RESULTS

1.0 SAMPLE CHARACTERISTICS
The participants were predominantly white males with a diagnosis of chronic, paranoid schizophrenia detained under the hospital and restriction order of the Mental Health Act 1983. Sample characteristics are shown in detail in table 1.

When the sample are compared with the remaining patients in Broadmoor Hospital with a diagnosis of a mental illness (see table 1), the sample can be considered representative of other patients in the hospital; the sample and the 182 other patients in the hospital with a mental illness were not significantly different in terms of proportions of males and females ($\chi^2(1, n=29)=1.17, p>.10$), age ($t(209)=-1.21, p=.264, 2$-tailed) or time spent in the hospital ($t(209)=.63, p=.529, 2$-tailed). The proportions of patients in the sample and the remaining patients who were White British, White European, Black British and Black African appear similar although it is not possible to test this statistically using the Chi-Square test for goodness of fit because the expected frequencies for some categories are less than five (Gravetter & Wallnau, 2000). Patients from other ethnic groups are underrepresented in the sample.

The sample contained a significantly higher proportion of patients with a legal classification of mental illness only and a smaller proportion of patients with a classification of mental illness and psychopathic disorder, than is typical of patients with mental illness in the hospital as a whole ($\chi^2(1, n=29)=3.96, p<.05$). Table 1 shows the proportion of patients from each ward and demonstrates that the sample represented patients from across the hospital.
Table 1: Sample characteristics and characteristics of all remaining patients in Broadmoor Hospital with a mental illness

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Sample (n=29)</th>
<th>Remaining Patients in Broadmoor Hospital with a Mental Illness (n=182)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (frequency; percentage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>26 (89.7%)</td>
<td>150 (82.4%)</td>
</tr>
<tr>
<td>Female</td>
<td>3 (10.3%)</td>
<td>32 (17.6%)</td>
</tr>
<tr>
<td>Age in years (mean; standard deviation; range)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>43.1 (11.8)</td>
<td>40.23 (11.0)</td>
</tr>
<tr>
<td></td>
<td>(22.4 - 64.3)</td>
<td>(23.1 - 77.5)</td>
</tr>
<tr>
<td>Ethnic origin (frequency; percentage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>18 (62.1%)</td>
<td>109 (59.9%)</td>
</tr>
<tr>
<td>White European</td>
<td>2 (6.9%)</td>
<td>12 (6.6%)</td>
</tr>
<tr>
<td>Black British</td>
<td>6 (20.7%)</td>
<td>24 (13.2%)</td>
</tr>
<tr>
<td>Black African</td>
<td>3 (10.3%)</td>
<td>18 (10.0%)</td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td>5 (2.7%)</td>
</tr>
<tr>
<td>Asian British</td>
<td>0</td>
<td>1 (0.5%)</td>
</tr>
<tr>
<td>Mixed ethnic background</td>
<td>0</td>
<td>6 (3.3%)</td>
</tr>
<tr>
<td>Other ethnic background</td>
<td>0</td>
<td>7 (3.8%)</td>
</tr>
<tr>
<td>Legal classification (frequency; percentage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental illness</td>
<td>25 (86.2%)</td>
<td>126 (69.2%)</td>
</tr>
<tr>
<td>Mental illness and psychopathic disorder</td>
<td>4 (13.8%)</td>
<td>56 (30.8%)</td>
</tr>
<tr>
<td>Diagnosis (frequency; percentage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia (no subtype specified)</td>
<td>9 (31.0%)</td>
<td></td>
</tr>
<tr>
<td>Paranoid schizophrenia</td>
<td>20 (69.0%)</td>
<td></td>
</tr>
<tr>
<td>Dual diagnosis of a personality disorder (frequency; percentage)</td>
<td>13 (44.8%)</td>
<td></td>
</tr>
<tr>
<td>Duration of mental illness in years (mean; standard deviation; range)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20.2 (10.8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(4.0 - 43.0)</td>
<td></td>
</tr>
<tr>
<td>Contact with mental health services prior to index admission (frequency; percentage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior contact</td>
<td>26 (89.7%)</td>
<td></td>
</tr>
<tr>
<td>No prior contact (experienced onset of illness in prison)</td>
<td>3 (10.3%)</td>
<td></td>
</tr>
</tbody>
</table>
### Table 1 continued

<table>
<thead>
<tr>
<th>MHA/CPIA Classification (frequency; percentage)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MHA 1983 Section</td>
<td></td>
</tr>
<tr>
<td>37/41 (Hospital and Restriction Order)</td>
<td>17 (58.6%)</td>
</tr>
<tr>
<td>47/49 (Transfer Order)</td>
<td>8 (27.6%)</td>
</tr>
<tr>
<td>37 (Hospital Order)</td>
<td>1 (3.4%)</td>
</tr>
<tr>
<td>3 (Treatment Order)</td>
<td>2 (6.9%)</td>
</tr>
<tr>
<td>CPIA 1991</td>
<td>1 (3.4%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward at time of participation in the research (frequency; percentage)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions ward</td>
<td>2 (6.9%)</td>
</tr>
<tr>
<td>Intensive care</td>
<td>2 (6.9%)</td>
</tr>
<tr>
<td>High dependency</td>
<td>5 (17.5%)</td>
</tr>
<tr>
<td>Medium dependency assertive rehabilitation</td>
<td>14 (48.3%)</td>
</tr>
<tr>
<td>Ward for older and vulnerable patients</td>
<td>6 (20.7%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Length of stay in Broadmoor Hospital in years (mean; standard deviation; range)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1 (7.9)</td>
<td>8.03 (6.84)</td>
</tr>
<tr>
<td>(0.2 - 29.8)</td>
<td>(0 - 38.4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place from which admitted and reason for admission (frequency; percentage)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medium secure unit; behaviour too difficult to manage in conditions of lesser security</td>
<td>11 (37.9%)</td>
</tr>
<tr>
<td>Prison; deterioration in mental health</td>
<td>8 (27.6%)</td>
</tr>
<tr>
<td>Court; admitted immediately following conviction of index offence</td>
<td>6 (20.7%)</td>
</tr>
<tr>
<td>Another high-security hospital; repatriation</td>
<td>4 (13.8%)</td>
</tr>
</tbody>
</table>

All participants had a history of violent behaviour and 28 had been convicted of a violent offence. One participant did not have a criminal conviction but had displayed serious violence in a medium secure unit warranting a move to a high-security hospital. Table 2 details the participants’ index offences and shows that the proportions of the sample and the proportions of patients in the hospital with a mental illness who had committed offences of homicide/attempted homicide, other interpersonal violence or sex offences appear similar. However it is not possible to test this statistically using the Chi-Square test for goodness of fit because the expected frequencies for some categories are less than five (Gravetter & Wallnau, 2000). Table 2 shows that the majority of the participants had a history of offences prior to their index offence.
Table 2: Index offences\(^4\) for the sample and all remaining patients in Broadmoor Hospital with a mental illness

<table>
<thead>
<tr>
<th>Offence-Related Characteristics</th>
<th>Sample (n=29)</th>
<th>Remaining Patients in Broadmoor Hospital with a Mental Illness (n=182)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Index offence (frequency; percentage)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homicide/attempted homicide</td>
<td>10 (34.5%)</td>
<td>74 (40.7%)</td>
</tr>
<tr>
<td>Murder/attempted murder</td>
<td>4 (13.8%)</td>
<td>37 (20.3%)</td>
</tr>
<tr>
<td>Manslaughter on the grounds of diminished responsibility</td>
<td>6 (20.7%)</td>
<td>37 (20.3%)</td>
</tr>
<tr>
<td>Other interpersonal violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual bodily harm/grievous bodily harm</td>
<td>5 (17.2%)</td>
<td>37 (20.3%)</td>
</tr>
<tr>
<td>Assault</td>
<td>2 (6.9%)</td>
<td></td>
</tr>
<tr>
<td>Adult sex offence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rape/attempted rape</td>
<td>4 (13.7%)</td>
<td>17 (9.3%)</td>
</tr>
<tr>
<td>Indecent assault</td>
<td>3 (10.3%)</td>
<td></td>
</tr>
<tr>
<td>Child offences</td>
<td>2 (6.9%)</td>
<td>3 (1.7%)</td>
</tr>
<tr>
<td>Robbery</td>
<td>3 (10.3%)</td>
<td>7 (3.9%)</td>
</tr>
<tr>
<td>Arson</td>
<td>0 (0%)</td>
<td>13 (7.1%)</td>
</tr>
<tr>
<td>Criminal damage/other offence</td>
<td>2 (6.9%)</td>
<td>24 (13.2%)</td>
</tr>
<tr>
<td>No conviction</td>
<td>1 (3.4%)</td>
<td>8 (4.4%)</td>
</tr>
<tr>
<td>Time elapsed since index offence in years (mean; standard deviation; range)</td>
<td>12.6 (8.8)</td>
<td>(2.0 – 32.0)</td>
</tr>
<tr>
<td>History of convictions for offences prior to index offence (frequency; percentage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No history</td>
<td>5 (17.2%)</td>
<td></td>
</tr>
<tr>
<td>History of non-violent offence(s)</td>
<td>3 (10.3%)</td>
<td></td>
</tr>
<tr>
<td>History of violent offence(s)</td>
<td>21 (72.4%)</td>
<td></td>
</tr>
<tr>
<td>One previous conviction</td>
<td>5 (17.2%)</td>
<td></td>
</tr>
<tr>
<td>Two or three previous convictions</td>
<td>6 (20.7%)</td>
<td></td>
</tr>
<tr>
<td>Four or more previous convictions</td>
<td>10 (34.5%)</td>
<td></td>
</tr>
</tbody>
</table>

\(^4\) Where more than one offence had been committed simultaneously the most serious offence was rated.
All participants were being treated with antipsychotic medication; 17 were receiving one antipsychotic (10: atypical; seven: typical), 11 were receiving two antipsychotics (four: atypical only; seven: atypical and typical), and one participant was receiving three types of antipsychotic medication (combination of typical and atypical). Twenty-five participants were also receiving concomitant antidepressant, anxiolytic and/or mood stabiliser medication.

Twenty-two (75.9%) participants were currently receiving or had received some form of therapeutic intervention. Seven had not received (or there was no record of) any therapeutic intervention. The type of intervention received by the participants is presented in table 3. Nine participants had also received electro-convulsive therapy in the past.

Table 3: Type of therapeutic intervention received by the participants (n=29)

<table>
<thead>
<tr>
<th>Type of Therapeutic Intervention</th>
<th>Number of Patients (percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy for psychosis</td>
<td>16 (62.1%)</td>
</tr>
<tr>
<td>Therapy for psychosis only</td>
<td>6 (20.7%)</td>
</tr>
<tr>
<td>Therapy for psychosis and other mental health difficulties</td>
<td>6 (20.7%)</td>
</tr>
<tr>
<td>Therapy for psychosis and offence-related therapy</td>
<td>4 (13.8%)</td>
</tr>
<tr>
<td>Therapy for psychosis, other mental health difficulties and offence-related therapy</td>
<td>2 (6.9%)</td>
</tr>
<tr>
<td>Other therapy</td>
<td></td>
</tr>
<tr>
<td>Therapy for other mental health difficulties only</td>
<td>2 (6.9%)</td>
</tr>
<tr>
<td>Offence-related therapy only</td>
<td>1 (3.4%)</td>
</tr>
<tr>
<td>Therapy for other mental health difficulties and offence-related therapy</td>
<td>1 (3.4%)</td>
</tr>
<tr>
<td>No therapy / no record of therapy</td>
<td>7 (24.1%)</td>
</tr>
</tbody>
</table>
2.0 CLINICAL CHARACTERISTICS OF THE SAMPLE

The clinical characteristics of the sample are shown in table 4.

2.1 Insight

Table 4 gives the descriptive statistics for the scores on the SAI-E and shows that the sample contains patients who scored across the range in their level of insight. The total and subscale scores from the current sample are similar to scores from samples in previously published studies (appendix 18). The participants scored highest on the awareness of the need for treatment subscale and lowest on the relabelling of psychotic phenomena subscale. There are no cut-off scores for the SAI-E, however, by taking the scores achieved on the recognition of illness subscale, 17.2% of the sample did not believe they had a mental illness (demonstrated by a score of 0), 60.1% had partial awareness (a score between 1 and 9) and 13.8% had full awareness (a score of 10).

The SAI-E subscales were all significantly intercorrelated with individual Spearman’s correlations ranging from .56 to .96 ($p<.01$).

\[\text{In appendix 18 the SAI-E scores are expressed as a percentage and compared with other samples from published studies that used either the SAI or the SAI-E to assess insight.}\]
<table>
<thead>
<tr>
<th>Score (scale score range)</th>
<th>Median</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insight (n=29)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAI-E Total Score (0-24)</td>
<td>13.00</td>
<td>12.50</td>
<td>7.38</td>
<td>2-24</td>
</tr>
<tr>
<td>SAI-E Recognition of Illness Score (0-10)</td>
<td>6.00</td>
<td>5.38</td>
<td>3.60</td>
<td>0-10</td>
</tr>
<tr>
<td>SAI-E Relabelling of Psychotic Phenomena Score (0-8)</td>
<td>2.00</td>
<td>3.36</td>
<td>3.03</td>
<td>0-8</td>
</tr>
<tr>
<td>SAI-E Awareness of Need for Treatment Score (0-6)</td>
<td>4.00</td>
<td>3.79</td>
<td>2.24</td>
<td>1-6</td>
</tr>
<tr>
<td><strong>Psychopathology (n=28)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PANSS Total Score (30-210)</td>
<td>48.50</td>
<td>55.54</td>
<td>19.75</td>
<td>31-125</td>
</tr>
<tr>
<td>PANSS General Psychopathology Score (16-112)</td>
<td>24.50</td>
<td>26.43</td>
<td>8.90</td>
<td>16-59</td>
</tr>
<tr>
<td>PANSS Positive Symptom Score (7-49)</td>
<td>14.50</td>
<td>15.21</td>
<td>7.40</td>
<td>7-36</td>
</tr>
<tr>
<td>PANSS Negative Symptom Score (7-49)</td>
<td>12.0</td>
<td>13.75</td>
<td>6.66</td>
<td>7-30</td>
</tr>
<tr>
<td>PANSS Depression Score (4-28)</td>
<td>5.00</td>
<td>5.57</td>
<td>1.79</td>
<td>4-10</td>
</tr>
<tr>
<td>PANSS Insight Score (1-7)</td>
<td>4.00</td>
<td>3.82</td>
<td>1.94</td>
<td>1-7</td>
</tr>
<tr>
<td><strong>Mood (n=28)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HADS Total Score (0-42)</td>
<td>12.00</td>
<td>11.18</td>
<td>8.25</td>
<td>0-29</td>
</tr>
<tr>
<td>HADS Depression Score (0-21)</td>
<td>4.00</td>
<td>5.06</td>
<td>4.22</td>
<td>0-14</td>
</tr>
<tr>
<td>HADS Anxiety Score (0-21)</td>
<td>6.00</td>
<td>6.14</td>
<td>4.62</td>
<td>0-15</td>
</tr>
<tr>
<td><strong>Cognitive Functioning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Function (n=28)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMGT Raw Score (0-42)</td>
<td>21.00</td>
<td>21.96</td>
<td>6.71</td>
<td>8-36</td>
</tr>
<tr>
<td>HMGT Scale Score (1-20)</td>
<td>8.00</td>
<td>9.00</td>
<td>4.16</td>
<td>1-18</td>
</tr>
<tr>
<td>Attention (n=27)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VSAT Raw Score (0-200)</td>
<td>72.00</td>
<td>78.85</td>
<td>28.14</td>
<td>28-154</td>
</tr>
<tr>
<td><strong>Understanding of Cognitive Functioning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding of Homophone Generation (0-6) (n=27)</td>
<td>1.00</td>
<td>1.41</td>
<td>1.42</td>
<td>0-6</td>
</tr>
<tr>
<td>Understanding of Attention 1 (0-6) (n=26)</td>
<td>3.00</td>
<td>3.50</td>
<td>1.14</td>
<td>2-6</td>
</tr>
<tr>
<td>Understanding of Attention 2 (0-6) (n=26)</td>
<td>3.00</td>
<td>3.04</td>
<td>0.96</td>
<td>2-6</td>
</tr>
</tbody>
</table>
2.2 Psychopathology

Table 4 shows that the degree of psychopathology in the sample is relatively low. Using the interpretative guidelines from Kay et al. (2000), developed from a normative sample of 240 people with schizophrenia on medication, on the general psychopathology scale the majority (89.3%) had below average (<28th percentile) levels of psychopathology, 10.7% had average levels (between the 28th and the 72nd percentile) and only 3.6% had above average levels (>72nd percentile). Using the composite score to classify participants as suffering from the positive or negative subtype of schizophrenia, 15 participants can be classified as suffering from the positive subtype and 12 from the negative subtype. One participant did not fall into either classification. In these subgroups the level of psychopathology can again be seen as small; in the positive subgroup 20% had above average levels of positive symptoms, 33.3% had an average level, but the majority (46.7%) had below average levels. In the negative subgroup, 16.7% had above average levels of negative symptoms, one quarter had an average level, but above half (58.3%) had levels of negative symptoms below average compared to the normative sample.

There were no significant differences between the PANSS scores given by the two raters.6

2.3 Mood

Using Zigmond and Snaith's (1983) cut-off scores on the HADS; just under half the participants (42.9%) scored within the normal range (0 to 7) on both the depression and anxiety subscales; one quarter (25%) scored within the normal range for depression but showed either the possible (8 to 10) or highly probable (score >11) presence of anxiety (14.3%: possible; 10.7%: highly probable); 17.9% scored within the normal range for anxiety but showed either the possible or highly probable presence of depression (14.3%: possible; 3.6%: highly probable); and 14.3% had the possible or highly probable presence of both depression and anxiety (3.6%: possible; 10.7%: highly probable).

6 Descriptive and inferential statistics are presented in appendix 19.
2.4 Cognitive functioning

The descriptive statistics in table 4 show that although there was a range of scores on the executive functioning task, the mean HMGT raw score is very similar to the mean raw score obtained from the standardisation sample (mean=23.7, s.d.=4.9) and left and right posterior lesion groups (mean=21.8, s.d.=5.7 and mean=24.1, s.d.=4.5 respectively) (Crawford & Warrington, 2002; Warrington, 2000). The participants’ mean raw score is also higher than that obtained by the left and right anterior lesion groups in Crawford and Warrington’s (2002) validation study (mean=16.7, s.d.=3.1 and mean=17.1, s.d.=5.8 respectively). Thus, the performance of the sample as a whole on the HMGT was not impaired and the participants performed demonstrably better on the HMGT than people with known frontal lobe pathology.

In contrast, the majority of the participants were impaired in their performance on the VSAT. Using Trenerry et al.’s (1990) criteria for cut-off scores on the VSAT, 63.0% of the participants who completed the VSAT performed within the impaired range (at or below the 2nd percentile), 29.6% performed within a range suggestive of impaired attention (at or between the 3rd and 16th percentile), and only two participants performed within the normal range (at or above the 17th percentile).

The participants’ scores on the HMGT and VSAT have been grouped into seven categories according to their percentile scores, and the numbers of participants performing at each category are shown in figures 1 and 2. Figure 1 and then figure 2 demonstrates that a range of scores was achieved on the HMGT but that there was not a range of percentile scores achieved on the VSAT. A possible bimodal distribution to the HMGT percentile scores is noticeable in figure 1.
Figure 1: Number of participants performing in each percentile category on the HMGT (n=28)

Figure 2: Number of participants performing in each percentile category on the VSAT (n=27)
Ideally, the VSAT percentile score would be used to correlate with other variables because it is the percentile and not the raw score that is age-adjusted. However, the lack of range to the percentile scores means it would not be meaningful to use them in correlations and therefore the raw score, in which there is a range of scores (figure 3), has been used to investigate the relationships between attention and insight.

Figure 3: Distribution of the participants’ raw scores on the VSAT (n=27)

2.5 Understanding of cognitive functioning
Figures 4 and 5 present the three understanding of cognitive functioning scores from -6 (an underestimate of cognitive ability) to +6 (an overestimate of cognitive ability). A score of 0 represents a fully accurate estimate of ability. Figure 4 shows that the participants were relatively accurate in perceiving their homophone generation skills with 63% achieving an understanding of homophone generation score between -1 and +1. In contrast, as shown in figure 5, participants were less accurate in their estimations of their attentional abilities; all but one overestimated their skills. The participant who underestimated was the participant who scored above the 90th percentile.
Figure 4: Number of participants achieving each understanding of homophone generation score (n=27)

Figure 5: Number of participants achieving each understanding of attention 1 and attention 2 score (n=26)
For further analyses, the directions of the understanding of cognitive functioning scores have been removed and the scores represented on a scale from 0 (fully accurate prediction/evaluation) to 6 (extremely poor prediction/evaluation). The descriptive statistics in table 4 are based on this 0 to 6 scale.

3.0 RELATIONSHIPS BETWEEN INSIGHT AND THE DEMOGRAPHIC AND CLINICAL VARIABLES
The correlations between insight and the demographic and clinical variables are shown in table 5.

3.1 Insight and demographic variables
Table 5 shows that there are no significant correlations between the insight scores and age, length of illness or time since index offence. A longer length of stay in Broadmoor Hospital is however significantly correlated with a greater ability to relabel psychotic phenomena as signs of illness ($p=.048$). It accounts for 10.2% of the variance in this subscale.

3.2 Insight and psychopathology
Table 5 shows that the insight scores measured by the SAI-E and the PANSS are significantly correlated ($r=-.45$ to -.54, $p=.001$ to .008), with participants rated as having greater insight on the SAI-E also rated as having higher levels of insight on the PANSS by a different rater on a separate occasion.

Table 5 shows that there are relationships between insight and general psychopathology and positive symptomatology, with the directions of these correlations showing that, as hypothesised, greater insight is associated with lower levels of psychopathology and symptomatology. Awareness of the need for treatment is significantly correlated with the PANSS total ($p=.04$), general psychopathology ($p=.009$) and positive symptom scores ($p=.03$) with each accounting for 10.9%, 20.5%, and 13.0% of the variance in awareness of the need for treatment respectively. There are non-significant trends in the correlations between scores on the subscale relabelling of psychotic phenomena and general
psychopathology ($p=.07$) and positive symptomatology ($p=.06$), and between the recognition of illness subscale and positive symptomatology ($p=.08$). In contrast, negative symptomatology is not significantly correlated with any aspects of insight; therefore the hypothesis that greater insight would be significantly associated with less negative symptomatology is not supported.

### 3.3 Insight and mood

There are three main findings in relation to the correlations between insight and mood shown in table 5. Firstly, it is noticeable that it is anxiety and not depression (as measured on the HADS) that is related to insight; secondly, anxiety is significantly related to the subscales recognition of illness ($p=.007$) and relabelling of psychotic phenomena ($p=.03$) but not to awareness of the need for treatment. Thirdly, greater insight is associated with higher anxiety. Anxiety accounts for 13.7%, 21.3%, and 13.7% of the variance in total insight, recognition of illness and relabelling of psychotic phenomena respectively. Thus, there is support for the hypothesis that greater insight would be associated with greater anxiety, but not for the hypothesis that insight would be related to depression.

Further inspection of table 5 shows that there are similar significant relationships between the SAI-E and HADS anxiety scores as between the SAI-E and PANSS depression scores. A Spearman’s correlation showed that there is a significant relationship between the HADS anxiety and PANSS depression scores ($r(27)=.48, p=.006, 1$-tailed). The items that comprise these scales do appear to measure similar symptoms; the PANSS depression items appear to relate more to anxiety symptoms than to symptoms of depression.
Table 5: Correlation co-efficients between insight and the demographic and clinical variables

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Insight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SAI-E Total Score</td>
</tr>
<tr>
<td>Age (n=29)</td>
<td>-.09</td>
</tr>
<tr>
<td>Duration of Mental Illness (n=29)</td>
<td>.04</td>
</tr>
<tr>
<td>Length of Stay in Broadmoor Hospital (n=29)</td>
<td>.26</td>
</tr>
<tr>
<td>Length of Time Since Index Offence (n=28)</td>
<td>-.01</td>
</tr>
<tr>
<td>Psychopathology (n=28)</td>
<td></td>
</tr>
<tr>
<td>PANSS Total Score</td>
<td>-.29</td>
</tr>
<tr>
<td>PANSS General Psychopathology Score</td>
<td>-.34*</td>
</tr>
<tr>
<td>PANSS Positive Symptom Score</td>
<td>-.35*</td>
</tr>
<tr>
<td>PANSS Negative Symptom Score</td>
<td>.03</td>
</tr>
<tr>
<td>PANSS Depression Score</td>
<td>.31</td>
</tr>
<tr>
<td>PANSS Insight Score</td>
<td>-.53**</td>
</tr>
<tr>
<td>Mood (n=28)</td>
<td></td>
</tr>
<tr>
<td>HADS Total Score</td>
<td>.24</td>
</tr>
<tr>
<td>HADS Depression Score</td>
<td>.12</td>
</tr>
<tr>
<td>HADS Anxiety Score</td>
<td>.37*</td>
</tr>
<tr>
<td>Cognitive Functioning</td>
<td></td>
</tr>
<tr>
<td>HMGT Scale Score (n=28)</td>
<td>.18</td>
</tr>
<tr>
<td>VSAT Raw Score (n=27)</td>
<td>.10</td>
</tr>
<tr>
<td>Understanding of Cognitive Functioning</td>
<td></td>
</tr>
<tr>
<td>Understanding of Homophone Generation (n=27)</td>
<td>.37*</td>
</tr>
<tr>
<td>Understanding of Attention 1 (n=26)</td>
<td>-.23</td>
</tr>
<tr>
<td>Understanding of Attention 2 (n=26)</td>
<td>-.32</td>
</tr>
</tbody>
</table>

**Correlation is significant at the .01 level (1-tailed))
*Correlation is significant at the .05 level (demographic: 2-tailed; other variables: 1-tailed)
Values are Spearman’s Rank Correlation Co-efficients
3.4 Insight and cognitive functioning

Table 5 shows that in the sample as a whole there are no significant correlations between insight and performance on either of the two cognitive tasks. The possible bimodal distribution of the HMGT scores (figure 1) suggests there could be two groups of participants divided into those scoring above the 40th percentile (n=12) and those scoring at or below the 40th percentile (n=16). These groups were compared on their SAI-E scores and the mean scores are shown in table 6. Mann-Whitney U-Tests however show that there are no significant differences between the groups on their total insight (Z=-1.46, p=.146), recognition of illness (Z=-1.12, p=.262), ability to relabel psychotic phenomena (Z=-1.29, p=.205), or awareness of the need for treatment (Z=-.95, p=.371). Overall, the hypothesis that greater insight would be associated with greater executive functioning and attention, as assessed by the HMGT and VSAT, was not supported.

Table 6: Descriptive statistics for the two groups of participants divided by their scores on the HMGT

<table>
<thead>
<tr>
<th></th>
<th>Insight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SAI-E Total Score Mean (s.d.)</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Group scoring above the 40th percentile (n=12)</td>
<td>15.13 (8.42)</td>
</tr>
<tr>
<td>Group scoring at or below the 40th percentile (n=16)</td>
<td>11.23 (5.94)</td>
</tr>
</tbody>
</table>

3.5 Insight and understanding of cognitive functioning

Table 5 shows there are three significant correlations between insight and the understanding of cognitive functioning scores; understanding of homophone generation is significantly related to total insight (p=.03), recognition of illness (p=.049) and ability to relabel psychotic phenomena as signs of illness (p=.03). The significant correlations are however in the opposite directions than were hypothesised. These results indicate that greater insight is associated with poorer understanding of cognitive functioning as related to homophone meaning generation performance. By contrast, the relationships between insight and understanding of attentional skills are in the hypothesised direction but fail to
reach significance, although there are non-significant trends in the correlations between understanding of attention 2 and total insight score \((p=.06)\), recognition of illness \((p=.09)\), relabelling of psychotic phenomena \((p=.09)\) and awareness of the need for treatment \((p=.06)\).

In order to understand further the relationships between insight and understanding of cognitive functioning, correlations between understanding of cognitive functioning and the demographic and clinical variables were conducted. These relationships are shown in table 7.

**Table 7: Correlation co-efficients between the understanding of cognitive functioning scores and the demographic and clinical variables**

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Understanding of Homophone Generation</th>
<th>Understanding of Attention 1</th>
<th>Understanding of Attention 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>(0.06)</td>
<td>(-0.07)</td>
<td>(0.01)</td>
</tr>
<tr>
<td>Duration of Mental Illness</td>
<td>(-0.00)</td>
<td>(-0.28)</td>
<td>(-0.23)</td>
</tr>
<tr>
<td>Length of Stay in Broadmoor Hospital</td>
<td>(0.09)</td>
<td>(-0.17)</td>
<td>(-0.21)</td>
</tr>
<tr>
<td>Length of Time Since Index Offence</td>
<td>(-0.07)</td>
<td>(-0.03)</td>
<td>(0.14)</td>
</tr>
<tr>
<td>Psychopathology</td>
<td>(n=27)</td>
<td>(n=26)</td>
<td>(n=26)</td>
</tr>
<tr>
<td>PANSS Total Score</td>
<td>(0.07)</td>
<td>(0.19)</td>
<td>(0.33)</td>
</tr>
<tr>
<td>PANSS General Psychopathology Score</td>
<td>(-0.03)</td>
<td>(0.30)</td>
<td>(0.37^*)</td>
</tr>
<tr>
<td>PANSS Positive Symptom Score</td>
<td>(-0.03)</td>
<td>(0.21)</td>
<td>(0.29)</td>
</tr>
<tr>
<td>PANSS Negative Symptom Score</td>
<td>(0.14)</td>
<td>(0.07)</td>
<td>(0.17)</td>
</tr>
<tr>
<td>Mood</td>
<td>(n=27)</td>
<td>(n=26)</td>
<td>(n=26)</td>
</tr>
<tr>
<td>HADS Total Score</td>
<td>(0.38^*)</td>
<td>(0.01)</td>
<td>(0.06)</td>
</tr>
<tr>
<td>HADS Depression Score</td>
<td>(0.42^*)</td>
<td>(0.06)</td>
<td>(0.04)</td>
</tr>
<tr>
<td>HADS Anxiety Score</td>
<td>(0.38^*)</td>
<td>(0.02)</td>
<td>(0.10)</td>
</tr>
</tbody>
</table>

* Correlation is significant at the .05 level (1-tailed)
Values are Spearman’s Rank Correlation Co-efficients

Understanding of homophone generation is significantly associated with levels of depression \((p=.02)\) and, like insight (subscales recognition of illness and relabelling of psychotic phenomena), with anxiety \((p=.03)\). Poorer understanding of homophone generation is associated with greater depression and anxiety. It is also noticeable in table
5 that the patterns of relationships between understanding of homophone generation and insight are similar to the patterns of relationships between anxiety and insight. It can also be interpreted from figure 4 how the distribution of understanding of homophone generation scores would look on the scale 0 to 6; 96.3% of the scores would fall between 0 and 3. This poor distribution of scores is likely to have affected the correlations between understanding of homophone generation and insight, and therefore these associations need to be interpreted with caution. Table 7 shows that greater levels of psychopathology are significantly associated with poorer evaluation of attentional ability ($p=.03$).

The hypothesis that greater insight would be associated with greater understanding of cognitive functioning was not supported.

**4.0 SUMMARY**

Awareness of the need for treatment was the insight component most related to psychopathology (general psychopathology and positive symptomatology), while recognition of illness and ability to relabel psychotic phenomena as signs of illness were the components significantly related to anxiety. Performance on the tests of cognitive functioning was not significantly correlated with insight and, in relation to understanding of cognitive functioning, there are counterintuitive relationships that need to be interpreted with caution. One demographic variable was significantly associated with insight: a longer length of stay in Broadmoor Hospital correlated with a greater ability to relabel psychotic phenomena as signs of mental illness. It is necessary to acknowledge that the small sample size determines that caution should be taken when interpreting the results and that the results expressed are relationships between two variables upon which there is the possibility that third variables could be influential.
DISCUSSION
This research asked: what are the clinical correlates of insight into mental illness in forensic patients with schizophrenia? and aimed to investigate whether or not there were significant correlations between insight and the clinical variables of psychopathology, mood, cognitive functioning and understanding of cognitive functioning in forensic patients; individuals with schizophrenia who have committed acts of violence and are currently patients in a high-security hospital because they are deemed to pose a significant risk to others. The research also considered: are there differential relationships between the components of insight and the clinical variables? The overall aim was to develop the understanding of the concept of insight in this specific patient group given the importance placed on it within clinical practice.

1.0 THE RELATIONSHIPS BETWEEN INSIGHT AND CLINICAL VARIABLES

1.1 Insight and psychopathology
In this study, as hypothesised, patients with a lesser degree of positive symptomatology did show greater overall insight, supporting a number of previous studies that have also found modest correlations between positive symptomatology and insight in community studies (Amador et al., 1994; Collins et al., 1997; Kim et al., 1997; Rossell et al., 2003; Sevy et al., 2004; Smith et al., 2000) and research conducted with forensic patients (Buckley et al., 2004; Carroll et al., 2004).

It is important, however, to retain a view of insight as a multidimensional phenomenon and take note that, while there were non-significant trends in the association between positive symptomatology and both awareness of illness and ability to relabel psychotic phenomena as signs of mental illness, it was awareness of the need for treatment that was the aspect of insight most related to severity of positive symptoms. A similar pattern was also found between the components of insight and general psychopathology; less general psychopathology was associated with greater overall insight but particularly with greater awareness of the need for treatment. The relationship between symptomatology/psychopathology and awareness of the need for treatment may be
strongest because it is a transactional relationship, in which symptoms and awareness of the need for, and compliance with, treatment interact with each other, reinforcing the reduction and increase in each respectively. Poorer adherence to treatment is related to an increased risk of relapse from clinical stability (Arango et al., 1999; Torrey, 2004). It is not so intuitive to suspect a direct transactional relationship between levels of symptomatology and awareness of illness and ability to perceive psychotic phenomena as symptoms of illness.

However, Mintz et al. (2003) in their meta-analysis of studies conducted with non-violent individuals with schizophrenia living in the community found that general psychopathology and positive symptoms were related to a similar degree to awareness of the need for treatment ($r=-.25$ and $r=-.31$ respectively) as they were to other aspects of insight ($r=-.20$ to -.41 and $r=-.16$ to -.33 respectively), therefore the findings of the present study do not appear to be replicated in the general literature. In this study the insufficient variance in the psychopathology scores may have reduced the size of the correlations and meant some insight-psychopathology correlations failed to reach significance; the patients were relatively clinically stable at the time of the research and did not include patients exhibiting the severest levels of psychopathology. However, there are still stronger associations between positive symptoms and general psychopathology and awareness of the need for treatment over and above the other aspects of insight.

It is plausible that it is the greater prominence of issues around treatment compliance for forensic patients compared with individuals living in the community that could account for the stronger relationship between psychopathology and awareness of the need for treatment in this client group. Unique to a forensic environment is that patients are explicitly exposed to a powerful message from both the health and legal systems that they have a ‘mental illness’ that requires ‘treatment’; if only by the fact that following committing a criminal offence they are detained under mental health rather than criminal justice legislation and in a hospital rather than a prison. The pattern of insight in this group of forensic patients did show that the patients had greatest awareness of the need for treatment, followed by awareness of having a mental illness, and had the lowest level of insight into their symptoms being a sign of illness. It may be that the greater awareness of
the need for, and compliance with, treatment is a reflection of the patients’ socialisation to
the culture of the forensic system rather than an expression of any greater insight into why
they may need treatment (McEvoy et al., 1989). The suggestion is that patients who are
more clinically stable may be more influenced by messages from the system around them
and in a hospitalised, forensic context the messages most dominant are those pertaining to
the need for treatment (rather than the need to recognise mental illness). It is unfortunate
that Carroll et al. (2004) in their study with forensic patients failed to report on the
separate components of insight (on the SAI) so it cannot be considered how these ideas fit
with their research.

**Negative symptomatology** was not associated with insight. This finding does not support
the original hypothesis, but is consistent with findings by other researchers (Amador et al.,
1994; Kim et al., 1997; Smith et al., 1998) and is not necessarily unexpected. Mintz et al.
(2003) and Rossell et al. (2003) highlight that insight can be considered to be more closely
related to severity of positive, rather than negative, symptomatology because for example,
in order to hold a delusional belief with conviction it seems necessary that one would have
to have a high degree of unawareness. The same cannot be said for negative symptoms.

Previous research with individuals living in the community has indicated that insight is
associated with symptoms of schizophrenia, and therefore is influenced by clinical state,
but because associations have been moderate, at best, an individual’s understanding of
illness is considered to be influenced by factors beyond processes associated with positive
and negative symptomatology (Amador & Kronengold, 2004; David, 2004; Mintz et al.,
2003). This study is in support of the same conclusions for forensic patients. However, it
must be re-emphasised that the patients were *relatively clinically stable* and therefore
severity of symptoms could contribute to a greater amount of variance in the insight of
forensic patients who are acutely psychotic. Severity of illness is a moderator of the
relationship between insight and psychopathology (Mintz et al., 2003).

**1.2 Insight and mood**
The clinical variable with the strongest relationship to insight in this study is anxiety;
patients with greater anxiety were found to have greater overall insight, recognition of
illness and ability to relabel psychotic phenomena as signs of illness. Contrary to expectation, depression was not related to insight; a finding that is at odds with numerous previous studies (Amador et al., 1994; Buckley et al., 2001; Carroll et al., 1999; Collins et al., 1997; Iqbal et al., 2000; Mintz et al., 2003; Moore et al., 1999; Rathod et al., 2005; Sanz et al., 1998; Schwartz, 2001; Smith et al., 1998; Smith et al., 2000) and therefore probably a reflection of methodological issues specific to this study. Depression is difficult to measure in individuals with schizophrenia because of the overlap between negative symptoms and symptoms of depression (Collins et al., 1997; Moore et al., 1999). There was not a significant correlation between HADS depression and PANSS negative symptom scores in this study ($r(27)=.18, p=.182, 1$-tailed). However the depression measures utilised in other research were probably more appropriate for the measurement of depression in schizophrenia than the HADS. For example, the Calgary Depression Scale (Addington et al., 1990; Addington et al., 1993), used by Collins et al. (1997) and Moore et al. (1999), was developed to assess depression in schizophrenia and on reflection would be a more appropriate scale for use in future studies.

There is minimal research that has considered the relationship of insight to affective experiences other than depression, however this research supports findings by Freudenreich et al. (2004) and Smith et al. (1998) and shows that anxiety is another clinical state worthy of consideration; anxiety accounted for 21.3% and 13.7% of the variance in awareness of illness and relabelling of psychotic phenomena respectively. However, correlations are not able to imply causation, therefore as in Freudenreich et al.'s (2004) study, in this research it is unclear whether insight led to greater anxiety or whether anxiety led to greater insight. Intuitively one might suggest that the former would be true, for the same reasons discussed in the introduction in relation to depression; holding a belief that one does not have a mental illness may reflect a coping style characterised by the avoidance of distress and anxiety around having a mental illness. Insight may cause anxiety because it leads patients to become more aware of the difficult reality of living with schizophrenia and of living in a high-security hospital. Researchers have cautioned that too much insight could lead to depression, demoralisation and suicide (Swartz et al., 2001) and a similar caution could be made based on the findings around anxiety in this research because for people with schizophrenia greater anxiety too is a risk factor for
suicide (Funahashi et al., 2000) and is related to poorer quality of life (Huppert et al., 2001).

In relation to depression, however, Iqbal et al. (2000) demonstrated that it was not insight that led to depression but the development of negative appraisals around humiliation, loss, self-blame and entrapment; which in turn developed following the experience of psychosis not the experience of gaining insight, and in fact it was greater depression that led to greater insight. Is the same direction of relationship possible for insight and anxiety? Freudenreich et al. (2004) suggest that anxiety could be an expression of distress and illness burden which acts as an ‘alarm signal’ and prompts individuals to appraise their experiences; thus anxiety could lead to greater awareness of mental illness.

This explanation by Freudenreich et al. (2004) suggests that greater anxiety is associated with greater levels of positive symptomatology and, although it is a non-significant trend, there is some suggestion that levels of anxiety and positive symptoms were positively related in this sample ($r(27)=.32$, $p=.051$, 1-tailed). The explanation however does not appear to fit with other findings in this study because, as figure 6 shows, it suggests that greater levels of positive symptomatology would be associated with greater insight, whereas the reverse was true in this study.

![Figure 6: Hypothesised relationship between anxiety, positive symptoms, and insight as suggested by Freudenreich et al. (2004)](image)

However, it is noticeable that in this study the aspects of insight to which anxiety was related (recognition of illness and ability to relabel psychotic phenomena) were the aspects
of insight least related to levels of positive symptomatology (table 5). It is a consideration that in some patients the above set of relationships (greater positive symptomatology, greater anxiety, and greater recognition of illness and ability to relabel psychotic phenomena) are present and that this offsets the fact that in other patients recognition of illness and ability to relabel psychotic phenomena is lower in those with more acute symptoms. The effect of this would be to reduce the relationships between positive symptoms and recognition of illness and relabelling of psychotic phenomena to the non-significant relationships (r=−.23 to r=−.30) found in this study. Unfortunately linear correlations, the small sample size, and ordinal level of data prevent the exploration of such complex interrelationships and therefore these ideas have to remain speculative.

In summary, anxiety does appear to be an important correlate of two components of insight but its temporal role is uncertain. Longitudinal research investigating the role of anxiety, similar to the study by Iqbal et al. (2000), would be necessary to increase understanding around causal processes.

1.3 Insight and cognitive functioning

This research failed to find associations between insight and performance on cognitive tasks designed to assess executive function and attention, and in this respect is not able to support a dominant idea in the literature that poor insight reflects a deficit in frontal lobe functioning. There are however studies that have cast doubt on the proposal that poor insight is secondary to executive dysfunction (Arudini et al., 2003; Freudenreich et al., 2004; Kim et al., 2003; Nakano et al., 2004; Sanz et al., 1998) or attentional deficits (Rossell et al., 2003), and the findings from the present study fit with this research. It is important however to give consideration to possible methodological and theoretical reasons for this study’s lack of significant findings, and these considerations show that it not possible to reject completely the frontal lobe model of insight based on the results of this study.

1.3.1 Methodological considerations

In this research the patients as a group were relatively unimpaired on the assessment of executive functioning. One might have expected these patients with a history of violence
to have shown greater impairment on a task of frontal function because impairment in the prefrontal cortex is associated with violence and aggression (Brower & Price, 2001; Golden et al., 1996; Morgan & Lilienfeld, 2000) and studies specifically considering aggressive behaviour in schizophrenia have found that these individuals have poorer executive functioning compared to individuals with schizophrenia who are not violent (Barkataki et al., 2005; Rasmussen et al., 1995). The relatively good performance of the patients on the HMGT can be contrasted with the extremely poor performance by the vast majority on the test of selective attention; a finding that is expected and supports the literature that states that poor selective attention is a main cognitive dysfunction in schizophrenia (Brebion et al., 1996; Elvevåg & Goldberg, 2000; Jones et al., 2001).

One explanation for the difference between the patients' performance on the attention task and the HMGT is the fact that only the attention task was timed. Previous research conducted at Broadmoor Hospital found that it was on executive functioning tasks with a timed element that individuals with schizophrenia gave a significantly poorer performance compared with patients with other mental illnesses or personality disorders (Hill et al., 1994). It is possible that, while the HMGT is a validated assessment of executive function, the lack of a timed element meant it did not assess efficiency of word retrieval (psychomotor speed), which has been shown to be impaired in the performance of people with schizophrenia on verbal fluency tasks (van Beilen et al., 2004; Vinogradov et al., 2002). This could have influenced the finding of a non-significant association between insight and performance on the HMGT. The lack of range to the percentile scores on the attention task, and the subsequent need to use the non-age-adjusted raw scores to correlate with insight, could have affected the relationship between attention and insight. Different results may also have been obtained had it been feasible to utilise more commonly used measures of executive function and attention, such as the WCST and the Continuous Performance Test.

### 1.3.2 Theoretical considerations

It is important to take note that schizophrenia is not an homogenous disorder. Liddle and Morris (1991) identified three symptom clusters; disorganisation (thought disorder), reality distortion (positive symptoms of delusions and hallucinations), and psychomotor
poverty (negative symptoms) that have been associated with deficits in different areas of
the prefrontal and temporal lobes and related to different cognitive profiles (Allen et al.,
2001; Kravariti et al., 2005; Liddle & Morris, 1991; Pantelis et al., 1999; Yogev et al.,
2003). The lack of a significant relationship between insight and cognitive functioning in
the present study could be explained by the heterogeneity of the symptom profiles of the
patients in the sample. Young et al. in 1993 stated that 'it may be particularly fruitful
to...explore the relationship between lack of awareness and the neurologically based
subtypes of schizophrenia that have been derived by Liddle and Morris (1991)' (p.122).
Unfortunately, the small sample size has prevented exploration of the results in accordance
with the above theoretical ideas but given the diverse findings in the general literature
perhaps it is time Young et al.’s (1993) recommendation is given more consideration in
future research.

1.4 Insight and understanding of cognitive functioning
This research is unable to support fresh ideas in the literature that, because both could be
considered aspects of ‘self-awareness’, insight may be associated with understanding of
cognitive functioning rather than with cognitive functioning per se (Koren et al., 2004;
Medalia & Lim, 2003).

The lack of consistency between the findings in this study and those of Koren et al. (2004)
who did find support for the above ideas is potentially attributable to cohort differences
(the participants in Koren et al.’s study had first-episode schizophrenia) or they may
reflect differences in methodology. Understanding of cognitive functioning has rarely
been assessed in people with schizophrenia and no standardised instruments have been
devised. It was necessary for both Koren et al. and this study to create instruments that
would assess patients’ understanding of their functioning on the specific cognitive
assessments used. This study did not use the WCST as utilised by Koren et al., for
reasons discussed in the method section, and therefore it was not possible to replicate their
methodology and thus perhaps their results. Koren et al. described their research as a
‘pilot metacognitive study’ and the same must be concluded for this research; the method
used in this study was devised from methods used to assess understanding in individuals
with neurological damage but it is recognised that the use of a Likert rating scale will
potentially open up participants’ responses to biases such as the tendency to rate oneself in the middle of a scale or in a socially desirable manner (Barker et al., 2002). Given the method of assessment, it is not surprising that some of the understanding of cognitive functioning scores were significantly related to anxiety and it is hypothesised that anxiety may have accounted for the counterintuitive relationships found between understanding of homophone generation and insight. It was not possible to explore this hypothesis given the necessity to use non-parametric statistics but the relationships with anxiety raise questions about the validity of the scores and are the reason for placing little weight on these findings. More sophisticated methods with demonstrable reliability and validity are yet to be established in the literature but are needed to enable this direction of enquiry to move forward.

2.0 STUDY LIMITATIONS

There are limitations with this study that restrict the extent to which the findings and conclusions of the research can be generalised. The main limitations reflect difficulties inherent in conducting research with forensic patients; the number of available patients with a history of violence and a diagnosis of schizophrenia is necessarily small (Carroll et al., 2004; Taylor et al., 1998) and it is difficult to control extraneous variables in a secure hospital setting (Buckley et al., 2004; Taylor et al., 1998; Torrey, 1994). This research has a small sample size and this introduces the possibility of making a type II error; the study does not have sufficient statistical power to discount with confidence possible relationships. The power to detect an effect size of $r=.30$, one-tailed, alpha .05 is 0.54, which does not achieve the desirable level of 0.80. In addition, multiple correlations were conducted and this will increase the possibility of a type I error; that significant findings are the result of multiple comparisons. A Bonferroni correction to reduce the significance level was not applied, rather the $p$-values for the main significant correlations are provided in the text for the reader, the proportion of variability in insight that can be accounted for by a given variable ($r^2$ value) is presented for the main variables as this provides the most useful information about the strength of a correlation (Gravetter & Wallnau, 2000), and it is emphasised that the results are exploratory and preliminary findings.

7 There were 31 comparisons conducted. Using a Bonferroni correction the required level of significance would be $p<0.0016$. 

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This research was conducted with a clinical sample and therefore encompassed all the heterogeneity inherent in such a group of patients. Unfortunately it was not possible to control for medication or psychotherapeutic interventions and it must be considered that these could have impacted on individuals' assessed insight, mood and psychopathology. One strength of the study is that insight and psychopathology were assessed by different raters and this will have reduced any bias introduced to the psychopathology assessment, however in order to achieve this, the assessments were completed some time apart and this is a limitation.

The patients in this study appear remarkably similar to other patients with a mental illness in Broadmoor Hospital and a research study conducted by Taylor et al. (1998) on individuals in the three secure forensic hospitals in England found that, like the patients in this study, the majority were men (83%) and White British, the sizeable ethnic minority group was Black British, ‘the most common disorder was schizophrenia, most usually in paranoid form’ (p.219), comorbid personality disorder was frequently present, and violence against another person was the most common index offence. In a general sense, the sample in this study can therefore be considered quite comparable with other cohorts of forensic patients however there will undoubtedly be bias in the sample due to its selected nature; individuals referred for participation by their RMOs and who consent to take part in research on insight could be biased towards individuals with less psychopathology and greater insight. The findings and conclusions should be interpreted with these limitations in mind.

3.0 CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

3.1 What were the clinical correlates of insight?
There are significant implications for forensic patients deemed to ‘lack insight’ and therefore research is important for increasing clinicians’ understanding around this concept. The main implications for practice that could arise from research assessing the clinical correlates of insight are:
If insight is directly associated with psychopathology it could be considered an integral aspect of mental illness and ‘treatable’ along with other signs and symptoms. If insight is related to depression or anxiety, there are implications for a need to focus on psychological factors that may lead to or arise from insight. If insight is associated with neuropsychological deficits consideration must be given to whether or not it is possible to increase individuals’ understanding of their illness as is often desired by risk assessors and Mental Health Review Tribunals (Diesfeld, 2003; Sturidsson et al., 2004; Webster et al., 1997).

This research found that insight in forensic patients was related to positive and general psychopathology and to anxiety but the importance of depression, executive functioning and attention, and understanding of cognitive functioning to insight in this population was not supported; although these conclusions should be tempered by the critique of the research raised in the discussion so far.

The results do therefore point to an element of insight that is state dependent and suggest implications for therapeutic practice in relation to the finding that anxiety was associated with awareness of illness and attribution of psychotic phenomena to mental illness. Clinicians need be aware that individuals who do construe their difficulties as reflective of mental illness may have associated high anxiety. It is not clear which comes first, awareness of illness or anxiety, but there are implications for both possibilities. In a forensic setting it is not uncommon for patients to be involved in psychoeducational or therapeutic interventions aimed at increasing understanding of mental illness and this research indicates that it is necessary that clinicians are aware that such interventions could increase anxiety in the individuals with whom they are working and therefore concomitant anxiety-related intervention may be needed. From the alternative perspective, clinicians need to ensure that, in focusing on engaging individuals deemed to need to increase their understanding of mental illness, there is not a simultaneous diversion away from the therapeutic needs of those individuals who do recognise they have a mental illness. This research shows that these individuals may require
psychotherapeutic assessment of, and potentially intervention aimed at reducing, their anxiety.

3.2 Were there differential relationships between the components of insight and the clinical variables?

The relationships between insight and psychopathology and insight and anxiety were not straightforward; differential relationships between the components of insight and these clinical factors were found. These results supported views that insight should be construed as a multidimensional phenomenon (Amador et al., 1993; David, 1990) but did not support the hypothesis that the ability to attribute psychotic phenomena to illness would be the aspect of insight most related to psychopathology and cognitive functioning.

In this group of forensic patients, recognition of having an illness and attribution of symptoms to mental illness appeared to be similar constructs; both were associated with anxiety but not with other clinical factors. In contrast, awareness of the need for treatment was the construct related to psychopathology but not to any other clinical variable. There appears to be a dissociation between awareness of the need for treatment and the other two aspects of insight and this finding supports arguments already raised within the literature that is not useful to ‘lump together’ what appear to be ‘such disparate concepts’ into a broader concept of insight (Beck-Sander, 1998).

The finding of an association between awareness of the need for treatment and positive symptomatology and general psychopathology could be construed to be at odds with the view in the literature that awareness of the need for treatment is least likely to be related to clinical variables and most likely to be influenced by sociocultural factors (Beck-Sander, 1998; David, 2004; Drake & Lewis, 2003; Freudenreich et al., 2004; Johnson & Orrell, 1995; Lysaker et al., 2003; McEvoy et al., 1996; Rossell et al., 2003). The findings in this research however lead more towards a suggestion that, in relation to this aspect of insight, there may be an interaction between clinical and sociocultural factors; an idea not yet raised from research conducted with non-violent individuals with schizophrenia living in the community. It is suggested that patients might not acknowledge that they have a mental illness or feel they experience symptoms of illness, but because of sociocultural
processes within a forensic hospital, do express a need for and adhere to treatment, and, additionally, the most clinically stable patients may be those that are most influenced by sociocultural processes. It is because awareness of the need for treatment is the factor most influenced by the culture of a high-security hospital that it is most associated to levels of psychopathology in this population.

In conclusion: the different aspects of insight do appear to have different aetiologies but none appear to be adequately explained by clinical factors; individual correlations suggest there is a large amount of variance in the three components of insight that is not explained by clinical state. It is unfortunate that the small sample size and ordinal level of data have prevented an exploration into the relative contributions of psychopathology and anxiety to the prediction of insight using a multiple regression analysis. However the results have to lead one to consider that insight, as it is currently construed and assessed, may not (in its entirety) be a clinical attribute but a product of sociocultural processes.

There are two important issues that now arise: what are the implications of this conclusion for the utility of the concept of ‘insight into mental illness’ and the reliance on it in a forensic context? and, to what extent should these results and conclusions be generalised to forensic patients with schizophrenia as a whole?

4.0 FURTHER IMPLICATIONS AND FUTURE DIRECTIONS

4.1 The utility of the concept of insight: insight as a sociocultural construction
Throughout this discussion there have been suggestions for how future research could expand the understanding of the concept of insight however consideration must be given to whether or not future directions should place an emphasis on this or whether in fact research should aim to move away from the construct of ‘insight’ and the current emphasis on its potential clinical or neuropsychological underpinnings. What may be necessary instead is the direction of more research towards a more sociocultural and individualised understanding of patients’ attitudes and beliefs. During the conduction of this research it was clear that the dominant method of scoring individuals’ responses from a brief semi-
structured interview did not give justice to vulnerable individuals' experiences, attitudes and beliefs around a very personal and sensitive topic. In the words of Diesfield (2003) it 'is worthy of further inter-disciplinary debate' as to 'whether this delicate and complex aspect of mental health is amenable to scientific assessment' (p.68).

From a methodological point view it is questionable as to whether the concept of insight as it currently stands can really be subject to thorough scientific enquiry. This research has shown, that like other studies investigating insight, it is difficult to draw definitive conclusions because there are such a vast number of factors that could be interrelating or exerting an influence on the account given by the individual at the time of the interview. For example, not only are there many factors that could influence individuals' actual beliefs about whether or not they have a mental illness or require treatment, but for participants whose power and autonomy are considerably reduced by their environment, there are likely to be additional factors operating that influence individuals' accounts of their beliefs. 'Insight', as it is currently conceptualised, may not be a concept that is quantifiable in a meaningful way.

At a theoretical level, it could be argued that 'insight' as it is construed and assessed in forensic research and clinical practice is a culturally and socially, not clinically, determined phenomenon. From this perspective 'insight' is considered to be:

...not so much within the individual as between individuals...or on a larger scale, between the individual and society. At its most constrained it refers to...the extent to which individual's agree to conform to certain behaviour...More broadly it refers to an individual's acceptance of a series of cultural norms and prevalent beliefs about the nature of illness and the manifestations of illness (David & Kemp, 1997, p.795).

This study can support the idea that measured insight is a reflection of sociocultural processes because it was on the aspect of insight that reflects the most powerful message within a high-security hospital that the participants demonstrated 'greatest insight' - awareness of the need for treatment. These conclusions are not new. A number of other
researchers (Beck-Sander, 1998; Johnson & Orrell, 1995; Kirmayer et al., 2004; Perkins & Moodley, 1993) have also argued that sociocultural processes influence levels of ‘assessed insight’ for a number of reasons and therefore challenge its utility as a concept or actively reject it. Beck-Sander (1998) states that the concept of insight and the assumptions that accompany it are ‘inherently flawed’. Over the years, researchers have attempted to develop the conceptualisation of insight, for example from a unidimensional to a multidimensional concept (Amador et al., 1993; David et al., 1992), but arguably the assessment and the concept remain ‘extremely crude’ (Perkins & Moodley, 1993).

So, does the concept have any utility in a forensic context?

4.2 The utility of the concept of insight: the importance of clinical state

It is important to place the findings from this research in the context of previous research conducted with individuals with a history of violence (see introduction: 4.1 and 4.2). The forensic patients in this study did not have considerably lower levels of ‘assessed’ insight compared with non-violent individuals living in the community who were also assessed on the same insight scale (SAI/SAI-E) (see appendix 18). This is in support of Carroll et al.’s (2004) findings but do not concur with Buckley et al.’s (2004) or Goodman et al.’s (2005) conclusions that poor insight is more pronounced in violent individuals. A review of the literature demonstrates that a crucial difference between the studies that found insight to be lower in forensic patients and/or associated with violence (Arango et al., 1999; Buckley et al., 2004; Goodman et al., 2005) and the studies that found forensic patients did not have lower insight or that insight did not appear to be important to violence (this study; Carroll et al., 2004; Yen et al., 2002) is clinical stability of the patients. The patients in this study were relatively clinically stable. Carroll et al. (2004) stated that the same was true for their participants and Yen et al. (2002) had a sample who were ‘considered to be in remission or to have minimal psychopathology’ (p.444) (defined as a PANSS total score of less than 60). In contrast, the PANSS mean scores in Buckley et al.’s (2004) and Arango et al.’s (1999) samples were 34.9 and 38.1 for general psychopathology, 21.2 and
23.9 for the positive subscale, and 17.2 and 19.4 for the negative subscale respectively, showing that their participants were much less clinically stable\(^8\). Therefore:

While patients who have been violent in the past are relatively clinically stable, the level of their measured insight appears similar to the level of insight in individuals who have not committed acts of violence (this study, Carroll \textit{et al.}, 2004), insight is not predictive of future violence (Yen \textit{et al.}, 2002) and the level of insight could be a reflection of more sociocultural rather than clinical variables (this study). \textit{When patients relapse and exhibit high levels of (general and positive) symptomatology} their level of insight is lower compared with non-violent individuals (Buckley \textit{et al.}, 2004), poorer insight is predictive of violence (Arango \textit{et al.}, 1999), and it is possible that the aetiology of measured insight is more clinically based. The integration of the findings from this study with previous research therefore raises the suggestion that clinical state could be a \textit{moderator of the importance of the concept of insight} in forensic patients with schizophrenia.

### 4.3 Final remarks

If the importance placed on the concept of insight in the assessment of risk at a clinical and legal level is to continue, there needs to be a recognition that lack of insight construed as ‘based within an individual and linked to clinical factors with clinical implications’ is limited in individuals in clinical remission. It could still be relevant to individuals who are acutely psychotic but further research is clearly needed; firstly, to directly investigate the impact of sociocultural factors on ‘assessed insight’ in forensic patients, and secondly to evaluate the differential importance of clinical and sociocultural factors to ‘assessed insight’ in stable versus acutely psychotic forensic patients. Important caveats are that any further research or assessment in clinical practice must treat insight as a multidimensional phenomenon and at a clinical level there must be more individualised methods of assessment.

The importance of developing an understanding of the factors that influence an individual’s understanding of mental distress and difficulties remains, but, as both Perkins and Moodley (1993) and Kirmayer \textit{et al.} (2004) highlight, there are many different

\(^8\)The PANSS mean scores in this study were 24.5 (general psychopathology), 14.5 (positive subscale) and 12.0 (negative subscale).
frameworks that individuals utilise to understand their difficulties and in many cases individuals draw on more than one explanatory framework. All frameworks are equally valid yet utilising the concept of 'insight' does lead one to privilege medical conceptualisations of mental distress. Unfortunately such practice can risk alienating individuals if it does not fit with their understanding of their experiences and clinicians should always work in ways that will create a willingness in individuals to articulate and explore their experiences. It is uncertain how drawing on the concept of insight can help clinicians achieve both the aim of reducing individuals’ risk to others and the aim of creating change that is therapeutic and empowering. This is a difficult tension to negotiate but is the endeavour of all clinicians working within a forensic setting, consequently it may be time to abandon altogether the idea that 'insight' is a useful concept in therapeutic practice.
REFERENCES


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Appendix 1: Diagnostic Criteria for Schizophrenia in the DSM-IV (American Psychiatric Association, 1994)

A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
   (1) delusions
   (2) hallucinations
   (3) disorganized speech (e.g., frequent derailment or incoherence)
   (4) grossly disorganized or catatonic behavior
   (5) negative symptoms, i.e., affective flattening, alogia, or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective and Mood Disorder exclusion: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Classification of longitudinal course (can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms):
- **Episodic With Interepisode Residual Symptoms** (episodes are defined by the reemergence of prominent psychotic symptoms); also specify if: **With Prominent Negative Symptoms**
- **Episodic With No Interepisode Residual Symptoms**
- **Continuous** (prominent psychotic symptoms are present throughout the period of observation); also specify if: **With Prominent Negative Symptoms**
- **Single Episode In Partial Remission; also specify if: With Prominent Negative Symptoms**
- **Single Episode In Full Remission**
- **Other or Unspecified Pattern**

### Appendix 2: Summary of Studies Investigating the Relationship Between Insight and Psychopathology and/or Depression/Anxiety

<table>
<thead>
<tr>
<th>Authors</th>
<th>Sample</th>
<th>Measures</th>
<th>Results</th>
<th>Methodological Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>McEvoy et al.</td>
<td>N=52 Inpatients Chronic SZ Acutely psychotic USA</td>
<td>ITAQ BPRS N/A</td>
<td>Psychopathology and insight not significantly correlated.</td>
<td>Correlational study. Independent ratings of variables.</td>
</tr>
<tr>
<td>Amador et al.</td>
<td>N=221 Chronic SZ USA</td>
<td>SUMD SAPS SANS DSM-IV Criteria for Major Depressive Disorder</td>
<td>Different symptoms associated with different aspects of awareness. Modest correlations between increase in delusions, thought disorder and disorganised behaviour, and less awareness of mental disorder and social consequences. Negative symptoms (generally) not significantly correlated with insight.</td>
<td>Patients with Major Depressive Disorder had more awareness of some symptoms. Correlational study. Lack of independent ratings of variables.</td>
</tr>
<tr>
<td>Kim et al.</td>
<td>N=63 Inpt/Outpts Chronic SZ Japan</td>
<td>SAI BPRS SANS HAM-D</td>
<td>Positive, but not negative, symptoms inversely correlated with awareness of illness and ability to relabel psychotic symptoms.</td>
<td>Insight and depression not significantly correlated. Correlational study.</td>
</tr>
<tr>
<td><strong>Collins et al. (1997)</strong></td>
<td><strong>N=58 Outpatients Chronc SZ Canada</strong></td>
<td><strong>SAI</strong></td>
<td><strong>PANSS</strong></td>
<td><strong>CDS</strong></td>
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<tr>
<td><strong>Smith et al. (1998)</strong></td>
<td><strong>N=33 Inpt/Outpts Chronic SZ/SA USA</strong></td>
<td><strong>SUMD</strong></td>
<td><strong>BPRS</strong></td>
<td><strong>BPRS Anxiety Scores</strong></td>
</tr>
<tr>
<td><strong>Sanz et al. (1998)</strong></td>
<td><strong>N=33 Inpts Non-organic psychotic illness UK</strong></td>
<td><strong>SAI</strong></td>
<td><strong>SAI-E ITAQ</strong></td>
<td><strong>BPRS</strong></td>
</tr>
<tr>
<td><strong>Carroll et al. (1999)</strong></td>
<td><strong>N=100 Chronic SZ UK</strong></td>
<td><strong>ITAQ</strong></td>
<td><strong>PANSS</strong></td>
<td><strong>MADRS</strong></td>
</tr>
<tr>
<td>Study</td>
<td>N=46</td>
<td>SUMD</td>
<td>SAPS</td>
<td>BDI</td>
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<tr>
<td>Moore et al. (1999)</td>
<td>Chronic SZ Ireland</td>
<td>SUMD</td>
<td>SAPS</td>
<td>BDI</td>
</tr>
<tr>
<td>Smith et al. (2000)</td>
<td>Outpatients Chronic SZ/SA USA</td>
<td>SUMD</td>
<td>BPRS</td>
<td>BPRS Depression Score</td>
</tr>
<tr>
<td>Weiler et al. (2000)</td>
<td>Inpatients SZ USA</td>
<td>ITAQ</td>
<td>BPRS</td>
<td>N/A</td>
</tr>
<tr>
<td>Study</td>
<td>N=</td>
<td>Scale</td>
<td>BDI</td>
<td>Patients who were depressed, compared with those who were not depressed, had greater insight into awareness of illness, labelling of symptoms, and need for treatment.</td>
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<tr>
<td>Iqbal et al. (2000)</td>
<td>105</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Buckley et al. (2001)</td>
<td>50</td>
<td>SUMD BPRS</td>
<td>BPRS Depression Score</td>
<td>No relationships between positive and negative symptoms and awareness of mental disorder and need for treatment. Modest correlation between positive and negative symptoms and current and past awareness of social consequences respectively (positive: $r=.29$ and $r=.31$; negative: $r=.33$ and $r=.33$).</td>
</tr>
<tr>
<td>Schwartz et al. (2001)</td>
<td>233</td>
<td>SUMD N/A</td>
<td>FARS</td>
<td>Significant correlation between depression rating and insight into illness, need for treatment and social consequences: increase in insight associated with increase in depression.</td>
</tr>
<tr>
<td>Mintz et al. (2003)</td>
<td>Meta-analysis of 40 studies</td>
<td>Increase in global, positive and negative symptoms related to decrease in insight (mean effect sizes = ( r = -0.27, -0.25, -0.23 ) respectively; 7.2%, 6.3% and 5.2% of variance in insight accounted for by global, positive and negative symptomatology respectively). Modest but significant negative relationships between global and positive symptomatology and the 5 dimensions of insight. Modest but significant negative relationships between negative symptomatology and awareness of mental disorder, need for treatment, social consequences and attribution of symptoms to mental illness.</td>
<td>Increase in depression related to increase in insight (mean effect size = ( r = 0.18 ); 3.2% of variance in insight accounted for by depressive symptoms). Effect sizes modest and positive for each dimension of insight (( r = 0.11 ) - awareness of mental disorder to ( r = 0.39 ) - awareness of symptoms of disorder).</td>
<td>Meta-analysis.</td>
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<tr>
<td>Rossell et al. (2003)</td>
<td>N=78 Inpt/Outpts SZ UK</td>
<td>SAI-E</td>
<td>SANS SAPS</td>
<td>N/A</td>
</tr>
<tr>
<td>Study</td>
<td>Sample Size</td>
<td>Scale</td>
<td>Measure</td>
<td>Findings</td>
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<tr>
<td>Freudenreich et al. (2004)</td>
<td>N=122 Outpatients Chronic SZ USA</td>
<td>SUMD</td>
<td>PANSS</td>
<td>HAM-D PANSS Anxiety Item</td>
</tr>
<tr>
<td>Study</td>
<td>Sample Size</td>
<td>Location</td>
<td>Measures</td>
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<tr>
<td>Rathod <em>et al.</em> (2005)</td>
<td>N=422</td>
<td>UK</td>
<td>Increase in insight related to an increase in depression.</td>
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</table>

**Measurements:**
- ITAQ – Insight and Treatment Attitudes Questionnaire (NB: higher score = better insight)
- SUMD – Scale for the Assessment of Mental Disorder (NB: lower score = better insight)
- SA1 (SAI-E) – Schedule for the Assessment of Insight (expanded version) (NB: higher score = better insight)
- SA1-J – Schedule for the Assessment of Insight – Japanese Version (NB: higher score = better insight)
- Insight Scale - Birchwood Self-report Scale
- BPRS – Brief Psychiatric Rating Scale
- PANSS – Positive and Negative Syndrome Scale
- SANS – Scale for the Assessment of Negative Symptoms
- SAPS – Scale for the Assessment of Positive Symptoms
- MADRS – Montgomery Asberg Depression Rating Scale
- BDI – Beck Depression Inventory
- FARS – Functional Assessment Rating Scale
- CDS – Calgary Depression Scale
- HAM-D – Hamilton Scale for Depression

**Abbreviations:**
- SZ – Schizophrenia
- SA – Schizoaffective Disorder

**Inpatient/Outpatient:**
- Inpts – Inpatients
- Outpts – Outpatients
### Appendix 3: Summary of Studies Investigating the Relationship Between Insight and Cognitive Functioning

<table>
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<tr>
<th>Authors</th>
<th>Sample</th>
<th>Measures</th>
<th>Results</th>
<th>Methodological Considerations</th>
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</thead>
<tbody>
<tr>
<td>Walker &amp; Rossiter</td>
<td>N=36 Oupts/Outpts/Inpt</td>
<td>Insight</td>
<td>Individuals who perceived themselves as having a mental illness obtained higher scores on the attention task (distraction and non-distraction conditions).</td>
<td>Did not use a standardised insight scale.</td>
</tr>
<tr>
<td>(1989)</td>
<td>SZ PH=3.4 USA</td>
<td>Self-perception questionnaire</td>
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<td></td>
<td></td>
<td>Neuropsychological Functioning</td>
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<td></td>
<td>General Functioning</td>
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<td></td>
<td></td>
<td>Executive Functioning</td>
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<td></td>
<td></td>
<td>Other</td>
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<td></td>
<td></td>
<td>N/A</td>
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<td>N/A</td>
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<tr>
<td></td>
<td></td>
<td>Digit Span Task with distraction and non-distraction conditions</td>
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<tr>
<td>Young et al.</td>
<td>N=31 SUMD Oupts/Outpts/Inpt</td>
<td>WAIS-R Vocabulary and Block Design Subtests</td>
<td>WCST per cent perseverative errors and categories completed significantly correlated with current awareness (r=.49 and r=.59 respectively) and attribution of symptoms (r=.42 and r=.50 respectively). Higher IQ was related to greater current awareness (r=.42).</td>
<td>Sample includes patients across the full range of severity of schizophrenia.</td>
</tr>
<tr>
<td>(1993)</td>
<td>Chronic SZ MDI=17.5 Canada</td>
<td>WAIS-R Verbal Fluency Test Trails A and B</td>
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<td></td>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lysaker &amp; Bell</td>
<td>N=44 PANSS Oupts/Outpts/Inpt</td>
<td>Slosson Intelligence Test</td>
<td>Poorer cognitive functioning (the IQ test, WCST and attention test) predicted improvement in insight (R² = .33).</td>
<td>Single global rating of insight.</td>
</tr>
<tr>
<td>(1995)</td>
<td>SZ/SA PH=7 USA</td>
<td>WCST</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>WAIS-R Digit Symbol Subtest (sustained attention)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>N=</td>
<td>Diagnosis</td>
<td>Test A</td>
<td>Test B</td>
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<tr>
<td>Kemp &amp; David (1996)</td>
<td>74</td>
<td>Inpts psychosis (including first onset) MDI=9.6 UK</td>
<td>SAI</td>
<td>NART</td>
</tr>
<tr>
<td>McEvoy et al. (1996)</td>
<td>32</td>
<td>Inpatient SZ/SA PH=6 USA</td>
<td>ITAQ</td>
<td>WAIS-R Vocabulary Subtest</td>
</tr>
<tr>
<td>Collins et al. (1997)</td>
<td>58</td>
<td>Outpatients Chronic SZ MDI=14.24 Canada</td>
<td>SAI</td>
<td>N/A</td>
</tr>
<tr>
<td>Voruganti et al. (1997)</td>
<td>52</td>
<td>Outpts Chronic SZ DI=9 Canada</td>
<td>PANSS Insight Item</td>
<td>N/A</td>
</tr>
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</table>

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<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Setting</th>
<th>Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sanz et al. (1998)</td>
<td>33</td>
<td>Inpts Non-organic psychotic illness MDI=7.5 UK</td>
<td>SAI SAI-E ITAQ, MMSE NART WCST Trails A and B, SCT (test of parietal function)</td>
<td>No relationships found between any of the insight and neurocognitive measures.</td>
</tr>
<tr>
<td>Mohamed et al. (1999)</td>
<td>46</td>
<td>Inpatients Chronic SZ USA</td>
<td>SUMD WAIS-R WCST COWAT Design Fluency Test Trails B N/A</td>
<td>After partially out effect of general intelligence: found significant correlations between executive function, as measured by verbal fluency, and awareness of negative symptoms ($r=.39$), but not awareness of positive symptoms. WCST (no. of categories achieved) associated with unawareness of positive symptoms ($r=.44$). Measures selected for well-established validity in measurement of executive function.</td>
</tr>
<tr>
<td>Marks et al. (2000)</td>
<td>59</td>
<td>Outpatients Chronic SZ/SA MDI=20.9 USA</td>
<td>SAIQ Items from SUMD PANSS Insight item NART WCST WAIS-III Similarities Subtest Stroop Colour and Word Test WAIS-III LNS and Symbol Search Subtests (to assess attention) Hopkins Verbal Learning Test and Logical Memory I (WMS-R) (to assess memory)</td>
<td>SAIQ need for treatment and presence/outcome of illness subscales significantly correlated with insight scales: showed significant relationship to executive function ($r=.38$ – similarities), and executive function ($r=.24$ – similarities), attention ($r=.30$ – LNS; $r=.28$ – symbol search) and memory ($r=.27$ – HVLT; $r=.29$ – logical memory) respectively.</td>
</tr>
<tr>
<td>Study</td>
<td>Sample</td>
<td>Measures</td>
<td>Subtest Details</td>
<td>BFRT Measurements</td>
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<tr>
<td>Smith <em>et al.</em> (2000)</td>
<td>N=46 Outpatients Chronic SZ/SA PH=7.7 USA</td>
<td>SUMD</td>
<td>Subtests from WAIS-R</td>
<td>WCST COWAT</td>
</tr>
<tr>
<td>Buckley <em>et al.</em> (2001)</td>
<td>N=50 Inpatients Chronic SZ/SA PH=6.7 USA</td>
<td>SUMD</td>
<td>N/A</td>
<td>Trails A and B</td>
</tr>
<tr>
<td>Arduini <em>et al.</em> (2003)</td>
<td>N=42 Inpatients Chronic SZ MDI=13.39 Italy</td>
<td>SUMD</td>
<td>N/A</td>
<td>WCST</td>
</tr>
<tr>
<td>Drake &amp; Lewis (2003)</td>
<td>N=33 Acutely psychotic SZ/related disorders DI=&lt;5 years UK</td>
<td>SUMD</td>
<td>SAI-E ITAQ Birchwood Insight Scale PANSS Insight Item David-hizar Insight Scale</td>
<td>NART</td>
</tr>
<tr>
<td>Kim <em>et al.</em> (2003)</td>
<td>N=151 Chronic SZ MDI=13.6 USA</td>
<td>Insight Items from SADS</td>
<td>WAIS-R</td>
<td>WCST COWAT</td>
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</tr>
<tr>
<td>N=132 Outpatients SZ/SA PH=8.1 USA</td>
<td>SUMD</td>
<td>N/A</td>
<td>WCST (total no. of perseverative errors) LNS on WAIS-III</td>
<td>WCST</td>
</tr>
<tr>
<td>N=78 Inpt/Outpts SZ MDI=11.2 UK</td>
<td>SAI-E</td>
<td>WAIS-R Short Version NART</td>
<td>WCST</td>
<td>CPT (sustained attention)</td>
</tr>
<tr>
<td>N=122 Outpatients Chronic SZ USA</td>
<td>SUMD (unawareness and mis-attribution of current symptoms only)</td>
<td>WAIS-III</td>
<td>WCST Stroop Colour and Word Test COWAT</td>
<td>CVLT</td>
</tr>
<tr>
<td>N=30 Inpatients First episode SZ Israel</td>
<td>SUMD</td>
<td>WAIS-R Similarities and Block Design Subtests</td>
<td>Metacognitive Version of WCST</td>
<td>N/A</td>
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<tr>
<td>N=37 Inpatients Chronic SZ MDI=29 Japan</td>
<td>SAI-J</td>
<td>WAIS-R</td>
<td>WCST</td>
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<tr>
<td>Subotnik et al. (2005)</td>
<td>N=52 outpatientsz/sa Di=&lt;2 years USA</td>
<td>SUMD</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

SAIQ – Self-Appraisal of Illness Questionnaire  
SADS – Schedule for Affective Disorders and Schizophrenia

WAIS-R – Wechsler Adult Intelligence Scale (Revised)  
WCST – Wisconsin Card Sort Test  
NART – National Adult Reading Test  
MMSE – Mini Mental State Examination  
COWAT – Controlled Oral Word Association Test (test of verbal fluency)  
JLO – Judgement of Line Orientation  
Rey CFT – Rey-Osterrieth Complex Figure Test  
FLT – Finger Localisation Test  
R-L OT - Right-Left Orientation Test  
SCT – Star Cancellation Test  
WAIS-III - Wechsler Adult Intelligence Scale (Third Edition)  
LNS – Letter Number Sequencing  
WMS-R – Wechsler Memory Scale (Revised)  
BFRT – Benton Facial Recognition Test  
VLL – Verbal List Learning  
CPT – Continuous Performance Test (test of attention)  
CVLT – Californian Verbal Learning Test

MDI – Mean Duration of Illness in Years  
DI – Duration of Illness in Years  
PH – Mean Number of Previous Hospitalisations
Appendix 4: Schedule for the Assessment of Insight – Expanded Version (Kemp & David, 1997)

1. “Do you think you have been experiencing any emotional or psychological changes or difficulties?”

   Often = 2 (thought present most of the day, most days)
   Sometimes = 1 (thought present occasionally)
   Never = 0 (ask why doctors/others think he/she does)

2. “Do you think this means there is something wrong with you?” (e.g. a nervous condition)

   Often = 2 (thought present most of the day, most days)
   Sometimes = 1 (thought present occasionally)
   Never = 0 (ask why doctors/others think he/she does)

3. “Do you think your condition amounts to a mental illness or mental disorder?”

   Often = 2 (thought present most of the day, most days)
   Sometimes = 1 (thought present occasionally)
   Never = 0 (ask why doctors/others think he/she does)

If positive score on previous two questions, proceed to 4.

4. “How do you explain your condition/disorder/illness?”

   Reasonable account given based on plausible mechanisms (appropriate given social, cultural and educational background, e.g. excess stress, chemical imbalance, family history) = 2
   Confused account, or overheard explanation without adequate understanding or “don’t know” = 1
   Delusional or bizarre explanation = 0

If positive score on 1, 2, 3, proceed to 5.
5. "Has your nervous/emotional/psychological/mental/psychiatric condition (use patient’s term) led to adverse consequences or problems in your life?" (e.g. conflict with other, neglect, financial, or accommodation difficulties, irrational, impulsive or dangerous behaviour)

Yes (with example) = 2
Unsure (cannot give example or contradicts self) = 1
No = 0

6. "Do you think your........condition (use patient’s term) or the problem resulting from it warrants treatment?"

Yes (with plausible reason) = 2
Unsure (cannot give reason or contradicts self) = 1
No = 0

Use primary nurse to rate following two items:

7. "How readily does patient accept treatment (includes passive acceptance)?"

Often = 2 (may rarely question the need for treatment)
Sometimes = 1 (may occasionally question need for treatment)
Never = 0 (ask why)

Treatment includes medication and/or hospitalisation and/or other physical and psychological therapies.

8. "Does patient ask for treatment unprompted?"

Often = 2 (excludes inappropriate requests for medication etc.)
Sometimes = 1 (rate if forgetfulness/disorganisation leads to occasional requests only)
Never = 0 (ask why doctors/others think so)
9. Pick the most prominent symptoms up to a maximum of 4. Then rate awareness of symptom out of 4 as below.

   Examples:
   “Do you think that the belief.... could not really true/happening?”
   “Do you think the ‘voices’ you hear are actually real people talking or is it something arising from your own mind?”
   “Have you been able to think clearly, or do your thoughts seem mixed up/confused? Is your speech jumbled?”
   “Would you say you have been more agitated/overactive/speeded up/withdrawn than usual?”
   “Are you aware of any problem with attention/concentration/memory?”
   “Have you a problem with doing what you intend/getting going/finishing tasks/motivation?”

   Definitely (full awareness) = 4
   Probably (moderate awareness) = 3
   Unsure (sometimes yes, sometimes no) = 2
   Possibly (slight awareness) = 1
   Absolutely not (no awareness) = 0

   Mean ........

10. For each symptom rated above (up to a maximum of 4), ask patient:
   “How do you explain........ (false beliefs, hearing voices, thoughts muddled, lack of drive etc.)?

   Part of my illness = 4
   Due to my nervous condition = 3
   Reaction to stress/fatigue = 2
   Unsure, maybe one of above = 1
   Can’t say, or delusional/bizarre explanation = 0

   Mean ........

TOTAL SCORE = 24
Appendix 5: Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983)

**HAD Scale**

<table>
<thead>
<tr>
<th>Item</th>
<th>Scale Options</th>
</tr>
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</table>
| I feel tense or wound up:                                            | Most of the time  
|                                                                  | A lot of the time  
|                                                                  | Time to time, Occasionally  
|                                                                  | Not at all  |
| I still enjoy the things I used to enjoy:                           | Definitely as much  
|                                                                  | Not quite so much  
|                                                                  | Only a little  
|                                                                  | Hardly at all  |
| I get a sort of frightened feeling as if something awful is about to happen: | Very definitely and quite badly  
|                                                                  | Yes, but not too badly  
|                                                                  | A little, but it doesn’t worry me  
|                                                                  | Not at all  |
| I can laugh and see the funny side of things:                       | As much as I always could  
|                                                                  | Not quite so much now  
|                                                                  | Definitely not so much now  
|                                                                  | Not at all  |
| Worrying thoughts go through my mind:                               | A great deal of the time  
|                                                                  | A lot of the time  
|                                                                  | From time to time but not too often  
|                                                                  | Only occasionally  |
| I feel cheerful:                                                    | Not at all  
|                                                                  | Not often  
|                                                                  | Sometimes  
|                                                                  | Most of the time  |
| I can sit at ease and feel relaxed:                                 | Definitely  
|                                                                  | Usually  
|                                                                  | Not often  
|                                                                  | Not at all  |
| I feel as if I am slowed down:                                      | Nearly all the time  
|                                                                  | Very often  
|                                                                  | Sometimes  
|                                                                  | Not at all  |
| I get a sort of frightened feeling like butterflies in the stomach: | Not at all  
|                                                                  | Occasionally  
|                                                                  | Quite often  
|                                                                  | Very often  |
| I have lost interest in my appearance:                              | Definitely  
|                                                                  | I don’t take so much care as I should  
|                                                                  | I may not take quite as much care  
|                                                                  | I take just as much care as ever  |
| I feel restless as if I have to be on the move:                     | Very much Indeed  
|                                                                  | Quite a lot  
|                                                                  | Not very much  
|                                                                  | Not at all  |
| I look forward with enjoyment to things:                             | As much as ever I did  
|                                                                  | Rather less than I used to  
|                                                                  | Definitely less than I used to  
|                                                                  | Hardly at all  |
| I get sudden feelings of panic:                                     | Very often indeed  
|                                                                  | Quite often  
|                                                                  | Not very often  
|                                                                  | Not at all  |
| I can enjoy a good book or radio or TV programme:                   | Often  
|                                                                  | Sometimes  
|                                                                  | Not often  
|                                                                  | Very seldom  |

**Instructions:**
- Do not write below this line.
- Tick only one box in each section.
Appendix 6: Homophone Meaning Generation Test (Warrington, 2000)

Administration Instructions:

I am going to say some words. When I say a word I would like you to give me as many different meanings of the word as you can. You can give me the meanings verbally or by gesturing. There is no time limit.

The first word is FORM. Please give me as many different meanings of the word FORM as you can.

Repeat these instructions for each of the words.

One point is rewarded for each distinct meaning generated.

Same Spelling Words

Form

Slip

Tick

Tip

Subtotal:___
Different Spelling Words

If the respondent asks if the spelling of the word is important, say that it is not.

<table>
<thead>
<tr>
<th>Bear</th>
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Subtotal: ___

TOTAL SCORE: ___

**HMGT Estimation Ratings**

Give respondent the HMGT estimation rating scales.

*Please look at each statement below and rate each statement by circling the appropriate number.*

Thank you the task has finished.
### APPENDIX A

**Percentile scores**

<table>
<thead>
<tr>
<th>Percentile score</th>
<th>Spelling same</th>
<th>Spelling different</th>
<th>Total score</th>
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<tbody>
<tr>
<td>5</td>
<td>6</td>
<td>8</td>
<td>14</td>
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<td>10</td>
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<td>95</td>
<td>16.5</td>
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</table>

### APPENDIX B

**Conversion table of raw scores to scaled scores**

<table>
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<th>Spelling different</th>
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<td>8</td>
<td>15-16</td>
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<td>6</td>
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MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix 9: Understanding of Cognitive Functioning Scales

**VSAT PREDICTION**

Please rate each statement below by circling the appropriate number:

1. My performance on this task compared to other people my age in the general population will be:

   1 --------------- 2 --------------- 3 --------------- 4 --------------- 5 --------------- 6 --------------- 7
   Extremely  Very  Poor  Average  Good  Very  Extremely
   Poor  Poor Poor  Average  Good  Good  Good

2. My performance on this task compared to other people in Broadmoor Hospital will be:

   1 --------------- 2 --------------- 3 --------------- 4 --------------- 5 --------------- 6 --------------- 7
   Extremely  Very  Poor  Average  Good  Very  Extremely
   Poor  Poor Poor  Average  Good  Good  Good

**VSAT EVALUATION**

Please rate each statement below by circling the appropriate number:

1. My performance on this task compared to other people my age in the general population was:

   1 --------------- 2 --------------- 3 --------------- 4 --------------- 5 --------------- 6 --------------- 7
   Extremely  Very  Poor  Average  Good  Very  Extremely
   Poor  Poor Poor  Average  Good  Good  Good

2. My performance on this task compared to other people in Broadmoor Hospital was:

   1 --------------- 2 --------------- 3 --------------- 4 --------------- 5 --------------- 6 --------------- 7
   Extremely  Very  Poor  Average  Good  Very  Extremely
   Poor  Poor Poor  Average  Good  Good  Good
HMGT EVALUATION

Please rate each statement below by circling the appropriate number:

1. My performance on this task **compared to other people my age in the general population was:**

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<tr>
<td>Extremely</td>
<td>Very Poor</td>
<td>Average</td>
<td>Good</td>
<td>Very</td>
<td>Extremely Poor</td>
<td>Good</td>
<td>Good</td>
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2. My performance on this task **compared to other people in Broadmoor Hospital was:**

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<td>Average</td>
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<td>Extremely Poor</td>
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</table>
Appendix 10: Full Explanation for the Final Understanding of Cognitive Functioning Scores

As stated in the method section, all participants were asked at both the prediction and evaluation stages, to rate themselves i) relative to someone their own age in the general population and ii) relative to the population of Broadmoor Hospital. Therefore, in total, participants were asked to make two predictions (VSAT only) and four evaluations (two each for the VSAT and HMGT).

Participants were asked to make a prediction/evaluation of their performance relative to other patients in Broadmoor Hospital because it was felt that participants might be more able to judge their cognitive abilities in relation to their peers rather than the general population. The intention was, that during the report-comparison stage, scores from all the participants would be used to comprise a Broadmoor Hospital Standardisation Sample. A separate percentile score (and a percentile category rating from 1 to 7) according to this sample would be calculated for each participant in addition to the percentile score and rating obtained from the HMGT and VSAT general population standardisation samples. The relevant percentile category rating would be then subtracted from the equivalent self-rating to calculate the understanding of cognitive functioning scores. Unfortunately, at the conclusion of data collection, the sample size obtained was not large enough to make the construction of the Broadmoor Hospital Standardisation Sample meaningful. Therefore only three understanding of cognitive functioning scores were calculated using only the prediction/evaluation ratings made relative to the general population and percentiles used from the standardisation samples of the HMGT or the VSAT.
Appendix 11: The Positive and Negative Syndrome Scale (Kay et al., 2000)

The Positive and Negative Syndrome Scale (Kay et al., 2000) is a measure used to assess symptoms of schizophrenia.

### CARD NUMBER

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### POSITIVE SCALE (P)

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<th>Description</th>
<th>Rating</th>
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<tbody>
<tr>
<td>P1</td>
<td>Delusions</td>
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</tr>
<tr>
<td>P2</td>
<td>Conceptual disorganization</td>
<td>[ ] 16</td>
</tr>
<tr>
<td>P3</td>
<td>Hallucinatory behavior</td>
<td>[ ] 17</td>
</tr>
<tr>
<td>P4</td>
<td>Excitement</td>
<td>[ ] 18</td>
</tr>
<tr>
<td>P5</td>
<td>Grandiosity</td>
<td>[ ] 19</td>
</tr>
<tr>
<td>P6</td>
<td>Suspiciousness/persecution</td>
<td>[ ] 20</td>
</tr>
<tr>
<td>P7</td>
<td>Hostility</td>
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### NEGATIVE SCALE (N)

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<th>Description</th>
<th>Rating</th>
</tr>
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<tbody>
<tr>
<td>N1</td>
<td>Blunted affect</td>
<td>[ ] 22</td>
</tr>
<tr>
<td>N2</td>
<td>Emotional withdrawal</td>
<td>[ ] 23</td>
</tr>
<tr>
<td>N3</td>
<td>Poor rapport</td>
<td>[ ] 24</td>
</tr>
</tbody>
</table>

**Key**

1 = Absent  2 = Minimal  3 = Mild  4 = Moderate  5 = Moderate Severe  6 = Severe  7 = Extreme
N4 Passive/apathetic social withdrawal
Diminished interest and initiative in social interactions due to passivity, apathy, anergy, or avolition. This leads to reduced interpersonal involvements and neglect of daily activities.

N5 Difficulty in abstract thinking
Impairment in the use of the abstract-symbolic mode of thinking, as evidenced by difficulty in classification, forming generalizations, and proceeding beyond concrete or egocentric thinking in problem-solving tasks. Basis for rating: Responses to questions on similarities and proverb interpretation, and use of concrete vs. abstract mode during the course of interview.

N6 Lack of spontaneity and flow of conversation
Reduction in the normal flow of communication associated with apathy, avolition, defensiveness, or cognitive deficit. This is manifested by diminished fluidity and productivity of the verbal-interactional process. Basis for rating: Cognitive-verbal processes observed during the course of interview.

N7 Stereotyped thinking
Decreased fluidity, spontaneity, and flexibility of thinking, as evidenced in rigid, repetitious, or barren thought content. Basis for rating: Cognitive-verbal processes during the course of interview.

GENERAL PSYCHOPATHOLOGY SCALE (G)

G1 Somatic concern
Physical complaints or beliefs about bodily illness or malfunctions. This may range from a vague sense of ill being to clear-cut delusions of catastrophic physical disease. Basic for rating: Thought content expressed in the interview.

G2 Anxiety
Subjective experience of nervousness, worry, apprehension, or restlessness, ranging from excessive concern about the present or future to feelings of panic. Basis for rating: Verbal report during the course of interview and corresponding physical manifestations.

G3 Guilt feelings
Sense of remorse or self-blame for real or imagined misdeeds in the past. Basis for rating: Verbal report of guilt feelings during the course of interview and the influence on attitudes and thoughts.

G4 Tension
Overt physical manifestations of fear, anxiety, and agitation, such as stiffness, tremor, profuse sweating, and restlessness. Basis for rating: Verbal report attesting to anxiety and, thereafter, the severity of physical manifestations of tension observed during the interview.

G5 Mannerisms and posturing
Unnatural movements or posture as characterized by an awkward, stilted, disorganized, or bizarre appearance. Basis for rating: Observation of physical manifestations during the course of interview as well as reports from primary care workers or family.

G6 Depression
Feelings of sadness, discouragement, helplessness, and pessimism. Basis for rating: Verbal report of depressed mood during the course of interview and its observed influence on attitude and behavior.

G7 Motor retardation
Reduction in motor activity as reflected in slowing or lessening of movements and speech, diminished responsiveness to stimuli, and reduced body tone. Basis for rating: Manifestations during the course of interview as well as reports by primary care workers or family.
G8 Uncooperativeness
Active refusal to comply with the will of significant others, including the interviewer, hospital staff, or family, which may be associated with distrust, defensiveness, stubbornness, negativism, rejection of authority, hostility, or belligerence. Basis for rating: Interpersonal behavior observed during the course of interview as well as reports by primary care workers or family.

G9 Unusual thought content
Thinking characterized by strange, fantastic, or bizarre ideas, ranging from those which are remote or atypical to those which are distorted, illogical, and patently absurd. Basis for rating: Thought content expressed during the course of interview.

G10 Disorientation
Lack of awareness of one's relationship to the milieu, including persons, place, and time, which may be due to confusion or withdrawal. Basis for rating: Responses to interview questions on orientation.

G11 Poor attention
Failure in focused alertness manifested by poor concentration, distractibility from internal and external stimuli, and difficulty in harnessing, sustaining, or shifting focus to new stimuli. Basis for rating: Manifestations during the course of interview.

G12 Lack of judgment and insight
Impaired awareness or understanding of one's own psychiatric condition and life situation. This is evidenced by failure to recognize past or present psychiatric illness or symptoms, denial of need for psychiatric hospitalization or treatment, decisions characterized by poor anticipation of consequences, and unrealistic short-term and long-range planning. Basis for rating: Thought content expressed during the interview.

G13 Disturbance of volition
Disturbance in the willful initiation, sustenance, and control of one's thoughts, behavior, movements, and speech. Basis for rating: Thought content and behavior manifested in the course of interview.

G14 Poor impulse control
Disordered regulation and control of action on inner urges, resulting in sudden, unmodulated, arbitrary, or misdirected discharge of tension and emotions without concern about consequences. Basis for rating: Behavior during the course of interview and reported by primary care workers or family.

G15 Preoccupation
Absorption with internally generated thoughts and feelings and with autistic experiences to the detriment of reality orientation and adaptive behavior. Basis for rating: Interpersonal behavior observed during the course of interview.

G16 Active social avoidance
Diminished social involvement associated with unwarranted fear, hostility, or distrust. Basis for rating: Reports of social functioning by primary care workers or family.

Depression Subscale = G1, G2, G3, G6
Dear Dr ...........

"Insight into mental illness and understanding of cognitive functioning in forensic patients with schizophrenia"

I am a trainee clinical psychologist working with Dr Mary Hill, Consultant Clinical Psychologist, and I am hoping to carry out the above piece of research at Broadmoor Hospital over the next 6 to 8 months as part of my post-graduate Clinical Doctorate (PsychD). I am approaching all RMOs within Broadmoor Hospital to ask if they could assist in identifying appropriate participants. It is hoped that I will include in the study 60 patients who meet DSM-IV criteria for a diagnosis of schizophrenia and have a current experience of psychotic symptomatology. For your information, further details of the study are attached.

I would be grateful if you could help in identifying participants by completing the attached form and returning it to me at the psychology department, or by e-mail if not including patients’ names. I am aiming to start approaching patients at the beginning of October 2005 and would therefore very much appreciate if you were able return the form by 30th September 2005.

The inclusion criteria for participants are:

- A DSM-IV diagnosis of schizophrenia (regardless of any dual diagnosis) with a current experience of psychotic symptomatology
- Aged 17 to 60
- A willingness to be approached

However, please exclude patients who:

- Are unable to give informed consent and
- Unable to complete research procedures in English because of poor functioning, linguistic factors or current mental state
- Have a known history of a significant closed head injury or other neurological condition
- To your knowledge have received the neurocognitive measures that will be used in this study

If you would like further information about this study please contact either myself or Dr Mary Hill in the Department of Psychology, Broadmoor Hospital.

Thank you very much for your time and assistance with this research study.

Alison Christie
Trainee Clinical Psychologist
Ext. No.:
Email:

Dr Mary Hill
Consultant Clinical Psychologist
Ext. No.:
Email:

NB: Since completing data collection the title of the project has been changed to reflect more accurately the nature of the project undertaken. However, no changes to the method or any other aspect of the project were made.

Major Research Project
"Insight into mental illness and understanding of cognitive functioning in forensic patients with schizophrenia"

I am hoping to carry out the above piece of research at Broadmoor Hospital over the next 6 to 8 months as part of my post-graduate Clinical Doctorate (PsychD). The study has been approved by the Trust R&D Group and by the Trust and University of Surrey Ethics Committees. Dr Mrigendra Das, Consultant Forensic Psychiatrist, has also provided his support for the research.

Primary Objective
The main aim is to consider personal evaluation of symptoms of mental illness (insight) in patients with schizophrenia who are thought to be actively psychotic at the time of assessment, and to compare this level of insight with a self-assessment of cognitive functioning made at the same time.

Secondary Objectives
(a) This work will allow "insight" in Broadmoor patients to be compared with existing data on non-forensic patients with schizophrenia reported in the literature.
(b) In Broadmoor patients, it will also be possible to say how self-reports of mental illness, symptomatology and cognitive functioning relate to each other and to measured psychometric ability.
(c) It is also hoped to establish whether or not there are relationships between affective state (mood) at the time of the assessment and self-reports of mental illness, symptomatology and cognitive functioning.

Procedures
Following the identification of potential participants, I will make arrangements to visit individual patients and will provide each patient with an information sheet and consent form. Patients will have the opportunity to consider whether or not they would like to take part in the study for at least 24 hours and then, subject to their agreement, they will be offered an appointment to carry out the following procedures:

a) A psychology session of approximately 50 minutes, which will include:
   i) An assessment of insight into mental illness using the Schedule for the Assessment of Insight (David, 1990).
   ii) An assessment of attention skills using the Visual Search and Attention Test (Trenerry et al., 1989).
   iv) An assessment of patients' understanding of their cognitive functioning by asking patients to rate their performance on the VSAT and HMGT.
   v) An assessment of current mood using the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983).
b) An assessment of current mental health status using the PANSS
This will take about 30 minutes and is being arranged in consultation with Dr Mrigendra Das. It will be carried out by one of the SHOs/Registrars who will visit Broadmoor Hospital for a rotational training placement between August 2005 and February 2006.

Consent and Ethical Considerations
Prior to each research session, patients will be asked if they have any questions and will be asked to sign a consent form. They will also be asked to give consent to access to their medical records.

Patients will be informed that their participation is entirely voluntary and they are under no obligation to participate in this research. They will also be informed that they are free to withdraw from the study at any time, without giving a reason, and that any information collected up to that point would be destroyed. Participants are made aware that if they decide not to take part or decide to withdraw from the study that this will not affect the standard of care they receive and will not affect any decisions on their length of stay in the hospital or their legal status.

Patients will be assured that all information disclosed is confidential, unless they disclose information that could raise concern about their safety or the safety of others.

Liaison with Clinical Teams
Clinical teams will be provided with a list of participants but all other information collected on participants will be confidential.

Contact for Further Information
If you would like further information about this study please contact either myself or Dr Mary Hill, in the Department of Psychology, Broadmoor Hospital.

Alison Christie
Trainee Clinical Psychologist
Ext. No.: Email:

Dr Mary Hill, Consultant Clinical Psychologist
Field Supervisor
Ext. No.: Email:
IDENTIFICATION OF POTENTIAL PARTICIPANTS

"Insight into mental illness and understanding of cognitive functioning in forensic patients with schizophrenia"

Please complete the following:

1. Your name: ____________________

2. Name of the ward: ____________________

3. Number of patients on this ward who meet the criteria: __________

4. Number of patients on this ward who do not meet the criteria: __________

5. If you feel it is appropriate please state the names of the patients on your ward who meet the criteria. This list will be kept entirely confidential. If you have not named the patients at this stage I will contact you at a later date.

Names of the patients on this ward who meet the criteria:

1. ____________________ 7. ____________________
2. ____________________ 8. ____________________
3. ____________________ 9. ____________________
4. ____________________ 10. ____________________
5. ____________________ 11. ____________________
6. ____________________ 12. ____________________

6. Please state how many patients you have excluded because you felt they were currently too unwell to take part or consent to taking part in this research but feel could potentially be approached at a later date. These patients will not be approached without consulting you first.

Number of patients on this ward who could potentially be approached at a later date: __________

Thank you very much for your time and assistance.
Research Title: *Insight into mental illness and understanding of cognitive functioning ('thinking abilities') in forensic patients with schizophrenia.*

**PATIENT INFORMATION SHEET**

You are being asked to take part in a research study. Before you decide if you would like to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. I will come and meet with you again so you can discuss the study further. Take time to decide whether or not you wish to take part.

Thank you for reading this.

**Research Topic**

This research is about patients with a diagnosis of schizophrenia in Broadmoor Hospital. It is about patients' understanding about their mental illness and patients' understanding about their 'thinking' abilities or difficulties.

**What is the purpose of the study?**

This study will help clinical staff to gain a better understanding about the types of difficulties people with schizophrenia can have, and which people may be more vulnerable to these difficulties. It may also be possible to say how these problems relate to treatment and future progress in individuals.

**Why have I been chosen?**

I am asking all patients in Broadmoor Hospital who have a diagnosis of schizophrenia if they would be willing to take part.

**Do I have to take part?**

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet and be asked to sign a consent form. You will be able to keep a copy of the consent form. If you decide to take part you are still free to withdraw at any time, without giving a reason, and any information already collected will be destroyed. If you decide not to take part or decide to withdraw from the study this will not affect the standard of care you receive and will not affect any decisions on your length of stay in the hospital or your legal status.

**What will I have to do if I take part?**

You will be asked to take part in a single session with me, which should take just under an hour. It can be arranged at a time to suit you.

i) I will ask you some questions about your understanding about your mental illness.

ii) I will ask you to complete two short tasks; one involves looking at visual symbols and one involves talking about the meanings of words.

iii) I will ask you to complete a short questionnaire about your current mood and emotions.

You will then be asked to meet with Dr Irani/Dr Garcia at another time. This will be for 30 minutes to talk about how well, mentally, you are feeling at the moment.
If you decide to take part I will also ask for your consent to have access to the information in your medical records.

**Will my taking part in this study be kept confidential?**
All information that is collected about you during the course of the research will be kept confidential. This means that anything that you tell me or Dr Irani/Dr Garcia will be confidential, we will not tell anyone else, including each other. Any information I take from your medical records will also be confidential. All information collected will have your name removed and it will be recorded under an anonymous number so that you cannot be recognised.

*The only exception would be if I or Dr Irani/Dr Garcia felt that you had told us something that made us concerned about your safety or the safety of others. We would then need to tell the clinical team but we would always tell you if we needed to do that.*

**What are the possible disadvantages or risks of taking part?**
During the study I will ask you about your mental illness and this may cause you some distress. If you experience any distress you will be able to take a break from the study or withdraw completely. I will ensure that you receive any support from the clinical team that you may need.

If you have any concerns about the way you have been approached or treated during the study, and wish to make a complaint, then the normal National Health Service complaints procedures are available to you. The members of staff on your ward will be able to tell you about these procedures.

**What are the possible benefits of taking part?**
No direct benefit to you is expected but I hope that you may find it useful to talk about your understanding about your mental illness. Also, the information I get from this study may help clinical staff to better understand and therefore help patients with schizophrenia in the future.

**What will happen to the results of the research study?**
The results of the study will be written up as a report in July 2006. This report will be kept in the University of Surrey library. By December 2006, a shorter summary of the results will also be written. This may be published in an academic journal. You will not be identified in any report. *If you would like to, you can have a copy of the summary.*

**Who has reviewed the study?**
This study has been reviewed and approved by the Ethics and Research and Development Committees of the West London Mental Health Trust, and by the University of Surrey Ethics Committee.

**Contact for further information**
If you would like further information about this study please ask the nursing staff on your ward to contact me. I will be pleased to meet with you and answer any questions you may have.

Alison Christie, Trainee Clinical Psychologist  
Department of Psychology, Broadmoor Hospital

*Thank you for your time*
Appendix 14: Patient Consent Form

Version 1: 05.07.05

West London Mental Health NHS Trust

Patient Identification Number:

CONSENT FORM

Research Title:
Insight into mental illness and understanding of cognitive functioning ("thinking abilities") in forensic patients with schizophrenia.

Name of Lead Researcher:
Alison Christie, Trainee Clinical Psychologist

Please Initial the Box

1. I confirm that I have read and understand the information sheet dated 17th October 2005 for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and that if I chose to withdraw neither, my medical care, decisions on my length of stay in the hospital, legal status, nor rights will be affected.

3. I understand that sections of my medical records may be looked at by the researcher where it is relevant to my taking part in the research. I give permission for the named researcher to have access to my records.

4. I understand that all information collected will be confidential but that information may need to be told to the clinical team if I disclose something that raises concerns about my safety or the safety of others. I am aware that I will always be informed if any information is told to the clinical team.

5. I understand that involvement in the study involves participating in two sessions; one with the researcher and one with Dr Irani/Dr Garcia and involves talking about my mental illness.

6. I agree to take part in the above study.

7. I would like to receive a copy of the summary of results

Name of Patient (CAPITALS) Date Signature

Researcher (CAPITALS) Date Signature

THANKYOU FOR PARTICIPATING

1 Copy for Patient; 1 Copy for Researcher
22 August 2005

Dear Ms Christie

Re: Insight into mental illness and understanding of cognitive functioning in forensic patients with schizophrenia

I am pleased to confirm that the above project has received Trust R&D approval, and you may now commence your research.

May I take the opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold a Trust/NHS contract (honorary or full) are allowed contact with Trust patients. If you do not hold a contract please contact the R&D Office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient’s notes. Research projects are subject to random audit by a member of the R&D Office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act.
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Adverse events:** adverse events or suspected misconduct should be reported to the R&D Office and the Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D Office.
- **Publications:** it is essential that you inform the R&D Office about any publications which result from your research.

We would like to wish you every success with your project.

Regards

Maria Tsappis
Research Governance Co-ordinator
Appendix 16: Ethical Approval from the Ealing and West London Local Research Ethics Committee

Ealing & WLMHT Local Research Ethics Committee
Thor House
349 Uxbridge Road
Southall
Middlesex
UB1 3DR
Telephone: 020 8893 6027
Voticemail: 020 8967 5101

02 August 2005

Miss Alison Christie
Trainee Clinical Psychologist
University of Surrey
Department of Psychology
University of Surrey
Guildford
GU2 7XH

Dear Miss Christie,

Full title of study: Insight into mental illness and understanding of cognitive functioning in forensic patients with schizophrenia.

REC reference number: 05/Q0410/57

The Research Ethics Committee reviewed the above application at the meeting held on 26 July 2005.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation. Many thanks for attending to answer questions from the Committee. It appears to the Committee to constitute a very large volume of work, we wish you all the best with this.

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td></td>
<td>05 July 2005</td>
</tr>
<tr>
<td>Investigator CV Christie</td>
<td>(None Specified)</td>
<td></td>
</tr>
<tr>
<td>Investigator CV Hill</td>
<td>(None Specified)</td>
<td></td>
</tr>
<tr>
<td>Protocol</td>
<td></td>
<td>05 July 2005</td>
</tr>
<tr>
<td>Covering Letter</td>
<td></td>
<td>05 July 2005</td>
</tr>
<tr>
<td>Peer Review Reviewer's feedback</td>
<td>(None Specified)</td>
<td></td>
</tr>
<tr>
<td>Peer Review</td>
<td></td>
<td>04 July 2005</td>
</tr>
</tbody>
</table>

An advisory committee to North West London Strategic Health Authority
Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

The Committee Administrator will notify the research sponsor and the R&D Department for NHS care organisation that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project,

Yours sincerely,

Dr Colin Michie
Chair

Email: alene.pointon@eht.nhs.uk

Endlosures:

Attendance at Committee meeting on 26 July 2005

SF1 list of approved sites

An advisory committee to North West London Strategic Health Authority

Major Research Project 306
Ealing & WLMHT Local Research Ethics Committee

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

<table>
<thead>
<tr>
<th>REC reference number: 05/Q0410/57</th>
<th>Issue number: 1</th>
<th>Date of issue: 02 August 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chief Investigator:</strong> Miss Alison Christie</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Full title of study:</strong> Insight into mental illness and understanding of cognitive functioning in forensic patients with schizophrenia.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This study was given a favourable ethical opinion by Ealing Local Research Ethics Committee on 26 July 2005. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

<table>
<thead>
<tr>
<th>Principal Investigator</th>
<th>Post</th>
<th>Research site</th>
<th>Site assessor</th>
<th>Date of favourable opinion for this site</th>
<th>Notes (*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Mary Hill</td>
<td>Consultant Clinical Psychologist</td>
<td>Broadmoor Hospital</td>
<td>Ealing Local Research Ethics Committee</td>
<td>02/08/2005</td>
<td></td>
</tr>
</tbody>
</table>

Approved by the Chair on behalf of the REC:

(Signature of Chair/Administrator)

................................. (Name)
19 April 2006

Miss Alison Christie  
Psychology Department  
Broadmoor Hospital  
Crowthorne  
Berkshire  
RG45 7EG

Dear Miss Christie,

Study title: Insight into mental illness and understanding of cognitive functioning in forensic patients with schizophrenia.

REC reference: 05/Q0410/57

Amendment number: 05/Q0410/57/AM01  
Amendment date: 13 February 2006

The above amendment was reviewed at the meeting of the Committee held on 11 April 2006.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covering Letter</td>
<td>05/Q0410/57/AM01</td>
<td>16 February 2006</td>
</tr>
<tr>
<td>Notice of Substantial Amendment (non-CTIMPs)</td>
<td>05/Q0410/57/AM01</td>
<td>13 February 2006</td>
</tr>
<tr>
<td>Covering Letter</td>
<td>05/Q0410/57/AM01</td>
<td>14 February 2006</td>
</tr>
<tr>
<td>Covering Letter</td>
<td>05/Q0410/57/AM01</td>
<td>13 February 2006</td>
</tr>
</tbody>
</table>

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

An advisory committee to North West London Strategic Health Authority
Research governance approval

All investigators and research collaborators in the NHS should notify the R&D Department for the relevant NHS care organisation of this amendment and check whether it affects research governance approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q0410/57: Please quote this number on all correspondence

Yours sincerely,

Mrs Aileen Pointon
Committee Co-ordinator

E-mail: aileen.pointon@eht.nhs.uk

Copy to: R&D Department for NHS care organisation at lead site

Endosures
List of names and professions of members who were present at the meeting
and those who submitted written comments

An advisory committee to North West London Strategic Health Authority
23 August 2005

Miss Alison Christie
Department of Psychology
School of Human Sciences

Dear Miss Christie

Insight into mental illness and understanding of cognitive functioning in forensic patients with schizophrenia (EC/2005/86/Psych) – FAST TRACK

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 23 August 2005

The list of documents reviewed and approved by the Committee under its Fast Track procedure is as follows:-

Document Type: Application
Dated: 12/08/05
Received: 12/08/05

Document Type: Summary of the Project
Received: 12/08/05

Document Type: Research Protocol
Received: 12/08/05

Document Type: Responsible Medical Officers Information Sheet
Dated: 05/07/05
Received: 12/08/05

Document Type: Patient Information Sheet
Dated: 05/07/05
Received: 12/08/05

Document Type: Patient Consent Form
Dated: 05/07/05
Received: 12/08/05
This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research, and with the condition set out below.

- That all documents sent to participants are presented on the University's headed paper.
The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected, with reasons.

I would be grateful if you would confirm, in writing, your acceptance of the condition above.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
Dr V Senior, Supervisor, Department of Psychology
Dr M Hill, Field Supervisor, Broadmoor Hospital
25 May 2006

Ms Alison Christie
Department of Psychology
School of Human Sciences

Dear Ms Christie

Insight into mental illness and understanding of cognitive functioning in forensic patients with schizophrenia (EC/2005/86/Psych) - Amendments

I am writing to inform you that the Chairman, on behalf of the Ethics Committee, has considered the Amendments requested to the above protocol and has approved them on the understanding that the Ethical Guidelines for Teaching and Research are observed.

Date of confirmation of ethical opinion: 23 August 2005
Date of approval of amendment to protocol: 25 May 2006

The list of amended documents reviewed and approved by the Chairman is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Letter Requesting Amendments</td>
<td>14/05/2006</td>
</tr>
<tr>
<td>Your Letter to West London Mental Health REC</td>
<td>16/02/2006</td>
</tr>
<tr>
<td>Notice of Substantial Amendment</td>
<td>16/02/2006</td>
</tr>
<tr>
<td>Approval of Amendment from Ealing &amp; WLMHT LREC</td>
<td>19/04/2006</td>
</tr>
</tbody>
</table>

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
Dr V Senior, Supervisor, Department of Psychology
Appendix 18: Mean Percentage Scores on the SAI-E Compared with Mean Percentage Insight Scores from Samples from Published Studies

Table showing the mean percentage scores on the SAI-E compared with mean percentage insight scores from samples from published studies

<table>
<thead>
<tr>
<th>Authors</th>
<th>Insight Scale</th>
<th>SAI/SAI-E Total Score</th>
<th>SAI/SAI-E Recognition of Illness Score</th>
<th>SAI/SAI-E Relabelling of Psychotic Phenomena Score</th>
<th>SAI/SAI-E Awareness of Need for Treatment Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Sample</td>
<td>SAI-E</td>
<td>52.22%</td>
<td>53.79%</td>
<td>42.00%</td>
<td>63.17%</td>
</tr>
<tr>
<td>David et al. (1992)</td>
<td>SAI</td>
<td>55.00%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>McPhearson et al. (1996)</td>
<td>SAI</td>
<td>36.43%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Collins et al. (1997)</td>
<td>SAI</td>
<td>60.71%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Kim et al. (1997)</td>
<td>SAI</td>
<td>55.00%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sanz et al. (1998)</td>
<td>SAI</td>
<td>50.00%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>SAI-E</td>
<td>50.42%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Yen et al. (2002)</td>
<td>SAI</td>
<td>52.86%</td>
<td>51.67%</td>
<td>40.00%</td>
<td>67.50%</td>
</tr>
<tr>
<td></td>
<td>SAI-E</td>
<td>54.58%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Drake &amp; Lewis (2003)</td>
<td>SAI-E</td>
<td>45.00%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Carroll et al. (2004)</td>
<td>SAI</td>
<td>59.93%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Values are expressed as a percentage (the mean score obtained as a percentage of the potential total score) because the SAI and SAI-E have different total scores; the SAI has a total of 14 and the SAI-E a total of 24.
Appendix 19: Descriptive and Inferential Statistics for Positive and Negative Syndrome Scale Scores between the Two Raters

Table showing the descriptive statistics for the Positive and Negative Syndrome Scale scores for the two raters

<table>
<thead>
<tr>
<th>Psychopathology</th>
<th>PANSS Total Score Mean (s.d.)</th>
<th>PANSS General Psychopathology Score Mean (s.d.)</th>
<th>PANSS Positive Symptom Score Mean (s.d.)</th>
<th>PANSS Negative Symptom Score Mean (s.d.)</th>
<th>PANSS Depression Score Mean (s.d.)</th>
<th>PANSS Insight Score Mean (s.d.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PANSS Rater 1</td>
<td>62.07 (22.42)</td>
<td>28.93 (10.96)</td>
<td>17.43 (8.70)</td>
<td>15.50 (7.02)</td>
<td>5.50 (2.07)</td>
<td>4.36 (2.06)</td>
</tr>
<tr>
<td>(n=14)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PANSS Rater 2</td>
<td>49.00 (14.69)</td>
<td>23.93 (5.58)</td>
<td>13.00 (5.23)</td>
<td>12.00 (6.03)</td>
<td>5.64 (3.29)</td>
<td>1.55 (1.73)</td>
</tr>
<tr>
<td>(n=14)</td>
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</table>

There were no significant differences between the PANSS scores given by the two raters (Mann-Whitney U-test, n=14, 14: PANSS Total Z=-1.86, p=.063; PANSS General Psychopathology Z=-1.22, p=.227; PANSS Positive Symptom Score Z=-1.22, p=.227; PANSS Negative Symptom Score Z=-1.50, p=.137; PANSS Depression Score Z=-.70, p=.511; PANSS Insight Score Z=-1.52, p=.137).