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Are sex offenders with both adult and child victims different from those with adult-only or child-only victims?  
A comparative study within a Special Hospital population

by

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submitted in part fulfilment of the degree  
PSYCHD, Clinical Psychology  
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Introduction to the Portfolio

This portfolio (Volume 1) includes selected pieces of work completed during the three-year doctoral training course in Clinical Psychology. It comprises three dossiers covering the academic, clinical and research components of the course.

The **Academic Dossier** comprises five out of six essays completed during the course, covering both core and specialist topics. The essays deal with aspects of the theory and practice of psychological approaches to human difficulties and have been selected to reflect the depth and breadth of topics encountered during the course of the author’s training.

The **Clinical Dossier** comprises the following: (i) A brief overview of the author’s clinical experience over the four core and two specialist placements; (ii) The contracts agreed with the supervisor for each of the placements; (iii) The summaries of five formal clinical case reports, four completed during the core placements and one completed during the specialist PTSD placement.

The clinical case reports have been selected to reflect the variety of clinical work undertaken on placement. They describe extended diagnostic and psychometric assessments, as well as individual therapeutic work with clients across the life-span, using different therapeutic approaches. All client names and other identifying details in these case reports have been changed to preserve their anonymity. The author is referred to as the ‘trainee therapist’ in the case report summaries.

The five clinical case reports are presented in full in a separate, confidential volume (Volume II). Also in Volume II are the log books of clinical activity and supervisor evaluation forms relevant to each placement.

The **Research Dossier** comprises the following: (i) A small-scale service-related research project undertaken during the Learning Disabilities Core Placement in the
first year; (ii) A literature review completed in the second year, which discusses the issue of sexual recidivism in sex offenders; (iii) The major research project, which was planned in the second year and completed in the third year. This is an investigation into factors which may discriminate sex offenders who offend against both adults and children from those who offend against only children or only adults. The rationale for such an investigation and the implications of the findings are discussed and are closely linked to the afore-mentioned literature review, which is referred to where appropriate.

The work in each dossier is presented in the order in which it was submitted, to reflect the ongoing learning process throughout clinical training.
ACADEMIC DOSSIER
Adult Mental Health (Long Term Disabilities): Essay

Can people recover from a mental illness without complete symptom relief?

MOMOTAJ ISLAM
Year 1: February 1998
Introduction
The concept of ‘recovery’ from severe mental illness is a relatively new one in the field of psychiatric rehabilitation. To set the scene, a brief summary of the development of psychiatric rehabilitation, and the nature and effects of severe mental illness will be provided. Then, the recovery model will be discussed and the implications of implementing this model into the mental health service will be considered.

Development of psychiatric rehabilitation services
Following the moral and political thinking of that era, the de-institution movement of the 1950s and 1960s gave rise to the idea that people who are mentally ill should no longer be removed from society and placed in large institutions but be maintained in the community to enable them to live as normal a life as possible. Mental illness began to be viewed as an illness which entitled the afflicted to the same consideration, help, or rehabilitation as people with a physical disease or disability (Bennett, 1991).

Historically, a clear definition of the concept of rehabilitation has proven difficult. Was the patient to be reintegrated into the general community, or to just live outside the mental institution, or to live in the community whilst being financially independent, or to be fully recovered from the illness?

Rehabilitation was initially seen as a process aimed at restoring the mentally ill patient to his or her former state. It took some time to realise that the patients with more serious and long-term problems would rarely experience a full return of psychosocial functioning. This realisation has gradually led to the more recent psychiatric rehabilitation services which generally aim to “assure that the person with a psychiatric disability can perform those physical, emotional, social and intellectual skills needed to live, learn, and work in the community with the least amount of support necessary from agents of the helping professional” (Anthony & Liberman, 1992). In other words, “rehabilitation is a conceptual framework aimed at helping clients to optimise their social performance in as socially valued a context as possible” (Lavender & Watts, 1994).
There are effectively two ways of achieving this goal in a rehabilitation setting: i) teaching the person the specific skills required to function effectively, or ii) developing the community and environmental resources needed to support or strengthen their present level of functioning.

Both the above definitions of rehabilitation focus on the first, skills-based approach but professional views have varied over the years as to which is the more effective of these strategies.

**Nature of mental illness**

Before recovery is discussed, it is important to gain an understanding of what exactly it is that the individual with serious and ongoing mental illness has to recover from. To take Goldman and Manderscheid’s (1987) definition, this population encompasses people who experience “certain mental or emotional disorders (organic brain syndrome, schizophrenia, recurrent depressive and manic depressive disorders, and paranoid and other psychoses, plus other disorders that may become chronic) that erode or prevent the development of their functional capacities in relation to three or more primary aspects of daily life - personal hygiene, self-care, self-direction, interpersonal relationships, social transactions, learning and recreation” (p13).

Thus we can see that the nature of severe mental illness is such that it involves not only the symptoms of the disease, but also other aspects of the individual’s life. For example, the symptoms of schizophrenia such as delusions, hallucinations and thought disorder, may impair the afflicted individual cognitively, emotionally and behaviourally. These impairments can impede an individual’s ability to perform certain skills and activities, which in turn, can limit the fulfilment of social and vocational roles, thus leading to significant disability and handicap. Table 1 summarises the negative effects of severe mental illness.
**Stages:**

<table>
<thead>
<tr>
<th>I. Impairment</th>
<th>II. Dysfunction</th>
<th>III. Disability</th>
<th>IV. Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any loss of ability of psychological, physiological, or anatomical structure or function.</td>
<td>Any restriction or lack of ability to perform an activity or task in the manner or within the range considered normal for a human being.</td>
<td>Any restriction or lack of ability to perform a role in the manner or within the range considered normal for a human being.</td>
<td>A lack of opportunity for an individual that limits or prevents the performance of an activity or the fulfilment of a role that is normal (depending on age, sex, social, cultural factors) for that individual.</td>
</tr>
</tbody>
</table>

**Definitions:**

<table>
<thead>
<tr>
<th>Examples</th>
<th>Hallucinations delusions depression</th>
<th>Lack of work adjustment skills</th>
<th>Unemployment homelessness</th>
<th>Discrimination and poverty</th>
</tr>
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</table>

**Table 1: The negative impact of severe mental illness**

Adapted from Anthony, Cohen & Farkas (1990), as cited in Anthony (1993)

**Definition of ‘recovery’ and the ‘recovery vision’?**

In recent years, the idea has developed that the long-term disabling effects of severe mental illness may be due not only to the disease itself, but the ignorant way in which mental illness is still viewed in society (Anthony, 1992). The 'social disablement' of people with severe mental illness was conceptualised by Wing and Morris (1981) as a setting in which such individuals are unable to act socially according to the standards they have set themselves and that others expect of them. They stated that this social disability is not only due to the emotional and cognitive impairments of the afflicted individual but equally due to the way society behaves towards that individual.

This kind of thinking has led to what Anthony (1992) calls a "revolution in thinking" and he states that "a vision of the possibilities of recovery can change how we treat people with mental illness even if the illness itself has not changed" (p1).

The concept of recovery may be interpreted in a variety of ways, leading to a number of definitions. Thus, in discussing recovery we need to consider whether it implies symptom elimination, symptom remission, or symptomatic improvement. Is it functional improvement despite the symptoms, or the absence of illness, or the psychological ability to cope with one’s illness? (Lefley, 1994).

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Anthony (1993) describes recovery as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (p.19). This is a subjective interpretation of the term ‘recovery’, derived from the writings of mental health service users.

Sullivan (1984) offers an operational definition of recovery: “participation in some form of vocational activity, residence in at least a semi-independent setting, and having avoided psychiatric hospitalisation for at least 2 years” (p.20). This definition is taken from the typical goals of community-based mental health services. With no mention of symptoms, it seems to focus on ability to function with or without symptoms.

Recovery is not cure

To most people recovery is defined as in the dictionary: “to regain a normal position or condition [as of health]” (Concise Oxford Dictionary, 1990). However, it has to be noted that, in this context, an expectation of return to a pre-existing state is not what is being described. To recover from mental illness is not to be cured of all the symptoms of the disease. Anthony (1993) draws parallels between recovery from physical illness and recovery from mental illness: “For example, a person with paraplegia can recover even though the spinal cord has not. Similarly, the person with mental illness can recover even though the illness is not “cured” (p.19). Also, like mental illness, there are physical illnesses, such as rheumatoid arthritis and multiple sclerosis, which may also have an episodic nature but from which people are said to have recovered despite the recurrence of symptoms.

Due to its nature, recovery from mental illness is often a more complicated affair than recovery from a physical illness. Other than the symptoms, people with mental illness have to recover from the stigma of being labelled (Deegan, 1993), from the sometimes negative effects of treatment; from the social effects such as unemployment; and from
shattered dreams. Hence, recovery from mental illness is often "a long and winding road" (Sullivan 1994). Also, as recovery is very much a personal experience, there is very little known about how people with severe mental illness experience this process.

**Assumptions about recovery**

Anthony (1993) states that, lacking adequate understanding of the recovery process due to absence of research in this area, some basic assumptions can be drawn from the reports of people who have experienced the process. The assumptions that he feels a "recovery-focused" mental health system needs to be aware of are:

i) There are many ways of achieving recovery, with or without the aid out of the mental health system. Professionals may facilitate the process, but it is actually the individual concerned who brings it about.

ii) A common factor that people report as being important to their recovery is the presence of significant people in their lives who believe in them and whom they can trust.

iii) Recovery is not based on the theoretical understanding of the illness, and can occur even when people have differing views about its cause.

iv) Recovery can occur even though symptoms recur. This is an important assumption because it states that the vision of recovery is not to be completely 'cured' of symptoms but to be able to function adequately despite the prospect that symptoms may reappear.

v) As the person recovers, symptoms interfere with functioning less often and for briefer periods of time.

vi) Recovery is not a linear process. Although, ultimately the person is improving, there may be setbacks as well as developments.

vii) Overcoming the secondary effects of having a mental illness, such as the disabilities and disadvantages discussed earlier, can sometimes be more difficult than recovering from the impairments caused by the illness itself.

viii) Sometimes people who have recovered from a mental illness are thought to "not really have been ill". Anthony states that this is a mistake, and is equivalent to saying "that someone who had quadriplegia but recovered did not really have a damaged spinal cord!".
Key elements in the recovery process

Taking up the issue of the lack of research in this area, Sullivan (1994) has carried out a study attempting to identify the important elements in the process of recovery. He asked forty-six former and current users of mental health services to "identify those activities, attitudes, and behaviours, initiated by self or others, that are essential to their success (in recovery)". The main factors identified by at least 30% of the participants are: medication; self-will/self-monitoring; community support/mental health services; vocational activity; spirituality; mutual aid/support groups; significant others; knowledge/acceptance of the illness.

Sullivan emphasises that these findings should not be seen as a "recipe for recovery" as this is a preliminary study. However, several of these factors have been described by other authors (eg. Chadwick, 1997) as being important in the aim of providing mental health service users with meaningful, 'normal' lives.

Medication - 72% of the participants identified medication as a critical element to their success. However, they also commented on the difficulties of collaborating with professionals in trying to find the right medication and dosage level.

Self-will/self-monitoring - 63% of participants felt they were able to control or at least successfully monitor their illness. Some had learnt to recognise their symptoms and to counteract them. Others had learnt to be vigilant to predictive signs of relapse, and to strategically employ professional help. Many also spoke of their success as a matter of attitude or drive, to be "normal" for example.

Community support/ Mental health services - Those still involved in community mental health services felt that this service was an important factor in their recovery. They appreciated the range of services, the tangible aid and the structure provided by these services. However, it was the relationships they formed with workers that was most beneficial, especially when they were treated "in a respective and normalised manner" (Sullivan, 1994, p.22).

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**Vocational Activity** - Work, either as paid employment or some meaningful activity, has been identified by both users and professionals as one of the most important elements of rehabilitation and recovery from mental illness. Work is a powerful source for meeting many needs. It represents social identity and status, social contacts and support, and it structures and occupies time as well as providing a sense of personal control and achievement (Shepherd, 1984).

**Spirituality** - In Sullivan's study, the definition of spirituality includes “participation in organised religious activities”. He states that “spirituality provides solace during illness, is a mechanism used to reduce the burden of the illness, and is a source of social support” (p.23).

**Mutual aid/support groups** - Sometimes it is not professionals but those who have lived through the experience who can provide most emotional support and expertise about the illness and its effects. This is the premise on which most self-help/peer support groups are based. Molta (1997) writes that support groups “alleviate the isolation and loneliness of living in a world that still does not understand mental illness.”

**Significant others** - This refers to the participants' personal relationships outside the family. Sullivan states that this is not to ignore the role of the family as caregivers, which has been studied extensively, but to draw more attention to the “basic needs of love and affection, and the opportunity for sexual expression [that has] been lacking in psychosocial rehabilitation” (p24). The participants described how their partners had helped them recover in different ways, ranging from offering support during difficult times to having a positive impact on their self-esteem.

**Knowledge/Acceptance of the illness** - It seems that increased knowledge of the illness leads to subsequent changes in behaviour which drive the process of recovery. Understanding the illness leads to the individual complying with medication, avoiding very stressful situations, managing symptomatology, and aiming to live a healthier life.
The role of society in the recovery process

Research in the cross-cultural aspects of severe mental illness (most commonly on schizophrenia) indicates that the social environment greatly influences prognosis. Cross-cultural findings have been observed for ideas on how the industrialised world may learn about recovery from the developing cultures in which the longer term prognosis has been found to be significantly better (Birchwood et al, 1992).

Sullivan's (1994a) description of enabling and entrapping niches captures well the type of social context that may foster or impede an individual's potential for progress. He states that "in terms of the community, work and family it appears that successful recovery from schizophrenia involves the ability to inhabit a socially meaningful niche" (p11). An entrapping niche is defined as one which is highly stigmatised with those caught in it being entirely defined by their social circumstances. The possibility that they may have aspirations and attributes apart from these circumstances is not usually recognised. In contrast, the enabling niche is defined as one which is often assumed naturally or may be created for certain populations to remain involved in or return to the everyday social life.

It is argued that the niches available to people may vary by culture, and in the West, more enabling niches are required. Sullivan suggests that the nearest the West has come to creating enabling niches for those with schizophrenia is in the community-based services which provide normalisation experiences that mimic naturally occurring niches.

The role of society in the recovery process of people with severe mental illness is also emphasised in the "disability and access model" described by Perkins and Repper (1996). Criticising the Wing and Morris (1981) model of social disability as being purely descriptive and focusing on the individual's 'problems', they call for a shift in focus from trying to change the individual to trying to change the society. Here again, analogies are drawn between physical and mental health problems. They state that "a person who experiences physical limitations is unable to negotiate the 'normal' (able-
bodied) physical world without the support, help and adaptation of that world, [so too] a person who is socially disabled are unable to negotiate the ‘normal’ (able-minded) social world without the help, support and adaptation of that world”(p27). Thus ‘access’ in their model refers to the facilitating and enabling of ordinary social roles, relationships and activities that are valuable to the person concerned. One application of this model has been in the form of a project enabling users to acquire jobs within the mental health system (Perkins et al, 1997).

**Individuals who have recovered**

There are many examples of people who have achieved recovery from a severe mental illness. That is, they have learnt to accept their illness, manage their symptoms which may recur from time to time, and lead a meaningful and fulfilling life (eg. Chapman, 1997; Molta, 1997). It is important to the recovery model to hear about these experiences so that more can be learnt about the process and so that these individuals can serve as role models for others. Some have become “peer professionals” (Chadwick, 1997) and are in a most advantageous position with personal knowledge of the illness and its effects and the opportunity to contribute to research and the provision of services, and in educating other professionals.

**Potential problems within the recovery model**

Critics of the concept of recovery model state that it is a way of thinking that blurs the realities of severe mental illness (Lamb, 1994).

Although the proponents of the recovery model clearly state that recovery does not assume cure, there is a problem that in general terms the word “recovery” does imply cure. Hence the use of this word might lead to denial of illness and rejection. Kersker (1994) states that “...The idea that we can be “cured” is counterproductive to recovery. When people with a mental illness believe they are cured they often believe they no longer need their medications. Thus relapse is frequently the consequence of our thinking that we are well.....".
Also, if the recovery vision is misinterpreted to mean cure, will service providers see a diminishing need for services? Will this mean that more psychiatric hospitals/wards can be closed and even community services reduced as “recovered” people will be functioning well enough not to need those either?

Lefley (1994) questions what the concept of recovery means for “the chronic, severe subset [of mentally ill persons] who are not capable of attaining the recovery vision as operationally defined” (p21). Will people be valued according to their potential for recovery?

The recovery model seems to be geared towards those who are regarded as “high-functioning” (Deegan, 1993). This would imply that people who are generally more articulate, well-groomed and not overtly symptomatic are less affected or better able to cope with the secondary effects of severe mental illness, and thus minimise their experiences. However, the effects of social stigma may be perceived even more acutely by those with higher levels of functioning and greater capacity for normal living (Lefley, 1994).

Thus it appears that the recovery model may hold problems for people at either end of the spectrum in terms of level of functioning and potential for progress.

**Conclusion**

The concept of recovery from severe mental illness is an optimistic and empowering one. It states that by recovering the individual is regaining control over his or her life and leading a useful, satisfying life even though symptoms may recur. In the field of rehabilitation, this is a very positive view to have and a good position from which to aim at helping people to deal with their illness and its consequences.

Anthony (1993) proposes that the concept of recovery is the “guiding mission for mental health services in the nineties and beyond”. However, there are certain precautions to keep in mind when implementing this model.
Recovery is very much an individual, personal experience. Thus, the aim of mental health services in facilitating recovery should be tailored to individual needs and abilities. It is important for professionals to know what steps each individual client is able to take, and how to encourage progress without fostering failure. There should be adequate support for those with the potential for recovery at the same time as not pressuring those for whom the goal may take longer to achieve or not be achieved at all. And most importantly, the fact that some people may recover relatively quickly should not lead to the diminishing of resources and hopes of those who are slow to recover.

To conclude, the simple answer to the question of whether people can recover from mental illness without complete symptom relief, is yes, because recovery in this context does not mean cure. But it is much dependent on the attitudes of the individual concerned, the people around them and society in general. Society has to become more accepting of people who have disabilities as a consequence of their mental illness, make allowances for their difficulties and provide opportunities for success.
REFERENCES


Birchwood, M., Cochrane, Macmillan, Copostake, Kucharska, & Cariss (1992) as cited in Sullivan (1994a); listed below


Birchwood, M., Cochrane, Macmillan, Copostake, Kucharska, & Cariss (1992) as cited in Sullivan (1994a); listed below


Learning Disabilities Essay

What were the driving forces behind the move towards care in the community for people with learning disabilities and what is the role of the clinical psychologist in resettlement?

MOMOTAJ ISLAM
Year 1: June 1998
Introduction

The provision of services for people with learning disabilities has always been an issue of concern in several domains, that is the medical profession, public morality and hard political economics, and the interplay amongst them. This was the case when the institutions were originally set up and also the case for the deinstitutionalisation movement.

The formation of the idea of care in the community and its development into service policy and practise will be discussed. As this has been a lengthy process, it is only possible to summarise the more significant events here. As a broad definition, community care means ‘helping people who need care and support to live with dignity and as much independence as possible in the community’ (Meredith, 1993). This resettlement involves various processes and the role of the clinical psychologist in these processes will be discussed.

It should be noted that although people with learning disabilities were first recognised in law when the first Mental Deficiency Act of 1913 was passed (Brigden & Todd, 1993), they, and people suffering from long term mental health problems were viewed as a homogenous group for some time afterwards, and there was little differentiation in services for them. The ideas about community care began in the area of mental illness and then extended to learning disabilities.

There have been a range of different, often derogatory, terms used to describe people with learning disabilities. Some of these terms, such as ‘mental deficiency’, will be used here only because they appear in the literature of the period being referred to.

Historical background

In the early part of the nineteenth century, the Victorians turned their attentions to reforming the treatment of those suffering from mental disorder. This led to the 1945 Lunatics Act which required the building of large hospitals, later to be known as institutions. There are differing views as to how much of this movement was driven by ‘a new standard of public morality by which the care of the helpless and degraded
classes of the community was to be seen as a social responsibility' (Jones, 1960, p.149), and how much it was influenced by the 'developing political economy of the mid-Victorian society, and was a sign of the triumph of the rising middle class' (Scull, 1984).

Whatever the motive for change, the outcome was that the standard of care provided by these institutions was a marked improvement on the provision of the past. As Mansell & Ericsson (1996) comment, 'It is interesting to note that institutions for people with intellectual disabilities began as a humane response to the oppression and misery of the general workhouse, and the lack of support in increasingly industrialised communities'(p.3).

However, these institutions soon became very overcrowded as they were used not only to provide asylum for people with chronic illnesses, but also relief to the community by housing the pauper mentally ill who formed 90% of the asylum population (Korman & Glennerster, 1990). The eugenics movement, instigated by Sir Francis Galton in the late nineteenth century, also accounted for these increased populations. The belief that mental deficiency was inherited led to higher demand for segregation and considerations of the need for sterilisation. However, even then, there also existed a less popular, view that perhaps people with mental deficiency could be trained to live in the community, maintaining acceptable moral standards, and thus not need to be permanently segregated.

The government set up a Royal Commission on the Care and Control of the Feeble-Minded (1904-1908) to examine these issues. The Commission rejected a policy of sterilisation and agreed to the teaching of skills, but concluded that the freedom of 'mental deficients' in the community was not acceptable.

In addition to these attitudes, the lack of economic input into institutions soon led to them becoming unhealthy environments with poor standards of care.
Criticisms of conditions in institutions

The range of social problems in existence after the Second World War and the creation of the National Health Service in 1948 brought issues of hospital care and mental disorder into the public domain. Thus the scrutiny of conditions in institutions, which was to be the impetus for ideas about alternative forms of care, began in the early 1950s.

A pamphlet entitled ‘50,000 Outside the Law’ (NCCL,1951) argued that many ‘mentally subnormal people’ were wrongfully detained, and also claimed that institutions had a ‘vested’ interest in retaining people for commercial gains, as cheap labour, and economical reasons, as the more able residents helped staff care for the less able, thus reducing the need for more paid staff. The Royal Commission on Mental Health (1954) was set up in response to demands for reforms in the law to address these issues.

In the mid to late 1950s and 1960s, social scientists carried out studies that aimed to either modify conditions in existing institutions or reject them altogether. In America, Goffman (1961) likened mental hospitals to prisons under the concept of a ‘total institution’. This was defined as ‘a place of residence and work where a large number of like-situated individuals, cut-off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life’ (p.11).

He described the negative features characteristic of institutions as:

1. The ‘breakdown of the barriers’ found in ordinary life normally separating the place to live, the place to work and the place for recreation. So the residents were expected to spend all their time in the same place.
2. Segregation from everyday social life, with residents having little contact with the outside world.
3. Rigid routines and an overall plan guiding even the smallest details of peoples’ lives, e.g. inflexible mealtimes and bedtimes.
4. Employment of block treatment, so that the same rules and practices applied to all residents irrespective of any particular needs.

5. Depersonalisation of residents, so that residents were not treated as individuals and were deprived of the rights and status of ordinary people.

6. Obvious social distancing between staff and residents, by the wearing of uniforms, use of separate cutlery, etc.

7. Residents had little control or choice in what happens to them or their environment.

In Britain, Barton (1959) had made similar criticisms of mental hospitals in his book 'Institutional Neurosis', and Morris (1969) specifically studied institutions for people with mental handicap and also found poor conditions. The conclusion was that institutions were based on an organisational structure that encouraged custodial care rather than cure or rehabilitation, as had been originally intended. These findings raised serious practical and ethical issues about the provision and management of care in institutions.

**Changes in professional ways of working**

Changes in the medical professions' attitudes towards people with mental disorder began in the 1930's with the growth of out-patient clinics and the inclusion of acute psychiatric wards in general hospitals. This, and the open-door policy of mental hospitals (unlocking wards and only keeping in-patients for limited periods) in the 1950s was 'an indication of the recognition that keeping people in hospital for lengthy periods was detrimental to their ability to live in the community again' (Korman & Glennerster, 1990). So, by the end of the 1950s and the early 1960s progressive thought in psychiatry was also quickly moving away from the hospital and towards the community as a base for care.

The period after the 2nd world war also saw the dawn of psychology. Developments, such as, group therapy; methods of treatment that did not require removal from everyday life; and ideas about therapeutic communities, all helped to foster a more positive approach to the treatment of the mentally disordered (Korman & Glennerster, 1990).

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In the 1960's, the Medical Research Council’s (UK) Psychiatric Research Unit examined the potential for the development of people with mental handicap. Several of their studies represent the first evidence of attempts to create alternative modes of provision (e.g. Tizard, 1964).

**Political- economical moves**

Despite the awareness of poor conditions in institutions and the change in professional attitudes there was little political action to deal with this situation. That is, until the late 1960's and the 1970s, when faced with economical stress, the political-economical argument developed that community care would be cheaper because it would cut down on spending in maintaining the deteriorating old buildings that were institutions, and staffing them. Also, the cost of care in the community could be shifted from the health service to the local authorities.

Also around this time, the public were alerted to the poor conditions in mental hospitals via two newspaper articles, the first about Ely Hospital in the ‘News of the World’ in 1968, and the second about Harperbury Hospital in the ‘Guardian’ in 1969 (Ryan & Thomas, 1987). These revealed extensive ill-treatment and neglect in squalid, over-crowded surroundings. In response to these and other exposures, the government published a policy document, ‘Better Services for the Mentally Handicapped’ (1971), which stated that the number of hospital places should be halved and replaced by a corresponding increase in local authority funded care, based on the principle that mentally handicapped people should not be ‘unnecessarily’ segregated from the community.

The Jay Report (DHSS, 1979), proposed a new philosophy of care which was accepted by the government in their policy document ‘Care in the Community (DHSS, 1981b) as ‘a model of care under which those mentally handicapped people who need residential care away from home should receive this in small residential units....’ This essentially marked the end of the traditional long-stay hospital.
Implementation of deinstitutionalisation policies

Once the ideological, moral and professional argument that care in the community is superior to care in institutions had been won, and the policies had been set in place, the implementation of these policies had to begin. Deinstitutionalisation, that is, ‘the movement of people from institutional forms of care, often hospital based, to other apparently superior environments’ (Allen, 1989) did not begin until the later part of the 70s when the process of hospital closure began. However, this could not occur on a large scale until community services were sufficiently developed to allow the final abandonment of institutional care, in the 1980s.

Also in the mid-80s, policy development concerned mainly with services for elderly and mental health problems, had a major impact on the learning disability services. The Griffiths Report (DHSS, 1983a) looked at the organisation and funding of community care services, and later became the basis of changes described in the government white paper, ‘Caring for People’ (1989). These issues led to major legislative reform in the National Health Service and Community Care Act (1990), which essentially imposed on local authorities the responsibility for providing residential care and stated that in future hospital care was to be almost entirely concerned with short-term treatment.

The normalisation principle

Alongside these events, in the arena of social scientists and reformers, an alternative positive vision of care was forming. This vision, the concept of normalisation, has proven to be a major driving force in the development of services for people with learning disabilities. It originated in Scandinavia in the 1960’s and was developed in America in the late 1960s. The Scandinavian version of normalisation, defined by Nirje (in Kugel & Wolfensenger, 1969), sought to provide for people with handicaps the same ‘rights and obligations’ and the same ‘pattern of activities’ as ‘normal’ members of society. However, this definition still allowed for such activities to occur in segregation.
Wolfensberger’s (1972) analysis of the concept concentrated on the way in which society and services, cast people with handicap into certain roles and reinforces those roles by the way in which services are carried out and the environment in which they are carried out (Shanley & Starrs, 1993). Thus the concept became known as ‘social role valorisation’, with the aim of providing people with valued roles in society.

Brigden and Todd (1993) describe normalisation as a ‘complex system which sets out to value positively devalued individuals and groups and is influential at three levels - a personal level; primary and intermediate social systems; and a societal level’.

In relation to policy making and service organisation, the normalisation principle began to be applied in Britain in the mid-1970s and its core value - that people with learning disabilities have the same human values as everyone else - is now written into virtually every service statement regarding planning and delivery of services.

A service based on the principle of normalisation should have certain aims with respect to the individual being served (Shanley & Starrs, 1993). These are described as: community presence; making choices and advocacy; developing and maintaining skills; gaining respect; positive relationships; being treated as an individual; having one’s rights supported; continuity; and dignity of risk. It can be seen how these aims are incorporated in the resettlement work described later.

**Resettlement**

At a basic level, resettlement literally refers to a person moving from one place and settling into another. However, for it to be beneficial for clients, it needs to be much more than a matter of relocation. It requires a change in the organisation and delivery of care in an attempt to reverse the deleterious effects of institutionalisation.

As resettlement can be a complicated operation requiring input from various sources, Community Mental Handicap Teams (CMHTs) were set up to co-ordinate the services and to draw together the various skills of the professionals who may be involved. These teams, now known as Community Teams for People with Learning Disabilities
(CTLDs), include psychiatrists, clinical psychologists, community nurses, and speech and language therapists. It is crucial that each professional works in collaboration with the rest of the team for the efficient running of the service and for the benefit of the clients.

**The role of the clinical psychologist**

As a member of a multidisciplinary team, the Clinical Psychologist has a number of roles to play in the process of resettlement. These roles may be divide into the four areas of: assessment and interpretation; intervention; teaching and consultation; and evaluation. Each of these roles will be discussed with particular reference to the resettlement of people with learning disabilities from a hospital setting to a community setting.

**Assessment and interpretation**

Before a person can be moved into the community there is a great deal of information that needs to be collated about the person and the placement, and clinical psychologists have the clinical judgement and experience that this task requires.

The aims of this assessment are to learn about the following:

1. The client's readiness to move - this includes finding out about the client's preferences and dependency level. The clinical psychologist would measure the client's intellectual, mental and emotional states.
2. The client's suitability for the new situation - the clinical psychologist would measure the clients adaptive living skills and social functioning, in order to identify his/her strengths and needs for support.
3. The possibilities for change - the clinical psychologist would explore how the client may improve his/her quality of life and plan achievable goals for the client. This would include issues such as social competence and community integration.

For resettlement to be successful, it is important to involve members of the client's family and others who play a key role in his/her life in this process. Perkins & Repper (1996) also suggest several other strategies for minimising the disruptive effects of
resettlement, such as, anticipating any potential difficulties and preparing to deal with setbacks, and maintaining as much continuity as possible (e.g. use of the same day centre; familiar staff).

The assessment and interpretations made by the clinical psychologist serve an essential purpose in the collaborative design of a ‘package of care’ (DoH, 1989) for the individual client, the implementation of the agreed ‘package’, and the monitoring of progress in the client’s life.

**Intervention**

To understand how a clinical psychologist may use psychological interventions with the client who is undergoing resettlement, it is important to see what problems this situation may give rise to for the individual.

For any member of society, moving home can be a stressful experience, involving many other possible changes such as a new job, new neighbours, and adjusting to new shopping and leisure facilities. Likewise, for the person with learning disabilities, who has perhaps spent most of his life in an institutional setting, the transition to a community setting, leaving behind everything familiar, including most of their friends, can be very frightening and almost like entering another world. Townsend (1981) compared them to emigrants in the challenges they faced - with the added burdens of disability and ‘enforced dependence’ to compound their problems of adjustment.

Macy (1984) uses the term ‘transition shock’ to describe this stress reaction, the symptoms of which may take two basic forms:

i) an outer directed reaction to the stress of relocation - usually manifest as an explosion of feeling against other people or things (aggression), or as aberrant behaviour (bullying, pilfering, shoplifting)

ii) an inner directed response to stressful change - manifest either as physical symptoms (e.g. non-specific aches and pains; enuresis; soiling) or as emotionally disturbed behaviour (e.g. self-injury, wandering, tearfulness and withdrawal).
A clinical psychologist would be involved in assessing these problems, observing the frequency of their occurrence and others’ reaction to them, and analysing the function they serve for the individual. Intervention would involve the application of a broad range of theoretical knowledge and skills in an attempt to either remove an excess behaviour or remedy a behavioural deficit (Cullen & Tennant, 1990).

**Teaching and consultation**

As there are too few clinical psychologists to carry out all the one-to-one client work that is required, they have developed other ways of dispersing their knowledge and skills. Clinical psychologists may provide expertise to other professionals concerning ways of maximising a person’s strengths and the effects of different interventions based on psychological theories and research, as well as taking an advisory role in service planning.

The studies of institutionalisation found that the staff were just as institutionalised as the residents as evident from their attitudes and work practises (Morris, 1969). Thus staff who have previously worked in hospital settings may need to be taught new work practises that are guided by the principle of normalisation.

Much of the behaviour-teaching type of work could be carried out by appropriately trained direct-care staff or parents. Thus, through staff-training workshops and home-teaching (Portage) systems, psychologists can operate through those who are in closest contact with the client (Cullen & Tennant, 1990). The clinical psychologist may be involved in teaching support workers a wide range of skills (either as individuals or as part of a wider support team) from simple assistance with budgeting to counselling and resolution of challenging behaviours.

**Evaluation and research**

Clinical psychologists have specific training in research and data collection, thereof, they will often be involved in monitoring and evaluation, and in developing systems of team working (Perkins & Repper, 1996).
Clifford and Damon (1988) divide evaluation into two basic types:

i) criterion-based evaluation - empirically examining the management of a residential setting and judging whether or not it is still 'institutional' in character. Quality assurance tools, such as the Program Analysis of Service Systems Implementation of Normalisation (PASS; Wolfsenberger & Glenn, 1987), may be used.

ii) outcome measures - to observe whether the aims of deinstitutionalisation have been met by measuring key factors such as change in people's adaptive behaviour, activity levels, social interaction, and the degree of community integration, and assessing the overall quality of their life.

Also, at the service planning level, the clinical psychologist may play an active role in, for example, gauging public opinion and providing reassurance about the development of a residential setting for people with learning disabilities.

**Conclusion**

Although historically community care was more of an ideology than a practised policy, by the 1980s it became a noticeable reality. The driving forces behind this move were a concomitant of social research, a public sense of morality and the political reaction to these, and, perhaps more importantly, the economic situation of the health service.

Care in the community calls for something more meaningful than simply substituting hostels or individual homes for hospitals. It requires that people with learning disabilities are respected and given equal opportunities to live a fulfilling life in the general community.

Clinical psychologists have many parts to play in the resettlement process, from direct work with clients and their families in preparing for and dealing with the transition, to staff training, to evaluation and service planning.
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Child and Adolescent Essay

Clinical depression is an adult phenomenon and is of little relevance for children and adolescents. Discuss

MOMOTAJ ISLAM
Year 2: February 1999
INTRODUCTION

The phenomenon of clinical depression as a psychiatric disorder has been recognised in adults for some time. Therefore, theories about its aetiology, knowledge about its presentations, criteria for its diagnosis, and strategies for its treatment are fairly well established. The concept of clinical depression in children, however, is a relatively recent development. This concept has created much confusion in the clinical and research fields with views as diverse as the claim that children do not suffer from significant depression, to the view that depression occurs as a specific illness in childhood and adolescence similar to that of adults.

In the literature of the last decade or so, there seems little doubt that depression as a major illness can and does exist in childhood, and that this disorder can meet the full criteria for adult depression. Hence, it might be thought that the issue of the validity of childhood depression has been resolved. However, this is not the case, as many uncertainties still exist about the concept. Questions have arisen about the developmental psychopathology of depression, the validity of the diagnosis in the younger years, and whether the disorder represents the same condition among young people and adults (Angold, 1988).

The current debate seems to be, not about the possibility of depression among children, but about the similarities and differences between child and adult depression, and the best means to diagnose depression in children and adolescents. So, the question of ‘relevance’ addresses the issue of whether the criteria developed for the diagnosis of depression in adults is relevant for making the same diagnosis in children.

The following discussion will begin with a general description of clinical depression as it is known in adults. Then, a brief outline of the development of the concept of depression in children will be given, with some arguments for the existence of depression in children, and a description of the main characteristics of this phenomenon. There will also be some discussion of similarities and differences between child and adult depression. Finally, the arguments will be presented regarding
the classification and diagnosis of depression in children and adolescents, and the clinical implications for understanding this phenomenon better.

**General characteristics of clinical depression**

The term 'depression' is used in our everyday language to describe a normal lowness in mood. Although this may have its adaptive functions, a general low mood can deepen and lead to other symptoms becoming drawn in, resulting in the syndrome that is 'clinical depression'. For the purpose of this discussion, the definition of depression will mainly rely on the criteria outlined by the Diagnostic and Statistical Manual, DSM-IV (APA, 1994) for the unipolar mood (affective) disorder termed 'major depression' or 'major depressive disorder (MDD)'.

The symptoms of depression are diverse, including emotional, cognitive, behavioural and physiological factors. The essential criteria for a diagnosis of major depression in DSM-IV are listed in Table 1. Significant symptoms of depression may be suffered at any one time by between 9% & 20% of the general adult population, with 12% requiring clinical intervention. An estimated 75% of psychiatric hospitalisations are accounted for by depression (Fennel, 1989). The prevalence of a major depressive disorder, as defined in DSM-IV ranges from 2.2 to 3.5% of the population.

At least five of the following symptoms must be present during the same 2-week period; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day (either by subjective account, e.g. feels "down" or "low" or is observed by others to look sad or depressed.
2. Loss of interest or pleasure in all or almost all activities nearly every day (either by subjective account or is observed by others to be apathetic).
3. Significant weight loss or weight gain (when not dieting or binge-eating) or decrease or increase in appetite nearly every day (in children consider failure to make expected weight gain).
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down), (in children under six, hypoactivity).
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt (either may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness nearly every day (either by subjective account or observed by others).
9. Thoughts that he or she would be better off dead or suicidal ideation, nearly every day; or suicide attempt.

Note: Several exclusion criteria must be met as well (e.g. to distinguish depressive disorder from other conditions such as bereavement).

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M Islam; PsychD; 2000
CONCEPTS OF DEPRESSION IN CHILDREN
The conceptualisation of depression in children is far less developed than that in adults. In fact, it is only within the last twenty years or so that it has received considerable clinical and research attention. Previously, the generally held view was that depression was extremely rare, or did not even exist, in children.

Psychoanalytic thinking, which was dominant in the 1950s and early 1960s, held that depression was a product of a persecutory superego. Thus it was argued that depression could not occur in pre-adolescents because their personality structure was too immature for their superego to direct aggression against their own egos (Rie, 1966). Even in adolescents, it was thought that depression, as a discrete phenomenon, was relatively uncommon.

However, even as early as 1921, Kraepelin had reported that 4% of his manic-depressive cases first presented their disorder before the age of 10. And, in the 1950s, researchers began to provide empirical evidence indicating the presentation of manic-depressive illness in children (e.g., Anthony & Scott, 1960). By the late 1960s, studies were showing the occurrence of marked levels of depressive symptoms in clinically referred young people (Angold, 1988).

This led to claims that depression did occur in childhood but that the depressive symptoms were expressed in a different way to that in adults. Cytryn and Mcknew (1972), for example, introduced the term ‘masked depression’ in line with their view that depression in children is masked by symptoms such as aggressiveness, tantrums, and anxiety, rather than the adult core symptoms such as dysphoric mood and loss of interest.

The idea of ‘masked depression’ helped to draw the attention of clinicians to the modes of presentation of depression that were easily missed in children. However, it became misleading because the symptoms that were thought to be ‘masks’ to depression were extended to include the behaviours seen in almost any form of childhood disorder, such as enuresis and hyperactivity (Puig-Antich &
Gittelman, 1982). Also, Kovacs (1986) pointed out that many of the behaviours thought to be masking depression in children were often a prominent part of the manifestation of adult depression.

As we shall see later, the co-occurrence of other disorders with symptoms similar to those in depression causes difficulties in identifying the underlying depression, and still remains a problem in assessment and diagnosis, especially in children.

**Evidence for depression in children**

Kovacs (1997) identifies at least “three lines of evidence” which indicate that depression can be diagnosed in childhood as a morbid or pathological state. These are:

1. **The Protracted Duration of Depression** - There is considerable evidence to suggest that clinical depression in young children is not a transient state. Kovacs et al. (1984a) found that first episode MDD (in 8-13yr olds) from onset to symptomatic recovery lasts an average of 11 months, with a median time to recovery of about 9 months.

2. **The Low Rate of Depression in Response to Loss** - There is evidence to show that most children and adolescents do not develop clinical depression in response to significant losses (e.g. death of a parent). Brent et al. (1992) found that 30% of adolescents develop MDD in response to loss of a peer through suicide. Kovacs argues that if the development of MDD was to be a “normal” response to major loss, we would expect rates much higher than 30% among young people exposed to such losses.

3. **Impaired Functioning in Depression** - There is evidence to indicate that depression in childhood is a form of psychopathology based on the range of associated problems in daily living. It has been documented that, like children with other types of psychiatric disorder, but unlike nonsymptomatic peers, depressed children display difficulties in maintaining good family and peer relationships. Depression in children
has also been found to interfere with school performance, academic achievement, and age-appropriate social behaviours (Kovacs & Goldston, 1992).

CHARACTERISTICS OF DEPRESSION IN CHILDREN AND ADOLESCENTS

Prevalence

Prevalence rates of depression in young people vary depending on the selected sample, the measures employed and the diagnostic criteria utilised. In early studies, this had much to do with “uncertainties surrounding the concept of depression in young people and unstandardised methods of assessment” (Angold, 1988). However, methodological improvements have led to some consistencies in the reported prevalence rates, though variations remain.

Depression has been studied among community/non-referred children as well as various clinical samples. In the general population, reported prevalence rates in children range from 0.4% to 2.5% in children and between 0.4% and 8.3% in adolescents (Anderson & McGee, 1994; Fleming & Offord, 1990). In clinical populations, typical estimates of those with diagnosable criteria fall between 10 and 20% (Puig-Antich & Gittelman, 1982). Thus, the data indicates that clinical depression occurs at rates comparable to those observed in adults.

The lifetime prevalence rates of MDD in adolescents has been estimated to range from 15% to 20%, which is comparable with the lifetime rate of MDD found in adult populations, suggesting that depression in adults often begins in adolescence (Kessler et al, 1994b). However, Frame and Cooper (1993) point out several reasons, such as the lower prevalence rate of childhood depression in the general population, for the lack of clarity in statements that childhood depression is a precursor for adult depressive disorder.

Age, gender and developmental differences

Prevalence appears to vary with age over the course of childhood. Some studies (e.g. Kashani et al, 1986) have shown in clinically referred samples, that young children
(aged 1-6yrs) have markedly lower rates (1%) of major depression compared to children aged 9-12yrs (13%).

Prevalence rates also appear to vary significantly as a function of pubertal status and sex. Analysing data from the Maudsley Hospital, Rutter (1986b) found that approximately 11% of prepubertal cases showed depressive symptoms, whereas only about 25% of postpubertal children did so. As has occasionally been found in other studies, Rutter also found depressive symptoms were twice as common in boys among prepubertal children, whereas the most commonly reported finding is that in prepubertal children MDD occurs at approximately the same rate in girls and boys (Frame & Cooper, 1993). However, in adolescents, it has unequivocally been found that female to male ratio of MDD is approximately 2:1, paralleling the ratio reported in adult MDD (Fleming & Offord, 1990; Lewinsohn et al, 1994).

Although overall it depends on the underlying personality of the child & his or her relationships with family and significant others, boys and girls seem to develop different coping mechanisms for dealing with their depressive symptoms. Amongst boys, there is a general tendency to adopt externalising mechanisms such as: hyperactivity, agitation, acting out, provocative and aggressive behaviours which attract a considerable amount of attention to the child. Amongst girls, the general tendency is to adopt internalising mechanisms such as: poor school attendance with recurrent psychosomatic problems, running away from home or wandering aimlessly, social withdrawal/lack of contact with peers. These have also been described as ‘flight or escape’ (for internalising) and ‘fight or aggression’ (for externalising) responses (e.g. Keneally, 1988).

As well as the age and sex dimensions, the presentation of depression in children and adolescents also differs according to the developmental level of the young person. These differences may be manifest in the pattern of symptoms, and severity and relative frequency of occurrence (Kazdin, 1990).
There also appear to be differences in presentation according to the developmental stage of the child. In toddlers & infants, the most characteristic symptoms of depression are associated with eating disturbances, failure to gain weight, significant developmental delay, a loss of already acquired achievement with associated regressive symptoms, sleep disturbance and a tendency to persistent illness (Gay & Vogels, 1993). Among prepubertal children, somatic complaints, psychomotor agitation, and mood-congruent hallucinations are considered more prevalent. Among adolescents, antisocial behaviour, substance use, restlessness, grouchiness, aggression, withdrawal, problems with family and school, and feelings of wanting to leave home or of not being understood and approved of are considered more frequent (Roberts, et al, 1995). Adolescents also appear to have greater self-esteem problems, and more suicide attempts (Carlson and Kashani, 1988) However, Lewinsohn et al (1994) found that suicidal behaviour is much more common in youths whose depression is comorbid with another disorder.

**Clinical course**

In general, findings from studies on children parallel those obtained with adults which show high rates of recovery for episodes of depression but a high risk for relapse. Clinical and epidemiological studies in children and adolescents have reported an average length of an episode of MDD to be approximately 7 to 9 months (e.g. Lewinsohn et al, 1994; Kovacs et al, 1984a). Approximately 90% of the major depressive episodes have remitted by 1.5 to 2 years after the onset, with 6-10% becoming protracted (e.g. Sanford et al, 1995). The probability of recurrence is 40% by 2 years and 70% by 5 years (e.g. Lewinsohn et al, 1994).

**DIFFICULTIES IN IDENTIFYING DEPRESSION IN CHILDREN AND ADOLESCENTS**

With all the information available regarding the prevalence and characteristics of depression in childhood, it may be thought that few questions remain regarding this phenomenon. However, as has been seen, this knowledge in not without debate. There are variations in the information available based on three significant sources of difficulty in identifying depression in young people. These are: psychiatric
comorbidity; assessment; and classification and diagnosis. These will be discussed in turn, though, of course, they do overlap.

1. Classification of childhood depression

The classification of depression in childhood and the criteria used to diagnose this disorder is still a matter requiring some clarification and development. The generally accepted features (as listed in DSM nomenclature) of MDD for children and adolescents have mostly been derived from experience with depressed adults (Carlson & Kashani, 1988). This gives rise to one of several important questions, that is, whether depression in childhood, defined according to criteria originally developed for adults, is the same thing as depression in adulthood? (Angold, 1993).

Cantwell and Baker (1991) have pointed out two possibilities: (1) there may be unique disorders among children and/or adolescents with symptomatology distinct from that of adults, or (2) childhood, adolescent and adult depression may represent the same fundamental phenomenon regardless of age (as accepted by DSM-IV). However, Roberts and his colleagues (1995) state that there would appear to be a third alternative, at least logically. That is, that there are similarities but also differences. These three possibilities will be discussed in turn.

i) Development of criteria for childhood syndromes resembling adult depression

Following the general acceptance that some form of depressive disorder does occur in children, the next major development in the area was the attempt by several authors to specify operational diagnostic criteria for depression in children that resembled the criteria used to diagnose depression in adults (e.g. Weinberg et al, 1973). These criteria indicated that multiple symptoms could be considered as evidence of depression. Many of the symptoms were common with those evident in adults (e.g. dysphoric mood), but other symptoms included dysfunction in domains obviously unique to children (e.g. school performance).

Such child-specific criteria represented an important advance in the evolution of the current concept of depression in children. However, they were criticised for being
rather non-specific, in fact, to the extent that a depressive disorder could still be
diagnosed in the absence of a majority of symptoms of depression. Also, the existence
of several different sets of criteria for childhood depression meant that there was little
uniformity within the field.

**ii) The use of unmodified adult criteria**

With the emergence of DSM-III, diagnosis became more clearly associated with a
narrower range of symptoms, independent of age. This was based on the findings of
significant studies (e.g. Ryan et al, 1987) which documented that with regard to
developmental variations in the features of MDD, there was “no compelling evidence
that the cardinal symptoms of MDD have significantly different rates of occurrence
across the age span in clinically referred samples” (Kovacs, 1996).

Such conclusions led to suggestions that depressive disorders among children should
be diagnosed with the standardised criteria that were used with adults, such as the
DSM-III at that time. Researchers then went on to identify major depressive disorder in

The main current classification systems make no distinction in the diagnostic criteria
for prepubertal, adolescent, or adult depression. DSM-IV does state in the text that
there may be age-specific associated features that differ across these age periods (e.g.
Harrington, 1993). But none of these features is actually part of the diagnostic criteria.
Major depressive disorders are seen as occurring at any age, including infancy. In the
ICD-10 (WHO, 1989) no mention is made of the features of major depression as they
occur in children.

From their analysis of data from a large, community-based prospective study of the
epidemiology of adolescent depression, Roberts and his colleagues (1995) state that
there is strong evidence that DSM criteria for major depression are appropriate for
adolescents. That is, DSM-III-R symptom criteria are manifest in adolescents and
adults, although the frequency of these symptom criteria appear to be age-related. They
go on to suggest that whether these findings are generisable to younger adolescents and children remains to be demonstrated.

Some longitudinal studies (e.g., Harrington, 1993) also provide strong support for the idea that depression in young people does represent the same psychiatric condition as depression in adulthood. However, it appears that the continuities are stronger from adolescent to adult depression than from child to adult depression, and that the child to adult links are weaker when there is comorbidity with conduct disorder.

To summarise, it appears that there has been a major change in viewpoint from the idea that depression cannot exist in children (or that it exists in a masked form) to the point where childhood disorders with features similar or identical to adult depression are part of the general classification systems.

There are however, some difficulties associated with the view that the manifestation of depression is almost invariant across diverse ages. The main criticism is that the strategy of applying unmodified adult criteria to children fails to allow for the potential impact of developmental effects on manifestation noted by some researchers. These developmental issues include differences in symptom manifestation (as discussed earlier), and children's limitations in accurately reporting symptoms (as will be discussed).

### iii) Similarities and differences between child and adult depression

Although the essential features of major depression are considered similar in children, adolescents, and adults, some differences in phenomenology are noted.

Several investigators have systematically compared the symptoms of depressed children with those of depressed adolescents or adults (e.g., Carlson & Kashani, 1988; Ryan et al, 1987). In their large comparative study of child, adolescent and adult depression, Ryan and colleagues (1987) describe many significant similarities between child and adult depression but also point out important dissimilarities. In fact, they state that some symptoms that are not part of the adult criteria for depression, such as somatic complaint and social withdrawal are so common among depressed children
and adolescents that they should be considered for inclusion in the criteria for depression in this age group.

In her evaluation of the relevant literature on MDD during childhood, adolescence, and the later years of the life span, Kovacs (1996) concluded that MDD in clinically referred youths is similar in many regards to MDD in adults. However, she also suggests that “early onset portends a worse course” in several respects, such that: although children and adolescents with MDD appear to recover faster from their index episode of depression than do adults, they have a higher rate of recurrence; and that there is a notable risk of conversion to bipolar illness.

2. Psychiatric Comorbidity
The difficulty in identifying depression in children is that it is extremely difficult to distinguish depression from the high rates of concurrent psychiatric disorders which have commonly been detected in studies of depression in children and adolescents. Clinical (e.g. Ryan et al., 1987) as well as epidemiological (e.g. Anderson & McGee,) studies have shown 40-70% of depressed children and adolescents have comorbid psychiatric disorders, and at least 20 to 50 % have two or more comorbid diagnoses. The most frequent comorbid diagnoses are - dysthymic disorder, anxiety, disruptive disorder and substance abuse (Birhamer et al,1996). The problem is that a set of criteria is yet to be devised which can reliably distinguish between symptoms that are due to depression and identical symptoms that occur as part of a different underlying disorder.

In her review of the literature on MDD, Kovacs (1996) also describes similarities and differences between children and adults regarding comorbidity. She draws two conclusions: regardless of age, the vast majority of depressed patients have comorbid disorders; also regardless of age, some type of anxiety disorder is the single most prevalent diagnosis in conjunction with depression.

However, within different age groups, the comorbid combinations and sequencing of specific disorders vary. Among depressed youths, attention deficit disorder or enuresis-
encopresis account for some of the overall comorbidity, whereas in older adults, other comorbid conditions such as panic disorder are more common. In children and young adolescents, separation anxiety predominates among the clinically referred, while among adults it is generalised anxiety disorder.

The prevalence of psychiatric comorbidity among youths led some investigators to question the validity of the DSM criteria for depression in younger age groups (e.g. Angold, 1988). However, as Kovacs (1996) has documented, high rates of comorbidity have been shown in adults as well.

3. Assessment of depression in children and adolescents
There are a variety of methods for assessing childhood depression. These are briefly mentioned below (for a full description, refer to Kazdin, 1990):

- Structured clinical interview involving appropriate diagnostic questioning
- Self-report measures - e.g. Childhood Depression Inventory (CDI, Kovacs, 1981)
- Peer report - e.g. Peer Nomination Inventory for Depression (PNID, Lefkowitz & Tesiny, 1980)
- Ratings by significant others - Children’s Depression Rating Scale (Poznanski et al, 1984)
- Measures of overt behaviour
- Biological and psychophysiological measures
- Electrophysiological recordings
- Other modalities - e.g. projective techniques, such as the Rorschach Test.

Although recent studies have shown that children are able to experience emotions and cognitions of a depressive nature, their ability to report them reliably has been questioned. This is particularly so in young children in which depression is largely under-recognised and misunderstood by professionals and parents, even though estimates in the USA indicate that 10% of the children suffer from some form of depression before age 12 (Dolgan, 1990). This misunderstanding is partly due to the young children’s lack of ability in accurately expressing in words their inner feelings.
According to Kovacs (1986), children from 8yrs up are able to consider their own affect separate from environmental context and also to separate sadness from dysphoria. However, concerning the onset and duration of symptoms, the capacity of children under 10 or 12 yrs to report them reliably is limited. The common clinical and research solution to this problem is to use multiple informants when assessing children, even though agreement between them may be poor (Puura et al., 1998).

By adolescence, assessment becomes easier because of their ability to articulate feelings and the increasing clarity of presentation of their mood state. However, the fact that that feelings of sadness and of negativity are quite normal in adolescent development make the process of assessment and diagnosis of depression in adolescents more complicated (Gay & Vogels, 1993).

CLINICAL IMPLICATIONS FOR UNDERSTANDING CHILDHOOD DEPRESSION

The problems caused by the experience of depressive symptoms in the everyday lives of children and adolescents is sufficient to justify clinical and research attention. However, there are several other important reasons why we should be concerned about identifying and treating depression in young people (Kovacs, 1997). These include:

1. **The detrimental consequences for subsequent development due to protracted depression** - the areas of development that are particularly vulnerable to the negative effects of depression are the development of social-cognitive and interpersonal skills, and the attachment bond between parent and child.

2. **The risk of suicidal behaviour** - Ryan et al. (1987) reported that between 25% and 34% of depressed children and adolescents had attempted suicide. Also, about 50% of those who had made one attempt eventually make further attempts (Kovacs et al., 1993). Among successful suicides among youngsters, there is 27 times more likelihood of the victim having had depression than in not (Shaffer et al., 1996).

3. **Sensitisation effects of the first episode** - It has been indicated that the first depressive episode may make individuals more likely to experiences further episodes
of affective illness (Post, 1992). The implications of such a deleterious effect for young people that it may hinder their development, and also there are concerns about the potential social and economic costs of this effect.

**Treatment and research considerations**

Compared to the information available regarding adult depression, there is little empirically-based knowledge regarding the effects of treatment strategies for childhood depression. In terms of pharmacological trials, the general conclusion has been that the superiority of antidepressant medication as compared to placebo has not yet been proven in youngsters with depressive disorder. Concerns about side-effects are increased with children, especially with the long-term effects that drugs may exert on growth, intelligence and non-symptomatic behaviours. Also medication has unclear effects on the treatment of depression in adolescents (Kazdin, 1990).

Controlled psychotherapy trials with depressed children have provided positive outcomes (e.g. Kendall, 1993) though only a limited range of interventions have been studied. It also appears that young people with clinical depression may be particularly difficult to treat with traditional psychotherapies (Fonagy & Target, 1994).

There appears to be a lack of empirical information about the circumstances under which children develop depressive disorders (Kovacs, 1997). Certain risk factors have been identified such as: vulnerability (due to individual differences in ability to tolerate stress); and previous experience of stress (e.g. life-threatening illness/chronic illness); and child physical and sexual abuse and neglect (Gay & Vogel, 1993).

It seems there is a need for early identification of depression in those children and adolescents who are likely to be most at risk, so that intervention can be more preventative. As Kovacs (1996) states, "the finding that similar clinical outcomes are observable among youths and adults, but on average, about 20 years earlier in the life span, underscores the gravity of early diagnosis".
CONCLUSION

The concept of depression in children and adolescents has been a challenging one for researchers and clinicians for many years. The previous debate over whether the phenomenon of childhood depression actually exists seems to have been settled with the generally accepted view that it does exist, even in quite young children. The existence of major depressive disorder among children and adolescents has now been conclusively documented in clinical settings and in the community (Angold, 1988; Fleming & Offord, 1990).

Previously, researchers thought that children and adolescents, when depressed, would exhibit different symptoms than adults. However, over the past 20 or so years, there has increasingly been a tendency towards viewing major depression in children as being as similar to that manifest in adults (e.g. Kazdin, 1990).

Also in this time, a great deal of knowledge has accumulated about very early-onset depression. We now have information about their presentation, course and outcome, epidemiology, psychological, social and familial correlates and selected risk factors, aspects of psychobiology and alternative treatments (Kovacs, 1997). As to the identification of the best means of diagnosing depression in children and adolescents, the debate continues.

To conclude, it seems that clinical depression as a phenomenon is not only of relevance to children and adolescents, but it occurs with sufficient frequency, severity and duration to be regarded as an entity deserving of clinical and research attention regardless of its relation to adult depression.
REFERENCES


Older Adults Essay

Discuss the issues and concerns in the provision of group therapy for older adults

MOMOTAJ ISLAM
Year 3: February 2000
INTRODUCTION

This discussion will begin with definitions of the main relevant terms and a brief historical outline of the provision of group psychotherapy for older adults. Then a description of the major general and clinical issues and concerns in this area will form the main part of the discussion. Finally, there will be an evaluation of some of the outcome research on the effectiveness of this treatment modality for this particular client group.

Definitions

Who are the older adults?

This question continues to be asked in the field of gerontology. The answer depends very much on the demographics and cultural norms of the society to which one refers. In the Western world, the usual arbitrary cut-off point for many purposes, including psychological research and practice, is 60 for women and 65 for men, that is, around retirement age. However this is becoming vague as the changing economic conditions mean that retirement age is becoming less fixed (Woods, 1999). The progress of biological science and improved living standards have increased the average lifetime in the industrialised countries. This, as well as the decrease in birth rates, has resulted in a social organisation with a broad elderly base.

The increase in the population of older people has not, however, proven to be as dramatic as predicted a decade or two ago. In the UK, the figures provided by the Office of National Statistics (Social Trends, 1997; cited in Woods, 1999) suggest that overall the population over 65 has stabilised, following dramatic growth in the 1960s and 1970s. The current trend is for there to be fewer 65-70 year olds but an increasing number in their 70s and 80s. In this discussion, the term ‘older adults’ will be used to refer to individuals aged over 65 years.

What is group therapy?

Berger and Berger(1973) define group psychotherapy as “a treatment in which acknowledged patients voluntarily attend meetings with an acknowledged therapist at regularly scheduled intervals in order to express, evoke, accept and work through
various aspects of the patient’s functioning to develop the patient’s healthier and more satisfying potentials”.

The most oft referred to work on group psychotherapy is probably, Yalom’s (1975) *The Theory and Practice of Group Psychotherapy*. Yalom described 11 “curative” factors that are crucial to create change in groups. These concepts will not be discussed in detail at this point, but some of them, such as ‘socialisation’; ‘group cohesiveness’; ‘universality’; and ‘impacting of knowledge’, shall be referred to at various stages throughout this discussion.

**GROUP WORK WITH OLDER ADULTS**

Group therapy for the elderly, as defined by Burnside (1978b) refers to “only groups that are conducted both with older people who have significant emotional and/or mental problems and by professionals with special training in psychiatry or psychology”. However, the criteria of the group therapist’s qualifications is not always adhered to, as shall be discussed later.

**Historical background**

Gurfein and Stutman (1993) state that as early as the beginning of the 20th century, Joseph H. Pratt (no reference cited) offered group therapy for elderly patients with organic and functional disorders. It is well known that Freud (1905) rejected the use of psychotherapy with the elderly (on the basis that older people, aged over 40, had characteristics too rigid to change). However, others, such as Abraham (1927), had a more optimistic view of this approach with this client group, and discussed its applicability.

In the 1950s, clinicians began to see evidence of the usefulness of group therapy with older adults. Silver (1950) reported on the improvement in the morale of both patients and staff members as a result of group psychotherapy with 70-80 year-old patients, with a diagnosis of ‘senile psychosis’. Also, Linden (1953) carried out a controlled study aimed at countering the condition he labelled “psychological senility”, and using
techniques such as education, humour, and interpretation, demonstrated substantially higher rates of discharge for the experimental groups than for the control groups.

During the 1970s there was a surge of literature on group work with elderly people, making a significant contribution to the application and understanding of group psychotherapy with this client group. Experiential and clinical experiences indicated that group psychotherapy was effective in a variety of settings (e.g. Altholz and Doss, 1973; Burnside, 1978a).

To date, over almost 50 years, group therapy has been successfully used with older adults in a range of settings (i.e. psychiatric hospitals, nursing homes, in the community) and for the treatment of a wide range of conditions, such as depression, dementia, social isolation, post-traumatic stress disorder, schizophrenia, etc. (Gurfein & Stutman, 1993 for review).

CLINICAL ISSUES AND CONCERNS

Stereotypes about older adults

In common, stereotypical thinking about ageing, it is often assumed that age changes are large and generally negative. Butler (1969) refers to the term, “ageism”, described as reflecting “a deep-seated uneasiness on the part of the young and the middle-aged - a personal revulsion to and distaste for growing old, disease, disability, and fear of powerlessness, uselessness and death”. Ageist beliefs - such as that older adults are incompetent, senile, dependent, unattractive, weak and inflexible - are rampant not only in society at large but also among older adults themselves (Gurfein & Stutman, 1993).

Ageism is now often more broadly defined, to include discrimination on the basis of age at any point in the life span (Bytheway, 1995), but the original sense of devaluing and distancing from older people remains of relevance, and raises personal and professional issues (Woods, 1999). For example, Belsky (1990) noted that professionals tend to be less enthusiastic in their treatment of the physical problem of older adults.
than those of young people, and to underestimate the older person’s potential for psychological change as a result of insight and understanding.

The fact that we use chronological age at all to define this group is another issue. Chronological age is often used in Western society as an explanation of behaviour and to indicate what can be expected of the individual person, especially in children and in older adults. Gerontological research, however, tends to question the value of chronological age as a predictor of any human characteristic (Knight, 1986). Age has been found to be a poor indicator of coping and adaptation in later life (e.g. Neugarten, 1987). Some people may experience decline in some areas, others will experience improvements. Some individuals are vigorous and vital in their 70s and 80s, while others are deteriorated before they reach 65. Hence, it is unfair to treat all older adults as a homogeneous group.

**Cohort effects**

Cohort effects are those differences between age groups that are all too often confused with developmental change (Knight, 1986). A cohort is a group of people born at about the same time, usually defined to be within a five-to-ten-year period. The cohort that an older person belongs to will determine the experiences they have. For example, an individual born around 1910 will have been an adult during the Second World War whereas an individual born around 1930 will have been a child, thus they will each have different experiences of the war and other social and economical changes. Thus, to group together people of different cohorts and to assume that they share the same experiences simply by being “older adults” is confusing and unfair. Therefore it is important for the therapist to be aware of the ages of the members in a group and acquire some general background knowledge on the major historical events the members may have experienced.

**Older adults’ attitudes towards psychotherapy**

Although Western society in general has become more psychologically aware, many older adults may be unfamiliar with psychological concepts and suspicious or doubtful as to their value (Yost et al, 1986). Many retain an attitude toward mental illness that
was prevalent in their youth, thus they often believe that someone who needs to see a ‘mental health specialist’ must be ‘crazy’ (Finkel 1980). Hence, older people may often be anxious about joining psychotherapy groups.

Another issue is that many older people have been taught to be ‘seen and not heard’ and have difficulty sharing their innermost feelings. Thus, feelings of shame and fear may be generated at the prospect of talking about personal concerns. People who are in their 70s and 80s today were profoundly influenced by the Second World War. During that time, the expression of feelings were secondary to survival. In many cases, feelings were knowingly repressed so the tasks of daily living could be accomplished. Allowing anyone, other than perhaps someone in one’s immediate family, to know of one’s problems was not readily done (Pearlman, 1993). Thus, even when members have a desire for close physical proximity, their sense of privacy may cause anxiety about their wish for such closeness (Finkel 1980).

Due to such issues, group psychotherapy is a “new language” for older adults, and may take some time to get used to. The use of language is also important when working psychologically with older adults, as concepts such as ‘depression’ may be perceived as pejorative, and so may need to be replaced by more acceptable terms such as ‘feeling blue’ or ‘down in the dumps’.

**Common themes and the benefits of group participation**

Despite large individual differences with regard to the timing and the rate of age-correlated changes, ageing usually involves an eventual progressive reduction in energy levels, alternatives, and opportunities. Rather than looking forward to future prospects and fulfilling potentials as they might have done earlier in their life, older adults generally tend to view life from the perspective of endurance, and retrospection (Gurfein & Stutman, 1993).

Toseland (1990) identified common themes of major concerns that arise in discussions among older adults, and how these can be helped by group participation:
1. Continuity with the past - Within their peer group, many older adults talk about their past accomplishments and life experiences. This may elicit both positive and negative memories, but many selectively remember the best times and the events which give their life most meaning (Atchley, 1989).

Professionals who are unfamiliar with working with older adults may become somewhat frustrated by their preoccupation with the past, interpreting it as a way of avoiding dealing with the present & the future, or as a form of rigidity. Although caution has to be taken with the severely depressed individuals who may review their life in a morbid way and thus consolidate their negative thoughts, reminiscing is usually a way for older people to socialise, to feel good about themselves, to put their life into perspective, to come to terms with who they are, and to use their past as a source of strength when coping with adapting to changes resulting from the ageing process.

2. Understanding the modern world - The ‘world’ that the contemporary older adult population were born into & grew up in has changed enormously. Thus, it is common for older adults to make comparisons between the past and present. Groups can be helpful by allowing them to interact with a peer group from a similar age cohort who share similar historical experiences and who confirm each others’ world views.

3. Independence - issues of dependence and independence are common concerns in older adults. As their physical disabilities may make them become more dependent on others, many older adults often struggle to retain some of their independence, in order to retain their own integrity and sense of self. Within the group setting, ventilation of feelings, discussion of how to handle conflictual relationships with children, and the sharing of resources to help maintain independent living can be very beneficial.

4. Physical and cognitive impairments - as their physical health and cognitive abilities may be deteriorating, this is a very real concern for older adults. The reassurance and support provided by a group can be particularly helpful for overcoming the anxiety that can result from preoccupation with physical ailments.
5. **Loss of friends, relatives and roles** - The ageing process continually confronts the older adult with the developmental task of adjusting to loss. In no other age group are losses as common. Losses will inevitably not only be of people but also of roles and responsibilities. Therefore it is essential for professionals who work with older adults to be knowledgeable about the process of grieving. Group workers should not assume however that all losses are devastating to older individuals. For example, carers may feel relief at the death of a long-suffering spouse. To assume that all losses are devastating may prevent members from talking about feelings of relief that are not perceived as "socially acceptable"

6. **Spouses and other family relationships** - Older people often discuss family relationships, which take on an added importance because of the loss of other social roles and relationships. Groups can be helpful in helping them reflect on what they can realistically expect from their spouse and other family members in the present and in the future, and to explore how relationships with these significant others may be improved.

7. **Children & grandchildren** - For those who have children and grandchildren and take pride in their achievements, discussions about them can be a source of great pleasure. For others however, who perhaps never had children of their own, or have lost children, or did not develop good relationships with their children’s spouses, such discussions may be painful. Group participation can help members support each other through unresolved issues and/or share in the joy that their children bring.

8. **Resources** - living on fixed incomes can make older people become concerned about their financial situations. Groups can be helpful by making them aware of resources & helping them to overcome the stigma attached to the "benefits/welfare system"

9. **Environmental vulnerability & adjustment** - An awareness on their increasing vulnerability can make older people more concerned about their own safety and mobility, fear crime, and changes in the community. Support groups can provide a safe
place for them to discuss their feelings of vulnerability and get ideas about adjusting to recent changes in their lives.

10. Leisure pursuits - discussions with other group members can help older adults gain insight into age-appropriate behavioural expectations & to consider becoming involved in new social roles.

Table 1 provides a summary of the most common themes covered in older adult groups, and table 2 lists of some of the main objectives of using group psychotherapy in treating older adults.

| Loss of significant relationships |
| Loss of physical and cognitive capacities |
| Loss of function and tasks |
| Loss of self-worth and self-esteem |
| Loneliness and isolation |
| Depression and demoralisation |
| Dependency-autonomy conflicts |
| Interpersonal conflict with spouse and family |
| Hopelessness, helplessness, and purposelessness |
| Wish for restoration of a sense of competence and mastery |

Table 1: Common themes in older adult groups (Sadavoy et al, 1991)

| Restoration of a sense of self-esteem and self-worth |
| Reduction of isolation and promotion of interpersonal engagement |
| Symptom reduction and mastery |
| Acquisition of coping skill and interpersonal skills |
| Grieving and adaptation to loss |
| Appropriate acceptance of dependency and rational use of available resources |

Table 2: Objectives of treatment (Sadavoy et al, 1991)

Qualifications, attitudes and characteristics of group therapists/leaders
There is much debate about who should run groups and what the qualification of the leader should be. Although ideally, a therapist or professional who is specifically qualified for the job should do it, in reality, and usually due to lack of resources, it tends to be a staff member within the setting with a basic knowledge of group process...
and ageing. However, unqualified nursing staff have been known to successfully run groups (Pearlman, 1993). Burnside (1994) states that the more difficult the group (i.e. the severity of problems in a given group), the more skilled the leaders need to be.

There are also other characteristics of importance specific to therapists working with older adults. Linden (1955), for example, emphasised the importance of therapists recognising their own stereotypes about ageing, which must be overcome if they are to be effective in helping older patients. MacLennan (1988) in his overview of psychotherapy with older people, concludes that the training of group therapists should include an understanding of their attitudes toward ageing and death, both their own and others', and must be adjusted to the age and experience of the trainees.

As the group members will all be over 60, the therapist will inevitably be younger than them. This issue needs to be addressed during the early stages of group development. The group may have concerns about the therapist's qualifications and what a younger person with "fewer life experiences" could possibly teach them, or they may be 'jealous' of the therapist's youth. There should be honest discussions around these issues, so that the group's expectations are identified and addressed and they are reassured of the therapist's capacity to run the group. In groups made up of relatives of the very old and disturbed, on the other hand, older therapists may encounter the same problems and frustrations they experienced with their own aged parents. Whatever the situation, therapists need to guard against countertransferences resulting from their own unresolved conflicts about ageing.

Burnside (1984) emphasises that group work with the elderly requires additional leadership characteristics. Group leaders need to be: more patient, recognising that elderly people change at a slower pace than younger people; persistent and flexible; and professionally and personally creative. Group leaders need to take a more active role in older adult groups in giving information, answering questions and engaging in some self-disclosure. Also, groups leaders should have a good knowledge of the ageing process, in both normal and abnormal ageing.
The use of a co-therapist is also widely practised and thought to be useful. Benefits of this approach include: taking away some of the disproportionate attention that older adults place on the group leader, as opposed to other group members; ensuring the continuity of a group in one therapist’s absence; the therapists being able to support each other in the transference and countertransference reactions which are so common in older adult groups.

Modification of group therapy techniques for older adults

The organisation of psychotherapeutic groups for older adults is similar to that of traditional therapy groups. However, certain modifications are required to make the groups accessible, acceptable and useful to older adults. The extent to which modifications are used depends on the particular group & on circumstances.

Process issues:
Corey et al (1982) discuss the process issue of confronting and probing. They emphasise that older people need support and encouragement more than they need confrontation, and that any such probing or confrontation must therefore be done gently and with caution.

The issues of transference and countertransference are of particular relevance in work with older adults, as discussed earlier. Also, the issue of termination of the group requires great attention from the group leader, given the general sensitivities of older adults to loss. Burnside (1984) points out that the elderly feel a sense of loss and mourn for the leader as well as the group experience.

Practical issues
Length of sessions and duration of group therapy- as the members may have cognitive and sensory impairments, the group sessions may need to be shorter than usual. Also, due to the possible slower rate of change, and the novelty of the group experience for this age group, they may require an increased number of sessions.
To accommodate physical impairment, therapists may need to use large print and other forms of magnification for visual materials, amplifiers and microphones for aurally presented material, and comfortable chairs, blankets etc.

Impediments to group cohesiveness

Yalom (1975) defined group cohesiveness as a feeling of togetherness among members, a sense of belonging that is developed overtime. There are certain issues specific to older adults which may impede cohesiveness in a therapy group (Pearlman, 1993).

1. Frequent absences - these may be due to medical illness, which are more frequent in the elderly, or other unplanned issues. Older adults tend to be particularly sensitive to absences of group members because of the multiplicity of losses that they face. Therefore, it is important for the therapist to reassure members by informing them about any absences.

2. Serious illness and death - this again is a more frequent occurrence with this population. This issue needs to be discussed openly and honestly within the group. This may lead to the members explorations of their own specific issues about loss and the understanding and acceptance of the life-death continuum.

3. Sensory loss - specifically in the areas of sight and hearing, these impairments can make group participation more difficult. It is the therapist's responsibility to minimise the difficulties caused by such impairments by for example: asking the patients to speak loudly and clearly; making note of important non-verbal cues that might be missed by those with visual impairments. The therapist needs to act as the eyes, ears and voice of the group as a whole, without embarrassing any individual.

4. Apprehension about socialising - many older people are fearful of new relationships because after losing their roles in work and family spheres they have often considerably reduced their social contacts too and feel unable to establish new ones (Ba, 1991). Also, they may have been traumatised by the losses of those close to them.
The energy required to develop a relationship may initially be perceived more as a burden than as a potential reward. The therapist needs to be aware of and sensitive to these issues.

**Inclusion and exclusion criteria for group participation**

During the planning stages of a group the therapist and other relevant professionals have to make decisions about those who are suitable to participate in group therapy and those for whom it would be inadvisable.

Toseland (1990) states that there are three categories of older adults for whom groups are particularly well suited. These are: 1) those who are socially isolated, shy and inhibited, and can benefit from the accepting interpersonal relationships which groups can provide; 2) those who have interpersonal problems, and can benefit from opportunities for peer feedback, reality testing & acquisition of new roles. 3) those who need help in identifying and participating in new social roles, and can benefit from the opportunity to learn about new roles from peers and stay active & involved.

Regarding the choice of the patient, Ba (1991) states that a small capacity of attention and communication is sufficient, but the patient’s motivation to join the group is essential. A pre-joining interview to check motivation and to help each individual understand the aims of the new experience being offered is helpful.

There are also a few categories of contra-indications for group participation in older adults. These include the following:

1) Practical barriers- such as physical frailty making it difficult to attend group meetings, and the unavailability of resources to transport community-based older adults to and from the group meetings (Toseland, 1990).

2) Hearing impairment - although in itself this is not an exclusionary factor, individuals with severe hearing loss, who would not be able to adequately hear the group discussions, should be excluded (Pearlman, 1993).
3) Particular therapeutic needs - for example, those who are experiencing acute crisis situations or who have highly personal information to disclose, and so may be better served by individual therapy. Also, when the concerns of the older adult is predominately focused on relationships with a spouse or other family members, couple or family work may meet the individual’s needs more adequately (Toseland, 1990).

4) Certain personality attributes and capacities - People who are experiencing problems that are dissimilar should not be encouraged to attend groups if it likely that other group members will experience their behaviour as alienating, e.g., if one member has dementia and others do not. Those with severe pathology and low frustration tolerance may find groups too stressful, particularly when there is a high demand for responsive interactions and pressure to form relationships (Toseland, 1990). Yalom (1985) also noted for exclusion the following: brain-damaged, paranoid, hypochondriachal, suicidal, drug or alcohol addicted, acutely psychotic, or sociopathic patients.

When it is not clear whether a person is suited to group work, it may be useful to initially provide both individual and group therapy, to ease the transition from individual to group treatment and to monitor the progress in the group.

**TYPES OF GROUP INTERVENTION**

There is currently a diverse range of group psychotherapeutic approaches available for use with older adults. Tross and Blum (1988) placed the approaches into two general categories: Insight-oriented and supportive. Insight-oriented therapy is the working through of emotional conflicts that have persisted throughout a lifetime; supportive therapy deals with current stresses and relationships. The former is generally used with active older adults whilst the latter is preferred for frail older adults, but there is much overlap and the distinctions are not always clear. Table 3 lists the range of group therapy modalities used with the elderly and the focus of each type of group. The type of group run will be greatly influenced by the setting, and group modalities may be combined, for example, many of the groups incorporate reminiscence techniques.
<table>
<thead>
<tr>
<th>Group Therapy Modality</th>
<th>Theoretical underpinning &amp; Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insight-oriented groups</strong></td>
<td>Based on the tenet that 'healing is understanding'. Directed to the working through of functional disorders, which are viewed as the result of lifelong, usually unconscious conflicts.</td>
</tr>
<tr>
<td>Psychodynamic group therapy</td>
<td></td>
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<tr>
<td>Psychoanalytic group</td>
<td>Aims at intrapsychic conflict resolution through the uncovering of therapy unconscious defences and resistance by means of interpretations of transference and resistance (insight).</td>
</tr>
<tr>
<td>Psychodrama groups</td>
<td>Uses role play &amp; dialogue to facilitate the psychological exploration of conflict and to generate alternative solutions.</td>
</tr>
<tr>
<td>Life review group therapy (reminiscence therapy)</td>
<td>Conceptualised as a developmentally-appropriate and natural process of review through which older adults organise and evaluate their lives, put it into perspective. This process is often used to enhance group cohesion (Beutler, 1987).</td>
</tr>
<tr>
<td><strong>Support-oriented groups</strong></td>
<td>Attempt to repair the damage from late-life stressors by re-establishing previously functional adaptive techniques. Emphasise strengths &amp; focus on structured solutions to current problems.</td>
</tr>
<tr>
<td>Resocialisation group therapy</td>
<td>Attempts to compensate for the diminishing social network &amp; role losses. Cohesive interaction, the creation of new social roles &amp; positive group reinforcement of valued behaviours are addressed (Liberman, 1971).</td>
</tr>
<tr>
<td>Validation group therapy</td>
<td>Focuses on the emotional &amp; psychological consequences of short-term memory loss (Feil, 1981).</td>
</tr>
<tr>
<td>Rehabilitation and activity therapies</td>
<td>Aimed at inpatient settings to improve basic self-care skills &amp; to speed discharge from the institution (Fisher, 1988).</td>
</tr>
<tr>
<td>Remotivation therapy</td>
<td>Aims to reach the intact interests of institutionalised older adults who are able to function on a verbal cognitive level, to resocialise &amp; arouse interest in the environment.</td>
</tr>
<tr>
<td>Art therapy</td>
<td>Aimed at providing cathartic experiences &amp; facilitating impulse control, by bypassing the need for words &amp; allowing expression of feeling which might otherwise appear too threatening or complex (Saul, 1988).</td>
</tr>
<tr>
<td>Reality orientation group therapy</td>
<td>Used as part of a milieu treatment in which the staff members remind the patients of time, place &amp; person in every interaction.</td>
</tr>
<tr>
<td>Homogeneous groups</td>
<td>Provides support to people with a particular common problem, characteristic, or developmental issue, e.g., retirement; widowhood, etc.</td>
</tr>
<tr>
<td>Carers support groups</td>
<td>Provides support for carers who are often highly burdened, isolated and frequently depressed themselves as a result of their caring role.</td>
</tr>
<tr>
<td>Cognitive-behavioural group therapy</td>
<td>Aimed at the patients' recognition &amp; correction of cognitive distortions &amp; negative self-attributions. Most commonly used to treat depression.</td>
</tr>
<tr>
<td>Cognitive-behavioural groups</td>
<td></td>
</tr>
<tr>
<td>Social skills training</td>
<td>Aimed at helping the institutionalised older adults to develop assertive behaviour or to reduce aggressive behaviour.</td>
</tr>
<tr>
<td>Family therapy</td>
<td>Can be used as an intergenerational approach to role disruption &amp; the other adaptational challenges presented by an ageing family member (e.g., McEwan, 1987).</td>
</tr>
</tbody>
</table>

Table 3: Group Therapy Approaches for Older Adults. Adapted from: Gurfein & Stutman (1993) and Sadavoy et al (1991)
EFFECTIVENESS OF GROUPS FOR OLDER ADULTS

Although there was an increase in the literature discussing the issue of group therapy with older adults in the late 1970s and the 1980s, the research data in this field is still limited. The scientific evaluation of the outcome of group treatments is hindered by factors such as, small sample size, brief time frames, study of non-patient populations, lack of consensus on outcome measures, patients concurrently receiving more than one mode of treatment, and ethical difficulties in maintaining a non-treatment control group (Steuer et al, 1984). Therefore, much of the literature contains clinical or anecdotal conclusions based on the therapists’ perceptions.

There have been some controlled studies, however, which have involved comparisons of approaches. Gallagher and Thompson (1982) demonstrated that a variety of group psychotherapy approaches are helpful for older people and that a cognitive behavioural approach has a longer-lasting effect. Steuer and colleagues (1984) compared the outcomes of psychodynamic group therapy with those of cognitive-behavioural group therapy and concluded that they were equally effective in reducing levels of depression. Although there was a 40% drop-out rate, of those who completed the 9-month treatment, 40% were in remission and 40% had some symptomatic reduction.

In one of a few studies where CBT has been compared to a pharmacological treatment (Beutler et al, 1987) the attrition rate was lower in the cognitive therapy group. However, due to the use of a drug which was not proven to be an effective anti-depressant nor widely used as one, the relative effectiveness of CBT was difficult to evaluate (Roth & Fonagy, 1996).

Roth and Fonagy (1996) state that although a comparison of individual and group CBT has yet to be performed, the success rates in eleviating depression do seem greater in the individual-therapy studies. However, they also comment on the need to balance this difference against the possible greater input of therapeutic time needed in individual therapy. In the climate of limited resources, the economical aspect of group therapy is important. It is generally believed to cost less than individual therapy, and

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takes up fewer professional resources in the older adults speciality where, in spite of increasing numbers, there is still a paucity of trained therapists (Finkel, 1991).

Recent efficacy studies on specific types of group intervention also appear to show positive outcomes. For example, Snell and Padin-Rivera (1997) found group therapy to be a “highly effective and efficient treatment modality for a cohort of elderly veterans with PTSD. Young and Reed (1995) concluded from their analysis of a group psychotherapy treatment, that as well as being a cost-effective treatment modality, “as a theory-based intervention it was developmentally-appropriate for elders”. One study has shown that a 12-month programme of group exercise had beneficial effects on physiological and cognitive functioning and mood in 187 older community-dwelling women (Williams and Lord, 1997)

In spite of the paucity of hard research data, Finkel (1991) reports that both therapists and staff believe that group psychotherapy is an excellent modality for dealing with the conflicts of late life.

CONCLUSION
As has been discussed, there are many general and clinical issues, and practical measures, to take into consideration in the use of group psychotherapy with older adults. Although the situation has much improved recently, one of the main barriers in this area seems to be the negative, stereotypical thinking about ageing and older people that society, individuals, institutions and older adults themselves, may still hold. Once this is overcome, many of the potential difficulties in providing group psychotherapy for older adults, as opposed to younger adults, can be reasonably managed in a clinical setting by a well trained therapist.

Much of the literature in this field indicates that group therapy with older adults can be a very effective treatment modality, either as the sole treatment or as an adjunctive to pharmacotherapy or individual therapy (Sadavoy, 1991). Tross and Blum (1988) believe that group psychotherapy is the treatment of choice for older individuals with problems of social isolation, a sense of inadequacy, and a lack of meaningful
interpersonal interactions. Gurfein and Stutman (1993) state that “therapeutic goals with elders, as with younger patients, are limited only by the functional integrity of the patient and may be expanded by their wealth of life experience”.

However, further scientific research is required to analyse the quality of the benefits of group therapy for older adults. Some important issues which remain to be addressed include: variables such as culture and how it affects the group; the differences, if any, between “young old” and “old old” individuals and how they function in the group; the possible effects of group participation on perceptions of physical illness (Pearlman, 1993). Such questions need to be answered in order to provide a relevant and effective service to this client group in the future.
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Specialist PTSD Essay

Critically evaluate the theoretical models available to explain the short and long term consequences of witnessing domestic violence as a child

MOMOTAJ ISLAM
Year 3: February 2000
INTRODUCTION

In order to arrive at an evaluative discussion of the theoretical explanations that have been put forward with respect to the consequences for, or effects on, children of witnessing domestic violence, certain background information needs to be provided first. Therefore, this discussion will begin with a brief historical account of this area of research, followed by definitions and prevalence rates, and summarised accounts of the short and long-term consequences which have been observed. This will lead on to descriptions and evaluations of the theoretical models that have been proposed to explain these consequences.

It should be noted here that this discussion is specific to children’s experience of witnessing domestic violence and not of the experience of being direct victims of abuse. However, as will become clear later, these experiences can be difficult to differentiate. Therefore, the direct physical and/or sexual abuse of children will be referred to where relevant, but a full description of these wider issues is beyond the scope of this discussion.

Brief Historical Background

In the past 20 years or so, researchers have become increasingly interested in the effects of domestic violence on children. The issue of the physical abuse by husbands towards their wives was a very topical one in the 1970s. It is perhaps because the topic was raised within the context of the Women’s Liberation Movement that the early literature concentrated on the incidence of violence against women and need for services to respond to the needs of women in this situation and overlooked the children who witnessed this behaviour. The impact on, and the needs of children in these families were rarely addressed, except when the children themselves were physically abused too.

The fact that marital violence could generate negative sequelae in children was first examined in Moore’s (1975) landmark article in which the child witnesses were referred to as “yo-yo children” because of the dysfunctional parental interactions
which left them ‘suspended in mid-air like a yo-yo’. They were found to be jumpy, anxious, scapegoated by parents, used as pawns in parents’ arguments; & had numerous school problems.

By the early 1980s these children were described as “forgotten” victims (Elbow, 1982). Researchers had a more complex view of possible consequences of children witnessing domestic violence, and even thought that such experiences could lead to them becoming abusers. It was not until the late 1980s that child witnessing of spousal violence was documented as a potential etiological factor for child psychopathology and associated problems (Hughes, 1988).

Over the years, reports on the high frequency and severity of domestic violence (Strauss & Gelles, 1990) as well as the high probability that children will witness this violence (Carlson, 1984) has motivated researchers to investigate the effects of this witnessing on children’s development.

**Definitions**

Defining what constitutes significant domestic violence is difficult, and a study by Greenblat (1983) showed that opinions about what is acceptable between spouses and in society varies widely. In Western societies, domestic violence may be a hidden problem because it generally occurs in the home and because many women are ashamed or frightened to seek help.

In the U.K., Victim Support's (1992) definition of domestic violence is that it is ‘the physical, sexual, emotional and mental abuse of women by male partners or ex-partners’. This definition is accepted for this discussion. It is acknowledged that women can abuse men too. However, women much less often resort to violence or to sexual abuse. In England, wife abuse is 5 times more common than husband abuse (Smith, 1992)

Domestic violence can range from an emotional slap to regular beating with or without an implement, choking, strangling, threatening or injuring with a knife or gun, rape
and other forced sexual acts, and can end in death. In about 50 families a year in the UK, a mother is killed by her male partner (Harris Hendriks et al, ‘93).

**Prevalence Rates**

Due to under-reporting, prevalence rates are difficult to obtain. However, it is estimated that in both USA and UK, spouse abuse occurs in 25 to 28% of married couples at some time in their marriage (Strauss & Gelles, 1990; NCH, 1994). Of course, this figure does not account for non-married, co-habiting couples.

Domestic violence is the second most frequent type of crime reported to the police, constituting more than 25% of all reported violent crime (NCH, 1994). One third of all reported crimes against women result from domestic violence (Victim Support, 1992). Reported incidents are probably only the tip of the iceberg. It is estimated that there are 530,000 assaults on women by men in the home each year, and that between 90% and 97% of all domestic violence is directed towards women, by men (NCH, 1994).

**The Frequency Of Children's Involvement**

Moffit et al (1998) cite four observations from the demographic literature on partner violence from which they infer that a large number of young children witness violence between adult partners in their homes.

1. The National Victimisation Survey (1993) of 100,000 American households showed that women aged 19 to 29 have rates of violent victimisation by a partner that are twice the rate for any other group (Bureau of Justice Statistics, 1995).

2. This peak age for victimisation coincides with the peak age for childbearing, which is 17-30yrs for women (Rindfuss, 1991).

3. The peak age for victimisation also coincides with the peak age for non-marital cohabitation. This is relevant because unmarried co-habiting couples have the higher rates of partner violence compared to couples of the same age who date or marry (Stets & Straus, 1990).
4. Partner abuse is most common amongst the young parents of small children. (Moffit et al, 1997)

Studies of the incidence of domestic violence in Australia, the UK, Canada and the USA testify to children witnessing the abuse of their mothers. These experiences range from hearing the violence occurring when they have gone to bed, to seeing the effects of the violence the following morning in terms of blood, bruises on the victim, and damages to the house, to being forced to watch the mother being assaulted, raped or even killed by the father.

One survey suggests that in 90% of cases of wife abuse, children are in the same or an adjacent room (NCH, 1994). Even if they do not directly observe the violent acts they may be aware of their mother’s fear either directly from her or by inference, for example, seeing her wounds or experiencing the disruption that follows their mother seeking refuge.

Even when parents believe that the children do not know what is going on, children may know much more than the parents realise. Jaffe et al (1990) state that from their clinical experience, many parents minimise or deny the presence of children during incidents of domestic violence by suggesting that the children were asleep or playing outside. However, from interviews with children, they find that almost all can describe detailed accounts of violent behaviour that their mother or father never realised they had witnessed.

THE CONSEQUENCES OF WITNESSING DOMESTIC VIOLENCE AS A CHILD

As will be seen from the following discussion, knowledge of the effects of domestic violence on children is still rather limited, particularly because research in this area has been constrained by conceptual and methodological problems. The best known studies
have been carried out by psychologists in North America (e.g. Hughes & Barad, 1983; Jaffe et al, 1990; Hughes, 1992), and their findings are used as the framework for understanding the issues in other areas of the world.

In his review of the literature on marital discord and divorce, Emery (1982) concluded that children are vulnerable to conflict and discord in the family even when it is non-violent. He stated that "the degree of marital combat in the home before divorce has a more serious impact on the child's psychological functioning than the parental separation itself". Though he did not discuss it specifically, it would follow that domestic violence would serve to compound this outcome.

The investigations into the effects of witnessing domestic violence have focused on various domains of children's functioning, namely, behavioural, emotional, social, cognitive and physical. Kolbo et al (1996) provide a recent review of 29 articles in which they summarise the consistencies and inconsistencies in the research findings along these domains. Although specific results across studies have not always been consistent, at a general level children of battered women have repeatedly been found to exhibit higher levels of problems when compared to children in community comparison samples (e.g. Holden & Ritchie, 1991). Also, the general indication is that marital violence is a more potent risk factor for both externalising and internalising behaviour than are marital verbal conflict or general marital discord (Fantuzzo et al, 1991).

**Short-Term Consequences**

This refers to the immediate effects on children of living in a situation in which they are witnessing domestic violence as well as the consequences of this in the short term, that is, within their childhood years.

Research data on children living in currently violent homes has been derived from a variety of samples, such as children accompanying their mother to shelters, children coming to the attention of social services agencies other than via battered-women's shelters, and community samples of children from both violent and non-violent homes.
Most studies assessing children of abused women report serious childhood problems. These include:

- Increased anxieties (Christopoulos et al, 1987)
- Poor social performance and conduct disorders (Carlson, 1984)
- Increased aggression (Christopoulos et al, 1987)
- Lower self-esteem (Hughes & Barad, 1983)
- Impaired social problem solving skills (Rosenberg, 1987)
- Generally high levels of behaviour problems and psychopathology (Fantuzzo et al, 1991; Holden & Ritchie, 1991)

In their study comparing children in a shelter and a matched comparison group of abused children, Wolfe et al, (1985) found them to exhibit comparable behavioural sequelae. They suggest that this indicates that the effects in children who witnessed domestic violence mirror those found in children who were direct victims of abuse.

Many of the initial studies were uncontrolled case studies in women's shelters, and thus were criticised for not differentiating whether the children's symptoms were due to the relocation to an unfamiliar environment, to the family violence, or to other forms of abuse within the family. However, later, studies which controlled for other risk factors, resulted in similar findings. (e.g. Wolfe et al, 1985; Holden & Ritchie, 1991; McClosky et al, 1995). Therefore, there is strong evidence for the immediate and short-term detrimental effects of exposure to domestic violence.

**Long-Term Consequences**

This refers to the effects that continue from childhood into adulthood or develop in adulthood as a consequence of the childhood witnessing of domestic violence. This is a lesser studied area, and at present little is known about the developmental course of these problems due to the lack of research on the long-term psychological impact of witnessing violence. However, the little evidence there is suggests that the problems exhibited by children of battered women remain stable over time when left untreated. Research data in this area has generally been acquired retrospectively from adolescents...
and young adults (usually, university students) from perpetrators and victims of domestic violence.

**Risk for psychopathology**

In their review of the literature specifically addressing the long-term consequences of witnessing domestic violence, Henning et al (1997) found only three published studies which reported the following findings:

1. Childhood exposure to interparental physical aggression was associated with a higher level of general psychological distress in adulthood (Henning et al, 1996).

2. Witnessing physical aggression between parents during adolescence led to reports of more depressive symptoms, self-reported stress, and substance abuse as adults (Strauss, 1992).

3. Women, not men, who witnessed physical conflicts between their parents reported more symptoms of depression and greater hostility (Forsstrom-Cohen & Rosenbaum, 1985).

**Risk for violence in adult relationships**

Exposure to domestic violence as a child has also been associated with involvement in an aggressive relationship and aggression towards one’s children a generation later (Cappell & Heiner, 1990). In their review of this literature, Hotaling & Sugarman (1986) found that 14 out of 16 studies, indicated exposure to domestic violence to be a predictive characteristic for male abusers. They state that retrospective data consistently indicates that boys’ exposure to fathers’ marital violence relates to partner abuse in adult intimate relationships. Also, 11 out of 15 studies indicated that exposure to domestic violence was a predictive characteristic for female victims. Doumas et al (1994) also found witnessing domestic violence to be a significant predictive factor for next generation abuse by men, and victimisation for women. This observation is commonly referred to as the ‘cycle of violence/abuse’ and will be discussed further later.
Thus, it seems that evidence from several sources converge to suggest that children's exposure to violence has potential long-term negative consequences.

THEORETICAL EXPLANATIONS FOR THE CONSEQUENCES OF WITNESSING DOMESTIC VIOLENCE

Much of the research investigating the association between exposure to domestic violence and child adjustment problems has predominately focused on identifying risk factors, that is variables which are statistically associated with a risk of problem behaviours. However, little is known about the mechanisms by which witnessing domestic violence affects children. Many of the ideas are adapted from the general area of marital discord and child problems.

Underlying theories

Many of the ideas about the mechanisms by which children are affected by witnessing domestic violence are rooted within two wider theoretical frameworks, namely, attachment theory and social learning theory.

a) Attachment Theories

These state that the early parent-child relationship sets the stage for the child's future development of relationships. If this early relationship is characterised by trust, reciprocity, consistency, and child-centred nurturing activities, the child's likelihood of developing positive, desirable relations with peers and other adults is considered to be significantly improved. Alternatively, an early parent-child relationship marked by fear, inconsistency and unmet physical and psychological needs is associated with poor formation of peer relationships and a higher frequency of behavioural & emotional disorders (e.g. Brassard et al, 1987). Therefore, the caregiver's interaction style with the child has relevance for explaining children's adaptation to violence.

b) Social Learning Theories

These also place heavy emphasis on the role of the caregiver in setting the stage for the children's ongoing development. In discussing family pathology, they exert that a crucial factor in children's adaptive development is the formation of a parent-child
relationship that is built upon consistent parental responses to the child’s prosocial and undesirable behaviour, such as praising the child’s attempts at compliance & effectively punishing the child’s coercive, disrupting style of interacting.

From a social -interactional (social learning) model of family dynamics, Patterson (1982), based on work with children with conduct disorders, states that the parents of such children fail to punish everyday behaviours effectively and, simultaneously, train the children to engage in coercive interactions. The main factors in this model include an unskilled parent and a difficult child and/or the presence of stressors, which serve to diminish the parents' already limited skills.

Kolbo et al (1996) state that much of the research in domestic violence appears to be based on social learning or learned helplessness models, but only two (Westra & Martin, 1981; Wolfe et al, 1985) of the 27 studies they reviewed provided explicit descriptions as to how their research was based on social learning theory.

Explanatory Models
Several possible explanations have been proposed for the mechanisms by which children who have witnessed domestic violence may exhibit behavioural, emotional and psychological problems. The main debate in this field is whether the effects of witnessing are direct consequences of the experience or consequences which are indirectly mediated through the parent-child relationship. The explanatory models tend to be based on the stance taken by the proponents of the model in this debate.

These models will be described here and some supportive evidence and criticisms mentioned. However, the scope of this discussion (specifically, word limitation) does not allow for in-depth analysis of each model.

1. Traumatising effect of observing violence
The most direct effect may simply be that witnessing the physical threats of one parent against another is traumatic and personally threatening, creating reactions akin to other traumatic stressors.
Investigations of post traumatic stress disorder (PTSD) in abused women has led to suggestions that children who witness domestic violence also may be at risk for PTSD, as are children who are victims of, or witnesses to, any life-threatening incident (Silvern et al, 1995).

In their numerous investigations of children’s responses to witnessing life-threatening violence which included the murder of their mother, Pynoos et al (e.g. Pynoos & Eth, 1984) found that virtually all the children showed the full range of symptoms associated with PTSD, including sleep disorders, severe anxiety, phobic responses, and compulsive re-enactment of the events in play. Such symptoms would inevitably have a negative impact upon children’s subsequent short and long-term psychological behaviour and social adjustment. In a later study, they (Pynoos & Eth, 1985) recorded post traumatic stress symptoms in 80% of uninjured child witnesses to violence.

It is also suggested that PTSD is usually more severe and longer lasting if the stress is related to the actions of one person or group against another, and is more likely in uninjured witnesses than in injured abused children whose perception and memories may focus more on their own pain and injury (Hariss Hendriks et al, 1993). Research findings on gender based parental identification (e.g. Forsstrom-Cohen & Rosenbaum, 1985; Henning et al, 1996)) have also led to suggestions that greater identification with the victim of marital violence may result in more severe trauma for the observing child.

As described earlier evidence from literature on marital conflict suggests that even non-violent interparental conflict is a significant stressor for children (Emery, 1982; Emery 1989). Therefore it seems pertinent to accept that children who witness domestic violence are vulnerable to higher degrees of stress. In violent families, the enduring threat of violence and uncertainty may cause children to be in a high affective state, making it difficult for them to regulate affect or causing them to become hypervigilent. Margolin (1998) states that this may explain why researchers have found that children from high conflict families “play at a low level with peers, display
negative peer interactions, and have health problems, ... a pattern of results [which] converges with some of the trauma responses related to PTSD”.

Applying the trauma model, to the long-term consequences of witnessing domestic violence, Henning et al (1997) tested two hypotheses. Firstly, that there would be a “dose-response effect, with more frequent and severe interpersonal aggression resulting in greater trauma for the child and worse adjustment in adulthood”. Secondly, given that children often have greater identification with the same-sex parent (Mitsch & Simmons, 1990) they predicted that witnessing the same-sex parent as the victim would be more traumatic for the child. Their findings provided insignificant support for the first hypothesis, but strong support for the second hypothesis, thus only partially supporting the trauma model.

2. **Modelling**

Modelling is another direct mechanism by which domestic violence could affect children. That is, the child who is exposed to violence will exhibit aggression towards others (Patterson, 1982; Widon, 1989). Although violent behaviour is not the only manifestation of witnessing domestic violence, the evidence does indicate an increased risk for aggression in a number of areas: with parents, siblings, sexual partners, and at a later time, one’s own spouse or children (Margolin, 1998).

The concern about modelling is not just that the child is learning aggressive behaviours by witnessing domestic violence, but more about the negative and maladaptive attitudes that the child may be developing about the acceptability of violence as a way of resolving conflicts, about rationalising the use of violence as essential in stressful circumstances, and about the devaluation of women (Wolfe et al, 1995).

Schwarz & Zuroff (1979) suggested that interparental conflict may interfere with imitation of the same-sex parent or may lead to rejection of both parents as role models. Either process would disrupt normal socialisation in that appropriate parental behaviours might not be imitated and other, more deviant, models might be found, for example, imitating the hostility and aggression of parents in conflict.
Many of the studies reviewed by Kolbo et al (1996) supported the view that children’s behaviour is learned through direct experience and modelling. However, the application of this model, and social learning theory in general, to the development of problems in children who witness domestic violence has been criticised on the following grounds: (i) although successful in predicting aggressive behaviour, it has been inadequate in explaining the wide range of behaviours, both internalising and externalising forms (Christopoulos et al, 1987); (ii) it has failed to explain the underlying processes in developing or not developing problems (Emery, 1989). As will be discussed later, not all children develop problems.

3. Sensitisation to conflict
Some research findings have suggested that repeated exposures to marital conflict and domestic violence can make children become more reactive to conflict. Davies and Cummings (1994) propose that repeated exposure to marital conflict increases children’s feelings of emotional insecurity, which makes it difficult for them to regulate their emotions and causes them to be more vulnerable to feelings of fear, distress and anger, and may result in behavioural reactivity and adjustment problems. However, due to the lack of research in this area, further investigations are required before this model can be elaborated upon.

4. Mediational model
This model proposes that children witnessing domestic violence are indirectly affected by disruptive parent-child relations which result from marital conflict. Fincham, Grych & Osborne (1994) stated that “marital and parent-child relationships are so closely interwoven that one cannot draw valid inferences about the effects of marital conflict without simultaneously considering the nature of parent-child relations” (p132).

If the parents are unhappy within their own relationship they are unlikely to present a positive, united front with respect to their parenting practises, which in turn will have...
negative effects on the child’s adjustment. Marital conflict may affect parenting practise in a number of ways, such as:
- disagreements over child-rearing practices
- parents’ emotional unavailability or withdrawal from their children
- inconsistent or punitive discipline
- cold, unresponsive, angry parenting style
- triangulation, whereby the child is drawn into the marital conflict through pressure by one parent to side against the other parent (Margolin et al, 1998)

Such practises are particularly likely in a domestic violence situation, as shown by Holden and Ritchie (1991) in their comprehensive study comparing parenting in abusive and non-abusive couples. The main criticism of this study, however, was that fathers were not included so that mothers were asked for descriptions of their husbands’ behaviours. Abused wives viewed their husbands as more short-tempered, irritable, and uninvolved in parenting than comparison women’s’ appraisals of their husbands.

Another concern about obtaining maternal or paternal reports is that both parents may have their own interests in the reporting. For example, an abusive father may minimise the effects on the children whereas an abused mother may maximise them. Therefore, ideally, children need to be observed or asked for their views on the effects. However, this has practical limitations and raises ethical issues about research with children.

In their testing of the mediational model, Henning et al (1997), found that physical violence between parents was actually associated with “decreased parental caring and warmth” during childhood. However, they found that after controlling for parental caring, there remained “a direct association between witnessing interparental physical conflict and psychological adjustment, though the extent of the association was substantially reduced”. These findings again only partially support the mediational model.
It is often suggested (e.g. Wolfe et al, 1985) that the effects on children in violent families are more specifically transmitted via the mother. Research indicates that women who are victims of domestic violence experience considerably more stresses and mental health problems than non-abused women (Stets & Straus, 1990). Therefore, the deleterious physical and psychological consequences of being abused may adversely affect the consistency of care and quality of care which the mother provides for her children. However, the degree to which the effects of witnessing domestic violence are mediated by the mother’s parenting remains uncertain (Emery et al 1992).

5. Greater frequency of other risk factors

Some researchers argue that the association between witnessing violence and subsequent adjustment may be purely the result of other risk factors of greater frequency, which usually co-occur with domestic violence, for example frequent parental verbal conflict (Fantuzzo et al, 1991); direct physical abuse of the child (Jourilles et al, 1987); and parental alcoholism (Barnett & Fagan, 1993).

Children of abused women are likely to be targets of their father’s aggression themselves, especially if they try to protect their mothers (Barnett et al, 1980). It has been estimated that up to 40% of the victims of physical child abuse are also exposed to domestic violence (Strauss et al, 1980).

In their investigation of the long term effects in young adults, Henning et al (1997) controlled for these additional risk factors and found that the experience of witnessing domestic violence alone had direct effects during childhood and continued to predict psychological difficulties in adulthood. Other studies (e.g. Strauss, 1992) have reported similar findings. Such findings appear to “challenge the hypothesis that the consequences of witnessing domestic violence are simply an artefact of other risk factors likely to co-occur with marital aggression” (Henning et al, 1997). However, it seems further investigation is required to better understand the effects of these overlapping variables.
6. Cycle of violence

The association between violence in one generation and exposure to violence in the previous generation has led to a model commonly described as the ‘cycle of violence’. This model proposes that “the childhood witnessing of violence can lay the foundation for an aggressively oriented behavioural repertoire as well as different expectations regarding aggression in adult intimate relationships” (Mullender & Morley, 1993).

Support for this model is provided by studies such as those of Cappell & Heiner (1990) and Doumas et al (1994) described earlier. However, there are two main criticisms of this model. Firstly, much of the data to support it has been obtained from samples of identified abusers and victims, thus excluding individuals who may have witnessed domestic violence but have not gone on to exhibit such abusive behaviours or become victims themselves. Secondly, literature on other types of exposure, such as child abuse (e.g. Widom, 1989) indicate that although individuals who were victimised as children may have a higher likelihood of becoming perpetrators of violence, the majority of them do not become perpetrators. Thus, it seems that more prospective investigations are required to gain a better understanding of any intergenerational associations.

UNDERSTANDING CHILDREN WHO ARE NOT AFFECTED

Although there is reasonable evidence that witnessing domestic violence has negative consequences for children both in the short term and the long term, there are two important points that need to be noted in relation to this: (i) Some studies find no such effects (e.g. Jouriles et al, 1987); (ii) Even in studies where effects emerge, many children appear to be functioning normally (e.g. Wolfe et al, 1986)

There is evidence of substantial variability in the level of behavioural and emotional adjustment displayed by the children of abused women. Although a large percentage of these children are reported to be exhibiting problems at clinical levels, many children who are raised in violent families largely seem to avoid the negative sequelae normally associated with such an environment. These “stress-resilient” children appear
to withstand their emotionally unsupportive and disruptive home environment and develop into competent adults (Masten et al., 1990; Hughes & Luke, 1998).

Traditionally, the approach taken to investigate the effects of stressors such as domestic violence on children's functioning has been to study poorly functioning groups in order to identify vulnerability factors. However, as some research has indicated, further insight may be gained by studying those who have overcome adversity, as well as those who have not (Cicchetti et al., 1993; Neighbors et al., 1993).

In the empirical literature on children's responses to stress, the numerous potential differentiating factors that have been identified for resilient children and adolescents can, according to Garmezy (1983), be divided into three categories: a) dispositional attributes of the child (e.g. ability to adjust to new situations); b) support within the family system (e.g. good relationship with one parent); and c) support figures outside the family system (e.g. peers, relatives).

SUMMARY AND CONCLUSION

In summary, it can be seen that the literature on domestic violence has come a long way from barely acknowledging that children are affected by being indirectly exposed to domestic violence to a more widespread awareness that children who witness such behaviour require some attention in dealing with the outcome of this experience. This has also led to important shifts at a service level in that there appears to be some provision emerging for these children. For example, some social services in the South Thames region which have been providing support groups for women who are victims of domestic violence, have begun to also provide groups for their children who witnessed the violent incidents.

The empirical investigation of the effects of domestic violence on children is, still in at a developmental phase. However, one conclusion which is widely accepted is that compared to children of non-violent community families, the children of battered women are at substantially increased risk for behaviour problems.
The specific manner in which exposure to domestic violence is harmful cannot be fully determined on the basis of the research findings to date. While studies have indicated that children who are exposed to stressful events are at a higher risk for psychopathology, results have not suggested that there is a specific pattern of child disturbance associated with a particular stressor. Even if children growing up with domestic violence do not experience obvious psychopathology, they still may be psychologically affected by this experience in terms of their self-respect and self-esteem and the extent to which they can trust and care for others (Jaffe et al, 1990).

Kolbo et al (1996) concluded that numerous findings over the years have pointed towards a general conclusion that a linear social learning model is not adequate for explaining the relationship between children’s witnessing domestic violence and their subsequent development. However, there is simply not sufficient empirical evidence to fully support any of the models that have been put forward. Henning et al (1997) concluded that, at least in terms of long-term effects, the best explanation is probably provided by a combination of the trauma model and the mediational model. It is only with considerably more, methodologically sound, work in this area that consistent findings may be obtained and evidence raised to develop theoretically sound conclusions about the consequences for children who witness domestic violence.
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CLINICAL DOSSIER
OVERVIEW OF CLINICAL EXPERIENCE
PLACEMENT SUMMARIES

Year 1 to Year 3: (September 1997 to September 2000)

MOMOTAJ ISLAM


**Year 1 - Adult Mental Health Core Placement**

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*Dates:* 15.10.97 to 03.04.98  
*Supervisor:* Janice Rigby

The placement provided mainly out-patient work and some involvement with a multi-disciplinary team on an acute psychiatric ward. Direct clinical work was undertaken with 8 clients and direct observation of the supervisor with 2 clients. 6 clients were female and 4 male, aged from 19 to 56 years. All were of White British ethnicity but from various socio-economical backgrounds. The clinical problems that the clients presented with included: anxiety (panic disorder, social anxiety, agoraphobia and obsessive-compulsive disorder); depression; bereavement; relationship problems, anger management difficulties; and memory problems. Eight clients were seen for individual therapy, mainly using a cognitive-behavioural approach and also some general counselling and psycho-educational intervention. Where appropriate, psychometric measures were used for assessment and evaluation of therapy. Two clients were seen specifically for neuropsychological assessment, using a range of standardised tests. In addition to direct clinical work, weekly multi-disciplinary team meetings were attended at the hospital for discussion of patients on the psychiatric ward and there was the opportunity to observe the administration of Electro-Convulsive Therapy. Professionals from other disciplines were observed in their work and referral meetings, seminars and a Special Interest Group(SIG) meeting were attended.

**Year 1 - Learning Disabilities Core Placement**

*Location:* Merton and Sutton Community Team for People with Learning Disabilities,  
Cricket Green, Mitcham, Surrey  
*Dates:* 22.04.98 to 02.10.98  
*Supervisor:* Dr. Gill Koheallee

Whilst working within a multi-disciplinary team, independent clinical work was undertaken with 12 clients (4 female and 8 male) from a range of cultural and social backgrounds with ages ranging from 9 to 43 years. The work included direct work with
clients with learning disabilities as well as with their families and carers in residential settings, using mainly behavioural approaches and some CBT. The presenting problems for which on-going clinical work was undertaken included: anxiety; sexual abuse; challenging behaviour; obsessive behaviour; bereavement; and absconding from college. Assessments (using a range of appropriate standardised measures) were also conducted to ascertain whether clients had learning disabilities and consultation provided with respect to accessing services. The trainee also took the lead role in developing the programme, selecting participants and facilitating a Social Skills Training Group with six clients at a Day Centre. The trainee also taught two sessions on “Setting Effective Objectives” on a nursing staff training course. Regular team referral meetings and Psychology Department meetings were attended as well as seminars and a SIG meeting. Also, a small-scale service-related research project was carried out whilst on this placement, the outcome of which was fed back to the team.

**Year 2 - Child and Adolescent Core Placement**

*Location:* Child and Adolescent Psychology Service, Sutton Hospital, Surrey, SM2 5NF  
*Dates:* 14.10.98 to 01.04.99  
*Supervisor:* Dr. Ruth Armstrong

This placement was with a uni-disciplinary psychology service which was linked to a multi-disciplinary service. Direct and independent clinical intervention was conducted with 9 children (5 girls and 4 boys) and their families. One intervention (comprising 10 sessions) was conducted jointly with the supervisor. The ages of the children ranged from 4 to 16 years and they were from different cultural and socio-economical backgrounds. The presenting problems included: enuresis; animal phobia; school refusal; social anxiety; challenging behaviour; post-traumatic stress symptoms; and other issues. A number of treatment approaches were used including: behavioural management; relaxation training; CBT; trauma debriefing and systemic family therapy. School observation and psychometric assessments, using the appropriate standardised tests, were carried out independently, as well as observation of the supervisor during assessments. Other agencies (e.g. Educational Psychology Service; Sleep and Behaviour Clinic) which refer children to the service were visited.
Psychology referral meetings and multi-disciplinary meetings were attended, as were academic and service-related seminars and a SIG meeting.

**Year 2 - Older Adults Core Placement**

*Location:* Psychology Services for Older Adults, 1 Oakhill, Surbiton, Surrey.

*Dates* 21.04.99 to 01.10.99

*Supervisor:* Catherine Dooley

Independent and direct clinical work was undertaken with 9 clients in out-patient and in-patient settings (at Tolworth Hospital). 4 were female and 5 male, aged between 69 and 79 years. All were of White British ethnicity but from various socio-economical backgrounds. The presenting problems included: bereavement; depression; anxiety; post-traumatic stress symptoms; adjustment issues (related to ageing; loss; dementia; Parkinson's Disease); and challenging behaviour in a nursing home. The intervention approaches included: CBT; life review; systemic (narrative); behavioural; and general counselling. A number of neuropsychological assessments were conducted in relation to queries such as memory problems, dementia and Korsakoff's Disease. For further experience in psychometric assessment, the trainee also assessed a 41-year old client with memory and concentration problems (with supervision from a clinical psychologist in the adult mental health service). The trainee also took an active role in designing, setting up and facilitating two groups at Tolworth Hospital. The first was as lead therapist with a nurse co-therapist for a Reminiscence Group which had 6 patients and ran for six sessions. The second was as co-therapist with another trainee clinical psychologist for a staff 'Team-Building Support Group' aimed at improving morale among nurses following a number of problems on the ward. The trainee gave a presentation to the Psychology team, did some staff teaching jointly with the supervisor and was involved in planning an audit project. Speciality team meetings, group supervision sessions and a PSIGE meeting were attended. Also, other professionals in different settings were observed and their roles discussed.
Year 3 - Post-Traumatic Stress Specialist Placement

Location: Post-Traumatic Stress Service, St. George's Hospital, London SW17
Dates: 13.10.99 to 24.03.2000
Supervisor: Dr. Ian Robbins

The setting for this placement was a Tier 3, specialist clinic for adults referred from local primary and secondary services as well as from other agencies nationally. The clients had been involved in incidences/situations resulting in symptoms of post-traumatic stress, such as intrusive thoughts and images; increased arousal and sleep disturbance, as well as secondary complaints such as depression and chronic pain from physical injuries. The trainee worked independently on assessment (using standardised measures specific to PTSD) and in-depth intervention with 5 clients (3 female and 2 male), aged 20 to 55 years, from different cultural and social backgrounds. Joint work with the supervisor and observation of the supervisor was undertaken with a further 4 clients. The traumatic events in which the clients had been involved included: road traffic accidents; childhood sexual abuse; physical attack by a psychiatric patient (client was a CPN); death of a child patient (client was a nurse); witnessing a shooting; and physical torture during a civil war (client was a refugee). The intervention approaches included: behavioural work; CBT; narrative work; and an integrative model. In addition to independent supervision, peer support was provided to deal with the distressing experiences related by the clients. A case presentation was given to the team and the trainee participated in data-collecting for the service’s auditing system. A Speciality Meeting with another PTSD service and a meeting with the Refugee Forum were attended, as well as a large conference on ‘War Trauma’ which had been organised by the supervisor and the Consultant Psychiatrist in the team.

Year 3 - Child and Adolescent Developmental Disabilities Specialist Placement

Location: Child and Adolescent Developmental Disorders Service, St. Goerge’s Hospital, London SW17
Supervisor: Dr, Maria Calias

The setting for this placement was a Tier 3, multi-disciplinary service for children and adolescents with developmental disorders and learning disabilities. Work was
undertaken both independently and in collaboration with other professionals in the team, namely, psychiatrists, social worker, nurse therapist and speech and language therapist. The casework involved individual work with children, work with families and liaison with other agencies (e.g. schools; social services). Thirteen children were seen, from different ethnic backgrounds, with ages ranging from 4 to 15 years. Presenting problems included: depression; behavioural problems; school-based problems; adjustment issues related to diagnosis of developmental disorders. Intervention approaches included: CBT; behavioural management; general counselling and psycho-education with families. A number of psychometric assessments were undertaken as part of the multi-disciplinary assessment of children with a range of developmental disabilities including: autistic spectrum disorders; ADHD; Fragile X Syndrome; learning disabilities. Weekly multi-disciplinary meetings and uni-disciplinary meetings were attended, which included academic discussions and case presentations (one of which was given by the trainee). Other CPD days and training seminars were also attended.
ADULT MENTAL HEALTH CORE PLACEMENT: CONTRACT

Placement Supervisor: Janice Rigby, St Helier NHS Trust, Psychology Dept
- Brecon House, Sutton Hospital, Cotswold Road,
  Sutton, SM2 5NF

Psychologist in Clinical Training: Momotaj Islam

Clinical Tutor: Mary John

CONDITIONS OF PLACEMENT

a) The trainee will work within the Trust from 15.10.97 to 03.04.98 for 2½ days each week. Annual leave can be taken during this time.

b) A minimum of 2 hours 1:1 contact will be allocated to supervision in order to review progress of current activities and reflect on issues arising.

c) A mid placement visit will take place on

AIMS OF PLACEMENT

1. To provide wide exposure to the Adult Mental Health practice of the Trust, in particular to the Community Mental Health Team.

2. To provide trainee with experience of the full range of clients referred to adult services and exposure to a wide variety of service settings.

3. To develop some competency in psychological assessment and, in the provision of cognitive-behavioural therapy in the adult mental health field. The trainee will develop a level of clinical skill and competence consistent with this stage of training.

4. To develop understanding of the roles of Clinical psychologists in the Trust.

5. To develop understanding of the roles of other professionals in the Trust.

Clinical Experience - Range of client work

Experience will be gained along a continuum as follows:

i. trainee observing supervisor
ii. supervisor observing trainee
iii. trainee seeing clients independently for assessment and therapy.

If direct experience is not possible, then experience will be gained through observation of the supervisor's work or through detailed case discussions (eg survivors of sexual abuse).
The trainee will see:

- clients across the age span
- an appropriate mix of male and female clients
- at least one client from a different cultural/ethnic background.

**a) Range of Presenting Problems:**

The trainee should gain experience of independent client work in the following problem areas:

- Anxiety
- Depression
- Obsessive Compulsive Disorder
- Eating disorders
- Adjustment and adaptation difficulties

It would be desirable for the trainee to gain experience of working with clients in the following problem areas:

- Sleep disorders
- Health/somatic difficulties
- Problems of emotional control and adjustment, social skills and assertiveness, suicide, parasuicide and personality disorders
- Survivors of sexual abuse
- Sexual relationship/family problems
- Disability
- Substance misuse.

**b) Cognitive Assessments**

The trainee should:

1. observe a Clinical Psychologist carrying out a psychometric assessment
2. conduct one while being observed by a Clinical Psychologist
3. carry out another psychometric assessment independently.

**c) Longer Term Mental Health Problems**

The trainee should gain experience working in the area of acute psychotic disorders, longer term mental health problems, rehabilitation and continuing care.

**Range of Settings**

The trainee will be exposed to a wide variety of service settings through:

a) carrying out clinical work in as wide a range of settings as possible

b) meetings (e.g., acute in-patient ward round)
c) meeting other Clinical Psychologists (eg the Day Hospital Psychologist)

d) visits (eg Henderson Hospital).

These will include:

Community Mental Health Teams
Resource Centres
Day Hospital
In-patient wards
Psychology Department

Role of Clinical Psychologists

The trainee should develop an increased understanding of the various roles undertaken by Clinical Psychologists in the Trust through:

a) clinical experience detailed above

b) spending specified time talking with the Psychologists who work in the areas of:

- pain management
- HIV/AIDS
- neuropsychology
- long term mental health problems
- the Day Hospital
- older adults
- child
- psychodynamic psychotherapy

Where possible the trainee will gain direct experience working in these areas (eg observing assessments).

c) involvement in multidisciplinary team meetings eg ward rounds/Case Conferences.

d) attending Special Interest Groups.

e) discussion with supervisor and other professionals in the Community Mental Health Team.

Roles of Other Professionals

The trainee will gain an increased understanding of the roles of other professionals in the Community Mental Health Team through:

a) involvement in multidisciplinary team meetings

b) spending specified time with:

- the Consultant Psychiatrist
- a Community Psychiatric Nurse
- the Occupational Therapist
a Social Worker
discussing their roles and, where possible, directly observing their work.
c) participation in shared clinical work (if appropriate).

Wide Exposure

The trainee will also attend components of the Trust’s professional training programme (Friday Conferences).

Signed:

Janice Rigby
(Supervisor)

Momotaj Islam
(Psychologist in Clinical Training)

Date:
AIMS:

1. To provide experience of the main elements of a psychology service for people with a learning disability.
2. To provide some knowledge of the less common elements.
3. To familiarise with philosophies, policies and services for people with a learning disability at national and local level.

PHILOSOPHY

1. Learn about normalisation philosophy.
2. Treat clients appropriately for their age.
3. Discuss deinstitutionalisation.
4. Visit a residence in an institution setting.
5. Visit a residence in a community setting.
6. Use acceptable language in report writing.

COMMUNICATION

1. Undertake an initial assessment interview with:
   (a) a person with mild learning disability.
   (b) a person/relative.
   (c) a paid carer.
   (d) another professional.
2. Converse with a person with moderate learning disability.
3. Interact with a person with:
   (a) profound learning disability.
   (b) multiple handicap.
4. Feed back to:
   (a) a person with mild learning disability.
   (b) a parent/relative
   (c) a paid carer
   (d) another professional
5. Discuss communication issues in the learning disabilities field.
ASSESSMENT PROCEDURES

1. Identify questions that can be answered by psychological assessments.

2. Apply and interpret:
   - WAIS-R
   - LEITER INTERNATIONAL PERFORMANCE

3. Apply and interpret a language assessment, e.g. Communication Assessment. Profile (CASP)
   - British Picture Vocabulary Scale (BPVS)

4. Be familiar with at least 2 of the following -
   - HAMPSHIRE ASSESSMENT FOR LIVING WITH OTHERS (HALO)
   - BEREWEEKE SKILL TEACHING SYSTEM
   - SCALE FOR ASSESSING COPING SKILLS.
   - VINELAND ADAPTIVE BEHAVIOUR SCALES
   - FUNCTIONAL PERFORMANCE RECORD.
   - STAR PROFILE

5. Undertake a functional analysis of challenging behaviour.

6. Discuss:
   (a) mental health.
   (b) social impairment
   - genetic syndromes
INTERVENTIONS

Carry out a behavioural intervention.

(a) Consult the literature
(b) Do a behavioural assessment.
(c) Collect baseline data
(d) Design programme.
(e) Explain and negotiate the implementation of programme with residential/day care staff.
(f) Monitor and evaluate programme.
(g) Discuss maintenance of programme.
(h) Select and apply, or be familiar with:
   (a) social skills
   (b) advocacy
   (c) interpersonal relationship
   (d) self awareness
   (e) loss and bereavement
   (f) anger management
   (g) assertiveness
   (h) cognitive methods
   (i) relaxation
   (j) desensitisation
WORK WITH STAFF/OTHER PROFESSIONALS

1. Identify the network of specialist and generic services and access these according to the needs of a client.
   
e.g. residential placement
day placement
social work
community nursing
psychiatry
general practitioners
occupational therapy
physiotherapy
speech therapy
disablement resettlement office
Pathways
voluntary agencies
education
register manager
Director of Care

2. Explain and, where possible, perform the generic keyworking role for a client within a multidisciplinary team.

3. Give a clear presentation of a psychological assessment/intervention within a multidisciplinary meeting.

4. Prepare, deliver and evaluate a presentation on a specific psychological topic to a group of staff.

5. Attend and critically evaluate:
   
   (a) Community Team meeting.

   (b) client review
PROFESSIONAL DEVELOPMENT

1. To write a clinical assessment report, to include method, outcome and interpretation.

2. To write an intervention report, to include formulation, method and outcome.

3. Chair a department meeting.

4. Write notes of a department meeting.

5. Do a journal club presentation to the department.

6. Discuss departmental goals and practices.

7. Have an understanding of the effect of current legislation on the service.

8. Attend weekly supervision.

9. Observe supervisor at work.

10. Be observed by supervisor at work.

11. Attend a Regional Special Interest Group meeting.

Signed: [Signature]

(Name of Trainee)

Signed: [Signature]

(G. Koheealle, Supervisor)

GK/11
11 June 1997
PLACEMENT AGREEMENT

TRAINEE: Momotaj Islam
SUPERVISOR: Ruth Armstrong

PLACEMENT: Child & Adolescent Psychology
Cotswold House
Sutton Hospital
Cotswold Road
SUTTON Surrey SM12 5NF

DATE: 14 October 1998 - 1 April 1999

SUPERVISION MEETING: Two hours per week to be arranged.
one hour with Ruth Armstrong and one hour
shared with Lisa Graham and Emma Meldrum
and other Child Psychologists

OBJECTIVES: Experience of working with developmental,,
emotional and behavioural problems in
children across the whole age range within the
Child & Adolescent Psychology Service.

Introduction to working in a variety of settings

An introduction to the Child & Adolescent
Psychology Service and its operation in Sutton
& Merton.

An introduction to the assessment of children
and therapeutic intervention across a broad
range of ages and presenting problems within
a variety of models

CONTENT: Orientation to the setting and the specialty. This
would involve meeting the key members of the
Child & Adolescent Mental Health Services in
Sutton and Merton.

Orientation to clinical work: Initial observation
of assessment carried out by supervisor and
other psychologists. Trainee to observe
supervisor two or three times. Supervisor to
observe trainee a similar number of times.

To aim to develop a case load of eight to twelve
individual cases at any one time. Clinical
contact to consist of 40-50% of the time spent
in the placement.
Opportunity to be involved in joint work with supervisor or other professionals.

To attend meetings as appropriate.

To begin to assess, formulate and carry out psychological interventions with clients.

To explore the possibility of group work with a client population.

To provide the opportunity to extend experience in psychometric assessment.

Other activities will include school visits, liaison with Educational Psychology visits to residential settings and paediatric liaison.

Room shared with one other psychologist. Bookable rooms for client contact. Telephone, access to computer, psychology tests, materials and library.

Mid-Placement Review: 09/12/98
Mid-Placement Visit: 05/01/99 2 pm
End of Placement Feedback

SIGNATURE OF TRAINEE: 

SIGNATURE OF SUPERVISOR: 

DATE: 10/12/98
CONTRACT FOR: Momotaj Islam

AIMS

• To gain an overview of the services available for Older Adults in Kingston and District and an understanding of how these fit together to form an organisation.

• To gain an understanding of the role of the Clinical Psychologist providing services for older adults and how this differs from other professions.

• To have experience of working in a variety of work settings, with a range of client groups and problems and to develop skills and approaches when carrying out interventions e.g. networking, liaising with other professionals, family therapy, martial work, behaviour modification, personal construct theory, bereavement counselling etc.

• To undertake some area of service development/project work/training.

OBJECTIVES

1. To carry out assessment and intervention with approximately ten clients with functional and organic conditions including:-

  1a. DIRECT WORK with clients and families in outpatient/community settings including problems of anxiety, depression, bereavement, adjustment to disability, health issues and carers issues.

  1b. INDIRECT WORK with clients and staff including dementia care in inpatient or residential settings, networking.

2. To become familiar with different settings - e.g.:

• Oak Day Hospital
• Wards for Older Adults with mental health problems at Tolworth Acacia Unit.
• Wards for Older Adults with physical health problems at Tolworth Hospital.
• Social Services Residential Homes, e.g. Newent House, Murray House.
• Private and Voluntary Residential Homes.
• South Place.

3. To spend time with a Consultant Psychiatrist, Social Worker and CPN both in client meetings and if possible in individual client work.
4. To meet Managers within EMI Service and Elderly Community Service.

5. To run a therapeutic group - reminiscence on Fuchsias.

6. To observe and carry out neuropsychological assessment using WAIS R, Coughlan, MEAMS or Mini Mental State with older clients and also one case with a younger client with Anna Iwnicki.

7. To attend meetings and seminars in Psychology Department and other meetings within Services for Older Adults.

8. To have 1.5 hours of supervision on a weekly basis.

9. To have one session of study time per week.

10. To possibly carry out some teaching - either at Tolworth or Surbiton.

11. To possibly undertake an area of project work to familiarise self with organisational issues.

12. To have joint supervision with a process/psycho-dynamic perspective with Sarah Fleming.

13. To carry out interviews with carers in relation to moves into residential care.

Personal goals:

By the end of the placement……

1. I will have a good understanding of the clinical presentation of the client group in relation to diagnostic categories and implications for them and their carers.

2. I will be competent to choose appropriate neuropsychological tests, to administer and to interpret them in a way that is clinically applicable.

3. I will be able to conceptualise and formulate clinical problems and apply models in an appropriate way for the client group.

Catherine Dooley
Consultant Clinical Psychologist

Trainee Clinical Psychologist

concore.doc

2575115
Placement Contract

Trainee. Ms Momotaj Islam  
Start: 13.10.99

Supervisor: Dr Ian Robbins  
Finish: March/April 99

Placement: PTSD Service  
Mid Placement: TBN

Location: St George’s Hospital

Placement requirements.

Agreed days: Wed-Fri

Agreed hours: 9-5 including work at home, library etc. On Friday – half day.

University day. Monday.

Aims of Placement:

To introduce the area of psychological reactions to severe trauma.

To gain experience with people suffering from PTSD, long term impact of abuse, torture, etc.

To be competent in formulating the problems of trauma survivors.

To become more familiar with applications of CBT and narrative approaches to trauma.

Experience Available:

Caseload of up to 6 people for treatment.

Experience of additional assessments.

Opportunity to observe supervisors work.

Opportunity to observe other team members.

Participation in meeting with Maudsley trauma team.
Opportunity for joint work.

Supervision will be for at least 1 hour per week with additional ad hoc supervision as required.

Trainees Doctoral research Project.

This is does not relate to the current placement. Where necessary, if short periods of time e.g. for data collection are this will be acceptable.

Resources available:

Room with telephone, computer, secretarial support. Library facilities at SGHMS.

Dr I Robbins

Ms Momotaj Islam

October 99
Placement Contract

Trainee: Momotaj Islam

Supervisor: Dr. Maria Callias

Placement Type: Specialist – Child and Adolescent Learning and Developmental Disabilities

Placement location: Child Mental Health Learning Disabilities Service, Clare House, St. George's Hospital, London SW17.

Placement dates: 12/04/00 to 29/09/00

Placement days: Wed, Thur, Fri (includes half-day study - usually to be taken on Friday afternoons)

Aims of placement

To acquire a good knowledge of the presenting problems of children and adolescents (ages ranging from birth to 19 years) presenting with learning and developmental disabilities.

To gain experience in the assessment and treatment of this client group within the context of a multi-disciplinary specialist service. This will involve both direct and indirect work, work with families, and liaison with schools and other professionals agencies as appropriate.

Assessment work

Initial assessment interviews – to consolidate existing skills in carrying out clinical assessment interviews by applying them to this area of work.

Psychometric assessments – to extend experience in using psychometric tests and other assessment tools previously used and gain experience in those not used previously.

The following tools are likely to be experienced:
- WISC-III
- WPPSI-R
- Merrill – Palmer
- Bayley Scales
- Vineland Adaptive Behaviour Scales
- Questionnaires – Birelson; Connors

Observational work – at school or home, as appropriate

Assessment of parenting competence

Intervention work

Cognitive-Behavioural Therapy – applying and consolidating skills with children with developmental disabilities

Functional analysis and behavioural intervention - applying and consolidating skills with parents and schools staff.

Family work – involving parents and siblings of children with developmental disabilities

Multi-disciplinary work – working in collaboration with professionals from other disciplines as a member of the multi-disciplinary team
Other experiences
1. Attend weekly MDT team meetings and contribute where appropriate
2. Attend Psychology Departmental Meetings
3. Attend relevant seminars and conferences

Supervision
1-1.5 hours weekly
Supervision cover in absence of Dr. Callias to be provided by Mette Knusden

Mid-placement visit
Date to be notified by Clinical Tutor

Leave
Momotaj: 26th April to 28th April (3 days); 31st May to 2nd June (3 days); 28th June to 30th June (3 days)
Maria: 26th May to 9th June; Mid Sept (2/3 weeks)

Momotaj Islam
Date: 05/06/00

Dr Maria Callias
Date: 05 May 2000
Clinical Case Report Summary
Adult Mental Health Placement

The assessment and treatment of a 53-year-old woman with panic disorder, using cognitive-behavioural therapy

MOMOTAJ ISLAM
Year 1: February 1998
Mrs P., a 53-year old woman who worked as a secretary at the business she shared with her husband, was referred by her G.P. for the treatment of recurrent panic attacks. She described various situations (e.g. whilst driving on the motorway; in public lifts) in which he felt extremely anxious. These were situations in which she felt entrapped, and the feelings of anxiety and panic were worsened when she was alone, that is, unaccompanied by a familiar person who might help reduce her anxiety. In these situations, she experienced physical symptoms (i.e. tightness of chest, feeling hot, sweating, breathlessness, nausiousness, and palpitations) and thought she would lose control of her senses, faint, and possibly die.

Over the previous six weeks, the frequency of the panic attacks had increased and having found them distressing, she had coped by increasingly avoiding anxiety-provoking situations. However, this was now disruptive to her life, especially as the panic attacks had started occurring in a wider range of everyday situations.

The Beck Depression Inventory and Beck Anxiety Inventory indicated that Mrs P. was not depressed but was anxious to a moderate level. Her symptoms met DSM-IV criteria for Panic Disorder (with agoraphobia). Mrs P. reported having a good relationship with her husband, and no particular worries other than her panic attacks.

A cognitive behavioural approach was used in the formulation of this case and intervention involved 10 sessions of CBT. The therapy included: psycho-education about the nature of anxiety and the "vicious circle" model of panic attacks; techniques for the management of the physical symptoms (e.g. slow breathing; progressive relaxation); modification of catastrophic thoughts; and a graded exposure programme. Later in therapy, the role of stress in maintaining panic attacks was discussed and strategies for reducing stress were developed.

Mrs P. presented as a practical-minded person who was motivated to effect change and seemed to understand well the rationale of the cognitive model. She learnt well the behavioural techniques and applied them aptly in controlling some of her symptoms.
The cognitive aspect of the work was slower to progress as this was initially hindered by Mrs P.'s resistance to exploring the possible underlying causes of her anxiety. She tended to minimise her problems and avoid any questions related to her emotions and personal relationships.

However, the 'shock' of a panic attack in a new, unexpected situation proved to be the impetus for change. Following this experience, she began to openly acknowledge and accept that the behavioural strategies alone were not sufficient to eliminate her panic attacks and that something else was maintaining them. Mrs. P began to open up more about the current stresses in her life. These included, the pressures of her job and worrying about the business, regularly visiting her elderly mother, worrying about her son going to university and her daughter doing her ‘A’ Level exams.

Once these issues were discussed, there was a major shift in the cognitive and affective domains. Mrs. P was able, with the help of the trainee therapist, to develop strategies to implement changes in her life to reduce the stresses and in turn, reduce her anxiety. There was a marked reduction in her avoidance behaviour and a reduction in the frequency of her panic attacks. Mrs. P. stated that she now felt more confident in the previously anxiety-provoking situations and thought she could cope with any unexpected panic attacks in the future.
Clinical Case Report Summary
Learning Disabilities Placement

The assessment of a 20-year-old male regarding the level of his learning disabilities and suitability for psychological treatment of his obsessive behaviours

MOMOTAJ ISLAM
Year 1: September 1998
AB, a 20-year-old male, was referred to the Community Team for People with Learning Disabilities by a social worker. The request was two-fold: to assess the extent of his learning disabilities, to enable social services to make decisions about his access to appropriate services; and to help in the management of obsessive and problems behaviours.

The behaviours in question included: (i) Neglect of personal hygiene - e.g. not changing his clothes for several days; (ii) "Obsessions" with his body and bodily functions - e.g. brushing his teeth for 2/3 hours at a time, often causing his gums to swell/bleed; spending up to an hour in the toilet; (iii) Verbal and physical aggression towards mother and sister - reportedly un-provoked.

AB lived with his mother and 16-year-old sister and some of his behaviours proved to be a problem for them (e.g. when he occupied the bathroom for lengthy periods) and others result in disruptions in his daily routines (e.g being extremely late for college).

The assessment procedure included psychometric assessment of AB’s cognitive abilities and clinical interviews to ascertain the exact nature of the problems before appropriate strategies for management could be devised. Also, although AB could engage in quite lengthy dialogue, this did not always appear meaningful, and he seemed to possess little insight. Therefore, his ability to engage in psychological work regarding his behaviours was questionable and a few initial sessions were planned to assess his suitability for psychological treatment.

AB’s scores on the WAIS-R (VIQ = 73; PIQ = 71; Full IQ = 72) placed him just above the cut-off point of 70 for a diagnosis of learning disabilities. However, the other assessment information gained from AB and his mother indicated that his social and adaptive living skills were considerably below his general intellectual abilities. Thus, it was concluded that AB had a mild learning disability.

As it was apparent that there was some discrepancy between AB and his mother’s views about his behaviours (AB did not believe they caused a problem to the same
extent), this was discussed with them both. AB accepted that his behaviours were distressing and disruptive to his family as well as to his academic and social functioning. He was willing to try to make some changes in reducing his aggressive behaviour towards his mother and sister. As for his obsessive behaviours, his prolonged teeth-brushing was the only one he agreed was causing problems at home and to his health, so agreed to work on changing that.

Several attempts were made to monitor AB’s teeth-brushing behaviour, but problems were encountered in doing so. Due to lack of time and energy AB’s mother and sister refused to do any monitoring, and due to AB’s mother’s refusal of home visits, the trainee therapist could not make any direct/naturalistic observations. Subsequently, AB agreed to self-monitor his teeth-brushing behaviour. A simple recording chart was drawn up and AB trained on when and how to complete it. However, over the following few weeks, he lost the chart twice and made excuses for not completing it.

Although AB acquiesced to the therapist’s suggestions in sessions, he was found to lack commitment to therapy and motivation for change. This appeared to be related to the fact that he did not view his behaviours as significant problems. It was decided that he would not work well in the psychological treatment being offered by the trainee therapist. Also, it appeared that in the context of various other stressors in the family (e.g. tensions in relationships with AB’s father, who lived separately), his mother was focusing on him as the main source of all the problems and overlooking other issues.

Recommendations were made for some family work, and for AB to receive some individual counselling (as this had been successful in the past) to improve his confidence and self-esteem with the aim of this, in turn, reducing his obsessive behaviours.
Clinical Case Report Summary
Child and Adolescent Placement

Asperger’s syndrome, depression and behavioural problems:
Intervention with a 10-year-old boy and his family

MOMOTAJ ISLAM
Year 2:
William, a 10-year-old boy, was referred to the multi-disciplinary child and adolescent service by his GP, following the recent diagnosis of Asperger’s Syndrome at a leading Children’s Hospital. The request was for assessment and treatment of sleep and emotional problems. William was assessed by a Psychiatrist who diagnosed long-term depressive disorder which he treated with pharmacotherapy. William also received CBT and some behavioural input from a Clinical Psychologist, whose departure from the service led to the referral to the trainee therapist for ongoing work.

The following issues were raised by William and his mother as current concerns:
(i) Aggressive “temper tantrums” at home during which he physically attacked his mother and younger sister and smashed up furniture. His behaviour was becoming more aggressive and his mother was finding it increasingly difficult to manage him;
(ii) Alternating low mood and hyperactivity (to a “manically high” level;
(iii) Difficulties at school, which William described as an “evil place where people make you do things you can’t do and don’t want to do”. He particularly hated playtimes and was very lonely; (iv) Difficulties in relationships with his sister and father, neither of whom he felt appreciated the difficulties he experienced as a result of his developmental disorders.

As William’s challenging behaviours were reported to be the main cause for concern, a functional analysis was conducted on the constellation of behaviours that his mother described as “temper tantrums”. It was concluded that the functions served by William’s tantrums were mainly ‘Attention’ from his mother and ‘Escape’ from situations which in which he felt distressed and could not communicate his feelings.

William’s behavioural problems and depression were formulated predominately within a behavioural framework. He had a complex set of problems comprising significant cognitive, social, emotional and behavioural difficulties which appeared to be related to his developmental disorders (namely Asperger’s Syndrome and dyspraxia), as well as to environmental factors (i.e. at school and at home).
The intervention, aimed to altering the functional relationship between William and his environment, focused on the following three areas:

(i) **Behavioural management**: Using a ‘time out’ and reinforcement programme to reward self-control, William was taught to exercise control of his aggression and his mother was helped to develop some management strategies for dealing with the behavioural problems. (Due to his imminent change of schools, William’s mother declined the trainee therapist’s suggestions for liaison with the school in relation to his difficulties in that environment.)

(ii) **Communication skills**: William was taught some strategies to enhance his expressive and receptive interpersonal communication skills with the aim of reducing the anxiety, anger and frustration caused by his difficulties in this area. This involved two tasks, namely: (i) “Mind-reading exercises” to improve his “theory of mind” as set out by Howlin et al (1999); and (ii) the development of hand signals to aid expression of emotions which he found difficult to express verbally.

(iii) **Family Relationships**: Issues about the family’s acceptance and understanding of William’s disabilities were discussed, with particular focus on helping William and his younger sister better understand each others’ needs.

The outcome of the intervention was that the rate of William’s tantrums was reduced and he was better able to communicate his distress using hand signals. His mood was somewhat improved, although he remained moderately depressed. As the trainee therapist was leaving the service, recommendations were made for ongoing work in the further development of communication skills and application of this in teaching William anger management strategies. Also, as much of the family-related issues involved problems in the parental relationship (his parents had recently separated) and the failure of William’s father to accept his disabilities, individual therapy for William’s parents was advised.

Clinical Case Report Summary
Older Adults Placement

The neuropsychological assessment of a 79-year-old woman
with a query of dementia

MOMOTAJ ISLAM
Year 2: September 1999
Mrs X, a 79-year-old widow, was referred by the Consultant Neurologist at her local hospital who examined her following her complaints to her G.P. of poor memory and occasional confusion as to her whereabouts. Medical evaluation had proven inconclusive as to any significant organic abnormalities and a neuropsychological assessment was requested to ascertain whether the cognitive problems may be due to the onset of dementia, or due to a functional cause.

Mrs. X described the following areas of difficulty, which had been developing over the previous three years: (i) Memory - she was finding it increasing difficult to remember everyday things like a few items of shopping and telephone numbers, was misplacing objects (e.g. keys), and having difficulty putting names to familiar faces; (ii) Confusion - she described “losing herself” at times, that is, momentary disorientation in space and time; (iii) Concentration - she reported becoming increasing easily distracted and being unable to concentrate whilst reading or watching a television programme.

Mrs. X hoped that the neuropsychological assessment would enable her to gain some understanding of what may be underlying her difficulties, as she feared that she may be developing a dementia like her mother and elder sister had done. Mrs X’s daughter reported that she too had noticed a gradual decline in her mother’s abilities, describing her as previously having a very good memory and always being very independent. She also suspected that her mother may be depressed due to recent family bereavements and being a reserved person, finding it difficult to talk about her feelings.

A detailed personal, family and medical history was taken. Mrs. X’s husband had died 2 years previously at the age of 92, and her younger daughter had died of cancer the following year, at the age of 42. Mrs. X was diagnosed with clinical depression during this period and was prescribed Prozac by her GP for a short time.

A thorough psychometric assessment was carried out using a number of standard general cognitive tests as well as tests specifically designed for the assessment of memory problems and dementia in older adults. Also, an anxiety and depression scale was administered. Mrs X happily co-operated in this process.
The outcome of the assessment was that Mrs. X’s current cognitive functioning was at an exceptionally high level for her age (consistent with her pre-morbid estimate) and there was no evidence of a global deterioration in her intellectual abilities. However, there was evidence of specific difficulties in relation to certain aspects of her memory, attention and concentration. She appeared to have a specific difficulty in learning new information. When compared to her reports of a previously very good memory, this indicated that there had been some deterioration. Mrs X also appeared to have definite levels of anxiety and was borderline for clinical depression.

A diagnosis of dementia according to DSM-IV was considered, but as the contra-indications outweighed the diagnostic features, it was not possible to give Mrs X such a diagnosis at this time. It seemed that her functional problems were playing a major role in her difficulties, but it was difficult to ascertain the extent of this due to her reluctance to discuss emotional issues. Also, due to the presentation of some prominent early signs of dementia and the strong familial link, it was not possible to rule out an underlying organic component to her difficulties.

Feedback was provided to Mrs X in a sensitive manner. Strengths as well as problem areas were discussed, and she expressed finding it reassuring that in many aspects she was still functioning at a level that was above average for her age. Recommendations were made for the future management of her problems. Mrs. X was provided with some literature and information on strategies for coping with her memory problems, memory training and external memory aids. Some formal emotional support was suggested, but she declined this, believing she was not depressed but simply anxious about her memory problems. Therefore, it was suggested to her daughter that Mrs. X should be encouraged by her family and friends to discuss her emotions with them and receive much support in doing so.
Clinical Case Report Summary
Specialist Placement: Post-Traumatic Stress Disorder

The assessment and treatment of a 30-year-old female with 'complex' post-traumatic stress disorder, using an integrative model

MOMOTAJ ISLAM
Year 3: March 2000
Ms N., a 30-year-old woman, was referred to the Post-Traumatic Stress Service by the staff nurse at a day centre affiliated to the local psychiatric hospital. Ms. N had been admitted to the hospital three years previously during an episode of severe depression and subsequently discharged. She had been the victim of a number of sexual assaults and due to her reports of experiencing flashbacks and nightmares, the referrer requested an assessment for the possibility of post-traumatic stress disorder (PTSD), and treatment if appropriate.

Her current symptoms included: low mood; irritability; difficulty in sleeping; intrusive thoughts and images; anxiety in public situations in the presence of men; and difficulty in planning ahead. She also expressed anger and resentment about her need to be in therapy, attributing this negative attitude to therapy to her previous experiences of psychoanalytical psychotherapy and inappropriate support groups. Having ascertained what Ms. N's apprehensions about therapy were, the trainee therapist informed her of what the assessment and therapeutic process would entail. After a week of deliberation, Ms N opted to continue attending the service.

Ms. N gave a detailed history of her family, educational, employment and social situations. She reported having an extremely unhappy childhood with a particularly difficult relationship with her father, whom she described as a bully. She was academically very able, but left school at 16 in order to leave home. She had progressed well in her career as a travel representative, but due to interpersonal problems with employers, had been discharged from a number of jobs. She had been in numerous short-term and several long-term relationships, but currently lived alone and had a close circle of friends.

Initially Ms. N was only able to briefly describe the sexual assault incidents to which she had been a victim. They included: indecent assault by a stranger when she was aged 12; rape by a stranger when she was 17; and attempted rape by an acquaintance when she was 24. Due to the extreme distress caused by the memory of these events, she was unable to elaborate on them and broke down into tears when asked to do so.
Ms N completed a number of standardised questionnaires which assess symptoms of PTSD, general health and depression. She was found to be suffering from PTSD, meeting the DSM-IV criteria and the criteria for “complex PTSD” as outlined by Herman (1992), and secondary depression. Her symptoms were having marked effects on her work and social functioning.

Formulation and treatment of Ms N’s problems were undertaken within an integrative approach, incorporating cognitive, narrative and psychodynamic approaches to the understanding of PTSD. The aims of the therapy were derived from Harvey’s (1996) criteria for the resolution of trauma, and the working model applied was the stages in the process of recovery from complex PTSD, as described by Herman (1992).

The trainee therapist began by helping Ms. N build up trust in the her and develop a sense of ‘safety’. Once this was established, Ms. N. was able to give vivid descriptions of her traumatic experiences in the context of other life events, describing her emotional state at the time of each incident. This process served the purpose of exposure and indicated increased affect tolerance on the part of Ms N.

There were a number of recurring themes which emerged from Ms N’s ‘story’, such as: anger; shame, self-blame; and loss of trust in others. Having identified these issues in collaboration with the therapist, Ms N. was able to address them with the aim of reconstructing her ‘story’ in a way that was more adaptive, in order to integrate the traumatic experiences with other life events and subsequently move on in her life.

Ms N made much progress towards these aims, making major shifts in her attitude to therapy, developing a good therapeutic relationship, and moving away from feeling like a victim to feeling like a ‘survivor’. Re-assessment on the standardised measures indicated improvements in symptoms and everyday functioning.

References:
Herman, J.L. (1992) Trauma & Recovery: From domestic abuse to political terror. London: Pandora.
Service-Related Research Project

Is it appropriate for children with learning disabilities to be referred to the CTLD, and do they provide an effective service?: Professionals' and parents' views

MOMOTAJ ISLAM
Year 1: July 1998
ABSTRACT

Objective: To identify the views of professionals (i.e. members of the Community Team for Learning Disabilities, CTLD) and parents with regard to the appropriateness of child referrals to the CTLD and the effectiveness of the CTLD’s intervention in the cases that are accepted.

Design: Selection of 10 closed cases of children (5-17yrs) that were referred to and accepted by the CTLD. Interviews with professionals (who dealt with the above cases) and with one parent (for each of the above cases) about their views on appropriateness and effectiveness.

Setting: Community Team for People with Learning Disabilities (CTLD) within a trust in the South Thames Region.

Participants: Members of the CTLD who were involved with the selected cases, and parents of these clients.

Main Outcome Measures: Professionals and parents’ views.

Results: The majority of the participants felt that the child cases were appropriately referred to the CTLD, and that the intervention was effective.

Conclusions: Thus it would appear that the CTLD is providing a valued service to this client group. Service implications and methodological limitations are discussed.
INTRODUCTION

Children with learning disabilities may have a variety of psychological, educational, social and health needs during their lives. However, due to the lack of cohesive links between the services which can meet these needs, many parents find they have to interact with a bewildering array of professionals to help their child (Murphy, 1994).

The development of Community Mental Handicap Teams in the late 1980s, as multi-disciplinary groupings of professional staff working at local level, was aimed at easing this problem and making services more accessible. Then, the NHS and Community Act 1990, together with the Children Act 1989, established new divisions in health and social services agencies along the line of purchasers and providers in both sectors. This also meant that social services for adults and children remained separate despite mutual dependence (Sutcliffe, 1990). This divide appears to be particularly significant at school leaving age when the transition from child to adult services is made in organisational terms. Hubert (1991) describes how this transition can be rather a distressing experience for the young people and their parents alike: 'Parents feel that as their children become adult they need increased help and support, whereas the provision of services become haphazard and uncoordinated' (p.74).

There appear to be two important questions to be answered with regard to the provision of services for children with learning disabilities. Firstly, whether the child with learning disabilities is to be viewed primarily as a child or as a person with learning disabilities. In terms of service provision at a wider level, this question was answered with the working philosophy based on the normalisation principle (Wolfensberger, 1969) which aimed to eliminate the stigma of being labelled with learning disability. Thus, the child was always to be viewed as a child first, and having a learning disability second.

The other question is one of identifying the most appropriate service for dealing with problems faced by children with learning disabilities - a specialist learning disabilities service or a generic child service. It is often argued that the former has more expertise in understanding learning disabilities and the latter in understanding children’s issues.
In their discussion of services for children with ‘intellectual disability’ and behavioural or emotional disturbances, Enfield and Tonge (1996) state that in their clinical experience, ‘parents often complain of their difficulty in obtaining help from specialised services, while believing that generic services will not understand their specialised needs.

In general, CMHTs - or Community Teams for Learning Disabilities (CTLDs) as they later became called - are only contracted to deal with adult cases, and children with learning disabilities are referred to child services. However, a common problem is that the age for defining the end of childhood/ beginning of adulthood varies from Trust to Trust, and even within the Trust, from service to service. For example, in one Trust in the South Thames Region, the age of transition from child services to adult learning disabilities services is 14yrs, with clear distinctions between the two services. In another Trust to the author’s knowledge, which is in the North Thames Region, the child service does not see children aged over 16yrs, and the adult service does not see under-18s, leaving a two-year gap in services for young people living in that area.

The setting for this study, the CTLD in a Service for People with Learning Disabilities, in a Trust in the South Thames Region, is in an ambiguous situation whereby it is not contracted to see children, but then a client age group is not specified either. Hence, in practice, individual members of the team agreed to take child referrals because they enjoyed working with children and/or they had experience of working with children. Recently however, the Service Manager has suggested that the CTLD should in the future make a policy for seeing children from 5yrs to 17yrs, as well as adults. This idea is under discussion.

Currently, the community nurses, the clinical psychologist and the assistant psychologist in the team work with children. The speech and language therapist and the consultant psychiatrist, however, do not. The latter states that he lacks the professional training to work in child and adolescent psychiatry or in child learning disability services and it is not recommended by the Royal College of Psychiatrists that
consultants should provide a ‘life-span service on an individual basis’. The problem this causes is that if one of the other team members works with a child and then that child requires psychiatric intervention, the case has to be referred to the child psychiatry team.

The CTLD has good links with social services (the main referrers), who have a knowledge of the types of referrals that will be accepted. However, sometimes, the referrals are not appropriate to the team and have to be re-referred. In some cases it appears that referrers are ‘hedging their bets’ and hoping the CTLD will accept the referral, rather than refer to the child and family services which have a waiting time of around 9 months. (Also, there is a commonly held view within the CTLD that the child services give children with learning disabilities a lower priority than children with other problems.)

The provision of services to children is not included in the team’s ‘Operations Policy’ and so there are no formally stated criteria for acceptance of child referrals. The informal basis on which the CTLD accepts a child referral is that the reason for referral has to be ‘related to the child’s learning disabilities’ (e.g. sexually inappropriate behaviour related to cognitive difficulties in understanding social rules) as opposed to only being about a “child-related issue” (e.g. challenging behaviour in a child of average intelligence). However, the definitions of these criteria are not clear and it often proves difficult to distinguish between them, especially at the point of referral. Therefore individual professionals have to use their own discretion in accepting referrals, or discuss the matter with colleagues.

Currently, the CTLD are working with children at their own discretion and without the provision of resources for this service. However, whether the CTLD should provide a service to children has always been debatable. This debate has recently been highlighted within this setting in the light of the current negotiations regarding the forthcoming merger of this Trust with a nearby Trust. As there is no formal recording of the work undertaken with children, the current research question was generated with an aim to gathering some useful data about this work.
It could be argued that the time spent on children is time less spent on adult clients (adults are not necessarily given priority over children). However, by taking on child cases the CTLD team are saving the child and family services some resources. Thus if the research indicates that child cases are appropriately referred to the CTLD, and promptly and effectively dealt with to the satisfaction of the referrers and service users (i.e. parents), then it could be argued that the CTLD should have the appropriate resources to provide this service. However, if those cases which are taken on are not thought to be satisfactorily dealt with, then the CTLD would find it difficult to justify the continuation of its work with children.

**Objective**

The aim of this study is to identify the views of CTLD members and parents with regard to the appropriateness of child referrals to the CTLD and the effectiveness of the CTLD's intervention in accepted referrals. As discussed above, the purpose of gaining this information is for the CTLD to decide whether the service they provide to children should continue and if so, to aid them in their negotiations during the forthcoming merger with another Trust. As this is a preliminary study, it is aimed at gathering information, rather than obtaining generisable data. If thought to be appropriate, the service may undertake a larger study in this area in the future.

**Research questions:**

The following questions were addressed:

i) Are children with learning disabilities appropriately referred to the CTLD and is there some consistency in the criteria the CTLD employ in accepting these referrals?

ii) Is the service the CTLD is providing for children perceived to be effective and valued by parents of the children involved?
METHOD

Design of study

(1) Selection of sample (cases)

Initially, the researcher attempted to select 10 closed cases of children (5-17yrs) that were referred to and accepted by the CTLD. The rationale for using closed cases was that the researcher thought participants would be more able to consider the appropriateness of referrals and effectiveness of intervention outcome if they considered these issues in retrospect. The reason for choosing 10 cases was that there were ten professionals who worked with children, thus one case would be discussed by each professional. However, as two of these professionals (nurses) dropped out of the study, there were only 8 cases included in the study.

In order to obtain a sample of child cases these members of the CTLD had worked with and closed, records of referrals were searched. Unfortunately, these records made no distinction between active & closed cases. Thus, a list was made of all referrals in the previous year (June 97- June 98) of children between the ages of 5 and 17. The date of birth of the child, the name of the CTLD member who had worked on the case, and the date of closure were noted. Then, for each CTLD member, 3 client names were randomly chosen (i.e. with no preference for age or sex of child) from this list and the files traced and checked to see whether or not the case was closed. More often than not, the cases were still active. Thus, this procedure was repeated but this time looking back a further 6 months of records. Again, it was not possible to find a closed case for each CTLD member by random selection, that is, by the researcher simply going through the list of names in the referral book.

Therefore, the only option remaining for selection of cases was to ask the members themselves to nominate 2/3 cases that they had closed within the last 12 months from which it would be possible to interview the parents. Most members nominated at least 2 cases, and one of these was selected by the researcher to participate in the project. (The effect that this type of case selection might have on the results is discussed later.)
In one case, the child’s parents had both recently been deceased and the child’s elder brother, who was his guardian, had been involved with the CTLD’s intervention.

(2) Measures

From the selected cases, the following information was noted: referrer’s profession; reason for referral; action/intervention; client’s level of learning disability.

Two separate interviews were designed, one for CTLD members & one for parents/guardians (see appendices 1a & 1b, respectively) based on the issues that were raised in the informal discussions described above. The interviews were structured with some closed questions and some open-ended questions as probes to elicit description or generate ideas, as in Q11 in the professionals’ questionnaire, which asks the professional to describe what in their view would be the ideal situation for provision of services for children with learning disabilities.

The interviews were designed to obtain the following information from the participants:

i) professionals (who dealt with the cases) - their views on the appropriateness of the referral of their particular case, and the effectiveness of their intervention.

ii) one parent/guardian (for each of the above cases) - their views on the appropriateness of the referral of their child to the CTLD and the outcome and this intervention.

Procedure

(1) Preliminary informal discussions

Due to the limited literature in this area, informal discussions were held in an attempt to generate some qualitative information (in the form of themes/issues) of relevance in this area so that valid questions would be asked in the structured interviews. To gain a knowledge of various perspectives, these discussions involved the following people: 3 nurses; 2 psychologists; the CTLD service manager; the consultant psychiatrist; 2 social workers who make referrals to the team; and 3 parents who have been involved
with the team. Unfortunately, it was not possible to get these people together for a
group discussion (as in a focus group) so these were individual discussions with the
researcher. These individuals were not later included for participation in the main
interviews for the study.

The main issues that arose from these discussions were:
- The child services have very long waiting lists, and referrers are aware of this.
- The CTLD have more specialist knowledge in dealing with people with learning
disabilities compared to the generic child services.
- The CTLD are more likely to do home visits and have more intensive contact with
the family.
- The parents are often not sure which service is providing the service nor which is
more appropriate.
- The parents are usually more concerned about getting a quick response than about
who is providing the service.
- Although most of the professionals stated that they felt confident working with
children based on their experience with this client group, one person stated that she
should really have had more training or experience in working with children before
taking on child referrals.

(2) Sampling procedure (participants)
For the professional participants, a memorandum was circulated to all CTLD members
who engage in working with children explaining the aim of the research and requesting
volunteers to participate in this project. Of the 10 members notified 8 agreed to be
interviewed.
The CTLD members contacted the relevant parents/relatives to inform them of the
work, ask their permission for participation and once agreed, to inform them that the
researcher would contact them for an interview in the near future. All those contacted
agreed to be interviewed (i.e. 100% response rate).
Therefore the final participants for the study were eight members of the CTLD who were involved with the selected cases, and one parent/guardian of each of these clients. Hence there were 16 interviews in total to be conducted.

(3) The interviews
All the interviews were administered by the researcher, who added probes to the structured questions where necessary and appropriate. The CTLD members’ interviews were conducted in a meeting room at the team base. The parents/relative’s interviews were conducted in their homes.

All the interviews were tape recorded with the participants’ permission, which was obtained at the time of arranging the appointment for interview. This was for ease of flow of the discussions & so that the interviewer could concentrate on the information given and ask any prompting questions when relevant. The interviews were than transcribed.

RESULTS
The methodological limitations of this study are discussed later. Unfortunately, due to the small sample size, it was not possible to carry out any statistical tests on the data obtained. Therefore the results will be presented descriptively. The demographic information about the two groups of participants and the child cases are provided in Tables 1 & 2. The main findings have been organised in the form of some basic categories or ‘themes’, (though not subjected to a strictly qualitative analysis), as shown in the Tables 3 to 11.
### Demographic information on participants

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<th>participant</th>
<th>sex</th>
<th>age range (yrs)</th>
<th>profession</th>
<th>qualifications &amp; grade</th>
<th>years since qualified</th>
<th>years involved with children</th>
<th>profession qualif. to work with children?</th>
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<td>35-44</td>
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**Table 1: Demographic information on CTLD members**

<table>
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<tr>
<th>parent/relative</th>
<th>age range (years)</th>
<th>parent/relative’s profession</th>
<th>relationship to client</th>
<th>age (yrs) &amp; gender of client</th>
<th>client’s level of LD</th>
<th>client’s daytime activity</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>25-34</td>
<td>carer</td>
<td>mother</td>
<td>8 (female)</td>
<td>moderate</td>
<td>spec. needs school</td>
</tr>
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<td>35-44</td>
<td>carer</td>
<td>mother</td>
<td>17 (female)</td>
<td>moderate</td>
<td>spec. needs school</td>
</tr>
<tr>
<td>3</td>
<td>45-54</td>
<td>retired policeman</td>
<td>father</td>
<td>16 (female)</td>
<td>severe</td>
<td>spec. needs school</td>
</tr>
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<td>brother</td>
<td>16 (male)</td>
<td>moderate</td>
<td>college - spec. needs</td>
</tr>
<tr>
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<td>35-44</td>
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<td>mother</td>
<td>14 (female)</td>
<td>severe</td>
<td>spec. needs school</td>
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<td>mother</td>
<td>16 (male)</td>
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<td>college - spec. needs</td>
</tr>
<tr>
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<td>mother</td>
<td>7 (male)</td>
<td>severe</td>
<td>spec. needs school</td>
</tr>
<tr>
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<td>mother</td>
<td>8 (male)</td>
<td>severe</td>
<td>spec. needs school</td>
</tr>
<tr>
<td>mean</td>
<td></td>
<td></td>
<td></td>
<td>12.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 2: Demographic Information on Clients and their Parents/Relative**
It is noted here that the majority of the ‘child’ cases selected for this study, are actually adolescents. The implications of this are discussed later.

*Interviews with CTLD members*

1. Reasons for referral

It appeared that the main referrers were the social workers and schools, for a range of problems, which are described in Table 3 below.

<table>
<thead>
<tr>
<th>Table 3: Reasons for referral/presenting problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate support to family concerning problem behaviour</td>
</tr>
<tr>
<td>Incontinence</td>
</tr>
<tr>
<td>Autism- education &amp; management of behaviour problems</td>
</tr>
<tr>
<td>Health banding for transition from child to adult services</td>
</tr>
<tr>
<td>Counselling parent in response to inappropriate management of child (Child Protection)</td>
</tr>
<tr>
<td>Counselling concerning sexually inappropriate behaviour</td>
</tr>
<tr>
<td>Support in feeding for child with cerebral palsy &amp; epilepsy</td>
</tr>
</tbody>
</table>

(2) Views on why the CTLD was selected by the referrer

The CTLD members stated that by referring to the CTLD as opposed to generic child services the referrers had certain expectations of them. These are described in Table 4. (There are only five statements because more than one professional gave the same response.)

<table>
<thead>
<tr>
<th>Table 4: CTLD members’ perceptions as to why referrers preferred them</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide a quicker response</td>
</tr>
<tr>
<td>Specialist knowledge/experience</td>
</tr>
<tr>
<td>Support in the community</td>
</tr>
<tr>
<td>Prior knowledge of the client.</td>
</tr>
<tr>
<td>“More than a diagnosis- i.e. education and support following diagnosis”</td>
</tr>
</tbody>
</table>

MIslam;PsychD;2000
(3) Appropriateness and acceptance of referral
The majority (87.5%) of participants never (62.5%) or rarely (25%) felt obliged to take on child referrals, whereas, one participant ‘frequently’ felt the pressure to do so, because other staff members were taking on such referrals. Most (87.5%) participants thought that their particular referral was either very appropriate (37.5%) or quite appropriate (50%) for the CTLD. Table 5 summarises the reasons why participants thought the referrals were either appropriate or inappropriate.

<table>
<thead>
<tr>
<th>Table 5: CTLD members’ views as to why the referral was appropriate for them</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If appropriate, why?</strong></td>
</tr>
<tr>
<td>Experience in communicating with people with LD which other service lacked</td>
</tr>
<tr>
<td>Specialist knowledge, and make for easy transition later</td>
</tr>
<tr>
<td>More knowledge about LD and autism than other services</td>
</tr>
<tr>
<td>Specialist knowledge in health banding work.</td>
</tr>
<tr>
<td>Familiarity with problems related to LD as opposed to just children</td>
</tr>
<tr>
<td>Ability to provide support out in the community which other services cannot always do.</td>
</tr>
</tbody>
</table>

| **If inappropriate, why?** |
| Should have gone to generic child service, eg. psychology or psychiatry. |
| They wouldn’t offer anything more but should go to generic services whenever possible & LD service only if specifically LD problem. |
| Continued to work with it because “it is currently within the team’s remit to accept such referrals”. |

The majority (75%) of participants also thought that the referral was specifically related to the client’s learning disability.

(4) Interventions employed and issues specific to child work
The range of interventions employed in dealing with these cases are listed in Table 6.

<table>
<thead>
<tr>
<th>Table 6: Main types of intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment (eg. functional analysis of problem behaviour)</td>
</tr>
<tr>
<td>Diagnosis</td>
</tr>
<tr>
<td>Education and advice, re: management of problem behaviour; autism</td>
</tr>
<tr>
<td>Support/advice to parents/school, re: personal hygiene; incontinence</td>
</tr>
<tr>
<td>School liason and advice to schools</td>
</tr>
<tr>
<td>Bereavement counselling (“When Dad Died ‘Pack)</td>
</tr>
<tr>
<td>Training in use of gastroarastomy button</td>
</tr>
</tbody>
</table>

MIslam;PsychD;2000
Other than their knowledge and experience in this field, the team members thought they possessed a range of skills in communication, nursing, assessment, and behavioural intervention in doing this work. They generally did not treat the child cases much differently to the way they would treat adult cases, however, there were some considerations and issues that arose specifically because the work was with a child (or rather, an adolescent who is a dependent) as opposed to an adult. These are summarised in Table 7.

<table>
<thead>
<tr>
<th>Table 7: Issues specific to child work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trying to communicate at the child’s developmental/cognitive level</td>
</tr>
<tr>
<td>Needing mother’s consent to do the work.</td>
</tr>
<tr>
<td>The issue of ‘neglect of care’ and the Children Act.</td>
</tr>
<tr>
<td>Issues of safety due to dangerous behaviours was more prominent because it was a child.</td>
</tr>
<tr>
<td>Dealing with the parents’ feelings in the issue of transition.</td>
</tr>
<tr>
<td>Involvement with the educational aspects of the child’s situation.</td>
</tr>
<tr>
<td>Confidentiality issues relating to how much information to relay to the parents.</td>
</tr>
</tbody>
</table>

"His age meant he was more vulnerable to effects of bereavement, so I had to be sensitive to that."

(5) Evaluation of service provided and views on other services available

The majority (75%) of participants thought they had provided the best service possible in that particular case, and only half of them could think of an alternative service which might have intervened in the case, but they did not think this service would be better. These responses are summarised in Table 8.

<table>
<thead>
<tr>
<th>Table 8: Other accessible services &amp; whether they would provide better service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>None - Child Guidance were good for family work but couldn’t deal with individual LD child.</td>
</tr>
<tr>
<td>Health visitors - they had already tried but required more specialist help.</td>
</tr>
<tr>
<td>Can’t think of any.</td>
</tr>
<tr>
<td>Not aware of any other services that could do the banding.</td>
</tr>
<tr>
<td>Specialist residential school - yes would provide greater input than CTLD.</td>
</tr>
<tr>
<td>Child psychotherapy - not sure that they would provide better service, also have 9 month waiting list.</td>
</tr>
<tr>
<td>Specialist residential school - better equipped to cater for his educational &amp; physical needs.</td>
</tr>
<tr>
<td>Can’t think of any other service that could combine the skills for LD &amp; bereavement.</td>
</tr>
</tbody>
</table>

MIslam;PsychD;2000
The participants had a range of different ideas about the best provision of services for children with learning disabilities. These are described in Table 9.

Table 9: Ideas about best provision of services for children with learning disabilities

<table>
<thead>
<tr>
<th>Idea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint working with Child Guidance - but problem of different waiting times.</td>
</tr>
<tr>
<td>Specialist health visitors for birth to 18yr-olds.</td>
</tr>
<tr>
<td>An agency to work more closely with children with LD, providing better link between generic child services &amp; CTLD, so people are aware of what is available.</td>
</tr>
<tr>
<td>Should be able to access a range of services, but whichever service they go to should provide a good support network - some services only proved short-term problem-focused intervention &amp; no on-going support.</td>
</tr>
<tr>
<td>Should always be able to access generic services first, unless problem is specific to learning disabilities. If requires specialist LD service, funding should go with the child to that service.</td>
</tr>
<tr>
<td>We shouldn’t necessarily be the first port of call, but another consulting agency, called upon when other services don’t meet their needs. From contractual perspective, should be flexible, because it’s not always obvious which service they should access.</td>
</tr>
<tr>
<td>Services are quite good as they are, but should be better organised so it is clearer who does what.</td>
</tr>
<tr>
<td>CTLD should only continue doing child work if a specialist children’s LD service is set up in collaboration with a primary health care panel.</td>
</tr>
</tbody>
</table>

Interviews with Parents/Relatives:

(1) Views on appropriateness of referral and evaluation of CTLD intervention

For some families, this was their first involvement with the CTLD whereas others had had previous involvement. For the purposes of this study, the parents/relatives were asked to consider the intervention of the named CTLD member who last worked with them.

In terms of their child being referred to the CTLD, 50% and 12.5% of the participants stated being completely or considerably (respectively) involved in this process, whereas the others’ responses ranged from some (12.5%) to little (12.5%) or no
(12.5%) involvement. The majority (87.5%) of participants either completely (50%) or quite (37.5%) agreed with the referral, whilst one (12.5%) were indifferent about it. Also, most (75%) of them thought it was either very (50%) or quite (25%) appropriate for the CTLD, whilst some (25%) were unsure about this.

All the participants were satisfied, to some extent (i.e. 50% ‘very’ and 50% ‘quite’ satisfied), with the outcome of the CTLD intervention. However, only half stated that they believed that the CTLD had provided the best service possible. Some (37.5%) were ‘unsure’ about the quality of the service, because they had nothing to compare it with, and some (25%) specifically stated that they thought the service could have been improved. Their responses are listed in Table 10. (Some responses were given by more than one parent/relative.)

Table 10: Were you satisfied with outcome of CTLD intervention?

<table>
<thead>
<tr>
<th>If yes, why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very supportive, straight and honest with me.</td>
</tr>
<tr>
<td>Has taken time to get to know us, and is great source of support.</td>
</tr>
<tr>
<td>Helped him a lot with his problem and it shows.</td>
</tr>
<tr>
<td>Don’t think they could have done much else.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If unsure, why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>It’s difficult to compare because I don’t know of anyone else that could have helped.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If no, why not?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stopped the work before we felt the problem was completely solved.</td>
</tr>
</tbody>
</table>

(2) Knowledge and experience of other services

When asked about their knowledge of other services their child might have had access to, the parents either did not know of any (50%) or guessed at the social services (25%) or Mencap (25%). None of them would have preferred an alternative service, either because of their lack of knowledge about alternatives (50%) or because they were happy with the CTLD service (50%).
All the parents required prompting with a list of alternative services to think about whether they had used any of them in the past. Table 11 provides a list of other services used and the collective number of times they were used by this particular group of clients. The overall impression of other services used in the past was that they were either very good (37.5%), quite good (37.5%) or quite bad (37.5%).

<table>
<thead>
<tr>
<th>Table 11: Experience of other services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Worker</td>
</tr>
<tr>
<td>Social Services Playschemes</td>
</tr>
<tr>
<td>Social Services Respite Care</td>
</tr>
<tr>
<td>Mencap Playschemes</td>
</tr>
<tr>
<td>Family Link Voluntary Services</td>
</tr>
<tr>
<td>Sleep &amp; Behaviour Clinic</td>
</tr>
<tr>
<td>Speech &amp; Language Therapy</td>
</tr>
<tr>
<td>Occupational Therapy</td>
</tr>
</tbody>
</table>

Whilst half the participants stated that they would use the CTLD in the future for a similar problem, the other half stated they were unsure because they were not very aware of the alternative services available.

**Comparing the two groups:**

The interviews for the two groups of participants overlapped on two questions, that is, whether the participants felt that the referral was appropriate for the CTLD and whether they felt that the CTLD provided the best service possible. Figures 1 and 2 show the range of responses from the two groups on these questions.
Figure 1: ‘Do you think this referral was appropriate for the CTLD?’

Figure 2: ‘Did the CTLD provide the best possible service for this child with this problem?’
DISCUSSION

It seems the CTLD members believe that there are two main reasons why they should be preferred over the generic child services in working with children with learning disabilities, that is, their expertise in learning disabilities and their ability to work in the community.

Most of the team members thought that the referrals were appropriate and the reason for referral was specifically related to the child’s learning disability. This was the team’s informal criteria for accepting child cases. The parents/relative also appear to agree that the referrals were appropriate for the CTLD (although they expressed a lack of awareness of alternative services), and were generally satisfied with the outcome of the CTLD’s intervention.

Possible biases in these results.

There is a major design flaw in this study in that it used closed cases. It was very likely that the team would think the referral was appropriate if they had already accepted and worked on it. Otherwise they would have to justify why they began and continued to work with it. Only one CTLD member did this.

The rationale for using closed cases was that the researcher thought the two groups of participants would be more able to consider the effectiveness of intervention outcome if the work had already been completed. However, in retrospect, it seems the participants could have been asked the same questions about ongoing work, and simply to express their views on the work to date.

Due to the team’s records not distinguishing between active & closed cases it was difficult to obtain a random sample of cases. Therefore the method eventually used meant that the members may have nominated the cases that they thought had been a success.
There were more community nurses in the team sample than other professionals, and referrals of children requiring nursing intervention are more likely to be appropriate for the team. Hence, there may have been a bias towards the finding that referrals were thought to be appropriate.

As parents do not appear to have a good knowledge of services, only limited information could be gained on their views of which service(s) would have been most appropriate for their child’s particular problem.

As noted previously, there was a limited age range among the child cases selected for this study. Due to the sampling limitations, it was difficult to ensure a wider age range. This limitation may have led to a greater likelihood of the cases being judged as appropriate and the intervention not being markedly different to that in adult cases as adolescents may approximate adults more closely. Thus, if younger children were included, the results may have differed.

**Methodological limitations**
The main limitation in this study was the lack of clarity in the epistemology underlying the methodological approach taken. The difficulties in this were partly due to the paucity of existing knowledge in this area which then led to difficulties in asking appropriate questions. An attempt was made to take this into account by holding informal discussions with people within this field, other than the participants in the main study. Unfortunately, this was not done in the form of a focus group which may have generated a richer level of qualitative information.

In retrospect, it may have been more effective to have employed a qualitative methodology for design and analysis instead of taking a quantitative approach. However, because more qualitative information was not sought at time of interview, the responses elicited from participants were not of sufficient depth to carry out a full qualitative analysis either.
Due to the small sample size, the chosen method led to a limited set of data which could not be statistically tested. Although it was difficult to increase the number of participants in the professional group, the parent group could have been increased by asking each professional to consider more than one case and then interviewing the parents of all those children.

Nonetheless, an attempt has been made to present the data in the most coherent manner possible. As a preliminary study, this has served a purpose in generating some useful information, at least within the particular setting in which the research question was generated. This report was presented to the CTLD and its collective feedback is provided in appendix 2.

**Implications of results for this service**

The results of this study seem to indicate that most of the CTLD members and the parents thought that the child cases that were referred to and accepted by the team were appropriately referred and effectively dealt with. These results indicate that there is no reason why the CTLD should not continue to provide this service. However, there is also an indication (based on age range of sample selected) that the child cases which the team work with may predominately be adolescents rather than younger children. This would need to be investigated further, and if it is indeed the case, then perhaps the service needs to consider whether it would be more appropriate to limit the 'child' aspect of their service to adolescents only. This may be an effective way of filling a gap in services for adolescents with learning disabilities as has been identified in the early part of this report.

**Wider service implications**

If, as in many services, the CTLD is primarily to serve adults with learning disabilities and not children, then the relationship between the CTLD and the services which meet the special health care needs of children with learning disabilities need to be clearly expressed to eliminate the chances of parents and children falling between the two
types of services. There need to be strong working networks established between the services to enable the easy transition from child to adult services.

Sines (1985) describes four models for planning at the interface between the community mental handicap team (CMHT), as it was previously called, and the child service. These models are described in tabulated form in Table 12.

In the context of the service in this study and the Child and Family Service with which it is linked, model I is applicable as they have recently come to an agreement about the age of transfer, etc. However, the Trust with which they are about to merge in the near future is operating within model IV. Thus, the operational policies of the new, merged services may need to be re-negotiated.

<table>
<thead>
<tr>
<th>MODEL</th>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. The child service and CTLD remain separate but collaboratively define age of transfer from one to other</td>
<td>Gives family time to adjust to change and get to know members of the CTLD.</td>
<td>Confusion between mental illness and learning disability may need to be explained as family may have difficulty accepting idea of seeing a psychiatrist instead of a paediatrician.</td>
</tr>
<tr>
<td>II. The two services are clearly separate in terms of the age range they serve, but a bridge is created between them in the way of joint appointments to the teams.</td>
<td>Enables parents and children to experience some continuity of personnel.</td>
<td>Difficulties may arise if the two services operate from different philosophical standpoints, e.g. strong medical bias vs. multi-disciplinary approach.</td>
</tr>
<tr>
<td>III. Transfer from one service to other is totally dependent on the particular needs of the family and the child, i.e. needs are mainly physical/paediatric, then remain in child service, but if needs more ‘psychiatric, then transfer to CTLD.</td>
<td>The family and both services need to know the facilities for a wide age range.</td>
<td></td>
</tr>
<tr>
<td>IV. The CTLD is an all-age service and the child-centred services exclude the child with learning disabilities at an early age.</td>
<td>The child is labelled early on irrespective of the presence of other disabilities, and such early labelling is frequently found to be incorrect. It also devalues the child by concentrating attention on the labelled disability and excludes him/her from many facilities which could be beneficial.</td>
<td>Provides a fully continuous service as it requires no major change in personnel as the child becomes an adult.</td>
</tr>
</tbody>
</table>

Table 12: Models for planning at the interface between the CTLD and the child service  (Adapted from: Sines, 1988)
CONCLUSION
The results of this study seem to indicate that most of the CTLD members and the parents believed that the child cases that were referred to and accepted by the team were appropriately referred and effectively dealt with. If they continue with this work, the service needs to state more specifically their criteria for accepting child referrals and the service they will provide.

Recommendations
A further study in this area should take into consideration the difficulties encountered and limitations of this study. In particular, the design should be improved by investigating active cases rather than closed ones and by trying to find a more random sampling procedure for selection of cases, including a wider age range of children. To increase the reliability of views on appropriateness of referrals, it may be better to carry out a prospective, longitudinal study looking at the decisions made in accepting or rejecting referrals as they arise, rather than to ask about referrals which have already been accepted.

To elicit more generisable data, a larger sample of participants should be used. A larger sample would also mean that participants may be less guarded in their responses as their confidence in not being identified, (as is possible in a small sample), would be increased. Perhaps more than one service could be investigated to increase the number of professional participants.

REFERENCES

Mislam;PsychD;2000
Appendix 1a

Interview with CTLD Member

As you know, I am a Clinical Psychology trainee on placement with this team. As part of my training I'm carrying out some research on the team's work with children and what the team and the parents think about this service. For these purposes I would like you to consider me independent of the team, so I would appreciate it if you felt that you can be open with me about your thoughts. Everything you say will remain confidential and your responses will be anonymous. I will eventually feed back to the team the main findings of my research, but not any details about what any individual said.

Demographic information
Name code:
Age range : 18-24; 25-34; 35-44; 45-54; 55+
Profession:
Qualification &/grade:
No. of years since qualification:
How many years have you been working with children?
Are you professionally qualified to work with children?
Is there any particular age of client you cannot or prefer not to work with?

In answering the following questions, I would like you to consider in particular the case we previously agreed upon.

Q1. Why did you take on this referral?

Q2. Do you feel obliged to take on child referrals because other team members do so?

Q2. How appropriate did you think this referral was for this team?

If not approp,
Q2a. Why was this case inappropriate for this team?
Q2b. Which service, if any would have been more appropriate to deal with this child with this problem?
Q2c. What could they offer that you felt your team was unable to?
Q2d. Why did you continue to work on this case if you thought it was inappropriate?

If approp,
Q2e. Why was this case appropriate for this team?
Q3. Was the reason for referral specifically related to the child’s learning disability?
   Very much so   Quite so   Unsure   Not quite so   Not at all so

Q4. Briefly describe your intervention in this case, naming any particular models or tools used

Q5. Which particular skills did you feel you had to make you a suitable person for dealing with this case?

Q6. How, if at all, did you treat this case differently to your adult cases?

Q7. Which, if any issues arose in this case because it was to do with a child as opposed to an adult?

Q8. Did you feel you provided the best service possible for this child with this problem?

Q9. Which other service, if any, may this child have benefited from?

Q10. Do you think this service might have provided a better service for this child?

Q11. You are probably aware of the contractual issues surrounding the provision of services to children with learning disabilities, especially regarding the point of whether they should be viewed as children first and seen by children’s services regardless of the problem or whether they should be seen by learning disability services regardless of their age. In your view, what would be the ideal situation for the provision of services for children with learning disabilities?
Appendix 1b

Interview with Parent

I am a Clinical Psychology trainee on placement with the Community Team for Learning Disabilities at Birches Close. As part of my training I’m carrying out some research on the team’s work with children and what parents think about this service. I am not a member of the team, so I would appreciate it if you felt that you can be open with me about your thoughts. Everything you say to me will remain confidential and your responses will be anonymous. I will eventually feed back to the team the main findings of my research, but not any details about what any individual said, so you cannot be identified by them.

Demographic information
Name code:
Which parent? mother/father
Parent’s occupation & qualifications:
Age of parent: 18-24; 25-34; 35-44; 45-54; 55+
Age of child:
Reason for referral:
Education/ daytime activity of child:
Child’s level of communication: verbal/ sign language/gestures

Now I shall ask you some specific questions about the work that------ (name of team member involved) did with you and your child, and some questions about services in general.

Q1. Why was your child referred to the CTLD?

Q2. How much involvement did you have in this referral being made?

Complete involvement Considerable involve Some involve Little involve No involvement

Q3. How much in agreement were you with this referral?

Completely agreed Quite agreed Indifferent Quite disagreed Completely disagreed

Q4. How appropriate did you think it was for your child to be referred to the CTLD for this particular problem?

Very approp Quite approp Unsure Quite inapprop Very inapprop

If approp, why?
If not approp, why not?

Q5. How did you feel about the outcome of the CTLD member’s intervention with your child in this case?

Very satisfied Quite satisfied Indifferent Quite dissatisfied Very dissatisfied

Mslam;PsychD;2000
Q6. Do you think the CTLD provided the best possible service for your child?  
If yes, why?  
If not, why not?

Q7. Would you tell me of any other service(s) in your knowledge that your child might have had access to?  

Q8. Would you have preferred your child to have been referred to any of these services instead of the CTLD?  

Q9. Have you had any experiences in the past of dealing with the CTLD or any of the child services, for this child or any other child(ren)?  

List of alternative services: (Prompt)

<table>
<thead>
<tr>
<th>Health-related</th>
<th>Social services-related</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polyclinic Assessment Team (all ages)</td>
<td>Day Care</td>
</tr>
<tr>
<td>Child &amp; Family Service*</td>
<td>Practical home help</td>
</tr>
<tr>
<td>Psychology</td>
<td>Respite care (short term)</td>
</tr>
<tr>
<td>Community Paediatrics</td>
<td>Counselling about childcare</td>
</tr>
<tr>
<td>Audiology</td>
<td>Short/long-term accommodation</td>
</tr>
<tr>
<td>Orthoptist</td>
<td>Financial assistance</td>
</tr>
<tr>
<td>Enuresis clinic</td>
<td>Special equipment</td>
</tr>
<tr>
<td>Sleep &amp; Behaviour Clinic* (up to 8yrs)</td>
<td></td>
</tr>
<tr>
<td>Speech &amp; Language Therapy (up to 6yrs)</td>
<td></td>
</tr>
<tr>
<td>Parenting Group (up to 3yrs)</td>
<td></td>
</tr>
<tr>
<td>(*Only take clients with mild/moderate LD, not severe)</td>
<td></td>
</tr>
</tbody>
</table>

Q10. What were your impressions of this(these) experience(s)?  
Very good   Quite good   Indifferent   Quite bad   Very bad

Q11. In the event of a similar problem recurring, where would you like your child to be referred next time?
18th January 2000

Ms Momotaj Islam
Psychologist in Clinical Training
Clinical Psychology Department
University of Surrey
Guildford
Surrey GU2 5XH

Dear Momotaj

Thank you for your letter of 11th January 2000 regarding feedback on your research project. I am sorry that you did not receive my previous reply, perhaps it got lost in the post.

The Team found your research and results informative and helpful. It was particularly welcoming to hear such positive views expressed about our involvement with children. In the near future, discussions will be taking place with the Health Authority to decide where children with learning disabilities should be seen. I shall endeavour to make sure that your information is made available.

Thank you once again.

Yours sincerely,

Dr G M Koheeallee
Clinical Psychologist
Literature Review

Predicting Sexual Recidivism in Sex Offenders: A Review

MOMOTAJ ISLAM
Year 2: July 1999
(1) INTRODUCTION
The literature on sex offenders and sexual offending behaviour spans a number of
different academic fields, including law, criminology and forensic psychiatry and
psychology. In the latter field, there appears to be three inter-related areas of research.
Firstly, there is the estimation of recidivism rates, secondly, the identification of
factors which may predict risk of re-offending behaviour and thirdly, the evaluation of
treatment effects on re-offending behaviour. The aim of this review is to provide an
overview of the literature on recidivism, and the identification and validity of
predictive factors in the assessment of risk of re-offending in sex offenders. Research
findings and a critical evaluation of that research will be provided and current issues
discussed. Treatment issues will be discussed where relevant but will not be the focus
of this review.

1.1 Definitions and Context of Discussion
A sex offence will be defined here as “any sexually motivated assault involving
physical contact with the victim”(Prentky, 1997). However, it should be noted that sex
offences also constitute certain non-contact sex offences (e.g. exhibitionism). Sex
offenders, that is, individuals who have been identified as having carried out illegal
behaviour of this nature, may be incarcerated, hospitalised, or living in the community.
Although there are a small proportion of sex offenders who are female, they are
predominately male, and are usually divided into rapists (i.e. men who assault adult
women over 16 years of age) and child molesters. However, it has also been
acknowledged that some sex offenders assault both adults and children (e.g. Abel &
Rouleau, 1990; Rice et al, 1991)

Sexual victimisation of adults and children is recognised as a serious and widespread
societal problem. One Canadian report (Badgely et al, 1984) stated that 25% of
children and 40% of females had experienced some form of sexual exploitation in their
lifetime. In the U.K., a recent Home Office report stated that over 100,000 individuals
in the population had convictions for sexual offences against children (Marshall,
1997). Such statistical findings indicate that sexual offending is a significant problem,
and one which demands an effective solution at legal, clinical and socio-political levels.

There has been increased recognition that efforts must be made to enhance our knowledge of sex offending behaviour in order to improve the assessment and management of sex offenders and to provide meaningful recommendations to better safeguard vulnerable members of the community. In both the US and the UK there has been a recent upsurge in measures designed to protect the public from sexual offenders (Grubin, 1997). The most recent discussions in the UK relevant to this group of offenders (though not specific to them) is the current Government proposal for the detention of ‘dangerous people with severe personality disorder’ even if they have yet to be convicted for an offence (Home Office, 1999).

One intrinsic difficulty with work in this area is that it is not normally possible to predict the occurrence of the first sexual offence. Hence attention is concentrated on efforts to predict the future likelihood of such behaviour in identified offenders, with the aim of prevention of further offences. Professionals working with sex offenders are often required to carry out risk assessments regarding the level of risk posed by particular individuals or by subgroups of offenders, to inform decisions about sentencing, supervision, treatment, and so on. Such judgements can have major consequences for the offenders concerned as well as for potential future victims. Therefore, empirical knowledge is required to increase efficacy in defining and improving assessment procedures and developing strategies for the treatment and management of known offenders.

(2) STUDIES OF RECIDIVISM IN SEX OFFENDERS

Empirical knowledge in this area has usually been sought via recidivism studies, which usually look back through existing data over a study period to estimate rates of recidivism, however defined. Such studies may also be referred to as follow-up studies in that they aim to identify risk factors for re-offending, by monitoring offenders for several years after release from a correctional institution. Follow-up studies initially assess various characteristics of a group of offenders, such as age or offence history.
and then look for any initial characteristics that differentiate subsequent recidivist from non-recidivists.

2.1 Methodological Issues

Studies aiming to estimate rates of recidivism have been greatly criticised for their methodological variations and diversity (e.g. Furby et al, 1989; Prentky et al, 1997). The variations have been in a number of critical dimensions, including the definition and use of the term 'recidivism', sample selection and the follow-up period. These will be briefly discussed here.

2.1.1 Definitions and criteria for recidivism

The literal definition of the term, 'recidivism' is to "relapse into a previous condition or mode of behaviour" (Gove, P.B; Webster's Dictionary, 1986). However, in forensic psychology research the use of this term is an issue of debate. The various definitions of recidivism that have been used in studies on sex offenders include:

1. Sexual recidivism - the commission of the same type of sex act, or a broader definition would include any type of sex act.
2. Violent recidivism - many sex offenders have a history of previous physical violence. Therefore, recidivism may include the commission by this category of sex offender of another physically aggressive (non-sexual) act. Some studies include sexual acts under the category of violent recidivism.
3. General recidivism - the broadest definition of recidivism is to include all offences, such as non-violent crimes, or broader still, probation or parole violations.

The use of these various conceptualisations of what constitutes recidivism is one of the main reasons for the high variability in recidivism rates reported by these studies (Prentky, 1997).

There is also the issue of the operationalisation of the term 'recidivism', that is, whether recidivism means simply to re-offend whether or not the offender is charged or convicted, or whether recidivism refers to those who are on some official record to show they were arrested or charged, or whether it refers only to those who are re-
convicted. Also, in the case of mentally disordered offenders, recidivism may refer to re-hospitalisation for re-offending. The criteria used for this may be determined by the researchers’ accessibility to certain types of data, and is an important issue when considering the extent of the problem of re-offending.

2.1.2 Sample selection
The populations from which samples for recidivism studies are selected is often dependent on the site of the study and can vary from general criminal populations, to offenders admitted to a maximum security psychiatric hospital (Prentky et al, 1997). Also, some studies fail to describe or differentiate the types of offenders (e.g. child molesters, rapist, etc.) of which their sample is composed. The source and composition of the samples in different studies can affect the recidivism outcomes. For example, factors such as the percentage of the sample with previous sex offence convictions, will differ markedly between a community-based population study and an incarcerated population study (Greenberg, 1998).

2.1.3 Duration of follow-up period
Studies vary widely in their consideration of the at-risk follow-up period, from as short a period as 12 months or less (Miller, 1984) to 5 years to 30 years (e.g. Hanson et al, 1993). Also, within a study’s follow-up period, due to different rates of discharge into the community, offenders may vary in the time they have the opportunity to re-offend (e.g. Hanson et al, 1993).

Such limitations have made the generalisation of results amongst studies extremely difficult, and led researchers to debate the meaningfulness of past research. In the first large review of sex offender recidivism in general, Furby et al (1989) concluded that by examining qualitative patterns across studies, it was possible to observe the following trends: recidivism (not necessarily sexual) increased with follow-up time; there was no indication that clinical treatment reduced risk of recidivism for any type of offender; and there was no indication that recidivism rates varied by subtype of offender. Such findings triggered an upsurge in studies throughout the 1990s looking into these factors.
2.2 *Reported Recidivism Rates and Continuing Issues*

Various researchers have attempted to deal with the methodological problems discussed above and provide more uniform recidivism data by carrying out meta-analytical studies. This procedure allows the results from numerous diverse studies to be combined to form a cohesive overview and provide sufficient statistical power to detect differences of moderate to small sizes. It also allows the comparison of the relative importance of different risk factors by testing the significance of such differences (e.g., Hanson & Bussiere, 1996).

Several meta-analytical studies of recidivism among sex offenders have found more consistent results than had been reported earlier (e.g., Rice et al, 1991; Hanson & Bussiere, 1996). In their meta-analysis of 61 studies from a variety of countries involving over 29,000 convicted sexual offenders followed up on average for 4 or 5 years, Hanson & Bussiere (1996) found a sexual recidivism rate of 13% for child molesters and 19% for rapists. However, they state that these figures should be interpreted with caution as findings were based on different follow-up periods and different measures of recidivism. Nonetheless, these figures compare with general recidivism rates of up to 80% that have been reported in lengthy follow-ups of non-sexual offenders (Hanson et al, 1995).

Prentky et al (1997) improved on the meta-analytic approach with their “methodological analysis”, a study which aimed to “assess some of the sources of variations [as described above] and to estimate their effects” on 136 rapists and 115 child molesters. They concluded that each of these areas of inconsistency had significant effects on recidivism rates and different impacts for rapists and child molesters. They calculated recidivism rates using two comparative methods:

1) the most common method, which is to report the simple proportion (as a percentage) of individuals known to have re-offended during the study period.

2) to report recidivism as a failure rate (FR) and calculated as the proportion of individuals who re-offended using survival analysis.
In studies using the first method, although the study period may be fixed (e.g. 15 years), the actual exposure time (i.e. for opportunity to re-offend) may vary considerably among subjects depending on the time of discharge within that study period. The rationale for using the second method was that failure rate is an estimation which takes into account the time each offender has been in the community and thus had the opportunity to re-offend. Hence, this method should provide more accurate recidivism rates.

Prentky et al analysed recidivism (failure rate) as a function of type of offence (e.g. sexual, victim involved; non-sexual, victim-involved; non-sexual, non-contact); legal disposition of offence (e.g. charge, conviction, or imprisonment); and exposure time (i.e. number of years from discharge, with the opportunity to re-offend). They found that using the first method does indeed lead to underestimation in recidivism rates. Their estimations of recidivism rates (using the FR method) and suggested degrees of underestimation in other studies (using the simple proportion method) are summarised in the table below. (Although they provide estimates for sexual, violent and general recidivism, only the sexual recidivism figures are reported here.)

<table>
<thead>
<tr>
<th>Category of Analysis</th>
<th>Recidivism Rate (FR)</th>
<th>Degree of Underestimation in Other Studies</th>
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<tbody>
<tr>
<td><strong>Type of offence</strong></td>
<td></td>
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<tr>
<td>Rapists: 26% with an average of 4.55 yrs before re-offending</td>
<td>Rapists: approx. 13%</td>
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<tr>
<td>Child molesters: 32% with an average of 3.64 yrs before re-offending</td>
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<tr>
<td><strong>Legal disposition</strong></td>
<td>Rapists: charge rate = 38%; conviction = 24%; incarceration = 19% Child molesters: charge rate = 51%; conviction = 41%; incarceration = 37%</td>
<td>Overall, for both rapists and child molesters: approx. 30 - 40%</td>
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<tr>
<td><strong>Exposure time</strong></td>
<td>Rapists: 9% in yr 1; 2-3% in yrs 2 to 5; 39% by yr 25 Child molesters: 6% in yr 1; 4% in yrs 2 to 3; 2-3% in yrs 4 to 5; 52% by yr 25</td>
<td>If the common follow-up risk period of 5yrs was adopted: 63% of new sexual charges for rapists and 51% for child molesters would have been missed.</td>
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Table 1: Estimated recidivism (FR) rates and suggested underestimations of recidivism
(Adapted from information in Prentky et al, 1997)
These findings support the well known fact that sexual offences are generally under-reported, and that perpetrators of sexual offences are often not reported, charged, or convicted, thus leading to underestimation of actual re-offending rates (Hanson & Bussiere, 1996). Also, such wide variations in findings indicate the need for more methodologically improved research to provide more sound empirical knowledge in this area.

One particular issue that still needs to be addressed is that of the discrepancy between reconviction and re-offending. Grubin (1988) cites Marshall & Barbaree's (1988) study, which made use of various "unofficial records" held by police and other agencies, as the only study to investigate this in detail. In their follow-up of 126 offenders and controls in one of their treatment studies, they detected 2.4 "offenders" for every official conviction. This gives an indication of the level of underestimation in recidivism rates when using reconviction rather than true re-offending in the operationalisation of recidivism.

Although it may seem that the best results of sexual recidivism would be obtained by using the definition of recidivism that strictly only considers arrests, re-convictions or re-hospitalisation due to new acts of sexual violence, Quinsey et al (1998) argue that this is not necessarily the case. They suggest that many offences which appear to be non-sexual violent offences are actually ones with a sexual component or sexual motivation. Also, many sex offenders, especially rapists, do not confine their recidivism offences to clearly sexual crimes. Thus, they suggest that, although overinclusive, the term 'violent recidivism' is likely to capture significantly more sexual re-offending behaviour than the more commonly used 'sexual recidivism' definition, thus leading to more accurate sexual recidivism rates.

(3) FACTORS THAT PREDICT AN INCREASED RISK OF RECIDIVISM
The prediction of human behaviour is always difficult because people and their circumstances change. However, predictable patterns of offending behaviour do exist. Certain characteristics increase the probability that a sex offender will commit further
sexual offences. The research interest in sex offender risk assessment over the past two decades has generated some consistent predictors of sexual recidivism.

Risk factors (or predictors) fall into two categories, static and dynamic. Static predictors are historical or background factors which are regarded as fixed and unchangeable, such as, the gender of the victim; previous sex offences; history of alcoholism. The presence of such a factor is thought to heighten the general probability that the given risk will be realised, but not that the risk criterion is bound to happen (Hollin, 1997). Dynamic predictors, which are potentially changeable may be relatively stable, such as personality characteristics, or acute features which can change rapidly, such as mood or intoxication. These are the critical factors that, when they occur against the background of the static risk factors, increase the likelihood of the potential risk becoming reality for the individual concerned.

3.1 Factors consistently found to predict recidivism

The most recent comprehensive study of predictors of recidivism in sex offenders, carried out by Hanson & Bussiere (1996), was a meta-analysis of 98 studies, half of which were completed between 1989 and 1995, with an average follow-up period of 5 years. They found 472 suggested correlations between a wide variety of characteristics and sexual offence recidivism, but rejected those that were not statistically significant or where the magnitude of the correlation was so small as to be of little practical value. This left only a few identified characteristics which were correlated to a significant level, and which they highlighted as predictors of risk for sexual recidivism in the general sex offender population (including mentally disordered offenders), as shown in table 2 below.

In a previous study, Quinsey et al (1995a) investigated actuarial predictors (discussed later) of sexual recidivism in a maximum security psychiatric hospital population, that is, a population of mentally disordered offenders. They identified a similar range of predictors as listed in table 2.
Demographic:  1. Age (younger more likely )
2. Unmarried

General criminal history:  1. Number of prior offences
2. Admissions to correctional institutions (prison, etc.)

Sexual criminal history:  1. History of prior sexual offences
2. Incest lower risk than others
3. Stranger victims higher risk
4. Sexual preference for children (PPG assessed)
5. Variety of sexual offences higher risk ("deviant sexual preference")

Clinical:  1. Diagnosis of antisocial personality disorder/psychopathy

Table 2: Predictors of recidivism in sex offenders (Hanson & Bussiere, 1996)

As there have been debates over many years about the relationship between mental disorder and crime (e.g. Hodgins, 1993; Monahan, 1993) and mentally disordered offenders are often studied as a separate group, it would be pertinent to briefly describe some of the findings of recidivism in this population. Bonta et al (1998) carried out an extensive meta-analytical review of recidivism in mentally disordered offenders, though this was not specific to sexual offending. They identified four categories of predictor variables for general and violent recidivism (which included sexual recidivism), as shown in table 3 below.

A. Demographic:  1. Age
2. Male
3. Being single

B. General criminal history:  1. Juvenile delinquency
2. Adult criminal history
3. Criminal history (violent & non-violent)
4. Escape history
5. Previous institutional adjustment
6. Index offence: Use of a weapon in the commission of a crime

C. Lifestyle/history:  1. Poor living arrangements
2. Substance abuse (particularly drug abuse)
3. Family dysfunction

D. Clinical:  1. Diagnosis of antisocial personality disorder
2. History of hospital admissions

Table 3: Actuarial predictors of general and violent recidivism in sex offenders (Bonta et al, 1998)
Thus, Bonta et al (1998) found that the major predictors of violent recidivism were the same for mentally disordered offenders as for non-disordered offenders, although they added the lifestyle/history category not included amongst Hanson and Bussiere’s categories, above. From these findings, Hollin (1997) suggests that when investigating mentally disordered offenders a number of factors should be considered, namely; institutional adjustment, level of hospital admission, and the use of weapons, in additional to those considered for the non-disordered offender population.

3.2 Most salient predictors of sexual recidivism
In studies such as those described above, the factors which have consistently been found to be the strongest predictors of sexual recidivism are a history of offending behaviour, deviant sexual arousal and psychopathy. These factors will be discussed in a little more detail.

3.2.1 History of sexual offending
As with violence generally (Monahan, 1995) having a history of a sexual offence is a well-known risk factor for committing another. Marshall (1994), for example, in his follow-up study of almost 13,000 offenders of all types released from prison in England and Wales in 1987, found that men with a history of sexual offences were seven times more likely to be convicted of another sexual offence during the next four years compared with men who did not have such a history, although it should be emphasised that just 7% of those with such a history actually re-offended in this way. Furthermore, the more sexual offences an individual has committed, the higher the risk. Recidivism rates in first time offenders tend to range from 10-21%, but rates are 33-71% amongst men who already have past convictions (Marshall et al, 1999).

Also, it has been shown that those who have committed different types of sexual offences are more likely to re-offend than those who have limited themselves to one sexual offence type (Hanson & Bussiere, 1996).
3.2.2 Psychopathy

It has been demonstrated that certain personality traits and disorders are significant risk factors for repetitive and persistent criminal behaviour (e.g. Widiger & Trull, 1994). In particular, there is a strong association in the empirical research between psychopathy and violence (including sexually aggressive acts), as concluded by various recent reviews (e.g. Hart & Dempster, 1997). As described by Hare (1991), psychopathy is a clinical construct which describes a "constellation of affective, interpersonal and behavioural characteristics ......which is compatible with a propensity to violate many of society's rules and expectations", and hence it is most often linked with offending behaviour. Psychopaths commit a disproportionately greater number of general offences and violent offences than do other offenders (e.g. Hart & Hare, 1996 for review).

In forensic research the most well-validated and widely used measure of psychopathy is the Hare Psychopathy Checklist Revised (PCL-R; Hare, 1991). The two factors it measures are: 'interpersonal and affective traits', and 'socially deviant lifestyle'. In their review of psychopathy and recidivism, Hemphill et al (1998) found that the PCL-R consistently was an important predictor across inmate samples and was consistently among the best predictors of recidivism. Relative risk statistics at one year indicated that psychopaths were approximately three times more likely to re-offend - or four times more likely to violently re-offend - than were non-psychopaths. They also compared the predictive utility of the PCL-R with other predictors of recidivism. The PCL-R routinely made a significant contribution towards predicting recidivism beyond that made by key demographic variables, criminal history, and personality disorder diagnosis (using DSM-IV).

3.2.3 Deviant sexual arousal

The strength of an offender’s deviant sexual interest - or extent of fixation on the deviant sexual object or sexual mode (such as use of force) - has consistently been found to be associated with higher sexual recidivism (Witt et al, 1996). This area of study is referred to as phallometry, which involves the measurement of male sexual
arousal by monitoring changes in penis size while stimuli are presented in a controlled fashion. It has clearly been shown that the combination of high psychopathy and particularly deviant sexual arousal patterns appears to be a very strong predictor for risk of sexual re-offending (Serin et al., 1994).

3.3 Identifying more dynamic predictors

Hanson & Bussiere's (1996) meta-analysis indicated that the factors most strongly associated with sexual recidivism were static or relatively stable variables. Such risk factors are useful and easy to access, but are not very helpful in the aim of reducing re-offending behaviour. As Hanson (1998) states, "offence history can only worsen, and deviant sexual preferences and personality disorders are difficult to change (e.g., Rice et al., 1991)". Thus, more information is needed about dynamic risk factors in the quest for knowledge as to when (in terms of time and place) recidivism might occur or how it might be reduced.

Long term recidivism studies are unlikely to identify changeable risk factors because many years elapse between assessment and recidivism. Therefore, it is suggested that other research designs are needed (Hanson, 1998). Zamble & Quinsey (1997) attempted to identify dynamic predictors by asking offenders about the events and behaviours that preceded their offences, but, of course, this required the honesty and insight of the offenders, which cannot always be relied upon. So, for dynamic predictors to be useful, they need to be observable by others.

In their large-scale study, Hanson & Harris (1998) asked probation and parole officers to observe sexual offending recidivists (n=208) and non-recidivists (n=201). Recidivism was defined by whether, during the period of study, the offenders committed a new sexual offence while under community supervision. The following characteristics were observed in the recidivist:
- having negative social relationships
- having attitudes tolerant of sexual offending
- presenting themselves as not needing to change and unwilling to make sacrifices to avoid
high-risk situations
- poor social controls
- poor self-management strategies
- increased anger and distress one month prior to re-offending
- difficulties coping with supervision, and particularly uncooperative one month prior to re-offending
- lacking motivation in treatment and frequently dropping out

As can be seen, this study identified stable dynamic factors that distinguish recidivist from nonrecidivist, as well as acute dynamic factors that immediately preceded re-offending. However, the main limitation of this study is that the officers were interviewed for reports on the participants after they knew the participant had re-offended, thus their reports may contain some degree of constructive recall bias (Hanson, 1998). Further research is required in this area to confirm these findings and perhaps to identify further clinically relevant dynamic predictors.

3.4 Response to Treatment (a dynamic predictor)

From a clinical perspective, the dynamic predictor of prime interest is the provision of treatment intended to lower the likelihood of recidivism. In cases where treatment is provided for sex offenders, information about response to treatment may be useful in identifying risk for re-offending. The following factors have been associated with lower recidivism:

i) **Completion of treatment** - there is clear evidence that those who drop out of treatment are at higher risk for re-offending than those who complete treatment programmes, whether this be provided in institutions (e.g. Marques et al, 1994) or in the community (e.g. Hall, 1995a).

ii) **Attainment of treatment goals** - it has been suggested that those who actively co-operate with and complete treatment showing definite in-programme progress have lower reconviction rates than those who passively co-operate with treatment and
appear not to make much progress in terms of in-programme goals (e.g. Marques et al, 1994).

iii) **Personality-based risk factors** - research has shown that those sex offenders most likely to re-offend despite involvement in treatment are those who are most psychopathic and most sexually deviant (Serin et al, 1994), who also tend to be the least responsive to treatment.

There is a continuous debate as to the effectiveness of sex offender treatment. In their thorough review of treatment outcome studies, Marshall et al (1999) concluded that some researchers (e.g., Quinsey et al, 1998) had been unfairly pessimistic about the effectiveness of treatment for sex offenders, as the “balance of the evidence weighs in favour of a positive treatment outcome” (p162). Indeed, recent reviews (Marques et al, 1994; Hall, 1995; Hedderman & Sugg, 1996) indicate that well designed treatment programmes - unlike those reviewed by Furby et al (1989) - are reasonably effective. For example, Hall (1995), reported that treatment reduces the average sex offence recidivism rate by about a third (from 27% to 17%).

Marshall et al (1999) point out that “it is unreasonable to expect all treatment programmes, for all sex offenders, to be effective, [especially as such] treatment is still in the early stages of development”. Researchers and clinicians need to gain more knowledge about the range of problems experienced by sex offenders and to determine how to make the most effective use of treatment resources for different types of offenders and for those at different levels of risk to re-offend. Also, treatment programmes need to be tailored to the needs of the individual offender wherever possible. This brings us on to the issue of risk assessment and the defining of groups of offenders according to similar characteristics or levels of risk.
4.1 Approaches To Risk Assessment

Social scientists and mental health professionals tend to define risk assessment as “the process of evaluating individuals to (1) characterise the likelihood they will commit acts of violence (including sexual acts) and (2) develop interventions to manage or reduce that likelihood” (Monahan & Steadman, 1994).

There are generally three decision-making approaches taken: (i) the guided clinical approach; (ii) the pure actuarial approach, and; (iii) the adjusted actuarial approach (Hanson, 1998). The advantages and disadvantages of these approaches will be briefly discussed.

4.1.1 Guided clinical approach

Traditionally, professionals have made unstructured clinical judgements using criteria based on their practical clinical experience. Now, with the advance of evidence-based practice, clinical experts consider a wide range of empirically validated risk factors and then form an overall opinion regarding the offender’s risk for re-offending. This approach has the advantage of being flexible and allowing more idiosyncratic evaluation of individuals. However, it has been criticised on a number of grounds such as low inter-rater reliability, high subjectivity and lack of transparency of the decision-making process (Grove & Meehl, 1996).

4.1.2 Pure actuarial approach

In this approach, evaluators make an ultimate decision according to fixed and explicit rules, based on the information available to them. The offender is evaluated on a limited set of empirically validated predictors and then these variables are combined using a predetermined numerical weighting scale. A number of actuarial scales have been developed for risk prediction purposes (e.g., Quinsey et al, 1995; Prentky et al, 1997). Grubin (1998) describes two models which have been well validated, namely the Rapid Risk Assessment for Sex Offence Recidivism (RRASOR) (Hanson 1997).

The assumed advantage of the actuarial approach is that it improves the consistency and accuracy of risk assessment. In so far as they identify factors that are associated with those men who appear to be at greater risk, actuarial approaches provide a useful starting point to risk assessment in clinical practice. However, actuarial scales are unfortunately often used as an end in themselves (Grubin & Wingate, 1996; Quinsey et al, 1995b), thus leading to a reduction of professional engagement in the process and potentially leading to professionals ignoring factors that may be important but idiosyncratic to the case at hand (Hart, 1998).

4.1.3 Adjusted actuarial approach
This approach begins with an actuarial prediction, but professional evaluators can then decide whether or not they want to adjust this after consideration of potentially important factors that were not included in the actuarial measure (Quinsey, Lalumiere et al., 1995). Within this approach, clinical guidelines have been developed to assist in the decision-making process, for example, Boer et al (1997) provide guidelines for assessing risk for sexual violence. This approach overcomes many of the criticisms individual to the above two approaches. It is systematic and consistent, yet flexible enough to allow for individual differences; it is transparent, yet allows the appropriate use of professional discretion; and it is based on empirical knowledge, yet is practically relevant (Hart, 1998).

4.2 Subgroups of sex offenders and levels of risk
Researchers in this area recognised over a decade ago that to consider sex offenders as a homogenous group, hindered professional understanding of sex offenders by not considering important differences between different types of sex offences and the characteristics of the offenders (e.g. Woods, 1993). Thus, some researchers have been developing clinically meaningful classification systems (e.g. Prentky et al, 1988).
Assumptions about the general level of risk of broad classes of offender are particularly influential. For example, professionals who believe that incest offenders rarely re-offend, may consider an offender presents a low risk even if he has abused three or four of his children (Fisher & Thornton, 1993). As certain personality traits have been shown to be characteristic in certain types of offenders (Prentky et al, 1997), these typological differences need to be incorporated into risk assessments.

Therefore reliable estimates of base rates for recidivism among subgroups of sex offenders are required. However, there is a lack of information on such base rates because, as described earlier. Although a few recidivism studies have distinguished between the types of offenders in their sample, many have not done so.

Actuarial studies which are carried out with the aim of developing risk assessment scales have made some progress in identifying broad risk groups, but again these have been applied to undifferentiated subsamples of sex offenders with widely varying base rates for recidivism.

Grubin (1998) describes the validity studies of the RRASOR and SACJ scales which have identified three groups according to level of risk to re-offend among undifferentiated groups of sex offenders, as follows:
- a lower risk group comprising a third of the sample with a low rate of sexual recovation;
- a high risk group comprising about a quarter of the sample of whom nearly half are reconvicted for sexual offences; and
- a middle risk group of about half the sample amongst whom a quarter are reconvicted.

Grubin concludes that these scales show the potential to accurately distinguish between sex offenders who are of high and low risk of being reconvicted. However, as a large proportion of the samples fell in the middle risk group - with reconviction scales of 20-25% - it is important for these scales to be refined to identify higher risk
sex offenders in the middle risk group. To not do so would be to ignore a considerable number of offenders with the potential to re-offend.

Also, because prior sexual offending is an important predictive factor, those who have committed their first sex offence tend to fall into the lower risk group. However, from a preventative perspective, it is important to know which of these offenders is likely to go on to commit further sexual offences.

(5) SUMMARY AND CONCLUSIONS
In summary, reported rates of sexual recidivism among sex offenders range from 19% to 39% in rapists and 13% to 52% in child molesters. Thus, despite greater consistency in recidivism rates reported in meta-analytical studies of the 1990s there is still high variability in these findings. This indicates the need to address the methodological problems that have been identified so that more accurate and standardised methods of assessing risk of recidivism can be determined.

Currently, there still appears to be a lack of a reliable base rate for recidivism. This is particularly indicated by the Prentky et al (1997) study which reported considerable underestimation in recidivism rates reported thus far, the main cause of which was shown to be the high methodological variability among studies in this area. The use of a consistent definition and operationalisation of recidivism is perhaps the most important issue for consideration in research in this area.

To summarise on risk factors, sexual re-offending is associated with:
- static predictors within the offence history e.g. number and type of offences and victims
- stable dynamic predictors, particularly, psychopathic personality and deviant sexual arousal
- acute dynamic predictors, notably negative emotional states, poor interpersonal skills and poor social support.

In order to aim intervention at reducing the likelihood of future sexual re-offending in sex offenders, more empirical evidence is required to establish common dynamic risk factors for sexual recidivism. Unfortunately, this is not a simple task as these factors
are difficult to measure, due to their frequently changing and often unobservable nature.

The most changeable risk factor is cooperation with treatment. Offenders who reject treatment are at higher risk for re-offending, but it is possible that such offenders might be able to reduce their level of risk by co-operating with a treatment programme (Hanson, 1998). Although the debate over the efficacy of treatment continues, it is important that research in evaluating and developing effective treatment and risk management strategies continues with rigour, as this is perhaps the best hope for reducing sexual recidivism rates.

Finally, although, the research thus far has managed to broadly discriminate among high- and low risk sex offenders, there is a need for further refinement of the risk groups in order to improve the accuracy of the decision-making process that is involved in risk assessment. This can best be achieved by continued research on the critical factors that discriminate subgroups of sex offenders.

REFERENCES


Major Research Project

Are sex offenders with both adult and child victims different from those with adult-only or child-only victims? A comparative study within a Special Hospital population

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Year 3: July 2000
ABSTRACT

It has been recognised in the research literature for some time now that sex offenders are not a homogenous group (e.g. Harry, 1993). Identification of important distinguishing factors between types of sex offences and the characteristics of the offenders have improved the knowledge base in this area. Unfortunately, much of the research thus far has focussed on comparative studies involving adult rapists and child molesters. Although it has been recognised that a proportion of sex offenders offend against both adults and children, very little research has been conducted within this subgroup. Based on recent suggestions that this subgroup may be more dangerous and at higher risk for recidivism (e.g. Rice & Harris), it is imperative that further information is acquired about this type of sex offender.

The setting for this study was Broadmoor Special Hospital, a maximum security psychiatric hospital in England for mentally disordered offenders judged to be dangerous. Within the adult male population, those patients known to have committed a Sex Offence (either as their index offence or at some time in their offence history) were identified. They were then categorised into the following subgroups: Adult Sex Offenders; Child Sex Offenders; and Mixed Sex Offenders, on the basis of whether their victims were aged 16 years or over, below 16yrs, or both, respectively.

The objective of this study was to compare these subgroups on the following variables: psychopathy; personality, social and emotional characteristics; attribution of blame; and history of childhood sexual abuse. The aim was to identify factors which may discriminate the Mixed Sex Offender subgroup from the other two subgroups, based on the hypothesis that this under-researched group is more psychopathic and presents a higher risk for recidivism (e.g. Rice & Harris; Hemphill et al, 1998).

Also, due to the lack of information in the literature on sex offenders in Special Hospitals, characteristics of the sample as a whole were described. In addition, as psychopathy and personality characteristics were the main measure on which the subgroups were compared, the standardised measures used to assess these characteristics were correlated for comparison purposes.

The measures used were: Psychopathy Checklist Revised (PCL-R: Hare, 1991); Millon Clinical Multiaxial Inventory (Millon, 1994); Sex Offender Assessment Pack (Beckett, Beech & Fisher, 1996); Guddjonsson Attribution of Blame Inventory (Guddjonsson & Singh, 1989).

As hypothesised, the Mixed Sex Offenders were found to be more psychopathic than the other two subgroups. Also, the Mixed Sex Offenders could be distinguished across other personality and social/emotional variables, such as compulsive and masochistic traits, emotional loneliness and deficits in perspective taking. The conclusion from this study is that further investigation of Mixed Sex Offenders as a distinct subgroup is warranted due to indications that they are a higher risk group for sexual offending behaviour and sexual and violent recidivism. The clinical implications of these findings in relation to risk assessment, treatment and management of sex offenders are discussed.
1. INTRODUCTION

The aim of this section is to briefly introduce the research literature relating to sex offenders, who are the focus of the present study, as well as to define the terms used here, provide a rationale for this study, and describe the aims and hypotheses.

As the literature on sex offenders is extensive and complex, this account is not definitive and will be specific to the aspects which are relevant to this study. For an initial introduction to the literature on sexual offending and a basic understanding of the context in which research in this area is conducted, the reader is referred to the literature review by the author, 'Predicting Sexual Recidivism in Sex Offenders: A Review' (Islam, 2000). The main conclusion of this literature review was that although the research thus far on sexual recidivism among sex offenders has broadly identified high- and low-risk offenders, there is a need for further refinement of the risk groups. The aim of this is to improve the decision-making process that is involved in risk assessment as well as the procedures for the management and treatment of sex offenders.

Following on from this review, the present study aims to investigate differences among subgroups of sex offenders (based on victim age) in order to identify any features which may distinguish the groups and may have theoretical and clinical implications. There will be a particular focus on the sex offenders who victimise both adults and children as they are an under-researched group and are thought to present a higher risk for recidivism, particularly of a violent nature (e.g. Rice & Harris, 1997; Hemphill et al, 1998), as will be discussed.

Much of the research thus far has been carried out in North America, in various settings and many of the comparative studies on rapists and child molesters did not include mentally disordered populations. Only a few studies have been carried out in Special Hospitals (e.g., Howard, 1990; O'Kane et al, 1996; Coid, 1992). Therefore, gaining a description of a British Special Hospital population of mentally disordered sex offenders, irrespective of the groups defined by victim age, will also be of interest.
1.1 Theoretical Rationale for Investigating Subgroups of Sex Offenders and Definition of Terms

Researchers have long been attempting to classify sex offenders according to various categories such as the nature of their offences or age of their victims (e.g. Shaskan, 1939; Henn et al, 1976; Kalichman, 1991). As highlighted in the above-mentioned review, one significant issue that has emerged in the understanding of sex offenders is that they are not a homogenous group and that there may be important differences between various types of sex offences and the characteristics of the offenders (e.g. Harry et al, 1993; Woods, 1993). This is a salient point for the assessment and treatment of offenders as well as for risk assessment and management, hence the development of typologies of offenders and investigations into the identification of risk groups (e.g. Knight et al, 1985; Prentky et al, 1988; )

Although typologies are still being developed within offender types, there appears to be a consensus among researchers and clinicians for the adult rapist and child sex offender dichotomy which is currently the most widely accepted classification (Bard et al, 1987). Thus, definitions of these subgroups are required for a discussion in this field.

i) Rapist - The Sexual Offences Act (1956) states: “It is an offence for a man to rape a woman or another man...a man commits rape if he has sexual intercourse with a person (whether vaginal or anal) who at the time of the intercourse does not consent to it; and at the time he knows that the person does not consent to the intercourse, or is reckless as to whether that person consents to it”. Legally, the ‘man’ and ‘woman’ in this definition are 16yrs or above.

ii) Child Molester - this a generic term typically used to encompass all individuals who sexually offend against individuals below the age of consent (legally, 16yrs). Hobson et al (1985) defined child molesters as: “individuals who are involved in any sexual contact with victims who, due to age and/or immaturity, are incapable either legally or realistically of giving informed consent. Sexual contact includes any sexual
acts ranging from mutual touching and fondling to actual sexual intercourse, but access to victims is always achieved through pressure, coercion, or deception.” Howitt (1995) argued that the term child molester should be considered a synonym for paedophile. However, the preferred professional term appears to be ‘child sex offender’.

For this study, a sex offence will refer to an offence which either comes under the Sexual Offences Act (1956) or Sex Offenders Act (1997) statutes, or an offence of violence which has been identified as being sexually motivated. Only sex offences which involve contact with a victim have been included here, as the subgroups are based on age(s) of the victim(s) and in the case of non-contact sex offences (eg exhibitionism) the victim, when there is one, is not always specified. Thus the working definition of a sex offence adopted here will be “a sexually motivated assault involving physical contact with the victim” (Prentky, 1997).

As for types of sex offenders, the terms “Adult Sex Offender (abbreviated to Adult SO)”, “Child Sex Offender (Child SO)” and “Mixed Sex Offender (Mixed SO)” will be used. The main reason for the use of these terms as opposed to those described above is to allow for comparison between the groups disregarding the severity of the offence (although this will be recorded for specific comparisons in terms of level of coercion used against sex offence victims). Thus, ‘Adult Sex Offender’ will refer to rapists as well as those with less serious sexual offences against adults and ‘Child Sex offender’ will refer to those with any sexual offence against a child.

An individual will be classified as:

**Adult Sex Offender** - if he is known to have committed a sex offence against an adult victim (of 16yrs or older) with no known sexual offence against children. The knowledge of this offence may be in the form of a conviction (for rape, attempted rape, buggery, indecent assault, incest, etc.) or reliable documentary evidence in a patient’s file, such as admission of an offence recorded by a professional (e.g. psychiatrist; clinical psychologist).
Child Sex Offender - if he is known to have committed a sex offence against a child (under 16yrs) or “immature” adult with learning disabilities (with a mental age below 16yrs) with no known sexual offence against an adult (16yrs or older). The knowledge of this offence may be in the form of a conviction (for gross indecency with a child, unlawful sexual intercourse, prostitution, etc.) or reliable documentary evidence in a patient’s file, such as admission of an offence recorded by a professional (e.g. psychiatrist or clinical psychologist).

Mixed Sex Offender - if he meets the criteria for both ‘adult sex offender’ and ‘child sex offender’, that is, if he has offended against at least one child and one adult.

Rationale for Mixed Sex Offender Category
Although research has conventionally assumed exclusivity of the adult rapist and child sex offender dichotomy, contemporary research has contradicted this. For example, it has been acknowledged that there are some sex offenders who do not select victims based on their age/maturity but, for example, on the immediate availability of the victim (Bard et al, 1987). Rice, Quinsey and Harris (1991) showed that 26% of incarcerated child sex offenders had previously committed sex offences against adults, and that 10% committed sex offences against adults following their release. Abel et al (1987) showed that 16% of non-incarcerated men, who had admitted to a sexual offence, had exclusively victimised adults, 46% had exclusively victimised children and 27% had sexually victimised both adults and children.

It was also previously assumed that sex offenders tended to exhibit only one specific type of sexually deviant behaviour, but again indications are that sex offenders commonly exhibit multiple types of sexually deviant behaviour (e.g. Abel & Rouleau, 1990). The term ‘polymorphic’ sex offenders has sometimes been used in the literature (e.g. Abel et al, 1987; Porporino & Motuik, 1991), but this would be misleading to use here as it refers to individuals with a variety of different types of sexual offences and not necessarily with victims of different ages.
1.2 Review of Research Literature on Rapists and Child Molesters

There have been numerous comparative studies on rapists of adults and child molesters (e.g. Serin et al, 1994; Marshall et al, 1995; Bumby & Hansen, 1997) which have suggested differences between these two subgroups of sex offenders. Amongst the variables across which the two groups have been compared are: levels of psychopathy; personality characteristics; attributional style, personal history (including childhood abuse) and offence characteristics. Some of the variables and the consistent findings regarding rapists and child molesters are discussed here.

1.2.1 Psychopathy

The concept of psychopathy was first introduced by Phillippe Pineal at the end of the 18th century (Stone, 1993). However, it was Cleckley's work described in 'The Mask of Sanity' (1941; 1982) which was most influential in the development of the concept as it is viewed today. Cleckley described psychopathy as a "distinct clinical entity characterised by deficiencies in emotional reactivity and concern for others" and defined 16 characteristics of psychopathy as an aid to identification and diagnosis (Cited in Blackburn, 1989).

Hare (1979) developed Cleckley's concept further and created the Psychopathy Checklist (PCL), an instrument to measure psychopathy, which was later refined as the Psychopathy Checklist - Revised (PCL-R; Hare et al, 1990; Hare, 1991). As described by Hare (1998), psychopathy is a clinical construct which describes a “constellation of affective, interpersonal and behavioural characteristics”. Affectively, psychopaths lack empathy, are callous and experience neither guilt nor remorse. Interpersonally, they are dominant, forceful, grandiose and manipulative. Behaviourally, they are impulsive and sensation-seeking. They have a propensity to violate social norms and engage in antisocial and criminal behaviour.

Serin et al (1994) found that rapists had significantly higher ratings for psychopathic tendencies (as measured by the PCL-R) than did child molesters. Harry et al, (1993) also claim that rapists have more psychopathic characteristics than sex offenders who offend
against young children or adolescents. It has been shown that a high score on the PCL-R is indicative of worse prognosis in treatment (Hare, 1998). Rapists have been shown to have worse prognosis in treatment and higher rates of violent recidivism than child molesters (Beckett et al, 1996). Thus, the indications are that rapists have more psychopathic tendencies and are more difficult to treat than are child molesters.

Psychopathy and recidivism

In their recent meta-analytical review of psychopathy and recidivism, Hemphill et al (1998) concluded that within a year of release from incarceration, general recidivism was three times higher and violent recidivism was four times higher amongst psychopathic offenders (not necessarily sex offenders) than amongst non-psychopathic offenders, as measured by the PCL-R. However, as discussed in detail in the review by the current author (Islam, 2000) there were limitations and methodological inconsistencies (e.g. in definitions of ‘recidivism’ and sampling criteria) amongst the recidivism studies. Therefore, further research with specific populations of offenders taking into account the limitations of previous studies is required.

Psychopathy and mental disorder

Research has also been conducted to investigate the association between psychopathy and other mental disorders. It has been shown that the psychometric properties of the PCL-R are as relevant to forensic psychiatric populations as they are to general prison populations (Harris et al, 1991). In their sample of offenders from a forensic psychiatric hospital, Hart & Hare (1989) assessed psychopathy with the PCL-R and diagnosed other mental disorders according to the Diagnostic and Statistical Manual for Mental Disorders (DSM-III) Axis I and II criteria (APA, 1980). They found that PCL-R scores were not correlated with Axis I ratings (e.g. schizophrenia), but were correlated with several Axis II ratings: positively with histrionic, narcissistic and antisocial personality disorder, and negatively with avoidance personality disorder. They concluded that psychopaths were significantly less likely to have a concurrent Axis I disorder and significantly more likely to have an Axis II disorder, particularly, antisocial personality disorder.
Other studies have replicated and extended these findings (e.g. Hart et al, 1991; Hart et al 1992). Hart et al (1991) found that the PCL-R correlated with six of the 13 personality disorder scales of the Millon Clinical Multiaxial Inventory (MCMI-II; Millon, 1987), namely, Narcissistic, Antisocial, Sadistic, Passive-Aggressive, Borderline, and Paranoid. These correlations and the significance levels are provided in appendix 1. However, as can be seen, their correlations were not at very high levels, ranging from .28 to .45. Therefore, further investigations are needed to replicate these findings before conclusions can be drawn about the relationship between the PCL-R and MCMI Personality Disorder Scales. Also, much of the research has been based on violent offenders, not necessarily including sex offenders. Therefore, further research is needed to elaborate on these findings with a more specific focus on sex offender populations.

Focussing on Hart et al’s (1991) finding of an association between psychopathy (as measured by the PCL-R) and Sadistic personality disorder (as measured by the MCMI-II), Holt et al (1999) have recently further investigated this link. They divided their sample of offenders in a maximum security prison into those who had committed ‘violent’ offences and those who had committed ‘sexually violent’ offences. They found psychopaths to be significantly more sadistic than nonpsychopaths, thus providing further empirical validity for the theoretically proposed and clinically observed relationship between sadistic traits and psychopathic personality.

Their hypothesis that sexually violent psychopaths would obtain higher Sadism scores than the generally violent psychopaths was, however, not supported. They suggest that this finding is consistent with the view that “sexualisation of violence is merely opportunistic and situational among most violent offenders, unrelated to the severity of their endogenous sadism” (Holt et al, 1999). However, an important limitation of their study was that their definitions of ‘violent’ and ‘sexually violent’ offenders were not clear and might have led to their groups not being entirely independent. Therefore, further investigation is needed to determine whether sexually violent offenders are any more sadistic in nature than are generally violent offenders.
Psychopathy and cross-cultural differences

Much of the research on psychopathy has been based on North-American samples and as the sample in this study is an English one, it is pertinent here to discuss cross-cultural differences in psychopathy as measured by the PCL-R.

It has been found that there is a significantly lower prevalence of psychopathy in European prison and secure hospital samples compared to North American ones, as reported by Cooke (1998) in his comparison of data from numerous European studies. In his sample of adult male prisoners in Scotland, Cooke (1995a), found the prevalence rates to be 3% for diagnostic levels of psychopathy, compared to the mean prevalence rate of 28% reported by Hare (1991) from his North American samples. Differences in prevalence rates and the argument for applying different diagnostic cut-off scores for psychopathy for different cultures are discussed in detail later (section 2.4.1) when the PCL-R is described, as it will be clearer then.

Cooke (1998) has considered three possible explanations for the lower rates of psychopathy observed in the Scottish sample when compared to North American samples. Firstly, he suggests that Scottish researchers were measuring different constructs as compared with North American researchers. Secondly, Cooke suggests that Scottish raters are under-rating PCL-R items as compared with their North American counterparts. Thirdly, he proposes that a genuine cross-cultural difference in the rate of psychopathy exists. From his in-depth analyses, he found that “item ratings obtained from the Scottish sample load on the same theoretical constructs as item ratings obtained in the North American sample”, and also that “the under-rating hypothesis does not explain the observed differences in mean PCL-R scores”. Thus, he concluded that the likely reason for the observed differences in rates of psychopathy is that there is a cross-cultural difference resulting in the lower prevalence rate of psychopathy in the Scottish sample.

Cooke proposes that there are cross-cultural differences in the presentation and expression of psychopathic traits. He suggests that compared to his North American
counterpart, in a Scottish prison inmate, the underlying psychopathic traits need to be stronger before many of the characteristics of the disorder (e.g. 'glibness/superficial charm) will become apparent. One explanation given for this is that Scottish culture may inhibit the expression of some psychopathic traits (e.g. a grossly inflated view of one's own abilities and self-worth) whereas the North American culture may not.

Another of Cooke's (1998) broad explanations for the low prevalence rate of psychopathy in Scottish prisons is the impact of migration. He suggests that there are fewer psychopaths in Scottish prisons because they tend to migrate to England. He supports this argument with his own clinical anecdotal evidence that "many of the more serious Scottish prisoners move to England at some stage during their criminal careers" and with citations of other research proposing this idea (e.g. Westermeyer, 1987; Mealey, 1995).

As Cooke is the main proponent of ideas about cross-cultural differences and there has been little other research in this area, there is currently a lack of empirical evidence to substantiate these possibilities. It might be expected that, due to their closer cultural links, the presentation of psychopathy in an English sample would be more similar to that of the Scottish sample than to that of the North American samples. However, according to Cooke’s migration argument, the prevalence rates within an English sample should be higher than within a Scottish sample. Such issues require further investigation.

Psychopathy and the Mental Health Act

The 1983 Mental Health Act (MHA) for England and Wales places mentally disordered offenders into one of three categories: mental illness (MI); psychopathic disorder (PD); mental illness and psychopathic disorder (MI/PD). The MHA defines 'psychopathic disorder' as a 'persistent disorder or disability of mind...which results in abnormally aggressive or seriously irresponsible conduct' (Cited in Jones et al, 1998). It should be noted that, in Britain, the label 'psychopathic disorder' is often used interchangeably with 'personality disorder'. However, this is misleading because personality dysfunction is not confined to 'psychopathic disorder' patients, and many
in the ‘mental illness’ category also have comorbid personality disorders (Blackburn, 1998).

Another point of potential confusion is that those in the MHA ‘psychopathic disorder’ category are not necessarily psychopathic. In a sample of 243 patients in English Special Hospitals detained under the MHA category of ‘psychopathic disorder’, Coid (1992) found that less than a quarter (21%) met PCL criteria for psychopathy, and only 38% met DSM-III criteria for antisocial personality disorder. However, although these patients are not all psychopaths according to the Hare concept currently in use, they are often described indiscriminately as “psychopaths” (Blackburn, 1998). Such findings point to the need for independently identifying psychopathic mentally disordered offenders with a robust measure of psychopathy, such as the PCL-R, rather than relying on the MHA category to which they have been allocated, if such individuals are to be better understood and appropriately treated.

1.2.2 Personality characteristics
Researchers have long been investigating the personality characteristics of sex offenders with the aim of identifying features that might distinguish them from non-offenders or other types of offenders (e.g. Shaskan, 1939; Bard et al, 1987). From their analysis of the MCMI-II (Millon, 1987) profiles of 603 recently convicted violent offenders, Chantry & Craig (1994a) found that both rapists and child molesters were more passive-aggressive than non-sex offenders, but child molesters were more dependent, anxious and depressed. In a further, similar study (Chantry & Craig, 1994b) they concluded that whilst the personality styles of sexual offenders are heterogeneous, the styles of dependent and narcissistic-antisocial are more prevalent within this population.

Amongst the violent mentally disordered population a considerable proportion have been considered to have concurrent personality disorders (e.g. Krakowski et al, 1986). Also, in their review of the literature, Litwack and Schlesinger (1987) suggested that “repetitive violence is more likely to stem from relatively enduring personality traits than from momentary crises of other difficult to predict events”. Such literature points
to the relevance of investigating personality characteristics among this population of offenders.

As for social and emotional characteristics, rapists are found to be more socially confident and assertive, less anxious, and more aggressive than child molesters (Marshall et al., 1995). Also, both groups have been shown to have greater overall intimacy deficits than non-sex offenders, reporting more emotional loneliness and overall loneliness (Bumby & Hansen, 1997). Child molesters are found to be more lonely and more lacking in intimacy than rapists (Garlick, et al., 1996).

There have been suggestions that intimacy deficits and emotional loneliness in adulthood arise as a result of poor-quality attachment to parents in childhood (e.g. Woods et al., 1995). As will be discussed next, sex offenders are found to have higher rates of childhood abuse experiences in their personal history. Bumby and Hanson (1997) suggest that these experiences of abuse may be associated with poor-quality attachments and subsequent interpersonal problems in adulthood. However, it needs to be considered whether the interpersonal difficulties such as emotional loneliness observed in sex offenders are pre-existing factors or a result of being identified and subsequently incarcerated for their sexual offending behaviour. This is a difficult issue to resolve empirically because it would require the use of retrospective reports from sex offenders about their levels of loneliness prior to their first sex offence, and such retrospective methodologies are considered unreliable (Henry et al., 1994).

1.2.3 History of childhood abuse and family violence

Several studies have indicated a relationship between childhood abuse and later aggressive and criminal behaviour (e.g. Luntz & Widom, 1994; Widom, 1991) including sexual offending behaviour (e.g. Benoit & Kennedy, 1992; Widom & Ames, 1994). There is also evidence that the experience of a violent family environment and the witnessing of parental violence may be linked to later aggressive behaviour among sex offenders (Marshall & Barbaree, 1990).
Sex offenders have consistently been shown to have a higher than average probability of having been victims of sexual, physical and emotional abuse during their childhood (e.g. Morrison et al, 1990; Waterhouse et al, 1994). Haapasalo and Kankkonen (1997) found that compared to violent (non-sex) offenders, sex offenders appear to come from more abusive childhood family environments. Within the sex offender population, child molesters tend to have a higher rate of experiencing childhood sexual abuse than do rapists. In their review of the research literature in this area, Watkins & Bentovim (1992) found 57% of child molesters and 23% of rapists had been sexually abused in childhood. Bumby & Hansen (1997) estimated figures of approximately 45% for child molesters and 19% for rapists. In terms of the experience of childhood physical abuse, Bumby & Hansen (1997) have reported rates of 78% amongst rapists and 39% amongst child molesters.

One of the explanations that has frequently been put forward for the proposed link between a history of childhood abuse and later aggressive and/or offending behaviour is the modelling of inappropriate conflict resolution (Klassen & O' Connor, 1994). For example, if a child frequently witnesses the use of violence to solve problems he may learn that strategy for conflict resolution in adulthood. Also, there is a 'cycle of abuse' model which proposes that child victims of abuse go on to become adult perpetrators of abuse (e.g. Doumas et al, 1994). However, it should be noted, of course, that although individuals victimised as children may have a higher likelihood of becoming perpetrators of violence, it has been shown that the majority do not become perpetrators (e.g. Widom, 1989).

1.2.4 Offence characteristics

When offending behaviour is considered, it appears that rapists have consistently been found to have committed a broader range of offences, including more violent offences, whereas child molesters have committed a lower rate of other violent offences (e.g. Harry et al, 1993). From their 13-year longitudinal study on sex offenders, Curtin & Niveau (1998) report that rapists use violence more often than child molesters, the rates being 86% and 45% (p=0.005) respectively.
1.2.5 Attribution of blame

"Attribution deals with the processes by which individuals attempt to construct causal explanations for their behaviour and the behaviour of others" (Gudjonsson & Singh, 1989).

Snyder (1976) proposed that there are two types of attributions that seem particularly relevant to criminal behaviour, that is, ‘internal vs. external’ and ‘perceived freedom to act’. Based on this idea, Gudjonsson (1984) developed a Blame Attribution Inventory to evaluate how offenders attribute blame for their criminal acts. This consisted of three independent factors: 

- external attribution (i.e. blaming the crime on social circumstances, victims or society);
- mental element attribution (i.e. placing responsibility for the crime on mental illness or poor self-control), and
- guilt feeling attribution (i.e. feelings of regret or remorse concerning the offence).

Gudjonsson & Petursson (1991) found that there were significant differences in attributional style between offender groups. Compared to other types of offender, they found that sex offenders and “those who had committed acts of interpersonal violence” reported most guilt feelings about their offence and attributed cause for their offence more to mental factors (e.g. loss of control). Also, it has been consistently been found that rapists tend to attribute their offending behaviour to external, stable causes, whereas child molesters tend to attribute their offending behaviour to internal, stable causes (McKay et al., 1996; Garlick et al., 1997). Child molesters also appear to report more guilt feeling attributions (Blumenthal et al., 1999).

1.3 Review of Research Literature on Mixed Offenders

To date, there appear to be few published studies which have directly investigated sex offenders with both adult and child victims. Some researchers deliberately exclude them from their comparative studies on child molesters and rapists in order to prevent confounding variables (e.g. Bard et al., 1987).

Although several studies have identified that a proportion (approximately 26-27%) of sex offenders offend against both adults and children (e.g. Rice et al., 1991), during a
thorough literature search, only one study was found which provided detailed
descriptions of the mixed offenders in its sample. This study, by Rice & Harris (1997),
was based at an American maximum security psychiatric institution, and was
conducted with an aim to validate and extend the 'Violence Risk Appraisal Guide', an
actuarial risk assessment tool. Their sample consisted of 142 child molesters, 88
rapists and 58 mixed offenders. By coding personal history variables during childhood
and adulthood and offence characteristics, they found mixed offenders to be the most
dangerous of all sex offenders due to their higher levels of violent recidivism &
agression and severity of injuries inflicted on their victims.

Rice & Harris (1997) also compared the sex offenders on PCL-R scores and found the
mixed offender group to be significantly more psychopathic (P<0.001), with a total
PCL-R score (group mean) of 21.5 (SD = 8.1) compared to the rapists’ group mean
total score of 18.8 (SD = 9.0) and the child molesters group mean total score of 13.4
(SD = 6.9).

In the U.K., a preliminary study at Broadmoor Special Hospital, a maximum security
psychiatric institute, supported the view that a distinctive subgroup of sex offenders
who sexually abuse both adults and children can be identified, and 12 were identified
in this setting (Elliot, 1998). Another report on this population (Perkins et al, 1998)
stated that one of the characteristics of the highest risk sex offenders is “diverse sexual
offending, i.e. different victim ages, gender, relationships, locations”. This appears to
include the ‘mixed offender’ group of sex offenders identified at the Hospital.

In summary, it appears that the mixed offender subgroup has been neglected in this
area of research. As initial findings seem to suggest that they are a higher risk group,
much more extensive research is needed in order to gain a better understanding of the
nature of the offences and psychosocial characteristics of this group, and if indeed they
are distinctively different from other groups of sex offenders.
1.4. Aims and Objectives of This Study

The aim of this study is to investigate the existing research findings on sex offenders in a mentally disordered population, with a particular focus on identifying the levels of psychopathic tendencies and personality traits of Mixed SOs. As Mixed SOs are an under-researched group, the hypotheses relating to them are essentially exploratory. The findings of this study are expected to make a useful contribution to the approaches taken in the clinical assessment and treatment of the patients at Broadmoor Hospital, from which this sample is derived.

The aims are:

1. To identify three subgroups of sex offenders based upon victim age, in a sample of adult male maximum security psychiatric hospital patients.

2. To compare the three subgroups on the following variables:
   i.) Psychopathy - that is, the existence of and levels of psychopathic tendencies
   ii) Personality, social and emotional characteristics
   iii) History of childhood sexual abuse
   iv) Characteristics of sexual offences
   v) Attribution of blame characteristics

3. To identify factors which may discriminate the Mixed SO group from the other two groups along the above variables

4. Taking the sample as a whole, to correlate scores on the standardised measures to identify any relationships between the variables that they measure.

1.5 Main Hypotheses

1.5.1. Psychopathy: Taking the above-mentioned findings into consideration, it is hypothesised that if the PCL-R profiles of Adult SOs and Child SOs are compared, Adult SOs should have higher mean total PCL-R scores (Serin et al, 1994). As for
Mixed SOs, the nature of their offending behaviour indicates a lack of selectivity or discrimination of victims and so it might be expected that they would be more psychopathic and therefore score higher on the PCL-R than Child SOs. Therefore, Child SOs are hypothesised to have the lowest PCL-R ratings and Mixed SOs the highest PCL-R ratings (Harry et al, 1993; Rice and Harris, 1997).

1.5.2 Personality, social & emotional characteristics: The sample as a whole is hypothesised to show some level of dependent and narcissistic personality characteristics (Chantry & Craig, 1994a). Child SOs are hypothesised to show lower self-esteem, more lack of assertiveness (Marshall et al, 1996) and more emotional loneliness, whereas Adult SOs and Mixed SOs are hypothesised to be more assertive and more aggressive than Child SOs (Bumby & Hansen, 1997).

1.5.3 Childhood abuse: All three groups are expected to have some experience of childhood abuse in their personal history. (The categories of abuse recorded is described later, in section 2.4.6). Child SOs are hypothesised to report a higher incidence of experiencing childhood sexual abuse compared to Adult SOs (Curtin & Niveau, 1998). As sexual abuse against children is linked to childhood sexual abuse, and Mixed SOs include children among their victims, it is hypothesised that they will have experienced similar rates of childhood sexual abuse as Child SOs.

Comparative investigations will also be made on the rates of childhood experiences of physical abuse and the witnessing of domestic violence as there are indications in the research literature that rapists have higher rates of such experiences than do child sex abusers.

1.5.4 Offence characteristics: Adult SOs and Mixed SOs are expected to have committed more violent offences, inflicting more victim injury (Rice & Harris, 1997).

1.5.5 Attribution of blame: Based on consistent findings in this area, it is hypothesised that Adult SOs will attribute their offending behaviour to external causes and Child SOs will attribute their offending behaviour to internal causes (Garlick et
al, 1997). There is no directional hypothesis for Mixed SOs on this variable as there are no indications in the existing literature - thus the investigation in this area will be more exploratory.

1.5.6 **Relationships between the measures:** It is hypothesised that some of the following personality disorders identified by the MCMI-III will be significantly correlated with the PCL-R ratings; Narcissistic, Antisocial, Sadistic, Passive-Aggressive, Borderline; and Paranoid. The rationale for this is elaborated upon in section 2.3 (Materials/Measures). As the BAI and the SOAP are not as well studied and validated as the PCL-R and MCMI-III, the correlations with these two measures are exploratory.

2. **METHOD**

2.1 **Setting**
This study was carried out at Broadmoor Special Hospital, which is the oldest of the three Special Hospitals in England and provides for patients who require treatment in conditions of maximum security. Patients are admitted under a Section of the Mental Health Act (1983), when their behaviour or mental state poses a significant danger to themselves or the general public. The majority of admissions to Broadmoor Special Hospital result from offending behaviour, but some patients are admitted when their behaviour has become unmanageable in facilities of lesser security.

2.2 **Sampling criteria**

2.2.1 **Inclusion criteria:**
Adult male individuals known to have committed a Sex Offence (either as their index offence or at some time in their offence history), were categorised as follows:
Adult SOs - with victim/s of 16yrs & over
Child SOs - with victim/s of under 16yrs
Mixed SOs - with both adults and children as victims
2.2.2 Exclusion criteria:
1. An adverse Responsible Medical Officer (RMO) or clinical team opinion concerning a patient’s participation (e.g. participation posing a potential hazard to the patient’s mental health status).
2. Current florid psychosis
3. Acute suicidal ideation

Female sex offenders were also excluded from this study because they were too few in number to form separate groups for comparison with the male groups. Only one female patient at Broadmoor Hospital was identified as having a conviction of a sexual offence, against a child. Anecdotal evidence from clinical psychologists at Broadmoor Hospital suggests that there are no more than about 10 female patients who have admitted committing a sexual offence.

2.3 Identification of sex offenders and allocation to subgroups
The final sample of participants for this study consisted of 61 male patients. The procedure in identifying potential participants is described later. However, since not all participants in this sample have the same amount of data, a brief outline is given here of how this final sample size was achieved.

Initially, a total of 90 male adult patients had been identified as meeting the criterion of either currently holding or previously having held a conviction for a sex-offence or sexually-motivated offence of murder or manslaughter, as defined by Home Office legislation. However, of these, 22 were excluded for the following reasons: 10 were actively psychotic for the duration of the study; 4 had a serious physical illness; 1 was undergoing serious personal problems; and 7 were on trial leave for the duration of the study.

Thus the remaining 68 patients were approached for participation in the study. Of these, 49 (72%) consented to participate. However, 4 patients who initially agreed to participate subsequently changed their mind, although 3 of them had completed one or two of the questionnaires and only 1 returned the whole set of questionnaires
uncompleted. This resulted in 45 patients for whom there was a complete set of data, giving a final a response rate of 66% (i.e. 45/68).

However, in addition to these 45 patients, 16 others from the original sample (who had refused to complete the questionnaires) were identified for whom PCL-R ratings already existed (from a previous research study, as discussed in Section 2.4.6). Thus, demographic information was also obtained for these patients from their files with the consent of the RMOs. Thus for PCL-Rs and demographic information, the sample size was 61, that is, 68% of the 90 sex offenders originally identified.

When divided into the three subgroups, the group sizes were as follows:

<table>
<thead>
<tr>
<th></th>
<th>Full set of data</th>
<th>Additional PCL-R/ demog/history data</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult SOs</strong> (with victim/s of 16yrs &amp; above)</td>
<td>25</td>
<td>9</td>
<td>34</td>
</tr>
<tr>
<td><strong>Child SOs</strong> (with victim/s of under 16yrs)</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td><strong>Mixed SOs</strong> (with adult/s and child/ren as victims)</td>
<td>11</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td><strong>Total:</strong></td>
<td></td>
<td><strong>61</strong></td>
</tr>
</tbody>
</table>

Basic demographic and offence-related data for the patients who refused to participate in this study is provided in appendix 2. As will be seen, they were not characteristically different from those who did participate.

2.4 Materials/Measures

This section will consist of descriptions of the standardised measures used in this study, the rationale for their use and other issues regarding the measures which are specifically relevant to this study.

2.4.1 Psychopathy Checklist Revised (PCL-R: Hare, 1991)

The PCL-R is a 20-item rating scale which measures both personality traits and behaviours which represent the extent to which the given individual is judged to match the “prototypical psychopath”. Brief descriptions of each of the PCL-R items are given
in Appendix 3. It has consistently been shown to be psychometrically valid and reliable (e.g., Hart et al, 1992), is widely used and considered the best validated procedure for assessing psychopathy in forensic populations (Hare & Hart, 1993; Stone, 1995). Hart et al (1992) reported that the internal consistency (alpha) for the PCL-R was .87 and the inter-rater reliability (intraclass correlation) was .83 for single ratings and .91 for the average of two ratings.

Although the PCL-R was initially developed and validated for use with white adult male general offenders, there is good research evidence to indicate that the psychometric properties generalise to other specific populations, including sex offenders (Cooke et al, 1996) and British male forensic populations (e.g., Hobson & Shine, 1998) although there have been shown to be some cultural variations in PCL-R total scores (Cooke, 1998), as will be discussed.

The 20 items can also be divided into 2 factors which are distinct but correlated by a coefficient of 0.5 (Hart & Hare, 1997). They are described as follows:

Factor 1: ‘interpersonal and affective traits’. This factor reflects the individual’s ability to relate to others, and general emotional expression and “represents a selfish, callous, and remorseless use of others” (Hare, 1998).

Factor 2: ‘socially deviant lifestyle’. This factor reflects behavioural characteristics and represents a “chronically unstable and antisocial lifestyle” (Hare, 1998).

Table 1 lists the 20 items of the PCL-R and indicates which factors the items are loaded onto. Several of the items do not load onto either of the factors, namely, ‘promiscuous sexual behaviour’, ‘many short-term marital problems’ and ‘criminal versatility’. The PCL-R Manual (Hare, 1991) provides detailed descriptions of what the items are measuring and how to obtain this information.
Table 1: PCL-R Items and their Factor Loadings (From Hare, 1991)

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Factor (F1)</th>
<th>Factor (F2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glibness/Superficial Charm (F1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandiose Sense of Self-Worth (F1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need for Stimulation/Proneness to Boredom (F2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathological lying (F1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conning/Manipulative (F1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of Remorse/Guilt (F1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shallow Affect (F1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Callous/Lack of Empathy (F1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parasitic Lifestyle (F2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Behavioural Controls (F2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promiscuous Sexual Behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Behavioural Problems (F2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of Realistic Long-Term Goals (F2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impulsivity (F2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irresponsibility (F2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to Accept Responsibility for Own Actions (F1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Many Short Term Marital Relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juvenile Delinquency (F2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revocation of Conditional Release (F2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

F1 = loads on Factor 1 (i.e. these factors constitute the factor described as 'interpersonal and affective traits')
F2 = loads on Factor 2 (i.e. these factors constitute the factor described as 'socially deviant lifestyle')

The rating is based on a semi-structured interview and the gathering of file-information to be carried out by a trained rater. The PCL-R can be scored on the basis of file information alone provided that the material in the files is extensive and detailed (Hare, 1998). For research purposes, this has been found to be a valid method (Wong, 1988; Grann et al, 1998; Hare, 1998).

The manual provides explicit criteria for scoring each item on the PCL-R on a 3-point scale: ‘0’ indicating that the individual shows no sign of the trait/behaviour; ‘1’ indicating that the individual shows the trait/behaviour to some degree, and; ‘2’ indicating that the individual strongly shows that trait/behaviour. Thus the total score can range from 0 to 40.

The PCL-R also gives Factor scores (the maximum score for Factor 1 is 16 and for Factor 2 is 18) which can be used to interpret the individual’s presentation on the two main aspects of psychopathy that the two factors represent. Individual item scores may also be useful for further investigation into the presentation of psychopathic traits, that is, to see whether the individual’s scores are heavily loaded on any particular traits that make up the construct.
Hare (1991) stated that a cut-off score of 30 for the PCL-R total score should be used for a ‘diagnosis’ of psychopathy, and that individuals with a score in the range of 20 to 29 may be considered as having ‘moderate’ levels of psychopathy, whilst those scoring below 20 are regarded as ‘non-psychopathic’. In his standardisation sample of North America prisoners, Hare found the mean total PCL-R score to be 23.6 (SD = 7.9) and in forensic patients he found it to be 20.6 (SD=7.8). Also, in his data from a variety of North American adult male prisoner samples, he showed the prevalence rate of psychopathy in this population was 28.4% with approximately 43% of prisoners falling in the ‘moderate’ psychopathy group (Hare, 1991)

Cross-cultural differences and the development of a British cut-off score
Hare’s cut-off scores are based on North-American samples. It has been found that there is a significantly lower prevalence of psychopathy in European prison and secure hospital samples, as reported by Cooke (1998). Using Hare’s original cut-off score of 30, Cooke (1995a), in his sample of adult male prisoners in Scotland, found the prevalence rates to be 3% for diagnostic levels of psychopathy, with 15% falling in the ‘moderate’ category.

Cooke and Michie (1997b) went on to demonstrate, using regression procedures, that the North American diagnostic cut-off score of 30 on the PCL-R is metrically equivalent to a diagnostic cut-off score of 25 in Scotland. Using this cut-off score, they found that the Scottish prevalence rate for psychopathy went up to 8%, still substantially lower than the North American prevalence rate.

In view of such findings, Hare (1998) endorses the use of different diagnostic cut-off scores for different cultures. For British samples, it has been suggested that a more appropriate diagnostic cut-off score is 25, as found in the Scottish sample (Cooke, 1995;1996). Thus, it would be reasonable to suggest that in a British sample, those scoring 15 to 24 would be regarded as ‘moderately’ psychopathic and those scoring below 15, as ‘non-psychopathic’. These criteria will be applied in this study, although differences in results caused by the use of the different cut-off scores will also be discussed.
2.4.2 Millon Clinical Multiaxial Inventory-III (Millon, 1994)

The Millon Clinical Multiaxial Inventory (MCMII; Millon, 1983) was a personality inventory designed to assess personality patterns and both acute clinical disorders and personality disorders specifically as established in DSM-III (APA, 1980). It has since been revised twice (MCMII-III: Millon, 1987; MCMII-III: Millon, 1994) to keep pace with changes in theory and as well as the revisions of the DSM, with the MCMII-III (see appendix 4) corresponding to disorders described in DSM-IV (APA, 1994).

The MCMII-III is used in this study because it is the personality inventory of choice at the Hospital and it has been shown to be a reliable and well validated measure in generic clinical settings (e.g., Davis et al., 1997) as well as in forensic populations (Dyer, 1997). It has been described as one of the few assessment instruments in psychology that was derived from a comprehensive theory (Craig, 1999). Also, studies that have focused on the nature of 'psychopathic' individuals have predominately used this measure (Hart et al., 1991), thus its use will make for ease of comparison with other findings in this area.

Table 2 below, provides a list of the MCMII-III scales and shows how they are divided into Modifier and Correction Indices, Personality Disorders and Clinical Syndromes (the letters/numbers in brackets are codes for the scales). The scales of particular interest in this study will be the 13 Personality Disorder scales as they will be discussed in relation to psychopathy.

The MCMII-III is a self-rating measure consisting of 175 statements to which the respondent is required to answer 'true' or 'false'. It is scored by converting raw scores to base rate (BR) scores, which take into account the prevalence of personality and clinical syndromes within clinical populations. BR scores of 75 and above indicate the presence of the personality disorder or clinical syndrome measured by the scale to a diagnosable level, and 85 and above indicate severe clinical significance. BR scores of 60 to 74 indicate a tendency towards the personality disorder or clinical syndrome measured by the scale.
Table 2: The MCMI-III Scales  (From: Millon, 1994)

The relationship between the MCMI-III and the PCL-R

The Antisocial Scale (6A) of the MCMI-III was designed to assess the DSM-III R category of antisocial personality disorder (APD). APD is conceptually and empirically related to psychopathy, and in particular to the social deviance component of psychopathy as measured by Factor 2 (‘socially deviant lifestyle’) of the PCL-R (Harpur et al, 1989). The MCMI-III has two other Personality Disorder scales, namely Narcissistic(5) and Aggressive/sadistic(6B), which appear to be very similar in content to the characteristics tapped by Factor 1 (‘interpersonal and affective traits’) of the PCL-R. Also, as discussed earlier, several of the MCMI personality disorder scales have been found to correlate with the PCL-R (Hart et al, 1991). Such findings indicate
that the MCMI-III should provide a good self-report assessment of psychopathy and is more appropriate for comparison with the PCL-R than other personality inventories which have not been used comparatively in past research. Whether this proves to be the case will be investigated in the present study.

2.4.3. Sex Offender Assessment Pack (Beckett, Beech & Fisher, 1996)

This assessment pack was developed by Beckett and his colleagues as part of the Home Office ‘Sex Offender Treatment Evaluation Project (STEP)’ which evaluated the efficacy of treatment for sex offenders in British prisons. It is currently being advocated by the Home Office as a useful tool for the assessment of sex offenders and for measuring treatment outcomes and so is used at Broadmoor Hospital. It was used in this study to identify personality, social and emotional characteristics which might pre-dispose to offending behaviour and perhaps differentiate amongst the subgroups of sex offenders.

The pack consists of 12 self-rating questionnaires, some of which had been previously developed by other researchers and validated and some of which were developed by Becket et al (1996) and validated with samples of offenders and non-offenders in their research study. The questionnaires were put together to measure four types of characteristics, that is, denial/admittance of deviant sexual interests and level of offending behaviours; pro-offending attitudes (e.g. cognitive distortions); predisposing personality factors; and relapse prevention skills (e.g. recognising own risk for re-offending). Completion of the whole assessment pack allows two profiles to be derived for the individual, namely, a Personality Inventories Profile and a Sex Inventories Profile. However, it is also valid to complete individual questionnaires, as norms are provided for individual questionnaires.

For the purpose of this study, the set of 5 questionnaires that comprise the Personality Inventories Profile was used. These measure a number of personality dimensions which might pre-dispose to offending, such as: low self-esteem and under-assertiveness; inability to be intimate with others and cope with negative emotions; and failure to accept accountability for one’s actions, in relation to offending and
generally (Beech, Fisher & Beckett, 1998). Also, the Social Desirability Measure and its Lie Scale was used, the purpose of which is explained below.

The decision not to use the offence-related and victim-related questionnaires was based on the fact that these would have required the patients to answer questions specific to their offences and it had been agreed with the Ethics Committee that this would not be asked of the patients, as it could potentially cause distress. Also a limit had to be imposed on the number of questionnaires the respondents would be required to complete.

The SOAP questionnaires that were used in this study are provided in full at appendices 5(a) to 5(f) and briefly described here (from Beech et al, 1998):

Questionnaire 1: **Social Desirability Measure: Personal Reaction Inventory**
A 12-item scale based on items from Greenwald & Satow (1970) and devised to overcome the problem of response bias. A procedure described by Saunders (1991) for adjusting self-report questionnaires for response bias is used to adjust the social desirability score to calculate a true measure of responding.

Questionnaire 2: **Emotional Loneliness Scale** (Russell et al, 1980)
A 20-item scale derived to detect variations in loneliness that occur in everyday life, and thus, measure possible social inadequacy. Russel and colleagues report that the scale has high internal consistency (alpha = .94).

Questionnaire 3: **Adult Norwicki-Strickland Internal-External Locus of Control Scale** (Norwicki, 1976)
A 40-item questionnaire which measures ‘the extent to which subjects feel that events are contingent on their behaviour and the extent to which they feel events are controlled externally’.
Questionnaire 4: *Empathy - Interpersonal Reactivity Index* (Davis, 1980)

A 28-item questionnaire that measures four dimensions of empathy which divide the generic term 'empathy' into its cognitive and emotional components, thus giving the following four subscales:

*Perspective Taking* - measures the ability to assume cognitively the role of the other

*Empathic Concern* - measures feelings of warmth, compassion and concern for others

*Fantasy* - addresses the ability to identify with fictional characters

*Personal Distress* - addresses anxiety and negative emotions resulting from the feelings of distress of others. However, it has been suggested that it is more accurate to view this subscale as a measure of the individual's inability to cope with negative feelings rather than to identify with them per se (Salter, 1988)

Questionnaire 5: *Self-Esteem Scale* (Thornton; unpublished)

An 8 item questionnaire used to measure levels of self-esteem, and includes a lie scale. Thornton (personal communication cited in Beech et al, 1998) reports the scale has high internal reliability (Cronbach alpha=0.8).

Questionnaire 6: *Assertiveness - Social Response Inventory* (Keltner et al, 1981)

This measures assertive behaviour in a variety of social situations by asking the individual what they would do in a given situation (intention) and testing their knowledge of what they believe they should do. 22 situations are given, each accompanied by five alternative responses, with ratings of assertiveness from 'extremely under-assertive' (-2) to 'extremely over-assertive' (+2). The authors also report high internal consistency.

2.4.4. *Guddjonsson Blame Attribution Inventory -Revised* (Guddjonsson & Singh, 1989)

In view of two specific limitations that had been identified, Guddjonsson & Singh (1989) revised the original Guddjonsson Blame Attribution Inventory (Gudjonsson, 1984), described earlier (see Section 1.2.5). The revised inventory, referred to hereon
as the GBAI, (appendix 6) consists of the same three independent factors: external attribution; mental element attribution; and guilt feeling attribution.

The BAI is routinely used at Broadmoor Hospital in assessment. It is a self-rating inventory consisting of 42 statements to which the individual has to answer ‘yes’ or ‘no’ to indicate the extent to which the statement is a true reflection of his belief in relation to his offence(s). Reliability and validity statistics and norms are provided for both general offender populations and mentally-disordered offender populations, including sex offenders (Guddjonsson & Singh, 1988; 1989).

2.4.5. Patients’ Psychology Files
A comprehensive file is kept on each patient admitted to the hospital. A routine psychological assessment is always carried out on admission. The file contains details of all assessments and clinical contact with the Psychology Department and key reports from other disciplines (e.g. psychiatric assessments reports; social workers’ reports; nursing reports). The present researcher acquired permission to access this information for the purposes of this study.

2.5 Procedures
2.5.1. Ethical approval and access to staff and records
With the approval of the Head of the Psychology Department at Broadmoor Hospital, a research proposal and protocol for the study was submitted to the Special Hospitals Research & Ethics Committee. The Committee initially responded to this proposal with a request for certain amendments to be made to the procedure of the study (see appendix 7). These conditions were met and subsequently, ethical approval was granted (see appendices 8 and 9). The researcher was then required to attend a one-week induction course in order to gain access to the hospital and patient records.

2.5.2. Identifying potential participants
Two separate databases at Broadmoor Hospital were screened in order to identify sex offenders on the basis of their index offence and history of offences. These were the
Case Register database and the Clinical Decision-Making Unit (CDMU) database. Also, psychologists were individually informed of the aims and objectives of the study and requested to nominate patients who, to their knowledge, met the criteria for participation.

2.5.3. Requesting consent from Responsible Medical Officers (RMOs)
Letters were sent to RMOs to explain the study and to request their consent for the identified patients to be approached for participation (see appendix 10). Copies of these were sent to the Link Psychologist who was involved with the ward on which the patient was resident to ensure they were informed as to which patients might be approached.

2.5.4. Recruiting participants
For the patients for whom RMOs had given consent, individual appointments were made via each patient's Primary Nurse to visit him on the ward. At this meeting, the researcher described the study, gave the patient an 'Information Sheet' (see appendix 11), reading this to the patient if required, and answering any queries put forward. If the patient agreed to participate, a consent form (see appendix 12) was given for signing. This was then signed by the researcher and witnessed by the Primary Nurse.

2.5.5. Completion of the questionnaires
Immediately after the consent form was completed, the researcher completed the standardised questionnaires (i.e. MCMI-III, GBAI and SOAP) with the patient. Often, there was not sufficient time, or the patient was not willing, to complete all the questionnaires during one interview and so a further appointment was made. In some cases the patient did not wish to complete the questionnaires immediately after the consent form was signed, therefore arrangements were made for the researcher to visit the patient again. The questionnaires could not be left with the patient for him to complete in his own time as this was one of the conditions set by the Ethics Committee, the reason being to avoid any potential distress that might be caused by the questions.
In addition, the following steps were taken to minimise the likelihood of any emotional distress that might be caused by participation in the study: (i) if any of the questionnaires had been completed by the patient within the past 6 months it need not be done again, and a separate consent form (see appendix 13) was signed by the patient allowing the researcher access to that information from his file; (ii) no details about offence history or abuse history were sought from the patient during the meeting, as this was gained from the patient’s file; (iii) if the participant displayed signs of distress or an issue arose during the session which caused the researcher to be concerned about the participant’s risk of harm to himself or to others, the nursing staff would be notified. [This did not actually arise as an issue.]

2.5.6. Obtaining demographic/personal and forensic history data and PCL-R ratings

For each patient who agreed to participate in the study and completed the questionnaires, the psychology file was thoroughly reviewed. A data sheet (see appendix 14) was designed for the collection of demographic information, personal and forensic history. This data sheet and the PCL-R rating sheet (see appendix 15) were completed simultaneously, allowing for a comprehensive review of the patient’s file for both sets of data concurrently and avoiding repetition of the exercise.

Specific issues relating to the collecting of this information and the variables used will be discussed here.

i) PCL-R

Some of the sex offenders’ files had been rated on the PCL-R approximately 12 months previously as part of another research project within the hospital. In collaboration with the researchers responsible for that project it was agreed that the PCL-R data on these individuals could be accessed for this study rather than to re-rate them.

Of the 45 patients who completed the standardised questionnaires for this study, 13 were found to already have PCL-R ratings. Thus 32 patients remained still to be rated on the PCL-R by the current researcher. In order to ensure consistency with existing
PCL-R ratings and inter-rater reliability, the current researcher was trained in the administration of the PCL-R using the file-only rating method by the researcher who performed the previous PCL-R ratings (also using the file-only method). The training required the researcher to become familiar with the PCL-R manual in order to understand the process and the criteria for rating on each item. The initial four PCL-R ratings were done jointly with the trainer and some of the subsequent ones were also checked by the trainer.

ii) Defining personal and forensic history variables

All the variables used on the data sheet for personal and forensic history information are specified in the demographic data sheet (appendix 14). Some variables and their categories are self-explanatory and others are less obvious because the researcher had to make decisions about their definitions. These latter variables and their categories are explained here:

**Group: Sex offender type** - this refers to the grouping of participants according to the age of victims of their sex offences, as has been defined above.

**Length of stay at Broadmoor Hospital** - in the cases where the participant had been discharged and re-admitted, the cumulative length of the two admissions was recorded.

**Mental Health Act category** - this refers to the legal categorisation of mentally disordered offenders as defined by the 1983 Mental Health Act (The Home Office) for England and Wales. The categories are: mental illness (MI); psychopathic disorder (PD); mental illness and psychopathic disorder (MI/ PD). Initially, the intention was to also record the clinical diagnosis of each individual, but this was considered unreliable because in some cases no clinical diagnosis was recorded, in others there was more than one diagnosis (based on different clinical opinions) and in others the MHA category and the diagnosis were used synonymously.

**Major disruptive events in childhood** - As it is expected that sex offenders will generally tend to have disproportionately more negative childhood experiences (Luntz...
& Widom, 1994), major disruptive events recorded in their files was noted. Childhood is defined here as the years from birth to 16 years of age, to be consistent with the legal definition of a child accepted in other areas of this research. The categories used for this variable were those most commonly recorded in the files, namely: death of mother; death of father; divorce/separation of parents; other disruptions (e.g. parental mental illness and/or hospitalisation).

**History of childhood abuse** - Again, sex offenders are expected to have experiences of abuse in their childhood, that is, birth to 16 years (e.g. Waterhouse et al, 1994). The categories used for this variable were: sexual abuse; physical abuse; witnessing domestic violence; other types of abuse (e.g. abandonment by parents). Unfortunately, as this information had to be obtained from file reports rather than via self-report, it was not possible for the current researcher to specify definitions for these categories. Thus, if the patient was recorded as having experienced abuse of these kinds it was recorded as present in his history, but the extent of the abuse could not be verified.

**Index offence** - This refers to the offence which led to the participant being incarcerated at Broadmoor hospital. The categories used were: rape of adult (16yrs & above); rape of child (<16yrs); other sexual offence against adult (including, indecent sexual assault; buggery; incest); other sexual offence against child (including, indecent sexual assault; buggery; incest); murder; manslaughter; other offence.

The first categories are based on legal (Home Office) categories for sexual offences. The last three categories were included for cases where the index offence might not have been a sex offence but the participant had a previous offence which was a sex offence. Also, in cases where the individual committed a sex offence as well as killing the victim, the index offence recorded would be the more serious offence (i.e. murder or manslaughter) although they would also have a current conviction for the sex offence.

**Type of coercion used** - To identify the extent of the violence and the seriousness of the harm caused to the victim(s) of the sex offence(s), six categories of escalating
levels of coercion were used. These were derived from the National Association for Treatment of Sex Offenders (NOTA) database and Porporino & Motuik's (1991) work, and were: no explicit threat of violence; threat of physical violence but no use of weapon; threat of physical violence with weapon; use of force not resulting in serious injury; use of force resulting in serious injury; injury/death of victim using weapon (e.g. stabbing). Where there was more than one offence/victim, the highest level of coercion was recorded.

*Age of victim(s)* - The age of the first/only victim and the second and third victims, where relevant, were recorded. It was found however, that although for child victims the age was always recorded in the file, for adult victims this was not the case. Thus, where an adult victim’s age was not specified in the file, it was recorded as 18+. However, for the purposes of statistical analysis, this was not practical. Therefore the victims’ ages were categorised into age bands as follows: 0 up to 12yrs (pre-pubescent); 12 up to 16yrs (pubescent); 16yrs and over (adult). This allowed for the categorisation of the participants according to whether their victims were children or adults, but also allowed for the information gained about the ages of child victims to be retained to an extent, in case needed for further analyses.

### 2.6 Statistical analysis

Parametric tests were used where preliminary observation showed that the data was normally distributed, otherwise non-parametric tests were used. For the PCL-R, although the total and factor scores were normally distributed, the 20 item scores were skewed. Therefore, parametric tests were used for the total and factor scores and non-parametric tests for the item scores. The types of statistical tests used were one-way ANOVAs, Chi-square tests and Pearson’s correlation coefficients, as appropriate to the nature of variables being analysed.
3. RESULTS
This section has been structured in a way that provides three types of results - firstly, identification and description of the sample as a whole; secondly, investigation of group differences; and finally, correlated comparisons between the standardised measures.

3.1. Description of the sample: Demographic, personal and forensic history variables
This is presented here for the sample as a whole (n=61). The mean current age was 39.7 years (SD= 9.1; min. =22yrs ; max. = 62yrs). The large majority, that is 43 participants (70%), were of White British origin; 11(18%), were Black West African; 3(5%), were Black African; and 4(7%), were of mixed race or other origin. The mean age for leaving school was 15.6 years (SD= 1.5; min.=13yrs; max. =16yrs), with the large majority (n=43) leaving with no qualifications. 6 acquired qualifications to below ‘O’ Level standard, 5, up to ‘O’ Level and 7 acquired other qualifications (e.g. vocational awards after leaving school).

The mean age for first contact with psychiatric services was 20.1 years (SD= 8.5; min.= 4yrs; max. = 44 yrs). 51 participants (83.6%) had some form of major disruption and 39 of them (63.9%) experienced some form of abuse in their childhood. These experiences are elaborated upon in section 3.2 below.

40 participants (65%) were recorded as having a history of substance abuse. 13 (21%) had a history of alcohol abuse, 10 (16%) had a history of drug abuse, 15 (25%) had abused both alcohol and drugs, and 2 (3%) had abused other substances (e.g. solvents).

The mean length of stay at Broadmoor Hospital was 8.8years (SD= 6.7; min.=1.1yrs; max. = 30.5yrs). 29 participants had a MHA classification of mental illness(MI), 22 psychopathic disorder(PD) and 10 a dual classification of MI/PD. As is the case for approximately 75% of the population of patients at Broadmoor Hospital, 47 (77%) members of this sample were restricted patients, that is, they were detained under...
Section 37/41 (n=24) and Section 47/49 (n=23) of the MHA. 2 (3%) participants were restricted remand patients, under Section 48/49. 4 (6.5%) were unrestricted patients, under Section 3 (n=1) and ‘Notional 37’ Section (n=3). 8 (13%) were unrestricted remand patients, under Section 38 (n=7) and on CPIA Section (n=1). Appendix 16 provides brief explanations of these MHA Sections.

The mean age for committing the first sexual offence was 22.5 years (SD= 6.6; min.=13yrs; max.=44yrs). As their index offence, 21(35%) participants had been convicted of the rape of an adult, 6 (10%) for other sexual offences against an adult, 1(2%) for unlawful sexual intercourse with a child, 8 (13%) for indecent sexual assault of a child, 9(15%) for murder, 5 (8%) for manslaughter and 11(18%) for other offences. 47 participants (77%) used some level of coercion against the victim(s) of their sexual offence, and of these, 14 (29%) had killed their victim.

Of those with child victims, 21(77.8%) of them had victims who were unrelated to them, 2 (3%) victimised their own daughters and 5 (8%) had a mixture of related and unrelated victims. Of those with adult victims, 28 (68.3%) had victims who were strangers, 10 (16%) had victims who were past or current acquaintances and 3 (5%) had victims with whom they were intimate or had been intimate (e.g. wife; ex-partner).

About two thirds (n=41, i.e 67%) of the participants were unemployed at the time of the index offence, whilst one third (n=20, i.e. 33%) were employed. The majority of the participants (n=46, i.e. 75%) were of single status at the time of their index offence, 8 (13%) were married or co-habiting and 7 (12%) had been divorced or separated.
3.2 Group Differences: Demographic, personal history and offence characteristics

The data provided above for the sample as a whole has also been provided for the sample as divided into the three groups at Table 3. These generally appear to follow the pattern of the data for the whole sample, with no significant differences amongst the groups (refer to appendix 17 for statistical test values).

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>Adult Sex Offenders (Group 1; n=34)</th>
<th>Child Sex Offenders (Group 2; n=11)</th>
<th>Mixed Sex Offenders (Group 3; n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current age (yrs): mean</strong></td>
<td>40.1 (27-56)</td>
<td>37.7 (22-54)</td>
<td>40.1 (24-62)</td>
</tr>
<tr>
<td><strong>Ethnic background:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>23 (68%)</td>
<td>9 (82%)</td>
<td>11 (69%)</td>
</tr>
<tr>
<td>Black West African</td>
<td>6 (18%)</td>
<td>2 (18%)</td>
<td>3 (19%)</td>
</tr>
<tr>
<td>Black African</td>
<td>2 (6%)</td>
<td>0</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>Mixed Race/Other</td>
<td>3 (8%)</td>
<td>0</td>
<td>1 (6%)</td>
</tr>
<tr>
<td><strong>Age when left school (yrs): mean</strong></td>
<td>15.4 (13-17)</td>
<td>15.6 (15-16)</td>
<td>15.4 (14-17)</td>
</tr>
<tr>
<td><strong>Education attainment:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No qualifications</td>
<td>23 (68%)</td>
<td>7 (64%)</td>
<td>13 (81%)</td>
</tr>
<tr>
<td>Below 'O'Level</td>
<td>2 (6%)</td>
<td>3 (27%)</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>'O'Level &amp; above</td>
<td>3 (8%)</td>
<td>1 (9%)</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>Other awards</td>
<td>6 (18%)</td>
<td>0</td>
<td>1 (6%)</td>
</tr>
<tr>
<td><strong>Age at 1st contact with Psychiatric services (yrs): mean</strong></td>
<td>21.3 (8-38)</td>
<td>18.1 (4-38)</td>
<td>18.8 (6-44)</td>
</tr>
<tr>
<td><strong>History of drug &amp;/or alcohol abuse</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td>12 (35%)</td>
<td>3 (27%)</td>
<td>5 (31%)</td>
</tr>
<tr>
<td>Present</td>
<td>22 (65%)</td>
<td>8 (73%)</td>
<td>11 (69%)</td>
</tr>
<tr>
<td><strong>Employment status at time of index offence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>14 (41%)</td>
<td>3 (27%)</td>
<td>3 (19%)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>20 (59%)</td>
<td>8 (73%)</td>
<td>13 (81%)</td>
</tr>
<tr>
<td><strong>Length of stay(yrs) at Broadmoor: mean (min - max)</strong></td>
<td>9.0 (1-29)</td>
<td>8.3 (2.3-30.5)</td>
<td>8.5 (3.4-28)</td>
</tr>
<tr>
<td><strong>MHA Classification:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MI</td>
<td>18 (53%)</td>
<td>9 (82%)</td>
<td>6 (38%)</td>
</tr>
<tr>
<td>PD</td>
<td>12 (35%)</td>
<td>2 (18%)</td>
<td>7 (44%)</td>
</tr>
<tr>
<td>MI/PD</td>
<td>4 (12%)</td>
<td>0 (0%)</td>
<td>3 (19%)</td>
</tr>
</tbody>
</table>

Table 3: Descriptive results: Comparative data on demographic, personal and forensic history variables
Some of the demographic, personal and forensic history variables which are of particular interest according to the hypotheses stated for this study have been converted into frequency tables in order to show how the variables were categorised and how the groups differ on these. (The whole sample data has also been included in these tables for comparison purposes.) Chi-square tests were conducted to investigate whether there might be any relationship between the variable and the group categories, and Fisher's Exact Tests to identify significance of differences between groups.

3.2.1 Major disruptive events in childhood

As can be seen from table 4(a), the sample as a whole had high levels of childhood disruption. 16.4% had no disruptions mentioned in their records, leaving 83.6% who were recorded to have experienced some major disruption in their childhood. Similarly, the overall disruption for the groups were calculated as follows: Adult SOs = 85.3%; Child SOs = 90.9%; Mixed SOs = 75.0%. Thus, Child SOs appeared to have the highest rate of childhood disruption. The significance of this was tested with a chi-square test.

<table>
<thead>
<tr>
<th>Disruptive event</th>
<th>Whole sample (n=61)</th>
<th>Group: Sex offender type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Adult SO (n=34)</td>
<td>Child SO (n=11)</td>
<td>Mixed SO (n=16)</td>
<td></td>
</tr>
<tr>
<td>None mentioned</td>
<td>16.4% (n=10)</td>
<td>14.75% (n=5)</td>
<td>9.1% (n=1)</td>
<td>25.0% (n=4)</td>
<td></td>
</tr>
<tr>
<td>Death of biological parent</td>
<td>21.3% (n=13)</td>
<td>14.6% (n=5)</td>
<td>18.2% (n=2)</td>
<td>6.3% (n=1)</td>
<td></td>
</tr>
<tr>
<td>Divorce/separation of parents</td>
<td>55.6% (n=34)</td>
<td>58.8% (n=20)</td>
<td>63.7% (n=7)</td>
<td>62.6% (n=10)</td>
<td></td>
</tr>
<tr>
<td>Other disruption (e.g. parental mental illness)</td>
<td>42.5% (n=26)</td>
<td>50.0% (n=17)</td>
<td>54.6% (n=6)</td>
<td>50.1% (n=8)</td>
<td></td>
</tr>
</tbody>
</table>

Table 4 (a) Frequencies: Major disruptive events in childhood

The chi-square test requires that no more than 25% of the cells of the contingency table have expected counts of less than 5. As this criterion was not met for the four categories of disruptive events shown in table 4(a), the cells were combined by creating dichotomous categories of the “presence” or absence” of any disruptive events (see Table 4(b). However, the problem was not overcome because 33.3% of the
cells had expected counts of less than 5. Although Child SOs appeared to have a higher rate of disruptive events in childhood, there appeared not to be a significant relationship between the disruptive events variable and sex offender grouping variable (p = 0.40).

<table>
<thead>
<tr>
<th>Major disruption in childhood</th>
<th>Group: sex offender type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult SO (n=34)</td>
<td></td>
</tr>
<tr>
<td>Absent:</td>
<td>4 (12%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child SO (n=11)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 (9%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mixed SO (n =16)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 (25%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Present:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30 (88%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 (91%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 (75%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>34</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>61</td>
<td></td>
</tr>
</tbody>
</table>

Pearson chi-square value = 1.86 ; df (2); p = 0.40

Table 4(b): Comparison of groups on major disruptive events in childhood

Observation within the cells indicated that the greatest differences were between the Adult SOs and each of the other two groups. To test whether these differences were significant, 2x2 Fisher’s Exact Tests were conducted and no significant difference was found between the Adult SOs and the Mixed SOs (p = 0.22), nor between the Adult SOs and Child SOs (p = 0.65)

3.2.2 History of childhood abuse and family violence
As can be seen from the frequency table 5(a), 36% of the sample as a whole did not have any childhood abuse experiences recorded in their files, and so, it can be deduced that 64% did have some type of childhood abuse recorded. The overall rates for experiencing childhood abuse for the groups were as follows: Adult SOs = 55.9%; Child SOs = 63.6%; Mixed SOs = 81.2%.
Chi-square tests were separately conducted for ‘presence’ or ‘absence’ of sexual abuse, physical abuse and domestic violence in childhood. The sex offender grouping variable was found not to be significantly related to the childhood sexual abuse variable (chi-sq = 1.04; df = 2; p = 0.59), nor the physical abuse variable (chi sq = 0.50; df = 2; p = 0.98), nor the witnessing domestic violence variable (chi sq = 1.80; df = 2; p = 0.40).

However, as the research literature has shown that Child SOs have higher rates of childhood sexual abuse in their history than do rapists (e.g. Watkins & Bentovim, 1992; Bumby & Hanson, 1997), the sample was divided into two groups according to those who had victimised children (i.e. Child SOs and Mixed SOs) and those who had not (i.e. Adult SOs) and a 2x2 Fisher’s Exact Test conducted to see whether there was any significant difference between the groups on this basis. As Table 5(b) shows, there was a significant difference at the 0.05 level (p = 0.048) indicating that those who had sexually abused children were more likely to have been sexually victimised as children themselves.
The research literature also suggests that rapists have higher rates of childhood physical abuse and family violence in their history than do child molesters (e.g. Bumby & Hanson, 1997). Thus, the sample was divided according to those who had victimed adults (i.e. Adult SOs and Mixed SOs) and those who had not (i.e. Child SOs) and a 2x2 Fisher’s Exact Test conducted. As Tables 5(c) shows, in this sample, those with adult victims did not have significantly higher rates of experiencing physical abuse ($p=0.22$). As for witnessing domestic violence in childhood, although it appeared that Adult SOs and Mixed SOs had higher rates of this experience than Child SOs (see Table 5(a)), this difference was also not found to be significant ($p = 0.59$).
### Table 5(c) Comparison of groups on history of childhood physical abuse on the basis of whether or not they had adult victims

<table>
<thead>
<tr>
<th>History of childhood physical abuse</th>
<th>Group: sex offender type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult SO + Mixed SO n= 50</td>
<td>Child SO n= 11</td>
</tr>
<tr>
<td>Absent:</td>
<td>37 (74%)</td>
<td>10 (91%)</td>
</tr>
<tr>
<td>Present:</td>
<td>13 (26%)</td>
<td>1 (9%)</td>
</tr>
<tr>
<td>Total:</td>
<td>50</td>
<td>11</td>
</tr>
</tbody>
</table>

Fisher's Exact Test: p = 0.22

### Table 5(d) Comparison of groups on history of childhood witnessing domestic violence on the basis of whether or not they had adult victims

<table>
<thead>
<tr>
<th>History of witnessing domestic violence</th>
<th>Group: sex offender type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult SO + Mixed SO n= 50</td>
<td>Child SO n= 11</td>
</tr>
<tr>
<td>Absent:</td>
<td>35 (70%)</td>
<td>8 (73%)</td>
</tr>
<tr>
<td>Present:</td>
<td>15 (30%)</td>
<td>3 (27%)</td>
</tr>
<tr>
<td>Total:</td>
<td>50</td>
<td>11</td>
</tr>
</tbody>
</table>

Fisher's Exact Test: p = 0.59
3.2.3 Use of coercion and injury caused to victim(s) of sex offence

As can be seen from table 6(a), all three groups used some level of coercion against their sexual offence victims. The rates were 79.4%, 36.7% and 100% for Adult SOs, Child SOs and Mixed SOs, respectively.

It was hypothesised that Adult SOs & Mixed SOs would show more violent offending behaviour than Child SOs. Indeed, Mixed SOs seemed to have the highest rate of threat with a weapon and use of force causing serious injury and Adult SOs appeared to have caused greater injury with a weapon. Child SOs seemed to have used far less coercion (79.4% used no force/threat) and caused less injury.

<table>
<thead>
<tr>
<th>Type of coercion used</th>
<th>Whole sample (n=61)</th>
<th>Group: Sex offender type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Adult SO (n=34)</td>
</tr>
<tr>
<td>No explicit threat</td>
<td>23.0% (n=14)</td>
<td>20.6% (n=7)</td>
</tr>
<tr>
<td>Threat without weapon</td>
<td>11.5% (n=7)</td>
<td>5.9% (n=2)</td>
</tr>
<tr>
<td>Threat with weapon</td>
<td>11.5% (n=7)</td>
<td>11.8% (n=4)</td>
</tr>
<tr>
<td>Use of force: no serious injury</td>
<td>13.1% (n=8)</td>
<td>14.7% (n=5)</td>
</tr>
<tr>
<td>Use of force: serious injury</td>
<td>11.5% (n=7)</td>
<td>8.8% (n=3)</td>
</tr>
<tr>
<td>Serious injury with weapon, incl. death</td>
<td>29.5% (n=18)</td>
<td>38.2% (n=23)</td>
</tr>
</tbody>
</table>

Table 6(a). Frequencies: Use of coercion during sex offence

As the ‘level of coercion’ categories included verbal threats with or without a weapon as well as physical force, in order to compare the groups on the level of physical force they used, the last three categories (i.e. ‘use of force: no serious injury’; ‘use of force: serious injury’; ‘serious injury with weapon’) were combined for the dichotomy of ‘absence/presence’ of ‘use of physical force’. The chi-sq test (see table 6(b)) indicated
a significant relationship (p= 0.019) between sex offender grouping and the use of physical force.

<table>
<thead>
<tr>
<th>Use of physical force in sexual offence(s)</th>
<th>Group: sex offender type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult SO n =34</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child SO n = 11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mixed SO n = 16</td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td>13 (38%)</td>
<td>5 (31%)</td>
</tr>
<tr>
<td>Present:</td>
<td>21 (62%)</td>
<td>11 (69%)</td>
</tr>
<tr>
<td>Total:</td>
<td>34</td>
<td>16</td>
</tr>
</tbody>
</table>

Pearson chi-square value = 7.89; df (2); p= 0.019

Table 6(b): Comparison of groups on use of coercion in sexual offence(s)

Observation within the cells clearly shows that both Adult SOs (62%) and Mixed SOs (69%) used more physical force than did the Child SOs (18%). As the literature states that rapist of adults use more force and are more violent than child molesters (e.g. Curtin & Niveau, 1998), the sample was again divided according to those who had victimised adults (i.e. Adult SOs and Mixed SOs) and those who had not (i.e. Child SOs). A 2x2 Fisher's Exact Test showed that there was a significant difference between the groups, at the 0.05 level (p=0.007), indicating that those who victimised adults used more coercion than those who victimised only children.

A chi-sq test was also conducted to investigate the relationship between groups on the level of victim injury caused (see table 6(c)). This showed that there was a significant relationship at the 0.01 level (p=0.00) between sex offender group and injury caused to victim. Again, it is clear from the cell counts that Adult SOs (76%) and Mixed SOs (50%) caused more victim injury than Child SOs (9%).
Injury caused to victim(s) of sexual offence(s) | Group: sex offender type | Total
--- | --- | ---
| Adult SO n=34 | Child SO n=11 | Mixed SO n=16 |
Absent: | 8 (24%) | 10 (91%) | 8 (50%) | 36
Present: | 26 (76%) | 1 (9%) | 8 (50%) | 25
Total: | 34 | 11 | 16 | 61

Pearson chi-square value = 15.9; df (2); p= 0.000

Table 6(c): Comparison of groups on injury cause to victim(s) of sexual offence(s)

This finding was further supported when a 2x2 Fisher’s Exact Test showed that those who victimised adults caused significantly more injury to their victims (p=0.000) than did those who victims only children.

3.2.4 Number of sexual offences and victims

Comparing Adult SOs and Child SOs, the preliminary observation, as shown in Table 7(a), was that Child SOs committed more sexual offences (mean = 3.92) than Adult SOs (mean = 2.44) and had more victims (mean= 3.73) compared to Adult SOs (mean = 2.41). However, none of these differences were found to be significant.

| Whole sample (n=61) | Group: Sex offender type |
|---|---|---|---|
| | Adult SO (n=34) | Child SO (n=11) | Mixed SO (n=16) |
Number of sex offences: mean(SD) | 3.28 (2.4) | 2.44 (1.5) | 3.92 (2.4) | 5.00 (3.0) |
Number of victims: mean (SD) | 3.30 (2.4) | 2.41 (1.5) | 3.73 (2.5) | 4.87 (3.1) |

Table 7(a) Comparison of groups on number of sex offences and victims

MIslam;PsychD;2000
As for the Mixed SOs, they were initially not considered on this point because, by definition, they had more sexual offences and more victims (ie they needed to have at least one adult and one child victim to meet the criteria for this group category). However, when this difference was accounted for by only considering members in the sample (i.e. from all groups) with more than two victims, the chi-square test indicated that there was a significant difference (at the 0.01 level) among the groups on this variable. It appeared that Mixed SOs had a significantly higher number of victims (87.5%) even when compared to Adult SOs (41%) and Child SOs (55%) with more than two victims. This may be taken as an indication of higher sexual recidivism amongst the Mixed SO group.

<table>
<thead>
<tr>
<th>More than two victims</th>
<th>Group: sex offender type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult SO  n=34</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child SO  n=11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mixed SO  n=16</td>
<td></td>
</tr>
<tr>
<td>No:</td>
<td>20 (59%)</td>
<td>5 (45%)</td>
</tr>
<tr>
<td>Yes:</td>
<td>14 (41%)</td>
<td>6 (55%)</td>
</tr>
<tr>
<td>Total:</td>
<td>34</td>
<td>11</td>
</tr>
</tbody>
</table>

Pearson chi-square value = 9.47; df (2); p= 0.009

Table 7(b): Comparison of groups on number of victims when more than two victims
3.3. Group Differences: Standardised Measures

3.3.1 Preliminary analysis: Group mean profiles

In order to provide a preliminary visual comparison of the three groups the mean scores for each group on the PCL-R (Figure 1), the MCMI-III (Figure 2), and the SOAP (Figure 3) were plotted to give group mean ‘profiles’ on the measures. The GBAI scores were not plotted as a graph because there were too few item scores to show graphically, so these can be seen later in table 13.

It should be noted here that although these profiles are shown as line graphs, the reader is not to assume that the data is continuous as the group mean scores plotted are for distinct items and have been joined as a graph simply to facilitate comparison between groups. The idea is extended from the MCMI-III Manual (Millon, 1994) where, although the scales are measuring distinct items, the mean BR scores are plotted and a profile (i.e. a graph like that in Figure 2) is produced for each individual (see ‘Millon Hand-Scoring Profile Sheet’ at appendix 4b). The difference here is that instead of representing scores for individuals, the profiles represent the mean scores for each group.
Figure 1. Group Differences: PCL-R Item Scores
Figure 2. Group Differences: MCMI-III Profiles
Figure 3. Group Differences: SOAP Scores
On the PCL-R, 5 (8%) participants met the British total cut-off score of 25 for a ‘diagnosis’ of psychopathy. 41 participants (i.e. 67%) of the sample had scores of 15-24, indicating ‘moderate’ psychopathy and 15 (25%) scored below 15, indicating ‘non-psychopathy’.

If the cut-off score of 30 based on Hare’s original standardised sample was used here, the result would be that only 1 participant (i.e.1.6% of the sample) would have a ‘diagnostic’ level of psychopathy, 19 (31%) would have a ‘moderate’ level of psychopathy and 41 (67%) would be regarded as ‘non-psychopathic’. The significance of these different rates based on the cut-off score applied will be discussed later.

It can be seen from figure 1 that on PCL-R mean total scores, the Mixed SOs have a profile that is consistently higher than the other two groups, indicating a generally higher presentation of psychopathic tendencies. Table 8 below, shows the proportion of participants in each group meeting ‘diagnostic’ and ‘moderate levels of psychopathy on the PCL-R.

<table>
<thead>
<tr>
<th>Level of Psychopathy</th>
<th>Adult Sex Offenders (n=34)</th>
<th>Child Sex Offenders (n=11)</th>
<th>Mixed Sex Offenders (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total PCL-R score of 25/&gt; (i.e. diagnostic level)</td>
<td>1 (3%)</td>
<td>0 (0%)</td>
<td>4 (25%)</td>
</tr>
<tr>
<td>Total PCL-R score between 15 and 24 (i.e. moderate level)</td>
<td>24 (70%)</td>
<td>6 (55%)</td>
<td>11 (69%)</td>
</tr>
</tbody>
</table>

Table 8: Proportions of participants meeting ‘diagnostic’ level and ‘moderate’ level of psychopathy on the PCL-R

On the MCMI-III, the Mixed SO profile also appears to be relatively higher. However, although individual participants’ scores reached diagnostic levels (i.e. BR score of 75 or over) on one or more Personality Disorder scales (see table 9, below), none of the group mean scores did so (see figure 2).
It had been expected that the sample as a whole would show some level of dependent and narcissistic personality characteristics (Chantery & Craig, 1994). Although the whole sample mean was 64.07, 46% of the sample obtained scores to a diagnostic level on the Dependent scale (see table 9), indicating that there is some tendency for this trait within the sample. On the MCMI Narcissistic scale, the whole sample mean was 48.7 and only 8% scored to a diagnostic level. Thus, the indication is that there is no particular tendency for this characteristic within this sample.

The SOAP group mean profiles (Figure 3) and GBAI mean scores (table 13) seem to indicate very little difference amongst the groups.

### Table 9: Proportions of participants meeting diagnostic criteria on MCMI Personality Disorder Scale

<table>
<thead>
<tr>
<th>MCMI variable</th>
<th>Adult Sex Offenders (n=26)</th>
<th>Child Sex Offenders (n=9)</th>
<th>Mixed Sex Offenders (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizoid (1)</td>
<td>8 (30%)</td>
<td>2 (22%)</td>
<td>8 (61%)</td>
</tr>
<tr>
<td>Avoidance (2A)</td>
<td>10 (38%)</td>
<td>3 (33%)</td>
<td>6 (46%)</td>
</tr>
<tr>
<td>Depressive (2B)</td>
<td>11 (42%)</td>
<td>3 (33%)</td>
<td>6 (46%)</td>
</tr>
<tr>
<td>Dependent (3)</td>
<td>13 (50%)</td>
<td>3 (33%)</td>
<td>6 (46%)</td>
</tr>
<tr>
<td>Histrionic (4)</td>
<td>1 (4%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Narcissistic (5)</td>
<td>1 (4%)</td>
<td>3 (33%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Antisocial (6A)</td>
<td>13 (50%)</td>
<td>2 (22%)</td>
<td>6 (46%)</td>
</tr>
<tr>
<td>Aggressive/sadistic (6B)</td>
<td>0 (0%)</td>
<td>2 (22%)</td>
<td>2 (15%)</td>
</tr>
<tr>
<td>Compulsive (7)</td>
<td>1 (4%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Passive-Aggressive (8A)</td>
<td>9 (35%)</td>
<td>3 (33%)</td>
<td>5 (38%)</td>
</tr>
<tr>
<td>Masochistic (8B)</td>
<td>4 (15%)</td>
<td>3 (33%)</td>
<td>9 (69%)</td>
</tr>
<tr>
<td>Schizotypal (S)</td>
<td>0 (0%)</td>
<td>1 (11%)</td>
<td>4 (31%)</td>
</tr>
<tr>
<td>Borderline (C)</td>
<td>1 (4%)</td>
<td>3 (33%)</td>
<td>5 (38%)</td>
</tr>
<tr>
<td>Paranoid (P)</td>
<td>1 (4%)</td>
<td>3 (33%)</td>
<td>4 (31%)</td>
</tr>
</tbody>
</table>

3.3.2 Statistical analysis of group differences

In order to examine whether the differences observed in preliminary analysis were statistically significant, one-way ANOVAs were carried out to compare the three groups on: PCL-R scores (Tables 10(a) and 10(b); MCMI-III scores (Table 11); SOAP scores (Table 12); and GBAI scores (Table 13).
It is acknowledged here that a considerable number of statistical tests have been conducted on this data, thus increasing the risk for false positive results. A Bonferroni correction was considered to account for this, however, it was found that to do this, the ANOVAs would have to be significant to a p value of 0.002 (i.e.0.05 divided by 23 one-way anovas). However, the relatively small sample size meant that the results were somewhat biased against significant differences amongst the data being identified. As the Bonferroni is a cautious measure, to use it on a small sample may be overly cautious, thus the correction was not applied.

3.3.2 (a): Comparison of groups on Psychopathy Checklist- Revised (PCL-R) scores

The mean PCL-R total score for the whole sample was found to be 16.90 (SD = 5.4). As can be seen from table 10(a), the Mixed SO group mean total score (20.63) was above the whole sample mean, whilst the mean total scores for the Adult SO group (15.74) and Child SO group (15.74) were below the sample mean. The ANOVAs indicated that there was a statistically significant difference amongst the 3 groups at the 0.01 level on the PCL-R total scores (see table 10(a)). A post hoc comparison test (the Scheffe test) showed that the PCL-R total scores for the Mixed SOs were significantly higher than for the Adult SOs (p = 0.01) and the Child SOs (p = 0.03) Thus, it appears that Mixed SOs are significantly more psychopathic, as measured by the PCL-R, than Adult SOs and Child SOs, as had been hypothesised.

<table>
<thead>
<tr>
<th>PCL-R</th>
<th>Adult SOs mean (sd)</th>
<th>Child SOs mean (sd)</th>
<th>Mixed SOs mean (sd)</th>
<th>ANOVA F ratio</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCL-R total</td>
<td>15.73 (4.90)</td>
<td>15.09 (6.17)</td>
<td>20.63 (4.51)</td>
<td>5.95</td>
<td>0.004**</td>
</tr>
<tr>
<td>Factor 1 total</td>
<td>5.56 (2.27)</td>
<td>5.55 (2.16)</td>
<td>7.88 (2.90)</td>
<td>5.37</td>
<td>0.007**</td>
</tr>
<tr>
<td>Factor 2 total</td>
<td>8.18 (2.92)</td>
<td>8.09 (3.48)</td>
<td>10.38 (2.90)</td>
<td>3.12</td>
<td>0.048*</td>
</tr>
</tbody>
</table>

* The mean difference is significant at the 0.05 level
** The mean difference is significant at the 0.01 level

Table 10(a): Comparison of groups on PCL-R total and factor scores
With respect to Factor 1 ('interpersonal and affective traits') scores and Factor 2 ('socially deviant lifestyle') scores, there was a significant difference between the groups on Factor 1 scores at the 0.01 level (see table 10(a) above), with Mixed SOs scoring higher than the other two groups (Scheffe test: $p = 0.05$). There is also a significant difference between the groups on Factor 2 scores at the 0.05 level ($p=0.048$), again with the Mixed SOs scoring higher than the other two groups (Scheffe test: $p= 0.05$). (There was no significant difference between Adult SOs and Child SOs on either of the factor scores.)

As shown in table 10(b), other significant differences on the PCL-R were found to be on: Item 6, ($p = 0.02$), with the Mixed SOs showing greater 'Lack of remorse/guilt' (Sheffe test: $p= 0.02$); and Item 7, ($p = 0.01$), with Mixed SOs showing a higher degree of 'Shallow affect' (Sheffe test: $p= 0.03$). (Again, the differences between Adult SOs and Child SOs were not found to be statistically significant.)
<table>
<thead>
<tr>
<th>PCL-R item</th>
<th>Adult SOs</th>
<th>Child SOs</th>
<th>Mixed SOs</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mean (sd)</td>
<td>mean (sd)</td>
<td>mean (sd)</td>
<td>Chi-sq</td>
</tr>
<tr>
<td></td>
<td>median</td>
<td>median</td>
<td>median</td>
<td>value</td>
</tr>
<tr>
<td>1.Glib/superficial</td>
<td>0.38 (0.55)</td>
<td>0.27 (0.46)</td>
<td>0.50 (0.63)</td>
<td>0.93</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2.Grandiose selfworth</td>
<td>0.47 (0.56)</td>
<td>0.36 (0.50)</td>
<td>0.44 (0.73)</td>
<td>0.44</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>3. Need stimulation/prone to boredom</td>
<td>0.82 (0.79)</td>
<td>0.73 (0.46)</td>
<td>0.88 (0.80)</td>
<td>0.13</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>4.Pathological lying</td>
<td>0.23 (0.49)</td>
<td>0.45 (0.82)</td>
<td>0.63 (0.88)</td>
<td>2.38</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>5.Conning/manipulative</td>
<td>0.50 (0.61)</td>
<td>0.45 (0.68)</td>
<td>0.88 (0.72)</td>
<td>3.94</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>6. Lack of remorse/guilt</td>
<td>1.23 (0.55)</td>
<td>1.36 (0.50)</td>
<td>1.69 (0.48)</td>
<td>7.34</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7.Shallow affect</td>
<td>0.76 (0.65)</td>
<td>0.64 (0.50)</td>
<td>1.31 (0.70)</td>
<td>8.24</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>8.Callous/ lack of empathy</td>
<td>1.03 (0.67)</td>
<td>1.00 (0.44)</td>
<td>1.44 (0.51)</td>
<td>5.33</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>9.Parasitic lifestyle</td>
<td>1.35 (0.64)</td>
<td>1.18 (0.87)</td>
<td>1.50 (0.82)</td>
<td>1.56</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>10. Poor behavioural control</td>
<td>1.12 (0.68)</td>
<td>0.91 (0.70)</td>
<td>1.31 (0.70)</td>
<td>2.28</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>11.Promiscuous sexual behaviour</td>
<td>0.94 (0.81)</td>
<td>0.54 (0.82)</td>
<td>0.94 (0.85)</td>
<td>2.19</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>12. Early behavioural problems</td>
<td>1.00 (0.65)</td>
<td>1.00 (0.63)</td>
<td>1.44 (0.73)</td>
<td>5.18</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>13. Lack of realistic goals</td>
<td>0.62 (0.60)</td>
<td>0.54 (0.52)</td>
<td>0.94 (0.78)</td>
<td>2.55</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>14.Impulsivity</td>
<td>1.03 (0.57)</td>
<td>1.09 (0.30)</td>
<td>1.38 (0.50)</td>
<td>4.60</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>15.Irresponsibility</td>
<td>0.73 (0.51)</td>
<td>0.81 (0.75)</td>
<td>0.75 (0.68)</td>
<td>0.07</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>16. Failure to accept responsibility</td>
<td>0.91 (0.71)</td>
<td>1.00 (0.63)</td>
<td>1.13 (0.81)</td>
<td>0.95</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>17. Many short term marital relationships</td>
<td>0.35 (0.59)</td>
<td>0.36 (0.50)</td>
<td>0.31 (0.60)</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>18.Juvenile delinquency</td>
<td>1.08 (0.86)</td>
<td>1.09 (0.94)</td>
<td>1.44 (0.89)</td>
<td>2.09</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>19.Revocation of conditional release</td>
<td>0.41 (0.60)</td>
<td>0.73 (0.78)</td>
<td>0.75 (0.86)</td>
<td>2.60</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>20.Criminal versatility</td>
<td>0.79 (0.84)</td>
<td>0.54 (0.68)</td>
<td>1.00 (0.97)</td>
<td>1.52</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

*The mean difference is significant at the 0.05 level. [Due to skewness of data, medians have been provided and non-parametric ANOVA (Kruskall-Wallis) test used.]

Table 10(b): Comparison of groups on PCL-R item scores

Mislam;PsychD;2000
### 3.3.2 (b) Comparison of groups on Millon Clinical Multi-axial Inventory (MCMI-III) scores

Comparison of the groups on the Personality Disorder scales are shown in table 11.

The only significant differences found were on the ‘Compulsive’ scale (p=0.048) and the ‘Masochistic (Self-defeating)’ scale (p=0.052, i.e. approaching significance at 0.05 level), with the Mixed SOs being more compulsive and more masochistic than the other two groups. [For comparison of groups on all the MCMI scales, refer to appendix 18].

<table>
<thead>
<tr>
<th>MCMI variable</th>
<th>Adult SOs</th>
<th>Child SOs</th>
<th>Mixed SOs</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mean (sd)</td>
<td>mean (sd)</td>
<td>mean (sd)</td>
<td>F ratio</td>
</tr>
<tr>
<td>Schizoid (1)</td>
<td>53.00 (27.50)</td>
<td>56.89 (24.40)</td>
<td>72.67 (24.13)</td>
<td>2.35</td>
</tr>
<tr>
<td>Avoidance (2A)</td>
<td>54.30 (30.39)</td>
<td>61.67 (26.48)</td>
<td>68.00 (21.49)</td>
<td>1.05</td>
</tr>
<tr>
<td>Depressive (2B)</td>
<td>64.77 (28.32)</td>
<td>64.44 (19.37)</td>
<td>67.83 (17.57)</td>
<td>0.04</td>
</tr>
<tr>
<td>Dependent (3)</td>
<td>61.96 (26.37)</td>
<td>62.33 (23.54)</td>
<td>67.92 (21.35)</td>
<td>0.25</td>
</tr>
<tr>
<td>Histrionic (4)</td>
<td>42.81 (18.13)</td>
<td>36.33 (15.47)</td>
<td>28.25 (19.30)</td>
<td>2.73</td>
</tr>
<tr>
<td>Narcissistic (5)</td>
<td>46.61 (18.76)</td>
<td>54.55 (24.10)</td>
<td>44.92 (23.17)</td>
<td>0.62</td>
</tr>
<tr>
<td>Antisocial (6A)</td>
<td>61.23 (22.68)</td>
<td>68.33 (17.15)</td>
<td>71.83 (10.81)</td>
<td>1.37</td>
</tr>
<tr>
<td>Aggressive/sadistic</td>
<td>47.54 (22.44)</td>
<td>51.33 (25.98)</td>
<td>60.33 (18.15)</td>
<td>1.37</td>
</tr>
<tr>
<td>Compulsive (7)</td>
<td>46.31 (13.52)</td>
<td>35.78 (16.53)</td>
<td>69.75 (13.71)</td>
<td>0.74</td>
</tr>
<tr>
<td>Passive-Agressive</td>
<td>48.73 (29.92)</td>
<td>58.67 (24.98)</td>
<td>60.33 (30.59)</td>
<td>0.81</td>
</tr>
<tr>
<td>Masochistic (8B)</td>
<td>53.77 (25.45)</td>
<td>62.22 (19.82)</td>
<td>73.42 (16.59)</td>
<td>3.15</td>
</tr>
<tr>
<td>Schizotypal (S)</td>
<td>53.23 (23.34)</td>
<td>48.78 (29.49)</td>
<td>64.25 (1.45)</td>
<td>1.25</td>
</tr>
<tr>
<td>Borderline (C)</td>
<td>54.42 (17.96)</td>
<td>60.33 (20.85)</td>
<td>67.67 (18.01)</td>
<td>2.13</td>
</tr>
<tr>
<td>Paranoid (P)</td>
<td>50.58 (24.58)</td>
<td>67.22 (21.82)</td>
<td>66.33 (24.84)</td>
<td>2.59</td>
</tr>
<tr>
<td>Anxiety (A)</td>
<td>62.19 (34.74)</td>
<td>60.44 (39.26)</td>
<td>65.83 (36.99)</td>
<td>0.06</td>
</tr>
</tbody>
</table>

* The mean difference is significant at the 0.05 level
# The mean difference is approaching significance at the 0.05 level i.e. p= <0.06

Table 11: Comparison of groups on MCMI-III scores
3.3.2 (c) Comparison of groups on Sex Offender Assessment Pack (SOAP) scores

As can be seen in table 12, the only significant differences found between the groups on the SOAP scores were on ‘Emotional Loneliness’ (p = 0.04), with the Mixed SOs being more emotionally lonely than the other two groups (Scheffe test: p = 0.05), and on ‘Perspective-Taking’ (p = 0.01), with the Adult SOs being better at considering the perspective of others, compared to the other two groups (Scheffe test: p = 0.04).

<table>
<thead>
<tr>
<th>SOAP variable</th>
<th>Score range</th>
<th>Group 1 Mean (sd)</th>
<th>Group 2 Mean (sd)</th>
<th>Group 3 Mean (sd)</th>
<th>ANOVA F ratio</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>social desirability</td>
<td>50-65 (50-65)</td>
<td>55.72 (9.86)</td>
<td>50.33 (9.24)</td>
<td>51.91 (11.73)</td>
<td>1.14</td>
<td>0.33</td>
</tr>
<tr>
<td>emotional loneliness</td>
<td>20-80 (27-40)</td>
<td>44.00 (6.50)</td>
<td>44.00 (7.39)</td>
<td>50.72 (9.14)</td>
<td>3.45</td>
<td>0.04*</td>
</tr>
<tr>
<td>locus of control</td>
<td>4-27 (5-16)</td>
<td>16.04 (4.07)</td>
<td>18.44 (4.15)</td>
<td>18.73 (5.81)</td>
<td>1.76</td>
<td>0.18</td>
</tr>
<tr>
<td>perspective-taking</td>
<td>4-28 (14-21)</td>
<td>15.72 (4.21)</td>
<td>11.55 (5.36)</td>
<td>11.09 (5.66)</td>
<td>4.69</td>
<td>0.01*</td>
</tr>
<tr>
<td>empathic concern</td>
<td>4-28 (14-21)</td>
<td>22.36 (19.35)</td>
<td>15.78 (5.04)</td>
<td>17.18 (5.83)</td>
<td>0.85</td>
<td>0.44</td>
</tr>
<tr>
<td>fantasy</td>
<td>4-28 (5-16)</td>
<td>12.60 (3.57)</td>
<td>14.44 (5.54)</td>
<td>10.18 (3.51)</td>
<td>2.88</td>
<td>0.07</td>
</tr>
<tr>
<td>personal distress</td>
<td>3-28 (4-11)</td>
<td>13.20 (4.96)</td>
<td>13.22 (6.20)</td>
<td>12.54 (8.31)</td>
<td>0.05</td>
<td>0.95</td>
</tr>
<tr>
<td>self-esteem</td>
<td>3-8 (6-8)</td>
<td>6.84 (2.51)</td>
<td>5.56 (3.04)</td>
<td>6.36 (3.64)</td>
<td>0.65</td>
<td>0.53</td>
</tr>
<tr>
<td>under-assertive</td>
<td>3-36 (3-14)</td>
<td>9.80 (6.19)</td>
<td>10.22 (5.19)</td>
<td>8.36 (5.37)</td>
<td>0.31</td>
<td>0.73</td>
</tr>
<tr>
<td>over-assertive</td>
<td>2-36 (2-4)</td>
<td>3.48 (2.72)</td>
<td>2.55 (2.55)</td>
<td>5.73 (5.42)</td>
<td>2.30</td>
<td>0.11</td>
</tr>
</tbody>
</table>

* The mean difference is significant at the 0.05 level

Table 12: Comparison of groups on SOAP scores

3.3.2 (d) Comparison of groups on Blame Attribution Inventory (GBAI) scores

All participants scores on the GBAI (see table 13) were within the normal range for sex offenders (Gudjonsson & Singh, 1988; 1989). There was found to be no significant differences amongst the groups on any of the GBAI measures. Thus, the hypothesis that Adult SOs would have a comparatively more external attributional style and Child
SOs a more internal attributional style (Garlick et al, 1997) is not supported. Also, although Child SOs do appear to have a slightly higher guilt attribution score, this too is within the normal range and not significantly higher, thus the hypothesis that child sex abusers have more guilt feelings about their crime as compared to adult sex offenders (Blumenthal et al, 1999) is also not supported.

<table>
<thead>
<tr>
<th>GBAI factor</th>
<th>Norms (SD) for sex offenders</th>
<th>Adult SOs</th>
<th>Child SOs</th>
<th>Mixed SOs</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (sd)</td>
<td>Mean (sd)</td>
<td>Mean (sd)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>external</td>
<td>2.8 (2.3)</td>
<td>2.60 (2.36)</td>
<td>2.89 (2.03)</td>
<td>3.58 (4.35)</td>
<td>0.45</td>
</tr>
<tr>
<td>guilt</td>
<td>12.6 (3.6)</td>
<td>11.80 (3.47)</td>
<td>12.78 (3.86)</td>
<td>12.17 (3.51)</td>
<td>0.25</td>
</tr>
<tr>
<td>mental</td>
<td>5.8 (2.5)</td>
<td>6.60 (3.05)</td>
<td>5.33 (3.35)</td>
<td>5.83 (2.62)</td>
<td>0.68</td>
</tr>
</tbody>
</table>

Table 13: Comparison of groups on GBAI scores
3.4 Correlations between the standardised measures

Pearson correlation coefficients were conducted for all the measures to identify any relationships between them. Three correlation matrices were produced, as can be seen in appendices 19(a) to 19(c). The main hypotheses in relation to the standardised measures was regarding the possibility of a relationship between the PCL-R and the Personality Disorder scales of the MCMI-III. The results of the correlation between these two measures are shown in table 14, below. (Correlations with the SOAP and the GBAI were exploratory, and although some significant correlations were observed, none were notable in relation to the stated hypotheses stated. Hence, these will not be discussed further here.)

<table>
<thead>
<tr>
<th>MCMI Personality Disorder scale</th>
<th>PCL FACTOR 1</th>
<th>PCL FACTOR 2</th>
<th>PCL TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizoid (1)</td>
<td>.23</td>
<td>.07</td>
<td>.15</td>
</tr>
<tr>
<td>Avoidance (2A)</td>
<td>.01</td>
<td>-.04</td>
<td>-.08</td>
</tr>
<tr>
<td>Depressive (2B)</td>
<td>-.27</td>
<td>.01</td>
<td>-.16</td>
</tr>
<tr>
<td>Dependent (3)</td>
<td>-.20</td>
<td>-.05</td>
<td>-.18</td>
</tr>
<tr>
<td>Histrionic (4)</td>
<td>-.07</td>
<td>-.03</td>
<td>-.01</td>
</tr>
<tr>
<td>Narcissistic (5)</td>
<td>.09</td>
<td>.03</td>
<td>.08</td>
</tr>
<tr>
<td>Antisocial (6A)</td>
<td>.11</td>
<td>.28#</td>
<td>.29*</td>
</tr>
<tr>
<td>Aggressive/sadistic (6B)</td>
<td>.14</td>
<td>.30*</td>
<td>.31*</td>
</tr>
<tr>
<td>Compulsive (7)</td>
<td>.08</td>
<td>-.28#</td>
<td>-.13</td>
</tr>
<tr>
<td>Passive-Agressive (8A)</td>
<td>-.01</td>
<td>.09</td>
<td>.04</td>
</tr>
<tr>
<td>Masochistic (8B)</td>
<td>-.10</td>
<td>.08</td>
<td>-.01</td>
</tr>
<tr>
<td>Schizotypal (S)</td>
<td>.02</td>
<td>.01</td>
<td>.02</td>
</tr>
<tr>
<td>Borderline (C)</td>
<td>-.03</td>
<td>.09</td>
<td>.04</td>
</tr>
<tr>
<td>Paranoid (P)</td>
<td>.12</td>
<td>.15</td>
<td>.14</td>
</tr>
</tbody>
</table>

* The correlation is significant at the 0.05 level; # The correlation is approaching significance at the 0.05 level

Table 14: Correlations between the PCL-R and MCMI-III Personality Disorder Scales
4. DISCUSSION

4.1 Demographic, personal history and offence characteristics

With a mean age of approximately 40 years, the large majority (70%) of this sample was of White British origin with no formal qualifications (70%). A large majority (75%) had been single (i.e. not in a steady relationship) and unemployed (67%) at the time of the index offence.

There have been continuous debates about the ‘predictive’ value of demographic variables such as ethnicity, educational level, and employment status on offending behaviour but, as Klassen & O'Connor (1994) concluded from their review, “it is impossible to draw firm conclusions from the evidence in patient populations”. Preliminary analyses indicated that there were no significant differences between the groups on the basic demographic variables with the exception of victim age.

Most (83.6%) of the participants had experienced some form of major disruption in their childhood, mainly related to divorce or separation of parents. This finding is as might be expected in a population of mentally disordered sex offenders as parental loss, whether due to death, separation, or divorce, has often been demonstrated to be a correlate of violence and of psychopathology (e.g. Quinsey et al, 1975; Pfeffer et al, 1983; Klassen & O’Connor, 1994).

The large majority of the sample had experienced some form of abuse in childhood, mostly in the form of sexual abuse. This finding fits with the existing reports of high levels of childhood sexual abuse experiences in sex offenders (e.g. Benoit & Kennedy, 1992; Widom & Ames, 1994). Previous research has suggested that child molesters have a higher incidence of sexual abuse in their childhood than rapists (e.g. Bumby and Hansen, 1997). Although with a rate of 64% for Child SOs and 38% for Adult SOs, the data from this study appears consistent with this, the difference was not found to be statistically significant.
However, when the sample was divided into those who had sexually abused children (i.e. Child SOs and Mixed SOs) and those who had not (i.e. Adult SOs), the former were found to have significantly higher rates of childhood sexual abuse in their personal history. This finding is consistent with the notion that being sexually abused as a child may lead to the abused individual assuming that as an adult it is acceptable to sexually exploit or attempt to have a sexual relationship with a child (e.g. Finklehor & Araji, 1986).

There is evidence that the experience of a violent family environment and the witnessing of parental violence may be linked to later aggressive behaviour among sex offenders (Marshall & Barbaree, 1990; Widom, 1991; Luntz & Widom, 1994). In the present sample, there was not a high rate of childhood witnessing of domestic violence (i.e. 23%) and although the Adult SOs (with 24%) and Mixed SOs (with 31%) had higher rates of this experience in their history than did Child SOs (with 9%), the difference was not significant. However, the Adult SOs and Mixed SOs did use significantly more coercion and inflicted significantly more victim injury during their sexual offences than did the Child SOs. This is also consistent with previous reports of rapists using violence more often in their offending behaviour than do child molesters (e.g. Curtin & Niveau, 1998). In fact the figures for use of coercion for Adult SOs (80%) and Child SOs (37%) are very similar to those reported for rapists (86%) and child molesters (45%) by Curtin & Niveau. In relation to their higher rates of witnessing domestic violence, it may be that the Adult SOs and Mixed SOs are modelling the aggression witnessed in childhood (Klassen & O’Connor, 1994).

In line with this argument, some research has also found that rapists report a higher level of childhood physical abuse than do child molesters. For example, Bumby & Hansen (1997) found the rates to be 78% and 39%, respectively. Their finding was not replicated here. This may be attributable to differences in definitions of abuse. Bumby and Hansen do not specify their criteria for recording experiences of abuse in their sample, and in the present study, as discussed earlier (in section 2.4.6) specific criteria could not be defined and consistently applied as the information was obtained from the reports of others and thus relied on their individual definitions.
Another point is that if more qualitative information about the experience of childhood abuse could have been collected (e.g., intensity, frequency and duration of abuse), perhaps more sophisticated statistical analyses might have been conducted. As the chi-square is a test of low statistical significance, there is more chance of a type 2 error (i.e., saying there is no relationship when there might actually be one) than a type 1 error. However, with nominal data such as those in this study, the options for further testing with more subtle tests was limited.

On the basis of the suggestions of links between childhood abuse and aggression in adulthood (Marshall & Barbaree, 1990; Luntz & Widom, 1994), it might also be argued that Child SOs, due to their high rates of experiencing childhood sexual abuse, would also be violent towards their victims. However, it emerged that the Child SOs used the least coercion and caused the least injury to their sex offence victims than did the other two groups. A plausible explanation for this finding is that the victims of Child SOs (i.e. children) are likely to be more vulnerable and accessible for victimisation (Barnard et al, 1989) and more likely to offer little or no resistance (Brunhold, 1980).

Again, an important point to make here is in the difference in definitions applied in the research literature. The literal meaning of aggression is 'unprovoked attacking/attack; hostile or destructive behaviour' (Oxford English Dictionary, 1992). In this study, aggression was not specifically defined but inferred from the offender's use of coercion in sexual offences, that is, 'persuasion or restraint by force' (Oxford English Dictionary, 1992) in escalating degrees from threat to serious injury or death of the victim. Variations in definitions used across studies will, of course, affect the comparability of the results. However, linking the childhood abuse-to-adult aggression hypothesis (Marshall & Barbaree, 1990) and the finding of the low level of coercion (especially in the form of physical force) used by the Child SOs in this study, it is suggested that perhaps this group of offenders are more covertly aggressive in nature, than the other two groups who would appear to be more overtly aggressive.
4.2 Psychopathy

4.2.1 The sample as a whole

Although individual participants obtained total PCL-R scores above the diagnostic cut-off level, the range of scores on the PCL-R indicate that the sample as a whole was not highly psychopathic. With PCL-R total scores ranging from 6 to 30 (mean = 16.90) only 8% of the sample scored to a diagnostic level, using the cut-off score of 25, as suggested by Cooke (1995a) and endorsed by Hare (1998). However, the majority (67%) had scores within a ‘moderate’ range (i.e. total scores between 15 and 24).

The majority of this sample did not score as highly on the PCL-R as North American samples have done in previous research. Using his diagnostic cut-off score of 30, Hare (1991) reported prevalence rates of 28% and a mean PCL-R total score of 20.6 (SD = 7.8) in his standardisation samples from forensic populations. If the cut-off score of 30 was applied to the current sample, the prevalence rate for diagnostic levels of psychopathy would be 1.6% (i.e. n=1). These differences in prevalence rates and mean total scores are consistent with Cooke’s (1998) suggestions that there are cultural differences in the presentation and prevalence of psychopathy as measured by the PCL-R.

As discussed earlier (in section 2.3.1), using the cut-off score of 25, Cooke and Michie (1997b) found that the Scottish prevalence rate for psychopathy went up to 8%, still substantially lower than the North American prevalence rate of 28%. The finding of this study (that is, 8% of the sample having PCL-R total score of 25 or more) is consistent with the prevalence rate in the Scottish sample. However, if Cooke’s (1998) suggestion that there are fewer psychopaths in Scottish prison because they tend to migrate to England is accepted, the prevalence rates in England should be higher than in Scotland. Prevalence rates were not available for English prison samples to enable a direct comparison with Cooke’s sample. However, the few studies that have investigated psychopathy using the PCL-R in English prison samples have tended to find mean PCL-R total scores to be slightly higher than the score of 13.8 found in...
Cooke’s Scottish sample. For example, Raine (1985) reported a PCL-R mean total score of 16.2 (SD = 8.6).

In an English sample taken from across three Special Hospitals, Coid (1992) found the prevalence to be 21%. In the present study, although the prevalence rate was lower than that found by Coid the mean total PCL-R score of 16.9 (SD = 5.4) was consistent with Raine’s finding. Therefore, it cannot be concluded that there is a higher prevalence of psychopathy in this English sample than in Cooke’s Scottish sample, but it can be suggested that this sample displays more psychopathic tendencies than does the Scottish one.

It must of course be acknowledged that the different prevalance rates and mean PCL-R total scores found in the various studies may be a result of sampling effects. Although the various studies state they used prison samples, it needs to be noted that the security level of the prisons may vary. For example, the sample in a maximum security prison may differ considerably from that obtained in a low security prison. Also, the samples may consist of different types of offenders with very different psychopathologies. Although, Cooke (1998) states, that the differences “should not be dismissed as an artefact of sampling”, these are important points to consider before data across studies can be accurately compared and inferences made about particular populations.

4.2.2 Group differences
As for group differences, none of the Child SOs and only 3% (1/34) of the Adult SOs obtained PCL-R total scores to a diagnostic level (i.e. score of 25/>, whereas 25% of the Mixed SOs did so. As for ‘moderate’ scores of psychopathy (i.e. total PCL-R scores between 15 and 24), the prevalence rates were 67% (23/34) for Adult SOs, 55% (6/11) for Child SOs and 69% (11/16) for Mixed SOs. Thus preliminary analysis supported the hypothesis that Mixed SOs are the most psychopathic and Child SOs the least psychopathic.

The failure to show the Child SOs to score significantly lower on the PCL-R than Adult SOs, as had been hypothesised, may be due to the relatively small size of the
Child SO group (n=11) compared to that of Adult SO group (n=34), thus reducing effect size for significant differences to become apparent.

As stated, the Mixed SOs, were found to be significantly more psychopathic than the other two groups, as had been hypothesised. This may be due to their apparent lack of selectivity of victims, perhaps indicating a more indiscriminately violent nature. The Mixed SOs also scored significantly higher on the two Factor scores, indicating that they are more psychopathic in the interpersonal/affect traits of psychopathy (Factor 1) as well as on the social deviance traits (Factor 2). This seems to be consistent with their relatively higher scores on the MCMI-III scales of Antisocial (6A) and Sadistic(6B) personality disorder and on the Emotional Loneliness measure of the SOAP. It might be inferred from these results that the Mixed SOs have difficulties with attachment and in the formation and maintenance of interpersonal relationships.

Although the PCL-R group mean profiles for the Mixed SOs were generally higher than the other two group mean profiles (see figure 1), the only items on which they were found to score higher to a statistically significant level were Item 6 ('Lack of remorse/guilt') and Item 7 ('Shallow affect'), indicating that the Mixed SOs show 'a general lack of concern for the negative consequences that [their] actions, both criminal and non-criminal, have on others' and that they 'appear to be unable to experience a normal range and depth of emotions' (Hare, 1991; See appendix 2).

Mitchell & Blair (2000) have recently argued that compared to mentally healthy individuals, psychopaths have difficulties in processing the expressions of distress in others and so are less sensitive to the pain of others. From a clinical perspective, this presentation might be viewed as a coping strategy in Mixed SOs, facilitating the indiscriminately violent nature of the offending behaviour of this group.

The finding that Mixed SOs scored significantly higher on Items 6 and 7 of the PCL-R is consistent with the idea that they are more psychopathic as these items are two of the three items most discriminative of psychopathy as measured by the PCL-R (Cooke and Michie's (1995a). This is demonstrated by Cooke and Michie's (1995a) Item Response
Theory (IRT) analyses of the PCL-R data from 10 North American samples. IRT is a psychometric methodology for analysing the relationships between individual items and an underlying latent trait. For the PCL-R it was used to analyse the PCL-R items in terms of their level of discrimination and their level of extremity. Their analyses revealed that Items 6, 7, and 8 ('Callousness/lack of empathy') distinguish between high and low levels of psychopathy more efficiently than do the other items. It might be expected then that the Mixed SOs would score significantly higher on all three of these items. The expectation was founded for Items 6 and 7, but on Item 8, although they did score higher than the other two groups, this was found to be of borderline statistical significance (p=0.07).

4.3 Personality, social and emotional characteristics

In terms of personality, many of the individual participant’s scores on the MCMI-III scales were indicative of a diagnosis of one or more personality disorder. This was particularly so for the following scales: Dependent; Antisocial; and Masochistic.

On the MCMI-III group mean profiles, it appears that the Mixed SOs scored higher on most of the personality disorder scales. Amongst the highest scores were on the Antisocial and Sadistic Personality Disorder scales, both of which have been associated with psychopathy in past research (e.g. Hart et al, 1991; Holt et al, 1997), as will be discussed later (see section 4.4.1). However, the only significant group differences were that the Mixed SOs were found to have more compulsive and masochistic personality traits. The Compulsive and Masochistic (Self-defeating) scales are not among the 6 personality disorders scales found to correlate with psychopathy in previous research (Hart et al, 1991; 1994). However, examination of the definitions of these scales indicates some overlap with each other and with other scales.

Millon (1994) describes compulsive individuals in the following way: “Their prudent, controlled and perfectionistic ways derive from a conflict between hostility towards others and fear of social disapproval......Behind their front of propriety and restraint, however, are intense anger and oppositional feelings that occasionally break through their controls”. The “hostility towards others” and the “public compliance masking
internal anger" would appear to fit with antisocial and sadistic traits. Sadists are also described as "cloaking their more malicious and power-oriented tendencies in publicly approved roles and vocations, [but then] giving themselves away by their dominating, antagonistic, and frequently persecutory actions" (Millon, 1994).

Masochistic (self-defeating) individuals are described as "relating to others in an obsequious and self-sacrificing manner, allowing, and sometimes encouraging, others to take advantage of them" (Millon, 1994). As this description appears to contradict the traits that constitute the construct of psychopathy, it is not clear why Mixed SOs, if they are more psychopathic, would want to seek the approval of others. Perhaps there is a link between the fear of social disapproval in these apparently compulsive individuals and their seemingly self-defeating nature, that is, seeking approval from others by allowing themselves to be manipulated in order to overcome their apparent social inadequacy in forming appropriate relationships (according to the 'Emotional Loneliness' results on the SOAP).

It may also be possible that there is a conflict between an inner self-defeating nature and an outward more psychopathic nature. The PCL-R is aimed at identifying the more actively psychopathic traits and tends not to identify vulnerabilities such as masochistic (self-defeating) tendencies, whereas the MCMI is sensitive to a wider range of personality traits. So, it may be that the two measures have highlighted two conflicting aspects of the Mixed SO’s nature.

On social and emotional characteristics, as measured by the SOAP, although individual participants scored above the normal range on certain items, the mean scores for the sample as a whole generally appear not to show characteristics outside the normal range. The highest score when compared to normative ranges were in Emotional Loneliness and Personal Distress, with scores above the 60th percentile range on both measures.

There may be a link between the high rates of experiencing major disruptions and abuse in childhood, which are indirect indications of poor-quality attachments, and the
high levels of emotional loneliness shown in this sample. It has been suggested that poor-quality attachments that develop in childhood and persist into adulthood may lead to significant intimacy defects and loneliness, which eventually may result in attempts to emoleriate the feelings of loneliness through inappropriate partners (Ward et al, 1995).

However, it should also be noted that the relatively high Emotional Loneliness scores may be a reflection of current level of loneliness in their status as residents in a maximum security psychiatric institution, and may differ from the degree of loneliness experienced during their cycles of sexual offending or prior to offending and conviction (Bumby & Hansen, 1997). Garlick et al (1996) acknowledge the extreme, negative attitudes of both the general public and other incarcerated offenders towards sexual offending behaviour. They suggest that the loneliness experienced by sex offenders may be due to their being identified and singled out as being 'worse' than other offenders, rather than to some process occurring prior to their identification as sex offenders.

In terms of group differences, the findings from previous research of differences between rapists and child molesters on characteristics such as emotional loneliness, self-esteem and assertiveness (e.g. Marshall et al, 1995; Bumby & Hansen, 1997) were not replicated here. Again this may be due to the small sample size of the Child SO group. The Mixed SOs, however, scored significantly higher on Emotional Loneliness (p = 0.052, i.e. approaching statistical significance at 0.05 level) and significantly lower on Perspective-Taking (p< 0.05). This indicates that they display more social inadequacy in forming appropriate relationships (Russell et al, 1980) and have less ability to cognitively assume the role of the other (Davis, 1980) than the other two groups. Deficits in perspective taking may help explain their apparent lack of selectivity of victims and the indiscriminate nature of their offending behaviour.

As for their attributional style, the sample as a whole did not appear to make attributions on the internal-external, guilt or mental element factors in any way that was beyond the norm for the general population or for the sex offender populations
(Gudjonsson & Singh, 1988; 1989). One problem with the GBAI is that it is a fairly transparent measure and also is sensitive to the time of reporting. Thus, the responses on this measure, by this sample of institutionalised offenders (with the mean length of stay at the hospital being 8.8yrs) who have received treatment during their stay in hospital, may not be very reliable or accurate in relation to how they viewed their offending behaviour nearer the time of having committed them.

4.4. Correlations between the PCL-R and MCMI-III

Based on previous research, it was hypothesised that the PCL-R score would correlate positively with 6 of the 13 MCMI personality disorder scales, namely, Narcissistic, Antisocial, Sadistic, Passive-Aggressive, Borderline and Paranoid (Hart et al, 1991; see appendix 1). The results of the current study did follow this trend, but the only correlations to reach statistical significance were between the PCL-R and the MCMI Antisocial (r = .29) and Sadistic (r = .31) scales. In fact, these were the two highest correlations (r = .45 and r = .36, respectively) found by Hart et al (1991). Also, when they later correlated DSM-III-R personality disorder criteria with the PCL-R (Hart et al 1994) they found the correlation with Antisocial PD to be the highest (.80) and with Sadistic PD to be relatively high (.60).

As the MCMI Antisocial PD scale is effectively supposed to be measuring the same construct as the PCL-R and sadism is perhaps the next most closely related construct (Holt et al, 1999), the correlations observed in this study were somewhat lower than might be expected. Also, they were lower than those previously reported (Hart et al, 1991;1994). This, and the failure to find correlations between psychopathy and the other MCMI Personality Disorder scales, which were shown to be correlated by Hare et al (1991) may be due again to the relatively small sample size. These results do, however, indicate that there is some correlation between the PCL-R and the MCMI-III. Thus, as Hart et al (1991) concluded, the MCMI may be useful for identifying psychopathic individuals, but should not be used alone to do so, especially as the PCL-R is a more robust measure of psychopathy.
Millon (1994) describes antisocial individuals as “engaging in duplicitous or illegal behaviour designed to exploit the environment, [that is], to counter the pain and depredation they expect from others” and sadistic individuals as those who are “not judged publicly to be antisocial [but] derive pleasure and satisfaction from humiliating others and violating their rights and feelings”. It seems that although antisocial tendencies and sadism are traits of psychopathy, they are not as broad or complex as the construct of psychopathy.

In the Holt et al (1999) study discussed earlier, they specifically investigated the relationship between sadism (using MCMI-II) and psychopathy (using PCL-R) and found that psychopaths were indeed more sadistic than non-psychopaths. They concluded that the finding of a significant correlation between sadism and psychopathy has theoretical and clinical implications. First, it provides empirical support to the theoretical premise that psychopaths relate to others on the basis of power and dominance rather than affection (Meloy, 1992), as many of the heavily weighted items on the MCMI Sadistic scale (6B) make references to damaged interpersonal relationships and control of others to regain feelings of personal adequacy (Millon, 1987). Second, these data predict that sadism or sadistic traits would have particular clinical salience in a patient whose PCL-R score were in the diagnostic range.

4.5 Summary and Implications of Findings

Having categorised the sample of sex offenders into three subgroups on the basis of victim age, it was possible to identify features that distinguish the Mixed SOs from the Adult SOs and Child SOs. From the results of this study, the picture that emerges of the Mixed SOs at Broadmoor Hospital is that they are ‘moderately’ psychopathic with correlating levels of antisocial and sadistic personality characteristics. They also show personality traits with a relatively higher tendency towards compulsivity and masochism. They are relatively more emotionally lonely (i.e. inadequate in forming appropriate relationships) and have particular difficulties in appreciating the perspectives of others. It is suggested that this presentation contributes to their high
level of violence towards their victims and lack of differentiation in terms of the age of their victims.

There is also an indication of higher sexual recidivism within the Mixed SO group as it was shown that the mean number of victims of this group was higher than for the other two groups. However, it should be noted that simply observing the 'number of victims' as a variable is misleading when considering recidivism in offender groups as some offences may have involved more than one victim (or more than two victims, in the case of Mixed SOs). As recidivism refers to 're-offending' (i.e. committing a further offence), to avoid confounding effects, researchers interested in comparing recidivism between groups should investigate number of separate offences as opposed to number of victims.

The main hypotheses that the Mixed SOs would be more psychopathic than the Child SOs and Adult SOs, was supported. Their higher psychopathy ratings on the PCL-R identifies them as a higher risk group for violent and sexual recidivism and hence, poorer prognosis in treatment (Hare, 1998; Perkins et al, 1998). This distinction is useful in terms of clinical assessment and treatment and in the areas of risk assessment, risk management and treatment outcome research (as was discussed in the literature review by the present author; Islam, 2000), where this under-researched subgroup may require specialised attention.

When presented with sex offenders who have victimised both adults and children, clinicians may need to incorporate the PCL-R and the MCMI Personality Disorder scales in their assessment procedure. To date, mixed sex-offenders have not been treated differently, but treated as either adult rapists or child sex offenders. The knowledge that mixed sex-offenders may be more psychopathic and hence more resistant to treatment (e.g. Hare, 1998), perhaps indicates the need for longer-term, specifically-designed treatment packages.

The indication that mixed sex-offenders have vulnerable personality characteristics as well as their aggressive and antisocial nature, points to the need to address factors such
as emotional loneliness and difficulties in perspective taking in the assessment and treatment process. Cognitively based interventions may be particularly effective and worthwhile in teaching sex offenders appropriate strategies for coping with such social inadequacies (Bumby & Hansen, 1997) and interpersonal therapies may help them learn how to form appropriate adult relationships.

In terms of the sample as a whole, the issue of cultural differences in prevalence rates of psychopathy as measured by the PCL-R is an important topic which has both research and clinical implications. As the PCL has proven itself to be a robust measure of psychopathy (e.g. Serin et al, 1994) it is becoming as widely used in Europe as it is in North America. PCL-R ratings may form part of the assessment of an individual offender upon which decisions are made about his disposal and treatment. Therefore, it is imperative that information disseminated by researchers about psychopathy as a construct is culturally-informed. However, more extensive research is required to understand the differences between cultures and within specific populations.

4.6. Methodological considerations

4.6.1. Sample size

Perhaps the main criticism of this study is in the sample size. Although the group of Adult SOs was of a reasonable size, the other two groups, particularly the Child SOs (n=11), were too small for any conclusive comments to be made from the statistical analyses. The Child SO group was not as large as had been estimated when planning the study. From the databases at Broadmoor hospital, 16 were identified, of whom 11 participated (i.e. 69%). This lower than expected outcome may partially be due to the fact that some of the offenders who had previously been considered to be child sex offenders were actually found to meet the criteria for the Mixed SO group in this study.

However, it should also be noted that, the sample of 61 sex offenders was a representative sample from the population of sex offenders currently resident at Broadmoor Hospital and the response rate of 68% is considered very reasonable for research in this setting. Also, for the Mixed SOs, of the 17 individuals identified who
met the criteria for this group in the hospital, 16 were included in this study. Therefore, the only way of improving on numbers for the Child SO and Mixed SO groups would be to combine samples from other Special Hospitals in the U.K. This option had been considered here, but was not practicable due to time and resource constraints.

4.5.2. Self-report measures

Other than the PCL-R ratings, much of the data in this study was acquired via self-report measures. Self-report measures of personality have played a significant role in establishing the relevance of individual differences to criminal behaviour (Andrews & Wormith, 1989), although there are obvious arguments about reliability. This problem is overcome by the use of the lie scales built into some measures.

In research with psychopaths, Hare and Hart (1993) argue that because the tendency for lying is one of the traits of psychopathy, psychopaths are particularly likely to falsify personality questionnaires. Blackburn (1998), however, cites research which indicates that psychopaths are not any more prone than other individuals to falsification on these measures. For example, Hogan and Nicholson (1988) argue self-report measures of personality are less concerned with verifiable facts than with beliefs about the sort of person one is, that is, responses to items on personality questionnaires are not, in fact, "self-reports", but are rather "self-presentations, formally identical to responses to questions in an employment interview". Also, it should be noted that the issue of low correlation between self-ratings and observer ratings is a persistent one in personality assessment and not unique to psychopathy research (Blackburn, 1998).

In terms of the childhood history of major disruptions and abuse, the limitation within the present study was that the information was recorded by different reporters and thus the definitions they applied may not have been consistent. However, the collection of this data from early historical documentation in the files, for example the social workers' comprehensive assessment report, had the advantage over retrospective self-reports which are generally viewed as being more unreliable (Henry et al, 1994).
4.5.3 File based PCL-R ratings

Although the validity of using file-only based PCL-R ratings was discussed (Wong, 1988; Grann et al, 1998), the limitations of doing this, as opposed to file-and-interview ratings, needs to be acknowledged. Hare (1998) states these to be: (1) the potential for the rater to place too much emphasis on specific entries made in the file by another professional, and (2) the difficulty in scoring Factor 1 ('interpersonal and affective traits') items properly without interviewing the individual.

The first problem can be resolved by the rater consciously seeking out multiple and consistent pieces of evidence to support a particular score on an item, as was done in this study. The second problem is a more difficult one to control. Factor 1 items tend to be based on what Cooke (1998) describes as “comparatively soft data”, which to score requires the application of considerable inference and judgement on the part of the rater (e.g. Item 1: Glibness/superficial charm). By comparison, “comparatively hard data” tend to be more fact based, requiring little inference or judgement (e.g. Item 12: Early behavioural problems).

In this study, although the PCL-R ratings were file-based, the rater also interviewed the participants for completion of the other questionnaires. This personal contact with the individuals helped in the scoring of the “soft data” items, by allowing the rater to judge whether there was consistency between the individual met and the individual described in the file.

In his comparison of file-only and file-and-interview based PCL-R ratings, Wong (1988) stated that although the overall means were the same with either method, “it is still possible that the structured interview may have increased scores for some cases and decreased scores for others”. He also stated that file-based PCL-Rs may slightly underestimate the number of subjects assigned to the “high-psychopathy group” (that is, those with PCL-R total score of 30 or more). Thus, perhaps if file-and-interview based PCL-R ratings were conducted in the present study, there may have been more participants with PCL-R ratings at ‘diagnostic’ levels.
5. CONCLUSIONS and RECOMMENDATIONS

The main hypothesis that mixed sex-offenders are a more psychopathic subgroup of sex offenders was supported. This is consistent with indications that sex offenders who offend against both children and adults represent a particularly high risk group for sexual offending and re-offending. They are characterised by high rates of childhood abuse experiences and the frequent use of threats and physical coercion in the commission of their offences.

Although not all the other hypotheses were supported to a statistically significant level, the trends in the results were generally in the expected direction, thus warranting further investigation on these issues with larger samples. A particularly useful extension of this study would be to sample across all the Special Hospitals in the UK as this could further the discussion on cultural influences on psychopathy and determine whether these results hold with larger samples.

This may be considered a pilot study. The sample was a relatively small, albeit specialised group of mentally disordered sex offenders incarcerated in a maximum security psychiatric institution, and is therefore not representative of the general population of sex offenders. Therefore caution needs to be applied in generalising the specifics of these findings to the broader population of sex offenders. It cannot, for example, be generalised to sex offenders in prison settings or those in the community, due to differences in psychopathology and the effects of institutionalisation.

As this study was conducted within a clinical setting, the findings offer insight into the possible usefulness of differentiating subgroups of sex offenders for assessment and treatment purposes. As for categorisation of sex offenders on the basis of the age of their victims, it is not suggested that this should stand alone as a distinguishing factor, but that victim age may be an important discriminator amongst this heterogeneous population of offenders which may contribute to assessment, management and treatment procedures.
Further exploration of the specific nature or direction that assessment and treatment approaches might take is clearly warranted. The psychopathology of the sex offender and different subgroups of sex offenders needs to be further examined and variables such as personality traits, social competence and other pre-disposing factors among sex offenders need to be addressed to a greater degree (Marshall et al, 1995). The objective of this would of course be to reduce the accelerating incidences of reported sex offences (e.g. Marshall, 1997) resulting in the sexual victimisation of increasing numbers of victims.
REFERENCES


Cleckley, H. (1941) The Mask of Sanity, St. Louis, MO: Mosby. [Cited in Blackburn, 1989; above]


### Appendix 1: Comparison of the MCMI-II Scales with the PCL-R and APD Measures

[From: Hart et al, 1991]

<table>
<thead>
<tr>
<th>MCMl-II scale</th>
<th>Mean (SD)</th>
<th>Total r</th>
<th>Fac. 1 r</th>
<th>Fac. 2 r</th>
<th>Diagnosis r</th>
<th>Symptoms r</th>
</tr>
</thead>
<tbody>
<tr>
<td>X'</td>
<td>68.9 (20.7)</td>
<td>.27</td>
<td>.10</td>
<td>.35*</td>
<td>.23</td>
<td>.32*</td>
</tr>
<tr>
<td>Y</td>
<td>63.0 (17.0)</td>
<td>-.05</td>
<td>.06</td>
<td>-.13</td>
<td>.04</td>
<td>-.18</td>
</tr>
<tr>
<td>Z</td>
<td>50.1 (20.3)</td>
<td>.13</td>
<td>.00</td>
<td>.21</td>
<td>.13</td>
<td>.17</td>
</tr>
<tr>
<td>1</td>
<td>63.5 (22.1)</td>
<td>.06</td>
<td>-.05</td>
<td>.16</td>
<td>.06</td>
<td>.11</td>
</tr>
<tr>
<td>2</td>
<td>63.4 (31.0)</td>
<td>.17</td>
<td>.00</td>
<td>.27</td>
<td>.14</td>
<td>.23</td>
</tr>
<tr>
<td>3</td>
<td>38.8 (33.2)</td>
<td>-.20</td>
<td>-.16</td>
<td>-.20</td>
<td>-.07</td>
<td>-.27</td>
</tr>
<tr>
<td>4</td>
<td>71.3 (16.6)</td>
<td>.14</td>
<td>.09</td>
<td>.13</td>
<td>.21</td>
<td>.24</td>
</tr>
<tr>
<td>5</td>
<td>82.9 (19.4)</td>
<td>.31*</td>
<td>.24</td>
<td>.28*</td>
<td>.27</td>
<td>.35*</td>
</tr>
<tr>
<td>6A</td>
<td>94.3 (22.6)</td>
<td>.45*</td>
<td>.24</td>
<td>.51*</td>
<td>.33*</td>
<td>.51*</td>
</tr>
<tr>
<td>6B</td>
<td>78.7 (24.4)</td>
<td>.35*</td>
<td>.28*</td>
<td>.34*</td>
<td>.17</td>
<td>.38*</td>
</tr>
<tr>
<td>7</td>
<td>57.5 (55.7)</td>
<td>-.02</td>
<td>.07</td>
<td>-.08</td>
<td>-.02</td>
<td>-.10</td>
</tr>
<tr>
<td>8A</td>
<td>74.8 (32.3)</td>
<td>.28*</td>
<td>.10</td>
<td>.36*</td>
<td>.22</td>
<td>.38*</td>
</tr>
<tr>
<td>8B</td>
<td>58.9 (24.8)</td>
<td>.14</td>
<td>.01</td>
<td>.22</td>
<td>.16</td>
<td></td>
</tr>
<tr>
<td>S</td>
<td>64.0 (19.9)</td>
<td>.27</td>
<td>.11</td>
<td>.34*</td>
<td>.17</td>
<td>.23</td>
</tr>
<tr>
<td>C</td>
<td>67.3 (21.5)</td>
<td>.28*</td>
<td>.11</td>
<td>.34*</td>
<td>.24</td>
<td>.35*</td>
</tr>
<tr>
<td>P</td>
<td>66.6 (14.9)</td>
<td>.33*</td>
<td>.26</td>
<td>.30*</td>
<td>.26</td>
<td>.29*</td>
</tr>
<tr>
<td>A</td>
<td>36.6 (29.2)</td>
<td>-.16</td>
<td>-.22</td>
<td>-.07</td>
<td>-.04</td>
<td>-.15</td>
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<tr>
<td>H</td>
<td>46.2 (19.0)</td>
<td>-.11</td>
<td>-.09</td>
<td>-.10</td>
<td>.04</td>
<td>.02</td>
</tr>
<tr>
<td>N</td>
<td>59.6 (15.6)</td>
<td>.17</td>
<td>.16</td>
<td>.13</td>
<td>.23</td>
<td>.25</td>
</tr>
<tr>
<td>D</td>
<td>41.4 (28.4)</td>
<td>-.13</td>
<td>-.15</td>
<td>-.07</td>
<td>-.04</td>
<td>-.10</td>
</tr>
<tr>
<td>B</td>
<td>66.8 (21.8)</td>
<td>.17</td>
<td>-.04</td>
<td>.30*</td>
<td>.16</td>
<td>.38*</td>
</tr>
<tr>
<td>T</td>
<td>79.9 (19.4)</td>
<td>.32*</td>
<td>.12</td>
<td>.41*</td>
<td>.32*</td>
<td>.51*</td>
</tr>
<tr>
<td>SS</td>
<td>55.6 (21.9)</td>
<td>.34*</td>
<td>.23</td>
<td>.37*</td>
<td>.23</td>
<td>.30*</td>
</tr>
<tr>
<td>CC</td>
<td>46.4 (19.1)</td>
<td>.03</td>
<td>-.14</td>
<td>.17</td>
<td>.09</td>
<td>.10</td>
</tr>
<tr>
<td>PP</td>
<td>56.5 (17.0)</td>
<td>.37*</td>
<td>.25</td>
<td>.38*</td>
<td>.29*</td>
<td>.32*</td>
</tr>
</tbody>
</table>

*Note. N = 119. See Table 1 for explanation of the MCMl-II scale abbreviations. PCL-R = Revised Psychopathy Checklist; Fac. 1 = PCL-R Factor 1; Fac. 2 = PCL-R Factor 2; APD = DSM-III-R antisocial personality disorder; Diagnosis = APD diagnosis (0 = no, 1 = yes); Symptoms = number of adult APD symptoms. The familywise Type I error rate for each column of correlations was held at αFW = .05 by setting the testwise Type I error rate at αFW = .05/25 = .002. *pFW < .002; pFW < .05.
Appendix 2: Basic demographic and offence-related data on patients who refused to participate in this study (n=23)

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>SPECIFICS / CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Age (yrs): mean (min-max)</td>
<td>43.0yrs (27-68yrs)</td>
</tr>
<tr>
<td>Ethnic Background</td>
<td>White British = 15 (65%); Black West African = 3 (13%); Black African = 3 (13%); Mixed race/Other = 2 (9%)</td>
</tr>
<tr>
<td>Length of stay at Broadmoor (yrs): mean (min-max)</td>
<td>7.9yrs (13months - 26.5 yrs)</td>
</tr>
<tr>
<td>MHA Classification</td>
<td>Mental illness = 12 (52%); Psychopathic disorder = 9 (39%); Dual Mental illness/Psychopathic Disorder = 2 (9%)</td>
</tr>
<tr>
<td>No. of victims of sex offences: mean</td>
<td>1.4 (range: 1 to 4)</td>
</tr>
<tr>
<td>Sex of victims of sex offences</td>
<td>Male = 6 (19%); Female = 26 (81%)</td>
</tr>
<tr>
<td>Age range of victims of sex offences</td>
<td>4yrs to 54yrs</td>
</tr>
<tr>
<td>Sex offender group allocation</td>
<td>Adult SOs = 17 ((74%); Child Sos = 5 (22%); Mixed SO = 1 (4%)</td>
</tr>
</tbody>
</table>
Appendix 3: PCL-R Item Descriptions

[From: PCL-R Manual; Hare, 1991]

Item 1: Glibness / Superficial Charm - Describes a glib, voluble, verbally facile individual who exudes an insincere and superficial sort of charm. He is often an amusing and entertaining conversationalist, is always ready with a quick and clever comeback, and is able to tell unlikely but convincing stories that place him in a good light. He may succeed in presenting himself well and seem likeable, but, he generally seems too slick and smooth to be entirely believable.

Item 2: Grandiose Sense of Self-Worth - Describes an individual with a grossly inflated view of his abilities and self-worth. His inflated ego and exaggerated regard for his own abilities are remarkable, given the facts of his life.

Item 3: Need for Stimulation/ Proneness to Boredom - Describes an individual who demonstrates a chronic and excessive need for novel and exciting stimulation, and an unusual proneness to boredom. He will usually express a strong interest in taking chances. “living life in the fast lane” or “on the edge”, being “where the action is” and in doing things that are exciting, risky, or challenging.

Item 4: Pathological Lying - Describes an individual for whom lying and deceit are a characteristic part of his interactions with others. He is capable of fabricating elaborate accounts of his past even though he knows that his story can easily be checked. When caught in a lie or when challenged with the truth, he seldom appears perplexed or embarrassed; he simply changes his story or attempts to rework the facts to fit his lies.

Item 5: Conning / Manipulative - Although similar in some respects to Item 4 (Pathological Lying), Item 5 is more concerned with the use of deceit and deception to cheat, bilk, defraud, or manipulate others. The use of schemes and scams, motivated by a desire for personal gain (money, sex, status, power, etc.) and carried out with no concern for their effects on victims.

Item 6: Lack of Remorse or Guilt - Describes an individual who shows a general lack of concern for the negative consequences that his actions, both criminal and noncriminal, have on others. He is more concerned with the effects that his actions have upon himself that he is about any suffering experienced by his victims or damage done to society.

Item 7: Shallow Affect - Describes an individual who appears unable to experience a normal range or depth of emotion. At times, he may impress as cold and unemotional. Displays of emotion generally are dramatic, shallow, short-lived; They leave careful observers with the impression that he is play-acting and that little of real significance is going on below the surface. He may admit that he is unemotional or that he shams emotions.

Item 8: Callous / Lack of Empathy - Describes an individual whose attitudes and behaviour indicate a profound lack of empathy and a callous disregard for the feelings, rights, and welfare of others. He is only concerned with “Number 1”, and views others as objects to be manipulated.

Item 9: Parasitic Lifestyle - Describes an individual for whom financial dependence on others is an intentional part of his lifestyle. Although able-bodied, he avoids steady, gainful employment; instead, he continually relies on family, relatives, friends, or social assistance.

Item 10: Poor Behavioural Controls - Describes an individual with inadequate behaviour controls. He may be described as short-tempered or hot-headed. He tends to respond to
frustration, failure, discipline, and criticism with violent behaviour or with threats and verbal abuse.

**Item 11: Promiscuous Sexual Behaviour** - Describes an individual whose sexual relations with others are impersonal, casual, or trivial. This may be reflected in frequent casual liaisons (e.g. "one-nights stands"), indiscriminate selection of sexual partners, maintenance of several sexual relationships concurrently, frequent infidelities, prostitution, or a willingness to participate in a wide variety of sexual activities.

**Item 12: Early Behaviour Problems** - Describes an individual who had serious behavioural problems as a child (i.e. age 12 and below). These problems may include persistent lying, theft, robbery, fire-setting, truancy, disruption of classroom activities, substance abuse, vandalism, violence, bullying, running away from home, and precocious sexual activities.

**Item 13: Lack of Realistic, Long-Term Goals** - Describes an individual who demonstrates an inability or unwillingness to formulate and carry out realistic, long-term plans and goals. He tends to live day to day and to change his plans frequently. He does not give serious thought to the future, nor does he worry about it very much.

**Item 14: Impulsivity** - Describes an individual whose behaviour is generally impulsive, unpremeditated, and lacking in reflection or forethought. He usually does things on the "spur of the moment" because he "feels like it" or because an opportunity presents itself. He is unlikely to spend much time weighing the pros and cons of a course of action, or in considering the possible consequences of his actions to himself or to others.

**Item 15: Irresponsibility** - Describes an individual who habitually fails to fulfill or honour obligations and commitments to others. He has little or no sense of duty or loyalty to family, friends, employers, society, ideas, or causes.

**Item 16: Failure to Accept Responsibility for Own Actions** - Describes an individual who is unable or unwilling to accept personal responsibility for his own actions (both criminal and noncriminal) or for the consequences of his actions. He usually has some excuse for his behaviour, placing the blame on others (society, family, accomplices, victims, the system, etc.)

**Item 17: Many Short-term Marital Relationships** - Describes an individual who has had many marital relationships (defined as, 'a live-in relationship that involves some degree of commitment from one or both partners') includes, heterosexual and homosexual partnerships.

**Item 18: Juvenile Delinquency** - Describes an individual who has a history of serious antisocial behaviour as an adolescent, aged 17 and below. This includes both charges and convictions for criminal and statutory offences.

**Item 19: Revocation of Conditional Release** - Describes an individual who, as an adult (aged 18 or older), has violated a conditional release or escaped from an institution. Violations of conditional release include technical but noncriminal breaches (i.e. drinking alcohol while on parole), or new charges or convictions, while on parole, mandatory supervision, probation, bail, or restraining orders. Escapes from institutions include jail-breaking and violation of temporary absences.

**Item 20: Criminal Versatility** - Describes an individual whose adult criminal record involves charges or convictions for many different types of offences.
Lately, my strength seems to be draining out of me, even in the morning.

I think highly of rules because they are a good guide to follow.

I enjoy doing so many different things that I can't make up my mind what to do first.

I feel weak and tired much of the time.

I know I'm a superior person, so I don't care what people think.

People have never given me enough recognition for the things I've done.

If my family puts pressure on me, I'm likely to feel angry and resist doing what they want.

People make fun of me behind my back, talking about the way I act or look.

I often criticize people strongly if they annoy me.

What few feelings I seem to have I rarely show to the outside world.

I have a hard time keeping my balance when walking.

I show my feelings easily and quickly.

My drug habits have often gotten me into a good deal of trouble in the past.

Sometimes I can be pretty rough and mean in my relations with my family.

Things that are going well today won't last very long.

I am a very agreeable and submissive person.

As a teenager, I got into lots of trouble because of bad school behavior.

I'm afraid to get really close to another person because it may end up with my being ridiculed or shamed.

I seem to choose friends who end up mistreating me.

I've had sad thoughts much of my life since I was a child.

21. I like to flirt with members of the opposite sex.

22. I'm a very erratic person, changing my mind and feelings all the time.

23. Drinking alcohol has never caused me any real problems in my work.

24. I began to feel like a failure some years ago.

25. I feel guilty much of the time for no reason that I know.

26. Other people envy my abilities.

27. When I have a choice, I prefer to do things alone.

28. I think it's necessary to place strict controls on the behavior of members of my family.

29. People usually think of me as a reserved and serious-minded person.

30. Lately, I have begun to feel like smashing things.

31. I think I'm a special person who deserves special attention from others.

32. I am always looking to make new friends and meet new people.

33. If someone criticized me for making a mistake, I would quickly point out some of that person's mistakes.

34. Lately, I have gone all to pieces.

35. I often give up doing things because I'm afraid I won't do them well.

36. I often let my angry feelings out and then feel terribly guilty about it.

37. I very often lose my ability to feel any sensations in parts of my body.

38. I do what I want without worrying about its effect on others.

39. Taking so-called illegal drugs may be unwise, but in the past I found I needed them.

40. I guess I'm a fearful and inhibited person.
41. I've done a number of stupid things on impulse that ended up causing me great trouble.
42. I never forgive an insult or forget an embarrassment that someone caused me.
43. I often feel sad or tense right after something good has happened to me.
44. I feel terribly depressed and sad much of the time now.
45. I always try hard to please others, even when I dislike them.
46. I've always had less interest in sex than most people do.
47. I tend to always blame myself when things go wrong.
48. A long time ago, I decided it's best to have little to do with people.
49. Since I was a child, I have always had to watch out for people who were trying to cheat me.
50. I strongly resent "big shots" who always think they can do things better than I can.
51. When things get boring, I like to stir up some excitement.
52. I have an alcohol problem that has made difficulties for me and my family.
53. Punishment never stopped me from doing what I wanted.
54. There are many times, when for no reason, I feel very cheerful and full of excitement.
55. In recent weeks I feel worn out for no special reason.
56. For some time now I've been feeling very guilty because I can't do things right anymore.
57. I think I am a very sociable and outgoing person.
58. I've become very jumpy in the last few weeks.
59. I keep very close track of my money so I am prepared if a need comes up.
60. It just hasn't had the luck in life that others have had.
61. Ideas keep turning over and over in my mind and they won't go away.
62. I've become quite discouraged and sad about life in the past year or two.
63. Many people have been spying into my private life for years.
64. I don't know why, but I sometimes say cruel things just to make others unhappy.
65. I flew across the Atlantic 30 times last year.
66. My habit of abusing drugs has caused me to miss work in the past.
67. I have many ideas that are ahead of the times.
68. Lately, I have to think things over and over again for no good reason.
69. I avoid most social situations because I expect people to criticize or reject me.
70. I often think that I don't deserve the good things that happen to me.
71. When I'm alone, I often feel the strong presence of someone nearby who can't be seen.
72. I feel pretty aimless and don't know where I'm going in life.
73. I often allow others to make important decisions for me.
74. I can't seem to sleep, and wake up just as tired as when I went to bed.
75. Lately, I've been sweating a great deal and feel very tense.
76. I keep having strange thoughts that I wish I could get rid of.
77. I have a great deal of trouble trying to control an impulse to drink to excess.
78. Even when I'm awake, I don't seem to notice people who are near me.
79. I am often cross and grouchy.
80. It is very easy for me to make many friends.
I'm ashamed of some of the abuses I suffered when I was young.

I always make sure that my work is well planned and organized.

My moods seem to change a great deal from one day to the next.

I'm too unsure of myself to risk trying something new.

I don't blame anyone who takes advantage of someone who allows it.

For some time now I've been feeling sad and blue and can't seem to snap out of it.

I often get angry with people who do things slowly.

I never sit on the sidelines when I'm at a party.

I watch my family closely so I'll know who can and who can't be trusted.

I sometimes get confused and feel upset when people are kind to me.

My use of so-called illegal drugs has led to family arguments.

I'm alone most of the time and I prefer it that way.

There are members of my family who say I'm selfish and think only of myself.

People can easily change my ideas, even if I thought my mind was made up.

I often make people angry by bossing them.

People have said in the past that I became too interested and too excited about too many things.

I believe in the saying, "early to bed and early to rise..."

My feelings toward important people in my life often swing from loving them to hating them.

In social groups I am almost always very self-conscious and tense.

I guess I'm no different from my parents in becoming somewhat of an alcoholic.

I guess I don't take many of my family responsibilities as seriously as I should.

Ever since I was a child, I have been losing touch with the real world.

Sneaky people often try to get the credit for things I have done or thought of.

I can't experience much pleasure because I don't feel I deserve it.

I have little desire for close friendships.

I've had many periods in my life when I was so cheerful and used up so much energy that I fell into a low mood.

I have completely lost my appetite and have trouble sleeping most nights.

I worry a great deal about being left alone and having to take care of myself.

The memory of a very upsetting experience in my past keeps coming back to haunt my thoughts.

I was on the front cover of several magazines last year.

I seem to have lost interest in most things that I used to find pleasurable, such as sex.

I have been downhearted and sad much of my life since I was quite young.

I've gotten into trouble with the law a couple of times.

A good way to avoid mistakes is to have a routine for doing things.

Other people often blame me for things I didn't do.

I have had to be really rough with some people to keep them in line.

People think I sometimes talk about strange or different things than they do.

There have been times when I couldn't get through the day without some street drugs.

People are trying to make me believe that I'm crazy.

I do something desperate to prevent a person I love from abandoning me.

Please go on to the next page
21. I go on eating binges a couple of times a week.
22. I seem to make a mess of good opportunities that come my way.
23. I've always had a hard time stopping myself from feeling blue and unhappy.
24. When I'm alone and away from home, I often begin to feel tense and panicky.
25. People sometimes get annoyed with me because they say I talk too much or too fast for them.
26. Most successful people today have been either lucky or dishonest.
27. I won't get involved with people unless I'm sure they'll like me.
28. I feel deeply depressed for no reason I can figure out.
29. Years later I still have nightmares about an event that was a real threat to my life.
30. I don't have the energy to concentrate on my everyday responsibilities anymore.
31. Drinking alcohol helps when I'm feeling down.
32. I hate to think about some of the ways I was abused as a child.
33. Even in good times, I've always been afraid that things would soon go bad.
34. I sometimes feel crazy-like or unreal when things start to go badly in my life.
35. Being alone, without the help of someone close to depend on, really frightens me.
36. I know I've spent more money than I should buying illegal drugs.
37. I always see to it that my work is finished before taking time out for leisure activities.
38. I can tell that people are talking about me when I pass by them.
39. I'm very good at making up excuses when I get into trouble.
40. I believe I'm being plotted against.

Please go on to the next page.
I seem to create situations with others in which I get hurt or feel rejected.

I often get lost in my thoughts and forget what's going on around me.

People say I'm a thin person, but I feel that my thighs and backside are much too big.

There are terrible events from my past that come back repeatedly to haunt my thoughts and dreams.

Other than my family, I have no close friends.

I act quickly much of the time and don't think things through as I should.

I take great care to keep my life a private matter so no one can take advantage of me.

I very often hear things so well that it bothers me.

169. I'm always willing to give in to others in a disagreement because I fear their anger or rejection.

170. I repeat certain behaviors again and again, sometimes to reduce my anxiety and sometimes to stop something bad from happening.

171. I have given serious thought recently to doing away with myself.

172. People tell me that I'm a very proper and moral person.

173. I still feel terrified when I think of a traumatic experience I had years ago.

174. Although I'm afraid to make friendships, I wish I had more than I do.

175. There are people who are supposed to be my friends who would like to do me harm.
<p>| NAME OR IDENTIFICATION NUMBER |
| TEST DATE | AGE | GENDER | RACE |
| 1 (T) F | 31 (T) F | 61 (T) F | 91 (T) F | 121 (T) F | 151 (T) F |
| 2 (T) F | 32 (T) F | 62 (T) F | 92 (T) F | 122 (T) F | 152 (T) F |
| 3 (T) F | 33 (T) F | 63 (T) F | 93 (T) F | 123 (T) F | 153 (T) F |
| 4 (T) F | 34 (T) F | 64 (T) F | 94 (T) F | 124 (T) F | 154 (T) F |
| 5 (T) F | 35 (T) F | 65 (T) F | 95 (T) F | 125 (T) F | 155 (T) F |
| 6 (T) F | 36 (T) F | 66 (T) F | 96 (T) F | 126 (T) F | 156 (T) F |
| 7 (T) F | 37 (T) F | 67 (T) F | 97 (T) F | 127 (T) F | 157 (T) F |
| 8 (T) F | 38 (T) F | 68 (T) F | 98 (T) F | 128 (T) F | 158 (T) F |
| 9 (T) F | 39 (T) F | 69 (T) F | 99 (T) F | 129 (T) F | 159 (T) F |
| 10 (T) F | 40 (T) F | 70 (T) F | 100 (T) F | 130 (T) F | 160 (T) F |
| 11 (T) F | 41 (T) F | 71 (T) F | 101 (T) F | 131 (T) F | 161 (T) F |
| 12 (T) F | 42 (T) F | 72 (T) F | 102 (T) F | 132 (T) F | 162 (T) F |
| 13 (T) F | 43 (T) F | 73 (T) F | 103 (T) F | 133 (T) F | 163 (T) F |
| 14 (T) F | 44 (T) F | 74 (T) F | 104 (T) F | 134 (T) F | 164 (T) F |
| 15 (T) F | 45 (T) F | 75 (T) F | 105 (T) F | 135 (T) F | 165 (T) F |
| 16 (T) F | 46 (T) F | 76 (T) F | 106 (T) F | 136 (T) F | 166 (T) F |
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| 20 (T) F | 50 (T) F | 80 (T) F | 110 (T) F | 140 (T) F | 170 (T) F |
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| 23 (T) F | 53 (T) F | 83 (T) F | 113 (T) F | 143 (T) F | 173 (T) F |
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| 25 (T) F | 55 (T) F | 85 (T) F | 115 (T) F | 145 (T) F | 175 (T) F |
| 26 (T) F | 56 (T) F | 86 (T) F | 116 (T) F | 146 (T) F | 176 (T) F |
| 27 (T) F | 57 (T) F | 87 (T) F | 117 (T) F | 147 (T) F | 177 (T) F |
| 28 (T) F | 58 (T) F | 88 (T) F | 118 (T) F | 148 (T) F | 178 (T) F |
| 29 (T) F | 59 (T) F | 89 (T) F | 119 (T) F | 149 (T) F | 179 (T) F |
| 30 (T) F | 60 (T) F | 90 (T) F | 120 (T) F | 150 (T) F |</p>
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<tr>
<th>MODIFYING INDICES</th>
<th>CLINICAL PERSONALITY PATTERNS</th>
<th>SEVERE PERSONALITY</th>
<th>CLINICAL SYNDROMES</th>
<th>SEVERE CLINICAL SYNDROMES</th>
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<td>Y</td>
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BR Score

Validity Scale

NCS®

Product Number 33009
PERSONAL REACTION INVENTORY.

Please indicate to what extent the following statements apply to you using the following key:

1. very like me
2. quite like me
3. a little like me
4. neither like or unlike me
5. a little unlike me
6. quite unlike me
7. very unlike me

1. No matter who I'm talking to I'm always a good listener. 1 2 3 4 5 6 7
2. I have sometimes taken unfair advantage of another person. 1 2 3 4 5 6 7
3. I am always courteous, even to people who are disagreeable. 1 2 3 4 5 6 7
4. I sometimes try to get even, rather than forgive and forget. 1 2 3 4 5 6 7
5. I am quick to admit making a mistake. 1 2 3 4 5 6 7
6. I have always faced up to the bad as well as the good consequences of things I have done. 1 2 3 4 5 6 7
7. I sometimes feel resentful when I don't get my own way. 1 2 3 4 5 6 7
8. I would never think of letting someone else be punished for my wrong-doing. 1 2 3 4 5 6 7
9. There have been occasions when I took advantage of someone. 1 2 3 4 5 6 7
10. At times I have wished that something bad would happen to someone I disliked. 1 2 3 4 5 6 7
11. I am always attentive to the person I am with. 1 2 3 4 5 6 7
12. There have been times when I felt like rebelling against people in authority even though I knew they were right. 1 2 3 4 5 6 7

pri.1
11 February 1997
Indicate how often you feel the way described in each of the following statements. Circle one number for each question.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel in tune with people around me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>2. I lack companionship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>3. There is no one I can turn to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>4. I do not feel alone</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>5. I feel part of a group of friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>6. I have a lot in common with people around me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>7. I am no longer close to anyone</td>
<td>1</td>
<td>2</td>
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<tr>
<td>8. My interests and ideas are not shared by those around me</td>
<td>1</td>
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<td>9. I am an outgoing person</td>
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<tr>
<td>10. There are people I feel close to</td>
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<td>4</td>
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<tr>
<td>11. I feel left out</td>
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<td>12. My social relationships are superficial</td>
<td>1</td>
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<td>13. No one really knows me well</td>
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<td>14. I feel isolated from others</td>
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<td>2</td>
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<tr>
<td>15. I can find companionship when I want it</td>
<td>1</td>
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<tr>
<td>16. There are people who really understand me</td>
<td>1</td>
<td>2</td>
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<tr>
<td>17. I am unhappy being so withdrawn</td>
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<td>4</td>
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<tr>
<td>18. People are around me but not with me</td>
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<tr>
<td>19. There are people I can talk to</td>
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<tr>
<td>20. There are people I can turn to</td>
<td>1</td>
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</tbody>
</table>

quest.sc
11 February 1997
ASSESSMENT PACKAGE - QUESTIONNAIRE #3

We are trying to find out what men and women your age think about certain things. We want you to answer the following questions the way you feel. There are no right or wrong answers. Don't take too much time answering any one question, and do try to answer them all. One of your concerns during the test may be, 'what should I do if I can answer both yes and no to a question?' It's not unusual for that to happen. If it does, think about whether your answer is just a little more one way than the other. For example, you'd assign a weighting of 51% to 'yes' and assign 49% to 'no,' mark the answer 'yes'.

Circle yes or no next to each item. Try to pick one response for all of the questions and not leave any blanks. Thank you

1. Do you believe that most problems will solve themselves if you just don't fool with them?  
   YES  
   NO

2. Do you believe that you can stop yourself from catching a cold?  
   YES  
   NO

3. Are some people born lucky?  
   YES  
   NO

4. Most of the time do you feel that getting good marks at school meant a great deal to you?  
   YES  
   NO

5. Are you often blamed for things that just aren't your fault?  
   YES  
   NO

6. Do you believe that if somebody studies hard enough he or she can pass any subject?  
   YES  
   NO

7. Do you feel that most of the time it doesn't pay to try hard because things never turn out right anyway?  
   YES  
   NO

8. Do you feel that if things start out well in the morning it is going to be a good day no matter what you do?  
   YES  
   NO

9. Do you feel that most of the time parents listen to what their children have to say?  
   YES  
   NO

10. Do you believe that wishing can make good things happen?  
    YES  
    NO

11. When you get punished does it usually seem it's for no good reason at all?  
    YES  
    NO

12. Most of the time do you find it hard to change a friend's (mind) opinion?  
    YES  
    NO

13. Do you think that cheering more than luck helps a team to win?  
    YES  
    NO

14. Did you feel that it was nearly impossible to change your parents' mind about anything?  
    YES  
    NO

15. Do you believe that parents should allow children to make most of their own decisions?  
    YES  
    NO

16. Do you feel that when you do something wrong there's very little you can do to make it right?  
    YES  
    NO

17. Do you believe that most people are just born good at sports?  
    YES  
    NO

18. Are most of the other people your age stronger than you are?  
    YES  
    NO

19. Do you feel that one of the best ways to handle most problems is just not to think about them?  
    YES  
    NO

20. Do you feel that you have a lot of choice in deciding whom your friends are?  
    YES  
    NO

PLEASE TURN OVER
21. If you find a four-leaf clover, do you believe that it might bring you good luck?  
22. Did you feel that whether you did your homework or not had much to do with what kind of marks you got at school?  
23. Do you feel that when a person your age decides to hit you there’s little you can do to stop him or her?  
24. Have you ever had a good luck charm?  
25. Do you believe that whether or not people like you depends on how you act?  
26. Did your parents usually help you if you asked them to?  
27. Have you felt that when people were angry with you it was usually for no reason at all?  
28. Most of the time, do you feel that you can change what might happen tomorrow by what you do today?  
29. Do you believe that when bad things are going to happen they just are going to happen no matter what you try to do to stop them?  
30. Do you think that people can get their own way if they just keep trying?  
31. Most of the time do you find it useless to try to get your own way at home?  
32. Do you feel that when good things happen they happen because of hard work?  
33. Do you feel that when somebody your age wants to be your enemy there's little you can do to change matters?  
34. Do you feel that it's easy to get friends to do what you want them to?  
35. Do you usually feel that you have little to say about what you get to eat at home?  
36. Do you feel that when someone doesn't like you there's little you can do about it?  
37. Did you usually feel that it was almost useless to try in school because most other children were just more clever than you were?  
38. Are you the kind of person who believes that planning ahead makes things turn out better?  
39. Most of the time do you feel that you have little to say about what your family decides to do?  
40. Do you think it's better to be clever than to be lucky?
The following statements ask about your thoughts and feelings in a variety of situations. For each item, show how well it describes you by choosing the appropriate number on the scale at the top of the page. When you have decided on your answer, fill in the space following the item. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly and as accurately as you can.

<table>
<thead>
<tr>
<th>Nothing like me</th>
<th>A little like me</th>
<th>Quite like me</th>
<th>Like me</th>
<th>A lot like me</th>
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</table>

1. I daydream quite often about things that might happen to me
2. I often feel sorry for people less fortunate than me
3. I sometimes find it difficult to see things from another person's point of view
4. Sometimes I don't feel very sorry for other people when they are having problems
5. I can really relate to the feelings of characters in a good book
6. In emergency situations I feel nervous
7. I don't usually get emotional (e.g. frightened or weepy) when I watch a film or TV drama
8. I try to look at everybody's side of an argument before I make a decision
9. When I see someone being bullied or 'ripped off' I feel a bit protective towards them
10. I sometimes feel helpless when I am in the middle of a very emotional situation
11. I sometimes try to understand my friends better by imagining how things look from their point of view
12. Becoming extremely involved in a good book or film is unusual for me
13. When I see someone get hurt I stay calm
14. Other people's bad luck does not usually upset me very much
15. If I'm sure I'm right about something I don't waste time listening to other people's arguments
16. After seeing a character on TV or in a film I have felt as though I was like that person
17. Being in a tense emotional situation scares me
18. When I see someone being treated unfairly I sometimes don't feel very much pity for them
19. I am usually pretty good at dealing with emergencies
20. I am often quite touched by things I see happen
21. I believe that there are two sides to every question and try to look at them both
22. I would describe myself as a pretty soft-hearted person
23. When I watch a good film I can very easily put myself in the place of the leading character
24. I tend to lose control during emergencies
25. When I am upset at someone I usually try to 'put myself in his shoes' for a while
26. When I am reading an interesting story I imagine how I would feel if the events in the story were happening to me
27. When I see someone who badly needs help in an emergency, I go to pieces
28. Before criticising somebody, I try to imagine how I would feel if I were in their place

uestiri.4
2.02.97
QUESTIONNAIRE 5

Name: ...........................................................................................................

Date: .............................................................................................

Please answer the following questions by ticking in the box for 'yes' or 'no'

1. Do you ever wish you were someone else? ☐ ☐
2. Do you like the sort of person you are? ☐ ☐
3. At an election, would you vote for someone you knew very little about? ☐ ☐
4. Do you often feel ashamed of yourself? ☐ ☐
5. Do you understand yourself? ☐ ☐
6. Do you have a low opinion of yourself? ☐ ☐
7. If you could get into the cinema without paying, and be sure you weren't seen, would you probably do it? ☐ ☐
8. Do you think you can make a success of your life? ☐ ☐
9. Are things all mixed up in your life? ☐ ☐
10. Do you like to know some important people because it makes you feel important? ☐ ☐
11. Are you happy with the way you are? ☐ ☐
12. When you are not feeling well, do you sometimes feel annoyed? ☐ ☐

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12.02.97
In each of the following items a Social Situation is described, together with a number of possible responses. Please place an X beside the response that you think you would do. If none of the alternatives seems exactly right for you, check the one that is closest to what you believe you would actually do. Remember we are interested in what you think you actually WOULD do rather than what you think is appropriate.

1. You are in the middle of eating supper when a man comes to the door to ask you questions about television programmes you watch. Would you.

   a. Ask him in and answer the questions while you finish eating.
   b. Answer all his questions immediately leaving your supper to get cold.
   c. Tell him, without giving any explanation that you will not answer his questions.
   d. Angrily tell him to go away and slam the door in his face.
   e. Explain that it is not a convenient time and politely tell him you will not answer the questions.

2. You would like to go out with a woman you know fairly well, but have never dated her before. Would you.

   a. Ask her for a date and be able to accept it if she refused.
   b. Find it impossible to ask her.
   c. Ask her for a date and become angry or abusive if she refused.
   d. Find it difficult to ask her.
   e. Ask her for a date and if she refused keep on asking to try to make her change her mind.

3. If a male friend, who has borrowed some money from you seemed to have forgotten about repaying it, would you:

   a. Demand the money back and threaten to hit him if he denied borrowing it.
   b. Ask him for the money back and insist that he did borrow it if he denied doing so.
   c. Say nothing to avoid possible trouble or embarrassment.
   d. Ask for the money back and become angry if he denied borrowing it.
   e. Ask if he could return the money but drop the matter if he denied borrowing it.

4. This attractive woman you work with is in the habit of not wearing a brassiere. One afternoon, when your car has broken down, she offers you a ride home. When the car stops at your place you make a pass at her and she angrily tells you to get out. Would you:

   a. Tell her to shut up and get out slamming the door behind you.
   b. Say something like: "Who the hell do you think you are, you slut?" and grab her breast before you get out.
   c. Tell her you are sorry for mistaking her intentions and apologise for upsetting her, then leave the car.
   d. Become embarrassed and jump out of the car and run inside.
   e. Embarrassedly say: "Sorry", and get out.
a. Go to an empty chair even if it meant disturbing people.
b. Go to an empty chair provided you could do so without disrupting the meeting.
c. Stand at the back even if there was an empty chair near the front.
d. Go cautiously to an empty chair feeling embarrassed about disturbing the meeting.
e. Go to an empty chair even if it meant disrupting the whole meeting.

6. If you had decided that you no longer wanted to date a woman, would you:

a. Gently but clearly explain your changed feelings to her.
b. Avoid telling her and go on as though nothing is wrong.
c. Abruptly tell her you are sick of her and that you can't stand the sight of her anymore.
d. Avoid telling her but be cold and distant to her.
e. Tell her you do not want to see her any more but refuse to explain why.

7. If, after leaving a shop, you realise you have been short-changed by the cashier, would you:

a. Return and ask for the correct change and, if necessary, complain to the Manager.
b. Return and tell the cashier he/she short-changed you and become abusive if he/she does not give you the change owing.
c. Go back and request the correct change but drop the matter if the cashier says it is too late to do anything about it.
d. Forget the matter rather than face possible embarrassment or trouble.
e. Go back and demand that the cashier give you the change owing immediately and become threatening or physically violent if he/she refuses.

8. The woman who lives next-door asks you to give her a ride to work. It's a good deal out of your way and you don't want to be inconvenienced. Would you:

a. Say you would be glad even though you are annoyed.
b. Give her a ride but do not speak to her.
c. Tell her you are not a free taxi service.
d. Tell her you are sorry but it is too far out of your way.
e. Abruptly tell her no, but offer her no explanation.

9. You are drinking in a hotel with a new girlfriend when the woman you used to go out with comes in. She is a bit drunk and comes over to sit beside you and begins to talk to you. If you wanted her to leave, would you:

a. Introduce her to your girlfriend and then politely tell her you wish to be alone.
b. Become embarrassed but say nothing.
c. Tell her to go away.
d. Tell her she is a drunken slut and to leave you alone.
e. Become embarrassed and introduce her to your girlfriend.
If you lived in an apartment and the man who owned the place failed to make certain necessary repairs after promising many times to do so, would you:

- Say nothing to avoid embarrassment or trouble.
- Nervously ask him if he would get the repairs done.
- Angrily demand that the repairs are done immediately.
- Threaten to report him to the authorities if he doesn’t get the repairs done immediately.
- Firmly state that it is his responsibility to see that the repairs are carried out and insist that they be done quickly.

11. You have a few drinks at a hotel and you are dancing with this attractive woman you have just met. You are feeling horny so you press yourself against her and she pushes you away. Would you:

- Become embarrassed and say simply “Sorry”.
- Tell her that you are sorry and you did not mean to upset her.
- Become embarrassed and pretend nothing happened.
- Angrily walk away and leave her on the dance floor.
- Pull her tightly against you and tell her not to be a bitch.

12. You have spent the day at the beach with a woman you have been dating for the past month. You want her to have supper with you but she says she already has promised to see another man. Would you:

- Tell her that if she wants to go out with someone else, she can go to hell.
- Tell her you are disappointed but you don’t say anything else.
- Tell her that you are angry and that you will call her tomorrow.
- Pretend that it is all right even though you are upset.
- Tell her you are disappointed and would like to know what this means regarding your relationship.

13. If you had told a male friend something in confidence and find out that he had told it to someone else, would you:

- Tell him you are upset.
- Become abusive and threatening.
- Say nothing about it and continue to be friendly to him.
- Say nothing and be cold to your friend for a while.
- Become verbally abusive and tell him that he is no longer your friend.

14. You are at a meeting and this woman who seems to have taken over the group asks for your opinion. Would you:

- Tell her that she is an bossy bitch and loudly state your opinion.
- Just say you agree with her even if you don't.
- State your opinion calmly even if it disagrees with her.
- State your opinion in a loud forceful voice.
- Be too uncomfortable to say anything.
A male friend asks to borrow some money and you definitely do not want to lend it to him. Would you:

a. Lend him the money anyway.
b. Say no, and stick to your decision even if your friend pleased with you.
c. Say no at first, but if he pleased, lend him the money.
d. Angrily tell him no and become abusive if he asks again.
e. Abruptly tell him no, and show your annoyance if he asks again.

16. You just had intercourse with a woman and she tells you that she didn't enjoy it. Would you:

a. Become embarrassed.
b. Tell her she is a bitch and hit her.
c. Become embarrassed and say nothing.
d. Tell her she is a bitch and leave immediately.
e. Tell her that her remark hurt your feelings and insist that she explain himself.

17. If you wanted to borrow your male friend's car and were not sure how he would respond, would you:

a. Not ask him to avoid possible embarrassment.
b. Ask him and become annoyed if he says no.
c. Ask and become abusive and threatening if he says no.
d. Ask him and accept if he says no.
e. Nervously ask him.

18. You have been out with a woman and have bought her supper and drinks, and taken her to a dance. You had a good time and she seems to like you. She invites you to her apartment and you make sexual advances towards her. If she refuses your advances, would you:

a. Stop your advances towards her but ask her to explain her refusal.
b. Immediately become embarrassed and leave.
c. Keep trying but stop if she begins to get upset.
d. Stop your advances and say nothing.
e. Keep trying and force her to have sex with you if she continues to refuse.

19. If you were with a group of people you did not know very well and they were discussing a topic you were interested in, would you:

a. Have no difficulty expressing any opinion you might have and, in turn, allow other people to have their say.
b. Tend to dominate the discussion.
c. Nervously express your opinion only if you felt very strongly about it.
d. Always keep your opinions to yourself however strongly you felt about the matter being discussed.
e. Expect to be viewed as the leader and expect others to keep quiet and listen only to your point of view.
If a sales assistant is trying to get you to buy a more expensive item than you want, would you:

a. Ask to see the cheaper item but do not insist when she continues to show you the expensive one.
b. Tell her firmly that you are not interested in the item and have her show you something else.
c. Tell her you don’t want that and become annoyed if she persists.
d. Tell her to shut up and threaten her if she doesn’t stop bugging you.
e. Buy the item even though you don’t want it.

21. If a man made fun of you to the point where it became annoying, would you:

a. Show your anger and be abusive to him.
b. Say nothing to avoid a possible scene.
c. Ask him to stop but say nothing more if he persisted.
d. Express your annoyance firmly and ask him to stop.
e. Become angry and try to hit him.

22. If a woman at a party speaks to you but you don’t want to talk to her, would you:

a. Tell her to get lost and become abusive if she does not leave.
b. Pretend to be interested rather than create a scene.
c. Tell her politely that you wish to be alone and insist if she doesn’t leave.
d. Tell her you do not wish to speak with her and turn your back on her.
e. Look disinterested but don’t tell her you would rather be left alone.
**B.A. Inventory**

**Name:**

**Date:**

**Nature of the Offence:**

---

Below are a number of questions related to the crime(s) you committed. Please read each item carefully and decide whether the statement is **TRUE** or **FALSE** as it applies to you personally. If the statement is true as applied to you then circle **True**; and if it is false as applied to you then circle **False**.

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel very ashamed of the crime(s) I committed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am entirely to-blame for my crime(s).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I did not deserve to get caught for the crime(s) I committed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am constantly troubled by my conscience for the crime(s) I committed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will never forgive myself for the crime(s) I committed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel no remorse or guilt for the crime(s) I committed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am responsible for my criminal act(s).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is definitely not in my nature to commit crimes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I should not blame myself for the crime(s) I committed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At the time of the crime(s) I was fully aware of what I was doing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would not have committed the crime(s) I did if I had not lost control of myself.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I should not blame other people for my crime(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The crime(s) I committed was very much out of character.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I hate myself for the crime(s) I committed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Society is to blame for the crime(s) I committed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I should not be punished for what I did.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was feeling no different to usual at the time of the crime(s).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In my case the victim(s) was largely to blame for my crime(s).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Statement</td>
<td>True</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>19.</td>
<td>I would not have committed any crime(s) if I had not been seriously provoked by the victim(s) / society.</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>What I did was beyond my control.</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>I deserved to be caught for what I did.</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>I would have been better off if I had not been caught.</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>I constantly have the urge to punish myself for the crime(s) I committed.</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>I fear that people will never accept me because of the crime(s) I committed.</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>I was very depressed when I committed the crime(s).</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>I was in no way provoked into committing a crime.</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>I have no need to feel ashamed of what I did.</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>I feel annoyed that I was caught.</td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>I must have been crazy to commit the crime(s) I did.</td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>There is no such thing as an innocent victim in my case.</td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>Other people are to blame for my crime(s).</td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>I could have avoided getting into trouble.</td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>I had very good reasons for committing the crime(s) I did.</td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>I should not punish myself for what I did.</td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>I deserve to be severely punished for the crime(s) I committed.</td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>I would certainly not have committed the crime(s) I did if I had been mentally well.</td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>I have no serious regrets about what I did.</td>
<td></td>
</tr>
<tr>
<td>38.</td>
<td>I was under a great deal of stress / pressure when I committed the crime(s).</td>
<td></td>
</tr>
<tr>
<td>39.</td>
<td>I would very much like to make amends for what I did.</td>
<td></td>
</tr>
<tr>
<td>40.</td>
<td>I sometimes have nightmares about the crime(s) I committed.</td>
<td></td>
</tr>
<tr>
<td>41.</td>
<td>I was in full control of my actions.</td>
<td></td>
</tr>
<tr>
<td>42.</td>
<td>I have no excuse for the crime(s) I committed.</td>
<td></td>
</tr>
</tbody>
</table>

**Scoring:**

$m$  |  $e$  |  $g$  
|------|------|------|


28 September 1999

Mrs M Islam
Clinical Psychology Office
Department of Psychology
University of Surrey
Guildford
Surrey
GU2 5XH

Dear Mrs Islam,

Re: AN INVESTIGATION INTO FACTORS WHICH MAY DISCRIMINATE SEX OFFENDERS WITH BOTH ADULT AND CHILD VICTIMS FROM THOSE WITH VICTIMS FROM ONLY ONE AGE GROUP IN A SPECIAL HOSPITAL MALE POPULATION.

The Committee discussed your proposal at its meeting on 27 September 1999.

The Committee would appreciate confirmation of its understanding that patients deemed “unsuitable for interview” are so on the basis of the Responsible Medical Officers judgement. If this is so can you be certain that you will obtain the numbers you require for your study?

In addition the Patient Information Sheet should omit any reference to patients completing questionnaires other than with the researcher, and not state that a summary sheet on the study outcome will be available. It was felt that without careful explanation this could be readily misinterpreted or used inappropriately by those who received it. The Patient Information Sheet should also include a statement to the effect that refusal or withdrawal from participation will not affect care or detention.

It was felt that the Consent Form also required amendment in as much that item ‘C’ would need to be excluded. The previous section should also be deleted as it is ethically unacceptable and probably practically impossible to ask patients to give informed consent in this way for future unidentified studies.

Finally a copy of the Standardised Interview referred to in item 5 on page 5 of the full protocol must be submitted.

Once your response and material are received it will be possible for me to take Chairman’s Action.

Yours sincerely,

Mandy Whittle

The Reverend Dr Peter Goold
Chairman
Ethics Committee
Appendix 8: Researcher's Response to Research and Ethics Committee's Correspondence

Clinical Psychology Office
Department of Psychology
University of Surrey
Guildford
Surrey
GU2 5XH

Tel: 01483 259441
Fax: 01483 259553

The Reverend Dr. Peter Goold
Chairman, Ethics Committee
Broadmoor Hospital
Crowthorne
Berkshire
RG45 7EG.

12th October 1999

Dear Reverend Dr. Goold,

Re: THE ETHICAL CONSIDERATION OF A RESEARCH PROJECT INVESTIGATING FACTORS WHICH MAY DISCRIMINATE SEX OFFENDERS WITH BOTH ADULT AND CHILD VICTIMS FROM THOSE WITH VICTIMS FROM ONLY ONE AGE GROUP, IN A SPECIAL HOSPITAL MALE POPULATION

Thank you for your letter of 28th September 1999 regarding the Ethics Committee’s views on this research proposal.

I have reconsidered my proposal in the light of this instructive feedback and attempted to address the Committee’s concerns point by point in the order stated in your letter.

1) Responsible Medical Officers’ judgement of their patients’ suitability for participation
I can confirm the committee’s understanding that patients deemed “unsuitable for interview” by the RMO will not be interviewed. It is accepted that this may reduce the numbers required for the study. For group 1 and group 2 (as defined in the proposal) this is not expected to pose a problem. However, as there is already expected to be a small number in Group 3, any refusals by the RMOs may make a significant difference.

This possibility has been considered and it is proposed that should the numbers in group 3 be too small to carry out meaningful quantitative statistical analysis, there are two options:

i) To undertake more qualitative analyses using the smaller numbers, in which case elaborate conclusions cannot be drawn about Group 3 but hypotheses can still be generated.

ii) As Group 3 is only one aspect of the study, more focus can be placed on Groups 1 and 2 only, as there are still meaningful hypotheses to be tested on these two groups, particularly with regard to psychopathy ratings.

It should however be noted that, based on past research experience, an 80% response rate is expected from this population, so there should not be a problem with the numbers.

Mislam;PsychD;2000
2) Patient Information Sheet
As suggested by the Committee, the following amendments have been made:

i) The reference to patients completing questionnaires other than with the researcher has been omitted.
ii) It no longer states that a summary sheet on the study outcome will be available.
iii) A statement has been included to the effect that refusal or withdrawal from participation will not affect care or detention.

The revised Patient Information Sheet is attached at appendix 1.

3) Consent Form
As suggested by the Committee, the following amendments have been made:

i) Item ‘B’, regarding consent for the future use of information gained from this study, has been omitted.
ii) Item ‘C’, regarding the summary sheet, has been omitted.

The revised Consent Form is attached at appendix 2.

4) 'Standardised Interview' referred to in item 5 on page 5 of the full protocol
There appears to have been a misunderstanding on this point. I apologise for this as it is due to my lack of clarity in writing this section of the proposal. The ‘standardised interview’ mentioned here actually refers to the completion of the interview schedules/questionnaires as described in the next part of the ‘Procedures’ section. These interview schedules/questionnaires are listed in the ‘Measures’ section as follows:

Sex Offender Assessment Pack (Beckett, Beech & Fisher, 1996)
Psychopathy Checklist Revised (PCL-R: Hare, 1991)
Attribution of Blame Inventory (Guddjonsson & Singh, 1989)
Millon Clinical Multiaxial Inventory (Millon, 1994)

Therefore, there is no ‘Standardised Interview’ to be submitted to the Committee. However, copies of the above measures are attached at appendix 3.

I hope that these amendments and clarifications are satisfactory and that it will now be possible for you to take Chairman’s Action, as stated in your letter, regarding this research proposal.

I look forward to hearing from you.

Yours sincerely,

Mrs. Momotaj Islam
Psychologist in Clinical Training/Principal Researcher

cc. Dr. Derek Perkins (Head of Psychological Services)
c. Dr. Nashater Deu (Principal Clinical Psychologist)
8 November 1999

Mrs M Islam
Clinical Psychology Office
Department of Psychology
University of Surrey
Guildford
GU2 5XH

Dear Mrs Islam,

Re: AN INVESTIGATION INTO FACTORS WHICH MAY DISCRIMINATE SEX OFFENDERS WITH BOTH ADULT AND CHILD VICTIMS FROM THOSE WITH VICTIMS FROM ONLY ONE AGE GROUP IN A SPECIAL HOSPITAL MALE POPULATION.

Thank you for your letter of 12 October 1999 in response to the Committees enquiries.

In respect of the patient information sheet I think it is most likely that the Committee would still wish that patients did not complete questionnaires other than in the presence of the researcher. If you felt this was too onerous at the time I feel that the Committee would accept that a questionnaire could be completed in the presence of another member of staff, but again material should not be taken from the interview environment to elsewhere.

In the light of your responses and changes I am happy to take Chairman’s Action and to approve your proposal. I shall alert the Committee to this at its next meeting on 15 November 1999.

The Committee wish to be kept informed of your progress and acceptance of your proposal has been given on the condition that the secretary, Mrs Mandy Whittingham, receives six monthly progress reports, together with a copy of your final findings. Any changes to the protocol made subsequent to this application must be notified to the secretary. If the project is not begun within 2 years then a resubmission will be necessary.

The Committee wish you well with this project.

Yours sincerely,

[Signature]

The Reverend Dr Peter Goold
Chairman
Ethics Committee
Appendix 10: Letter to Responsible Medical Officer explaining research and requesting consent

Dear Dr.

Re: Research into factors which may discriminate sex offenders with both adult and child victims from those with victims from only one age group, in a male Special Hospital population

I am a Clinical Psychologist in Training on the Psych D Clinical Psychology course at Surrey University. As part of my Clinical Doctorate I am carrying out the above mentioned research project, for which ethical approval has been acquired. The main objectives of the study are:

1. To identify three subgroups of sex offenders based upon victim's age, within a Special Hospital setting. The three groups would be: adult sex offenders (with victims of 16yrs+); child sex offenders (with victims below 16yrs); mixed sex offenders (victims from both age groups).
2. To compare the three subgroups on the following variables: personality characteristics; social, emotional & cognitive characteristics as measured by the Sex Offender Assessment Pack (SOAP); attribution of blame; psychopathy as measured by the Hare Psychopathy Checklist Revised (PCL-R); history of childhood sexual abuse
3. To identify factors which may discriminate the mixed offender group from the other two groups
4. To specifically compare the PCL-R profiles of the three groups.

The theoretical rationale for this study is that the mixed offenders are a distinct subgroup of sex offenders who pose a higher risk of violent recidivism about whom very little is known. Knowledge in this area would aid better professional understanding of this group and may have treatment implications.

The following procedures will be carried out:
1. Screening of the Case Register database to identify sex offenders on the basis of index offence and history of offences (this may be based on a conviction or other documentation)
2. Screening of data in patients' files
3. Explanation and request for consent from RMO, and then from identified patients (using standard Broadmoor Hospital consent form)
4. Meeting with participant to complete standardised interview schedules/questionnaires.

If any of the interview schedules/questionnaires has been completed by the patient within the past 6 months, this information will be gained from his file rather than requesting the patient to re-do it. Therefore the duration of the interview will vary from approximately 20 minutes to approximately 60 minutes. No details about offence history or abuse history will be sought from the patient during the meeting. This will minimise the likelihood of any emotional distress that might be caused by the interview. The participant will be assured of confidentiality and informed of the right to terminate their involvement in the study at any stage.

I would therefore be grateful if you could give consent for each of your patients listed on the attached sheet, who have been identified from the Case Register and file information, to participate in this study. If for any reason you feel a patient is not suitable for the study or to be interviewed would you please state your reasons. Following your consent, the relevant key nurses will be contacted and arrangements made to approach each patient in person for their consent.

Please do not hesitate to contact myself (0181 725 0350) or the Project Supervisor, Dr. Deu (ext 4138), if you require further details or clarification about this study. I would be very happy to meet with you for a discussion if this would be helpful. I thank you in anticipation of your co-operation.

Yours sincerely,

Momotaj Islam  
(Clinical Psychologist in Training)

Dr. Nashater Deu  
(Principal Clinical Psychologist/Project Supervisor)

RMO's CONSENT FORM FOR PATIENT PARTICIPATION IN RESEARCH STUDY
Research into factors which may discriminate sex offenders with both adult and child victims from those with victims from only one age group, in a male Special Hospital population

[Researcher: Momotaj Islam, Psychologist in Clinical Training]
[Supervisor: Dr. Nashater Deu, Principal Clinical Psychologist]

Name of RMO:

<table>
<thead>
<tr>
<th>Name Of Patient</th>
<th>Consent Given</th>
<th>Consent Not Given</th>
<th>Any Other Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>(please tick)</td>
<td>(please tick &amp; give reasons)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 11: Patients Information Sheet

PATIENTS INFORMATION SHEET

RESEARCH INTO THE PERSONALITY CHARACTERISTICS OF DIFFERENT GROUPS OF PATIENTS

Dear Patient,

You have been invited to participate in the above research project. The study aims to investigate personality characteristics of male patients at Broadmoor Hospital with an aim to getting a better understanding of the patients and to inform treatment approaches.

The researcher will be required to complete up to four standard questionnaires about you. If you have recently completed any of these questionnaires, you will not be required to do them again. For those you have not completed, the researcher will either ask you the questions directly and complete the questionnaire or ask you to complete the questionnaire yourself. (If you wish, you may do this in your own time and return them to the researcher in the envelope provided, marked 'confidential'). Therefore the meeting may last between 20 and 60 minutes.

No names are required on any of the sheets, so your anonymity is assured. Your involvement in the study and all information relating to your involvement will be confidential and will not effect your treatment or detention directly.

The meeting is not expected to cause you any distress. However, you are notified that if you do become distressed during the meeting and the researcher is concerned about the about risk of harm to yourself or to others, the nursing staff will be notified.

Your participation in this study is appreciated. Furthermore, you are reminded that you are free to terminate your involvement at any stage in the study. If you refuse to participate or later withdraw from participation, this will not affect your treatment or detention.

You will be asked to sign an official form as a record of your consent. This must be signed in the presence of the researcher and another witness. By signing this form you will be giving consent for the information to be used for this research study only. However, if you would like the information to be available to the staff at Broadmoor Hospital for future clinical or research purposes, you may sign the appropriate boxes on the consent form to indicate this.

Also, if you would like to receive a summary sheet on the outcome of the study (not individual feedback), you may indicate this on the consent form.

I would like to thank you for your assistance in this study, and look forward to meeting with you.

Yours sincerely,

Mmotaj Islam
(Clinical Psychologist in Training)

Dr. Nashater Deu
(Principal Clinical Psychologist/
Project Supervisor)

Mislam;PsychD;2000
Appendix 12: Patient Consent Form - for participation in study

Patients Consent Form

<table>
<thead>
<tr>
<th>Title of Project</th>
<th>Patient Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>An Investigation of the Personality</td>
<td>Surname:</td>
</tr>
<tr>
<td>Characteristics of Different Groups of</td>
<td>Forename:</td>
</tr>
<tr>
<td>Patients</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td></td>
<td>House &amp; Ward:</td>
</tr>
</tbody>
</table>

(a) I, JSON, HEREBY CONSENT to take part in a clinical research investigation, the nature and purpose of which have been explained to me by Momotaj Islam. And that I have received a written outline of the proposed project.

Date: Patient’s Signature:

(b) I, Momotaj Islam, CONFIRM that I have explained to clinical research investigation and have handed him a written outline of the proposed project.

Date: Researcher’s signature:

(c) I, Momotaj Islam, CONFIRM that

has explained the nature and purpose of the clinical research investigation to
And that he has received a written outline of the proposed project.

Date: Witness’s Signature:

M Islam; PsychD; 2000
Consent Form For Use Of Psychometric Data For Purposes Of Research

Research Project: RESEARCH INTO THE PERSONALITY CHARACTERISTICS OF DIFFERENT GROUPS OF PATIENTS

Name of researcher: Momotaj Islam, Psychologist in Clinical Training, University of Surrey
Supervisor: Dr. Nashater Deu, Principal Clinical Psychologist, Broadmoor Hospital

Dear Patient,

As you are aware, your RMO gave me consent to approach you for participation in the above research study. When I spoke to you about this study you kindly agreed to participate. However, you also stated that, during recent clinical contact, you had recently completed the following standard questionnaires which the study required you to complete.

Millon Clinical Multiaxial Inventory
SOAP Questionnaires 1,2,3,4,5 & 6
ABI Questionnaire

You also stated that you would prefer me to use this information for the study, rather than to complete the questionnaires again.

Therefore, would you please sign this consent form as a written record of your consent for the use of previously obtained psychometric data for the research study.

I give consent that the above-mentioned questionnaire data, previously provided by me for clinical purposes, may be used for the research study described above.

Patient name:

Hospital number:

Patient Signature:

Date:

Researcher's signature:

Witness name:

Witness signature:

MIslam;PsychD,2000
Appendix 14: DEMOGRAPHIC DATA SHEET

Study ID no:
Hospital no:
RMO:

INDIVIDUAL CHARACTERISTICS

Age:
Length of time in Broadmoor (months):

MHA category: MI PD Dual MI/PD

Diagnosis:

Section: 37 37/41 3 38 47/49 48/49 CPIA Informal

Ethnic background: White Indian
Pakistani Bangladeshi
Black - Caribbean Chinese
Black - African Other -------
Black - Other

Relationship Status at time of index offence:
Single Divorced/Separated
Married Not known
Widowed Other -------
Cohabited

Employment status at time of index offence: Employed/unemployed

PSYCHIATRIC HISTORY

Age when 1st contact with psychiatric services:

ADDITIONS HISTORY

Drugs Yes No ?
Alcohol Yes No ?
Other------- Yes No ?

CHILDHOOD HISTORY

Disruption(s):
None
Mother’s death Yes No ? Age
Father’s death Yes No ? Age
Significant other’s death Yes No ? Age
Parents’ divorce/separation Yes No ? Age
Other------------- Yes No ? Age

ABUSE:
None

MIslam;PsychD;2000
Sexual abuse
Physical abuse
Emotional abuse
Domestic violence
2/3 of above

Yes  No  Age
Yes  No  Age
Yes  No  Age
Yes  No  Age
Yes  No  Age

Education:
Age left school:  <15(specify age)
15  16  17  18  19

Qualifications on leaving school: None  GCSEs  CSEs  ‘A’ Levels  Other------
Further education:  Yes  No  N/K

SEXUAL HISTORY
Sexual Experience: (Pre 16 years)

Types:  Exposed to sexual material
Witnessed sexual activity of other
Sexual activity with adults
Sexual activity with own-age child
Sexual activity with relative

Yes  No  Age
Yes  No  Age
Yes  No  Age
Yes  No  Age
Yes  No  Age

Relationship status:
(at time of offence) Single  Married  Co-habit  Divorced/separated

CRIMINAL OFFENDING HISTORY

Index offence:
Current convictions:
(in addition to index offence)

Rape of adult (16yrs>)  0  1  2+
Rape of child (13-15yrs)  0  1  2+
Rape of child (<13yrs)  0  1  2+
Buggery (Specify victim sex & age)------
Incest  0  1  2+
Other sexual offence against and adult  0  1  2+
Other sexual offence against (13-15yrs)  0  1  2+
Other sexual offence against (<13yrs)  0  1  2+
Murder  0  1  2+
Manslaughter  0  1  2+
Other  0  1  2+

Types of previous convictions:

Mislam;PsychD;2000
<table>
<thead>
<tr>
<th>Sex Offence</th>
<th>Convicted</th>
<th>Admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape of adult (16yrs&gt;)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Rape of child (13-15yrs)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Rape of child (&lt;13yrs)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Buggery (Specify victim sex &amp; age)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Incest</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other sexual offence against and adult</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other sexual offence against (13-15yrs)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other sexual offence against (&lt;13yrs)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Murder</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Manslaughter</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**SEX OFFENDING CHARACTERISTICS**

- **Age at first sex offence:**
  - Convicted:
  - Admitted:

- **Sex offence convictions:** Including current offence how many convictions of sexual offence?
  - 0 1 2 3 4 5 6 7 8 9+

- **Sex offence admissions:** Including current offence how many convictions of sexual offence?
  - 0 1 2 3 4 5 6 7 8 9+

**Level Of Coercion:**

<table>
<thead>
<tr>
<th>Force Alleged</th>
<th>Force Admitted</th>
</tr>
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<tbody>
<tr>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Y</td>
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<td>N</td>
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<tr>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

**VICTIM CHARACTERISTICS**

**Number of victims:**

- Convicted: Males--------- Females---------
- Admitted: Males--------- Females---------

**Age Range Of Victims:**

- Age of 1st sexual offence victim:
- Age of 1st sexual offence victim:
- Age of 1st sexual offence victim:

Mislam; PsychD; 2000
Age range of 4th and other victims: all <16yrs  all 16yrs/> mixed age group

**RELATIONSHIP TO VICTIM(S):**

**Child victims:**
- **Related:** Son, Stepson, Male sibling, Male step/foster sibling, Other male relative(s)
- **Unrelated:** Boy - known, Boy - unknown

**Adult victims:**
- **Intimates:** Previously intimate male, Previously intimate female
- **Acquaintances:** Previously known male, Previously known female
- **Recent acquaintance:** Recently met male, Recently met female
- **Strangers:** Unknown male, Unknown female

Islam; PsychD; 2000
<table>
<thead>
<tr>
<th></th>
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<th>Case No:</th>
<th>Date:</th>
<th>Rater:</th>
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<tbody>
<tr>
<td>1</td>
<td>Glibness Superficial Charm</td>
<td>..........</td>
<td>0</td>
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</tr>
<tr>
<td>2</td>
<td>Grandiose Sense of Self-worth</td>
<td>..........</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Need for Stimulation</td>
<td>..........</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>Pathological Lying</td>
<td>..........</td>
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<tr>
<td>5</td>
<td>Conning Manipulative</td>
<td>..........</td>
<td>0</td>
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<tr>
<td>6</td>
<td>Lack of Remorse / Guilt</td>
<td>..........</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>Shallow Affect</td>
<td>..........</td>
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</tr>
<tr>
<td>8</td>
<td>Callous / Lack of Empathy</td>
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<td>2</td>
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<td>9</td>
<td>Parasitic Lifestyle</td>
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<td>10</td>
<td>Poor Behavioural Controls</td>
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<td>2</td>
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<td>11</td>
<td>Promiscuous Sexuality Behaviour</td>
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<td>2</td>
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<td>12</td>
<td>Early Behavioural Problems</td>
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<td>2</td>
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<td>13</td>
<td>Lack of Realistic Long term Goals</td>
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<td>2</td>
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<tr>
<td>14</td>
<td>Impulsivity</td>
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<td>1</td>
<td>2</td>
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<tr>
<td></td>
<td>Irresponsibility</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
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<td>--------------------------------------</td>
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<tr>
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<th>Failure to Accept Responsibility for Actions</th>
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<table>
<thead>
<tr>
<th></th>
<th>Many Short term Marital Relationships</th>
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<tr>
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<th>Juvenile Delinquency</th>
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<table>
<thead>
<tr>
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<th>Revocation of Conditional Release</th>
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<tbody>
<tr>
<td>19.</td>
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<table>
<thead>
<tr>
<th></th>
<th>Criminal Versatility</th>
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<tbody>
<tr>
<td>20.</td>
<td></td>
<td></td>
<td></td>
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</table>
Appendix 16: Brief explanations of the Mental Health Act (1983) Sections under which patients at Broadmoor Hospital are detained

RESTRICTED PATIENTS
(Approx. 75% of Broadmoor patients)

Section 37/41: Hospital Order (37) with restrictions (41) made by court. Restrictions can be for a specified time, or indefinite. Patient to be admitted within 28 days of making order.

Section 47/49: Applies to prisoners already serving sentence. Home Office issues warrant. Restrictions (49) are in force up until the date of expiration of sentence, or can be indefinite if patient is serving life. Patient to be admitted within 14 days of issuing warrant.

UNRESTRICTED PATIENTS
(Approx. 25% of Broadmoor patients)

Section 3: Civil Section (pettiness have not been through court). Two doctors examine patient and complete medical recommendations. Approved social worker then makes application for patient’s admission to hospital.

Section 37: Hospital Order without restrictions. Patient must be admitted to hospital within 28 days of court making order.

Notional 37: Applies to patients whose sentence has expired. Detained as if subject to a hospital order made on date of expiration of sentence.

REMAND PATIENTS

Section 48/49 (Restricted): Patients admitted for urgent treatment (not usually convicted). Home Office issues warrant. Patient must be admitted within 14 days of date of warrant. Can be kept in hospital indefinitely under this Section. When RMO considers patient is well enough to stand trial, case goes to court.

Section 38 (Unrestricted): Patient admitted for assessment (convicted but not sentenced). Court issues interim hospital order. Patient must be admitted within 28 days of making order. Can only be kept in hospital for a maximum of 12 calendar months under this Section. Patient then attends court for sentencing.

Section 35 (Unrestricted): Patient remanded for report (not treatment) on mental condition. Court issues Order. Patient must be admitted within 7 days of Order date. Can only be kept in hospital for a maximum of 12 weeks under this Section. RMO subsequently provides Court with report and case is dealt with by court.

Section 36: Patient remanded for treatment. Same rules apply as for Section 35.
Appendix 17: Test statistics for comparative data on demographic, personal and forensic history variables

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>TEST STATISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chi-sq test value or Kruskal-Wallis chi-sq value</td>
</tr>
<tr>
<td>Current age (yrs)</td>
<td>*F-ratio = 0.30</td>
</tr>
<tr>
<td>Ethnic background</td>
<td>#</td>
</tr>
<tr>
<td>Age when left school (yrs)</td>
<td>2.55</td>
</tr>
<tr>
<td>Educational attainment</td>
<td>#</td>
</tr>
<tr>
<td>Age at 1st contact with psychiatric services (yrs)</td>
<td>1.70</td>
</tr>
<tr>
<td>History of drug &amp;/or alcohol abuse</td>
<td>2.00</td>
</tr>
<tr>
<td>Employment status at time of index offence</td>
<td>0.68</td>
</tr>
<tr>
<td>Length of stay (yrs) at Broadmoor</td>
<td>0.42</td>
</tr>
<tr>
<td>MHA Classification:</td>
<td>#</td>
</tr>
</tbody>
</table>

*As preliminary analysis indicated that the variable, ‘current age’ was normally distributed, a parametric test was conducted (i.e. one-way ANOVA)

For all other continuous variables, which were found to be skewed, non-parametric ANOVAs (i.e. Kruskal Wallis test) were conducted.

For categorical variables, chi-square tests were conducted

# Test statistic not provided as, due to small numbers (i.e. cell counts <5) the chi-square test was invalid.
Appendix 18: Group differences on standardised measures: Comparison on MCMI-III scores

<table>
<thead>
<tr>
<th>MCMI variable</th>
<th>Adult SOs</th>
<th>Child SOs</th>
<th>Mixed SOs</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mean</td>
<td>mean</td>
<td>mean</td>
<td>F ratio</td>
</tr>
<tr>
<td></td>
<td>(sd)</td>
<td>(sd)</td>
<td>(sd)</td>
<td></td>
</tr>
<tr>
<td>Disclosure (X)</td>
<td>60.11(19.25)</td>
<td>70.78(19.46)</td>
<td>72.00(20.92)</td>
<td>1.94</td>
</tr>
<tr>
<td>Desirability (Y)</td>
<td>56.15(19.19)</td>
<td>55.78(17.82)</td>
<td>52.75(25.48)</td>
<td>0.12</td>
</tr>
<tr>
<td>Debasement (Z)</td>
<td>55.46(20.20)</td>
<td>60.78(16.64)</td>
<td>58.33(26.15)</td>
<td>0.23</td>
</tr>
<tr>
<td>Schizoid (1)</td>
<td>53.00(27.50)</td>
<td>56.89(24.40)</td>
<td>72.67(24.13)</td>
<td>2.35</td>
</tr>
<tr>
<td>Avoidance (2A)</td>
<td>54.30(30.39)</td>
<td>61.67(26.48)</td>
<td>68.00(21.49)</td>
<td>1.05</td>
</tr>
<tr>
<td>Depressive (2B)</td>
<td>64.77(28.32)</td>
<td>64.44(19.37)</td>
<td>67.83(17.57)</td>
<td>0.04</td>
</tr>
<tr>
<td>Dependent (3)</td>
<td>61.96(28.37)</td>
<td>62.33(23.54)</td>
<td>67.92(21.35)</td>
<td>0.25</td>
</tr>
<tr>
<td>Histrionic (4)</td>
<td>42.81(18.13)</td>
<td>36.33(15.47)</td>
<td>28.25(19.30)</td>
<td>2.73</td>
</tr>
<tr>
<td>Narcissistic (5)</td>
<td>46.61(18.76)</td>
<td>54.55(24.10)</td>
<td>44.92(23.17)</td>
<td>0.62</td>
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<tr>
<td>Antisocial (6A)</td>
<td>61.23(22.68)</td>
<td>68.33(17.15)</td>
<td>71.83(10.81)</td>
<td>1.37</td>
</tr>
<tr>
<td>Aggressive/sadistic (6B)</td>
<td>47.54(22.44)</td>
<td>51.33(25.98)</td>
<td>60.33(18.15)</td>
<td>1.37</td>
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<tr>
<td>Compulsive (7)</td>
<td>46.31(13.52)</td>
<td>35.78(16.53)</td>
<td>69.75(13.71)</td>
<td>0.74</td>
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<tr>
<td>Passive-Aggressive (8A)</td>
<td>48.73(29.92)</td>
<td>58.67(24.98)</td>
<td>60.33(30.59)</td>
<td>0.81</td>
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<tr>
<td>Masochistic (8B)</td>
<td>53.77(25.45)</td>
<td>62.22(19.82)</td>
<td>73.42(16.59)</td>
<td>3.15</td>
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<tr>
<td>Schizotypal (S)</td>
<td>53.23(23.34)</td>
<td>48.78(29.49)</td>
<td>64.25(21.45)</td>
<td>1.25</td>
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<tr>
<td>Borderline (C)</td>
<td>54.42(17.96)</td>
<td>60.33(20.85)</td>
<td>67.67(18.01)</td>
<td>2.13</td>
</tr>
<tr>
<td>Paranoid (P)</td>
<td>50.58(24.58)</td>
<td>67.22(21.82)</td>
<td>66.33(24.84)</td>
<td>2.59</td>
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<tr>
<td>Anxiety (A)</td>
<td>62.19(34.74)</td>
<td>60.44(39.26)</td>
<td>65.83(36.99)</td>
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<td>Somatoform (H)</td>
<td>43.46(32.45)</td>
<td>49.00(28.09)</td>
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<td>Bipolar: manic (N)</td>
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<tr>
<td>Diagnosis</td>
<td>Mean</td>
<td>SE</td>
<td>Mean</td>
<td>SE</td>
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<td>Dysthmic (D)</td>
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<td>30.30</td>
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<td>Alcohol dependent (B)</td>
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<td>22.01</td>
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<td>25.92</td>
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<td>Drug dependent (T)</td>
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<td>10.00</td>
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<td>Thought disorder (R)</td>
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<td>46.11</td>
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<td>Major depression (SS)</td>
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<td>49.89</td>
<td>27.65</td>
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<td>Delusional (CC)</td>
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<td>26.00</td>
<td>65.33</td>
<td>22.96</td>
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<tr>
<td>PP</td>
<td>47.76</td>
<td>28.77</td>
<td>62.44</td>
<td>24.69</td>
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[# The mean difference is approaching significance at the 0.05 level #]
## Appendix 19a: Correlations between the standardised measures: PCL-R, GBAI and MCMI-III

<table>
<thead>
<tr>
<th>MCMI variable</th>
<th>PCL FACTOR 1</th>
<th>PCL FACTOR 2</th>
<th>PCL TOTAL</th>
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<td>.13</td>
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<td>Debasement (Z)</td>
<td>-.40*</td>
<td>-.03</td>
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<td>Schizoid (1)</td>
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* The correlation is significant at the 0.05 level
# The correlation is approaching significance at the 0.05 level
Appendix 19b: Correlations between the standardised measures: PCL-R, GBAI and SOAP

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* The correlation is significant at the 0.05 level
** The correlation is significant at the 0.01 level
# The correlation is approaching significance at the 0.05 level
### Appendix 19c: Correlations between the standardised measures: MCMII-III, GBAI and SOAP

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<th>SOAP EC</th>
<th>SOAP FF</th>
<th>SOAP PD</th>
<th>SOAP SE</th>
<th>SOAP U/ASS</th>
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* The correlation is significant at the 0.05 level; ** The correlation is significant at the 0.01 level; # The correlation is approaching significance at the 0.05 level