

Schema Profiles of Mentally Disordered Sexual Offenders

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Abstract

There has been growing interest in exploring the underlying schemas of sexual offenders in order to help understand the occurrences of such societal norm-breaking behaviour. Previous research has suggested that there may be differences between the schema profiles of those who offend against adults compared to those who offend against children. The research in this field is limited however, and largely focussed on those sexual offenders without a severe mental illness. This research therefore aimed at identifying if there are distinct differences between the schema profiles of those mentally disordered sexual offenders (MDSOs) who offended against children and those who offended against adults. Men detained within secure hospitals under the Mental Health Act 1983 (as amended by the 2007 act) that have a well-documented history of sexual offending were invited to take part. Each participant completed the Young Schema Questionnaire and My Life questionnaire. Demographic and offence related information was collected through a semi-structured interview and file review. There were no significant differences between the profiles of those who offended against adults and those who offended against children. There were positive correlations found between certain Early Maladaptive Schema domains and the offending schemas. Significant differences were identified between the profiles of MDSOs and non-MDSOs (prison population) gained from published data. These results are suggestive of there not being as distinct schema profiles within the MDSO population as there is for the non-MDSO population. As the profiles differ between the populations however, this may be resultant of the mental illness within the MDSO population. The findings are discussed in regards to the literature, and the limitations and future research highlighted. The clinical implications of these results, specifically on the treatment offered to MDSOs, is also considered.

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1 Introduction

1.1 Overview

This thesis is concerned with exploring the schema profiles of sexual offenders who are detained under the Mental Health Act 1983 (as amended by 2007 act) in secure hospitals in England. The relative absence of research on this issue with this specific population highlights the importance of increasing our understanding of the role schemas play within sexual offending in those with a mental illness or personality disorder. This awareness is likely to impact on the treatments offered to these individuals. The schema profiles of those who offend against adults will be compared against those who offend against children in order to see if there is a significant difference between the two. It is expected (from previous research with prison samples) that the profiles of those who offend against adults will have more prevalent schemas relating to control, entitlement, and emotional inhibition, whereas the profiles of those who offend against children will more highly endorse schemas relating to feelings of worthlessness and being a victim themselves. A correlation between different schema measures will also be carried out to assess the possible inter-relationships. It is felt that this population will have more schemas comparable to clinical populations, compared to the sexual offender counterparts that are detained within a prison setting and not detained under the Mental Health Act.

1.2 Theories of Sexual Offending

There have been many theories proposed to explain why some people sexually offend.

Understanding why rape, child molestation and other sexual offences occur, develop and change over time is extremely important in order for us as a society to help find ways to reduce the frequency of this extremely serious social problem (Ward, Polaschek & Beech, 2006). The theories are varied, and have also been used to help guide effective treatment for these individuals. One of the earliest that has been most cited is the Four Precondition Model (Finkelhor, 1984). This theory stated that there are a number of conditions in which sexual offenders must achieve prior to sexually offending. These are;

- 1) Having a motivation to sexually abuse, e.g. sexual arousal, emotional congruence with victim, inability to form suitable or satisfactory relationships with peers.
- 2) Overcoming internal inhibitors, e.g. stress, alcohol/drugs or cognitive distortions that do not prohibit such behaviour.
- 3) Overcoming external inhibitors, e.g. planning, opportunistic or circumstantial.
- 4) Overcoming resistance, e.g. threats/violence, gifts, abuse of trust.

The Precondition Model was first used to explain sexual offences against children, however it has since been widened and applied to those who offend against adults also. This was the first theory that was multi-factorial in nature and accounted for the complexity of these societal norm-breaking behaviours. However, it did lack aspects regarding developmental influences on such behaviour.

Another influential theory is Marshall and Barbaree's Integrated Theory (1990). This theory proposes that sexual offending is caused by a number of interacting distal and proximal developmental, biological, social and situational factors. The authors argue that early developmental factors are integral in the production of offence-related vulnerabilities, however more transient situational factors provide the triggers to sexually offend.

Marshall and Barbaree describe three key factors or stages that increase the likelihood for a male to sexually offend. The first of which is the development of vulnerability, which may include being abused or neglected themselves, and/or exposure to antisocial or misogynist behaviour. These experiences would result in insecure attachments and difficulties in interacting and relating to others. They propose that these developmental vulnerabilities often leave the individual with poor emotional regulation, difficulties with problem solving and poor impulse control, as well as being socially isolated. As the male arrives into puberty and there is an influx of hormones, he becomes unaware of how to manage his sexual urges given his poor adaptive functioning skills and inability to form and maintain relationships. This may result in a number of failed intimate seeking attempts, furthering his anger, frustration, low self-esteem and negative attitudes towards women. This may in turn result in the individual developing more deviant sexual fantasies which may include sadistic and aggressive themes to which he masturbates to that reinforces these fantasies. Finally, with these developmental and biological vulnerabilities in place these may interact dynamically with situational factors to make a sexual offence more likely to occur. These factors may include extreme loneliness, social rejection, or the loss of a relationship. If the offence occurs this provides the individual with both positive and negative reinforcement (sexual gratification and removal of negative emotion such as loneliness), which is therefore an

encouragement to reoffend. Cognitive distortions then develop to rationalise and legitimise the sexually abusive acts.

Hall and Hirschman (1992) developed a theory to capture the heterogeneous nature of child sexual offenders, and identified four key common factors that could be assessed to develop individualised formulations and tailored interventions. This theory was developed from their original theory explaining the occurrence of rape (Hall & Hirschman, 1991). The four factors they identified from the literature to be integral were;

- 1) Inappropriate physiological sexual arousal, i.e. having a sexual preference of children, persistent and intrusive deviant sexual urges and fantasies involving sex with children.
- 2) Distorted cognition, i.e. the beliefs and attitudes held by the offenders regarding the costs and benefits to sexual interaction with children, such as a child's desire to have sex, and the benefit to children of them having sex with an adult. These may be used to rationalise and justify their actions.
- 3) Affective dyscontrol, i.e. inability to adaptively detect, control, and manage their emotions.
- 4) Problematic personality factors, i.e. these include more enduring trait-like symptoms developed from adverse early experiences and resulting in antisocial attitudes and interpersonal difficulties.

The authors viewed these factors as able to function independently or in conjunction with each other to generate sexual abuse, however there appeared to often be a dominant factor.

As well as these integrated theories, specific single-factor theories have been developed to explore the individual aspects identified to be important within the multi-factorial theories in more detail. One significant single-factor theory that is the most theoretically developed is that of cognitive distortions. This can be seen to be present within all of the above mentioned multi-factorial theories. The term cognitive distortions is used widely in the sex offending literature to describe the maladaptive beliefs, attitudes and problematic thinking styles (such as excuse-making, blaming, rationalising and justifying) used by the offender to support their behaviour, and to limit the impact of guilt, anxiety and loss of self-esteem (Abel, Gore, Holland, Camp, Becker & Rathner, 1989). However, there has been a more recent debate about the utility of mixing post-offending behavioural rationalisations with pre-offending cognitions (Ciardha & Gannon, 2011).

The first single factor theory of sexual offenders' cognitive distortions was provided by Abel, Becker and Cunningham-Rathner (1984). This theory was focussed on men who target child victims, however the authors claimed in later writings that the theory can also be generalised to those with adult victims (e.g. Abel, Becker & Skinner, 1987). The theory states that boys from a young age are able to learn which sexual arousal patterns are societally inappropriate, and therefore aim to inhibit such interests. These interests may sometimes still be fantasised about however. When this is the case, these boys will develop a pattern of sexual deviancy carried through to adulthood, unless they are met with disapproval from significant others. As the boy develops into a young man, he becomes more acutely aware that his sexual preferences are deviant from the social norm. In response he may develop idiosyncratic beliefs, which Abel et al. (1984) called cognitive distortions, which maintain the deviant preferences, protect himself from internal conflict, and also reinforce any actual offending that may occur (e.g. sex with children is harmless). The cognitive distortions are

also externally reinforced through masturbation and repeat offending. It is therefore extrapolated that the authors viewed cognitive distortions as maintaining or facilitating sexual offending, rather than causing it.

This cognitive distortion theory pathed the way for the subsequent cognitive-behavioural treatment for sex offenders, and still remains the dominant theoretical viewpoint on sex offender cognition (Ward et al. 2006). Research on sex offenders has largely focussed on the distorted ways in which the offenders describe and justify their offending behaviour, and treatment focussing on how to address and change these cognitions (Ward, 2000).

Based upon the general psychological literature it can be seen that focussing on the removal of an offender's excuses and justifications within their offence attributions (which has been the goal of treatments based upon this model) is not necessarily the most effective way to treat such individuals (Mann & Shingler, 2006). Excuse making has been found to be an adaptive and normal response in a variety of contexts where failure or mistakes are faced (e.g. Dweck, 1975; Snyder & Higgins, 1988). Individuals with a more external and unstable causal attribution for their offending have been shown to have an increased desistance from re-offending (Maruna, 2001). This is therefore an extremely important consideration when planning and implementing treatment programmes for offenders, including sexual offenders.

More recently there has been a shift in focus on developing a theoretical understanding of the mechanisms that underlie and generate these distorted cognitions. Current research

suggests the existence of cognitive structures, called schemas, from which these distortions arise.

Szlachcic, Fox, Conway, Lord and Christie (2014) provided evidence to support the link between offence supportive attitudes (cognitive distortions) and schemas. They found a positive correlation between a certain collection of schemas and a higher proportion of offence supportive attitudes held by sexual offenders. This supported previous theories (Ward, 2000; Mann & Shingler, 2006) regarding offence supportive attitudes being the product of maladaptive schema held by an individual.

1.3 Schemas

Schemas, as defined by Beck (1996), are underlying cognitive structures that are the basis for guiding perceptions about the self, others and the world. First introduced within Cognitive Therapy they form *“a basis for screening out, differentiating, and coding the stimuli that confront the individual”* (Beck, Rush, Shaw & Emery, 1979, p.12-13). Schemas contain beliefs, assumptions, rules, and attitudes of which their contents all adhere to a certain theme (e.g. power, revenge, suspiciousness) and are the organising framework for processing new information (Mann & Shingler, 2006). When an individual perceives incoming stimuli, schemas are activated and used as a heuristic in order to save mental energy by providing shortcuts to interpret and understand this stimulus (Beech, Bartels & Dixon, 2013). This results in a consistency of processing information across situations, and therefore largely yields schema-confirming results on all occasions. In combination with

other factors, schemas are partially responsible for the behavioural responses that individuals exhibit to certain stimuli.

The development of schemas mostly takes place within one's early formative years. A child tries to make sense of the world around them, to understand the behaviour of others and attempt to predict others' behaviours and mental states (Ward, 2000). When a child is subjected to continued adverse experiences, these beliefs and predictions of the world, self and others become distorted and therefore maladaptive schemas arise. Schemas accumulate more knowledge and evidence over time, but are difficult to shift after they have fully formed as they are entangled in a network of other schemas. Information that may contradict one's schema is either interpreted in a way that aligns itself with its theme, or is rejected as being an anomaly.

1.4 Schema Theories of Sexual Offending

Given that maladaptive schemas develop through the core needs of a child not being met or violated (Young, 1990), and reflect the core of psychopathology underlying personal, interpersonal and social difficulties (Young, 1994), it is theorised that the sexual offender population will be adversely effected by maladaptive schemas. This has been substantiated by the empirical evidence of the presence of deficits and dysfunctions in the personal, interpersonal and social functioning of populations of adult and adolescent sexual abusers (Richardson, 2005). In addition there is evidence showing a high prevalence of adverse experiences, abuse and trauma in the early lives of sexual offenders (Richardson, 2005). For

instance, Craissati, McClurg and Browne (2002) found that there were high levels of neglect, disruption and violence in the childhood of those who sexually offend. Leonard (1993) identified more physical abuse within the families of rapists when compared to non-sexual offenders. Psychosexual disturbance has a positive correlation with that of sexual abuse victimisation in childhood, where those who sexually offend have a higher rate of being sexually abused than other offenders and the general population (Craissati et al. 2002; Dhawan & Marshall, 1996). This is all suggestive of the proposition that their core needs have been violated, and therefore maladaptive schemas developed within these individuals.

In response to the criticisms identified with the cognitive distortion theories of sexual offending, researchers began to explore the role of schemas as a potential explanation model for sexual offending behaviour. There are multiple conceptualisations within the sexual offending literature that report a significant role of schemas. These include the Early Maladaptive Schemas described within Young's Schema Model (Young, 1990; Young, Klosko & Weishaar, 2003); the Implicit Theories (Ward & Keenan, 1999; Polaschek & Ward, 2002); a Schema-based Model of Sexual Assault (Mann & Beech, 2003); and Mann and Shingler's sexual offending schemas. Despite these being separate theories or models, they all heavily overlap and include the shared notion that such schemas bias one's information processing, and that the schemas are all maladaptive to a greater or lesser extent.

1.4.1 Young's Schema Model (1990)

Young developed a specific schema based therapy of psychopathology and personality disorder to address some common challenges found within cognitive therapy (Young, 1990), such as chronic and long-term presenting problems, axis 1 disorders that are non responsive to therapy or the individual has had a chronic relapse, and long-term relationship problems. Young identified that through core childhood needs not being met, an individual would develop dysfunctional schemas, called 'Early Maladaptive Schemas'. Young describes these as:

"extremely stable and enduring themes that develop during childhood, are elaborated throughout an individual's lifetime, and are dysfunctional to a significant degree. These schemas serve as templates for the processing of later experience. They are comprised of memories, bodily sensations, emotions and cognitions." (Young, 1990, p. 9).

Young initially identified 16 Early Maladaptive Schemas that reflect the enduring maladaptive patterns of such individuals. These are broad and pervasive themes that characterise the individual and their relationship with others. In further work on this model he then revised this to 18 Early Maladaptive Schemas (Young et al. 2003), which are subdivided into five clusters, or 'schema domains'; *Disconnection/Rejection, Impaired Autonomy and/or Performance, Impaired Limits, Other-Directedness, and Over Vigilance/Inhibition*. The specific Early Maladaptive Schemas that are held within each of these domains are listed and described below:

Disconnection/Rejection:

- *Abandonment/Instability* – The perceived unreliability and instability of others around who will provide support and connection. Includes a fear that those around will leave them.
- *Mistrust/Abuse* – The belief that others will hurt, take advantage, or be abusive towards them.
- *Emotional Deprivation* – The belief that others will not be able to appropriately meet their needs for emotional support.
- *Defectiveness/Shame* – The belief that they are defective, inferior or bad in some way, and that they are unlovable to significant others if these aspects are exposed.
- *Social Isolation/Alienation* – The feeling that they are different and separate from others and the rest of the world, and do not fit in.

Impaired Autonomy and/or Performance:

- *Dependence/Incompetence* – The belief that they cannot manage their everyday tasks or problems in a competent manner without help from others.
- *Vulnerability to Harm or Illness* – An exaggerated fear that imminent danger or harm will occur at any time, and feeling unable to prevent it.
- *Enmeshment/Undeveloped Self* – Over emotional involvement or closeness stemming from overly close relationships, typically with a primary care giver, at the expense of full individuation. Includes a belief that one cannot survive without the other.
- *Failure to Achieve* – The belief that they have or are inevitably likely to fail relative to others. Subsequent feelings of being stupid and inept.

Impaired Limits:

- *Entitlement/Grandiosity* – The belief that they are superior to others and should be entitled to special rights and privileges, not be constrained by the same rules or regulations as everyone else.
- *Insufficient Self-Control/Self-Discipline* – A pervasive difficulty or refusal to inhibit emotions or impulses, which may interfere with meeting goals.

Other-Directedness:

- *Subjugation* – The belief that their desires and needs are not as important as others, leading to frequent surrendering of control and excessive compliance.
- *Self-Sacrifice* – A tendency to focus excessively on the needs of others, often to their own detriment and gratification.
- *Admiration/Recognition Seeking* – A desire for attention and approval from others, at the expense of developing a secure and true sense of self. Their self-esteem is contingent on the reactions of others.

Over vigilance and Inhibition:

- *Pessimism/Worry* – A pervasive and life-long tendency to focus on negative aspects of experience, including the belief that ultimately things will go wrong.
- *Emotional Inhibition* – The belief that emotions should be controlled and not shown to others for fear of negative reaction or losing control.
- *Unrelenting Standards/Hypercriticalness* – The belief that they must meet inflexible high standards, including a tendency to be critical of themselves and others.

- *Self-Punitiveness* – The belief that people should be punished harshly for any mistakes that they make.

Due to a paucity of research exploring Early Maladaptive Schemas within sexual offending there is very limited understanding on the role they may play towards these behaviours. However, Mann and Beech (2003) hypothesised that an interaction between Early Maladaptive Schemas and other factors (e.g. deviant sexual preferences) may play a causal role in sexual offending. Given that Early Maladaptive Schemas guide information processing and interpersonal interactions, and can result in maladaptive behaviours (Young et al. 2003), it is therefore plausible that such cognitive structures could result in specific beliefs and views towards themselves, others or the world that would invoke, allow or justify sexually aggressive behaviour.

1.4.2 Implicit Theories (Ward & Keenan, 1999; Polaschek & Ward, 2002)

In response to more specific offence-related schemas being required to explain such societal norm-breaking behaviour, rather than personality disorder, researchers in this area have developed offending schemas. These were first termed 'Implicit Theories' in the literature (Ward, 2000; Ward & Keenan, 1999). These cognitive processes, which appear to reflect the same underlying structures as schemas, have been described by Ward (2000) as similar to scientific theories in that "*they exhibit qualities of consistency, coherence, comprehensiveness, and explanatory power*" (p. 495). They are developed about an aspect

of an individual's world to understand, explain and control it. The implicit theory dictates what counts as evidence and how it is to be interpreted (Ward, 2000). For example a sexual offender is more likely to interpret friendly behaviour of a woman as a sexual invitation, rather than her simply being friendly. These different interpretations will therefore produce different behavioural responses, with the former being more likely to generate a sexually inappropriate or abusive response (Ward, 2000). It is theorised that these underlying structures bias social information processing and in turn make a sexual offence a more likely behavioural response when faced with certain stimuli (Mann & Shingler, 2006).

Cognitive distortions are generated by theories about their beliefs and desires and those of the people around them. Many more researchers have contributed to the field of implicit theories and so there is a less unified collection of these in comparison to Early Maladaptive Schemas. However, Ward and colleagues have outlined specific theories that they have identified to be particularly prevalent within sex offenders. These are described in detail within section 1.6.1 and 1.6.2 below.

1.4.3 Schema Model of Sexual Assault (Mann & Beech, 2003)

Mann and Beech (2003) outlined a way in which schemas may interact with environmental variables and other risk variables together that may lead to a sexual offence occurring. They made this into a model (see Figure 1). The authors proposed that the maladaptive schemas work in conjunction with negative or ambiguous life events to process any incoming information in a schema-congruent manner. Once activated, the schemas then produce

surface cognitions followed by affective and motivational states, which act together to make the idea to carry out a sexual assault appear appropriate, necessary, or attractive to the individual. This view shows that schemas play a role within sexual offending, however whilst interacting with other important variables, such as sexual arousal and emotional dysregulation.

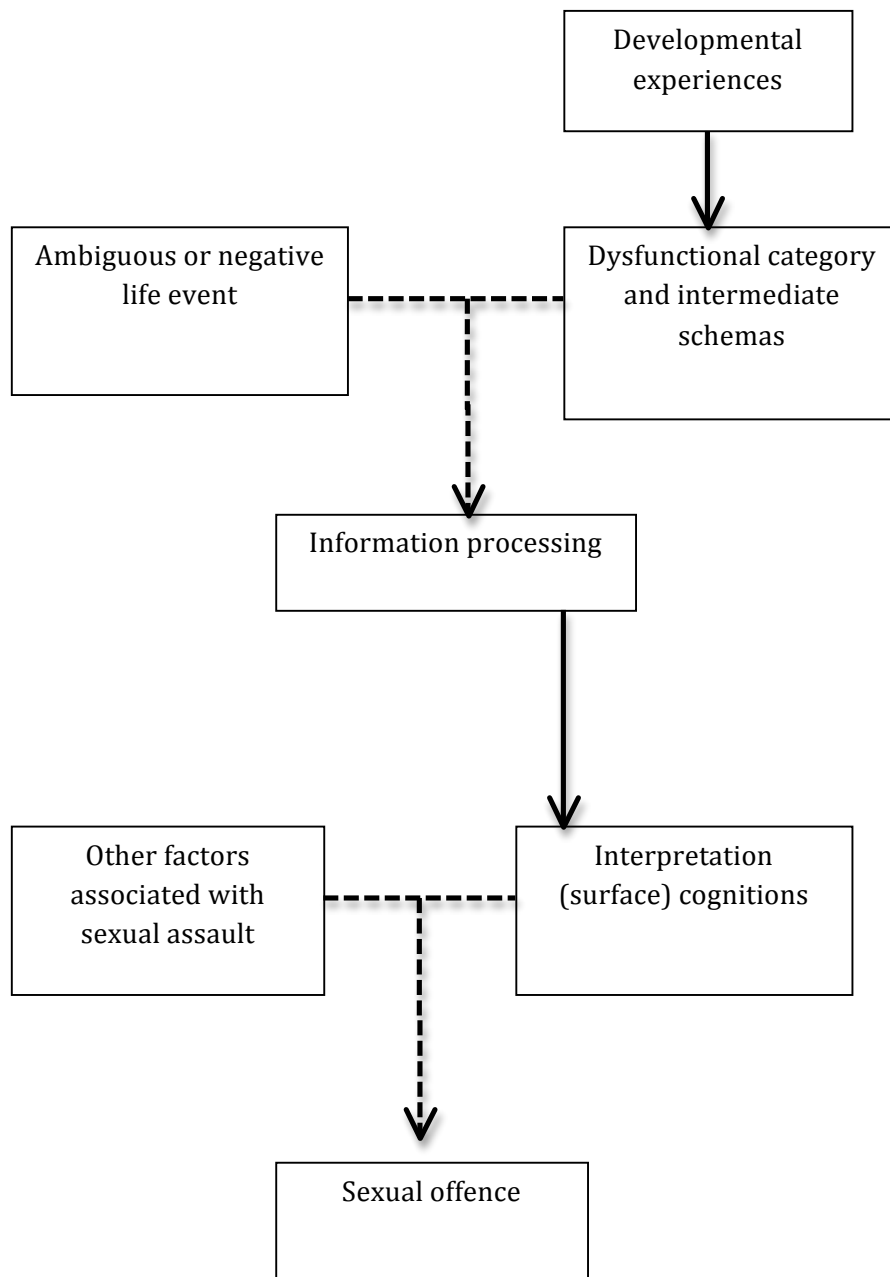


Figure 1: A schema-based model of cognition in sexual offending (Mann & Beech, 2003).

1.4.4 Sexual Offending Schemas (Mann & Shingler, 2006)

Mann and Shingler (2006) collated information from the sex offender literature to theoretically propose three potential offence related schemas that are specific to sexual offending. These were *Hostile Masculinity* (Malamuth, Heavy & Linz, 1993); *Suspiciousness of Women* (Malamuth & Brown, 1994); and *Sexual Entitlement* (Hanson, Gizzarelli & Scott, 1994).

Mann and Shingler propose that hostile masculinity may develop as a schema when certain childhood experiences, such as witnessing violence between parents, develop into aggressive adversarial schemas that refer to intimate relationships. If this is combined with associations with antisocial peers, and the socio-cultural environment (which in Western culture tends to value toughness and power (Mann & Shingler, 2006)) will reinforce these schemas. These are again strengthened if pro-social protective skills, such as emotion regulation and conflict negotiation, do not develop. When this hostile masculinity is coupled with influences of sexual promiscuity and sexual conquest as a source of identity, then this could lead to sexual aggression and offending. This proposal was supported by the work of Malamuth et al. (1993) that found rapists had a high level of hostile masculinity and sexual promiscuity, whereas non-sexual aggression just had high levels of hostile masculinity.

The suspiciousness of women schema suggests a mistrust of the validity of women's responses. It was found that men who have a high level of sexual aggression misinterpret women's reactions, where women are seen as game-playing and use aggression as a seductive tool, and act deceitfully when they are acting seductively (Malamuth & Brown, 1994). This was found using a video of a man making sexual advances to a woman who

reacted in one of four ways: friendly, seductive, assertively rejecting, and hostile. Those men high on sexual aggression believed the hostile responses to be a seductive approach, and the seductive response to signify a hostile and negative stance. A misinterpretation of social cues could therefore lead to an inappropriate behavioural response. This is the case initially when first meeting or talking to the woman, as well as if the woman continues to be hostile which would result in the sexually aggressive man to believe she is being seductive and wants to have sex with him.

The sexual entitlement schema highlights a belief that an individual's sexual needs are of more importance than others, and that he should be granted sex from others when he wishes it and that others should not, or cannot, deny him this. This schema was derived from a questionnaire that was administered to three groups of men ('incest offenders', 'male batterers', and 'non-offending males') (Hanson et al. 1994). The analysis of the questionnaire responses found a higher level of endorsement of sexual entitlement themed beliefs (such as "A person should have sex whenever it is needed", and "Women should oblige men's sexual needs") within the 'incest offenders' group when compared to the other groups that consisted of non-sexual offenders and non-offenders.

Therefore men who hold one or more of such schemas would potentially be more likely to (mis)interpret a woman's responses in a way that would fit with their schemas, and seek out such situations that confirm their beliefs and act upon them.

1.5 Measuring Schemas

The contents held within these cognitive structures may, or may not, be within the realms of conscious awareness to the individual (Beck, 1996). The measurement of schemas has been subject to much debate and scrutiny. As these structures that impact the social information processing usually lie outside of one's conscious awareness, it is uncertain whether they can be fully assessed through self-report methodologies. Less direct methodologies, such as Stroop tasks, memory tasks, sentence completion tasks and implicit association tasks have been suggested as more appropriate tools to assess the underlying schemas. However, Mann and Shingler (2006) highlight that even if the schemas are out of conscious awareness, the attitudes and beliefs that form their contents should resonate with an individual, as they are likely to reflect frequently experienced surface cognitions. Therefore, self-report measures using attitudes and beliefs are appropriate to use. Mann and Hollin (2010) highlight the fact that research and practice of cognitive therapy uses attitude scales and hold the view that schemas can be inferred from such tools.

Within the field of research of this topic schemas are measured in different ways. Young has developed a self-report questionnaire (Young Schema Questionnaire (YSQ); Young, 1990) to assess for Early Maladaptive Schemas. This has gone through a number of revisions and has different versions, i.e. short and long versions. Implicit theories have largely been measured through interviewing the individual and analysing the content of what they have said and categorising their beliefs, attitudes and other cognitive distortions into themes, which represent the underlying implicit theory. Mann and Hollin (2010) have however developed a self-report questionnaire, 'My Life' that assesses certain offending schemas; 'Disadvantaged' and 'Dominance'. The authors described these as 'modes', as they contain behavioural, cognitive, motivational and physiological components. The Disadvantaged mode includes

beliefs that one is damaged, and controlled by the past. The Dominance mode includes beliefs relating to wanting to take revenge, and a need for respect. The results of the measures or analysed interviews allows for the development of schema profiles of these individuals.

1.6 Schema Profiles of Sexual Offenders

It was theorised by Ward (2000) that it is plausible for the schema profiles (or implicit theory profiles) to be distinctly different between those men who sexually offend against adult victims (which the author labels as 'rapists') and child molesters. Ward (2000) postulated that rapists would hold more hostile and deprecating theories of the victim than a child molester would. He predicted that rapists would feel more able to redress the perceived injustices against them, and take a hostile combative stance in their relationships with others. In turn, he felt child molesters would also hold a belief that the world is dangerous, but in contrast would not feel capable of direct retaliation or dominance over an adult, so would choose a child victim instead. Theories based around fear of rejection and exploitation may be more prevalent amongst child molesters, and they may feel children would be less likely to react in this way to them. Finally, Ward (2000) felt that the emotional tone of the theories of rapists would be characterised by anger, whereas child molesters would mostly involve anxiety with a sense of vulnerability.

The above are theories highlighted by Ward (2000) and were not empirically based.

However, research exploring these further is suggestive of Ward's theories holding some

truth. The previous research of sexual offenders' cognitive distortions has been reviewed and these distortions have been categorised into greater meta-themes or schemas (e.g. Ward & Keenan, 1999; Polaschek & Ward, 2002) from where these distortions arise. This was based on the premise that these distortions were not independent or stem from unrelated beliefs, but that there were underlying causal theories about the nature of their victims (Ward, 2000).

1.6.1 Schema Profiles of Sexual Offenders against children

Ward and Keenan (1999) reviewed three scales: MOLEST scale (Bumby, 1996); Cognitions scale (Abel et al. 1984); Hanson Sex Attitude Questionnaire (Hanson et al. 1994) that are used to measure cognitive distortions in sexual offenders. The authors identified 5 prevalent themes (implicit theories) that account for the majority of the specific distortions for child molesters highlighted within the scales and the published literature of these scales. The 5 theories were:

- 1) *Children as sexual objects* - This refers to a belief that children enjoy and desire sex. This theory can lead to the interpretation of everyday child behaviour (e.g. sitting on an adults lap) as indicating sexual intent and preferences.

- 2) *Entitlement* - This theory dictates that certain people are more important and superior to others, and therefore can assert their (sexual and emotional) needs above others.

- 3) *Dangerous world* - Within this theory people view the world as a dangerous place where others are abusive and rejecting. This can result in two variations: i) that it is therefore necessary to fight back to gain dominance and control over these people; and ii) that adults are unreliable, whereas children can be depended upon.

- 4) *Uncontrollability* - This depicts the view that the world is uncontrollable and humans are made up of structures and processes that cannot be altered or managed (e.g. emotions, sexual feelings). This places one's sexual desires as external to the individual, and as a result is personally not responsible.

- 5) *Nature of harm* - This theory views harm on a continuum, and moderated by a number of factors such as amount of force used, the victims' awareness etc. This theory also encapsulates the idea that sex is a beneficial experience for children, as is a natural desire of humans.

1.6.2 Schema Profiles of Sexual Offenders against adults

A similar process was carried out by Polaschek and Ward (2002) to describe the core underlying theories of rapists. The authors reviewed eight measures: RAPE scale (Bumby, 1996); Adversarial Sexual Beliefs (Burt, 1980); Attitudes Towards Interpersonal Violence Towards Women (Burt, 1980); The Rape Myth Acceptance Scale (Burt, 1980); Hostility Towards Women (Check, Malamuth, Elias & Barton, 1985); General Attitudes Towards Rape (Larsen & Long, 1988); Rape scale from the Multiphasic Sex Inventory (Nichols & Molinder, 1984); and the Texas Rape Scale (Young & Thiessen, 1992) as well as reviewing the

attitudinal statements that were reported in an interview-based research article (Scully & Marolla, 1984, 1985). Again, five themes were identified. The themes for the rapists were:

- 1) *Women are unknowable* - The basis of this theory is that women are inherently different from men, and men cannot easily understand these differences. This results in men not seeking intimacy from women, and thus they become more suspicious and hostile towards them, and misread cues that they give.
- 2) *Women as sex objects*. In this theory it is conceived that women exist to meet the sexual needs of men, and that they constantly desire sex. It follows that women should be receptive to meet men's sexual needs as they arise. This theory leads to the misattribution of sexual intent in nonsexual behaviour.
- 3) *Male sex drive is uncontrollable*. This theory postulates that men's sexual energy is difficult to control, and that women are responsible in its loss of control. Similar to Ward and Keenan's (1999) 'Uncontrollability' theory, this positions the cause of their offence as external to themselves.
- 4) *Entitlement*. This contains beliefs that men are intrinsically superior to women and they should have all their needs (including sexual ones) met whenever they want.

- 5) *Dangerous world*. This is reported as similar to Ward and Keenan's (1999) description, however when in reference to rapists, even children are seen as malevolent, no one can be trusted. The view of 'a dog-eat-dog world' represents this theory well.

As can be seen there is some overlap between the two core lists of implicit theories between child molesters and rapists, for instance both referring to a dangerous world and a sense of entitlement. However, there are distinctions that do set the two groups apart. This provides evidence to suggest that the two sub-groups of sex offenders do have different underlying schemas present. It should be noted however that these lists of identified implicit theories were based on pre-existing measures of sexual offending cognitions, so it could be that other underlying schemas not accessed by such measures could also play a role within the offending.

1.6.3 Evidence for Schema Profiles

There has been further research using these identified implicit theories to explore whether these are apparent within the offenders themselves, rather than relying on existing questionnaires. A qualitative analysis of interviews with child molesters from a sex offender treatment programme was carried out to assess the accuracy of the five implicit theories highlighted by Ward and Keenan (1999) (Marziano, Ward, Beech & Pattison, 2006). The authors interviewed 22 adult males convicted of sexually abusing children. The interview questions used were based partly on themes from the five implicit theories identified by Ward and Keenan (1999), reviewing these at different stages of the offending sequence, i.e.

pre-offence, offending stage, and post-offence. Open questions were used to explore the offenders' beliefs and views of different aspects, e.g. belief of the victims' sexual knowledge, and level of control exercised at the time of the offence. The authors identified that the offenders' beliefs and views (cognitive distortions) elicited from the interview could be categorised into the five implicit theories, and these were sufficient to explain all the cognitive distortions. However, given that the questions were based on these theories it may not be too surprising that no other information that did not fit these was found, as the questions may have been priming the individual for distortions that fit the set theories.

Polaschek and Gannon (2004) reviewed interviews with 37 convicted rapists and, similarly to Marziano et al. (2006), aimed to identify the pre-existing five implicit theories from the literature (Polaschek & Ward, 2002). Evidence for all five theories was found after the analysis and coding of the interviews. These were found to differing degrees, three of which were highly prevalent in the reports of the rapists ('Women are unknowable' (relabelled to 'Women are dangerous') 65%, 'Women are sex objects' 70%, and 'Entitlement' 68%) and the remaining two ('Male sex drive is uncontrollable' and 'Dangerous world') were found to be reported less commonly; 16% and 19% respectively. This provides further evidence for the identified implicit theories to be present within the sex offenders, both rapists and child molesters.

These findings also showed an overlap with previous unpublished research highlighted in Mann and Beech (2003) where Mann and Hollin (2001) coded explanations of offending of 45 rapists. They identified five schemas: 'grievance', 'self as victim', 'control', 'entitlement', and 'disrespect for certain women'. Polaschek and Gannon (2004) highlighted the close

resemblance of Mann and Hollin's 'entitlement' and 'control' schemas with their 'entitlement' and 'dangerous world' implicit theories. The 'disrespect for certain women' schema is a more specific variation of the implicit theories of 'women are dangerous' and 'women as sex objects' supported by Polaschek and Gannon (2004), who used more generalized disrespect than Mann and Hollin. This shows that there have been separate studies exploring the underlying cognitive structures that have resulted in overlapping themes, signifying the presence of such maladaptive processes and beliefs within this population. The differences found could be down to certain variables such as whether the individuals assessed have undergone (or are undergoing) treatment or not, the methodology used, the questions asked to the offenders, as well as the researchers' coding system.

When using Young's Early Maladaptive Schemas as a basis for comparison, Carvalho and Nobre (2014) identified that there were differences between the schemas held by convicted child sexual molesters, rapists and a comparison group of non-offenders. The two offending groups were incarcerated within prisons. Each individual completed the YSQ-S3 (Young, 2005) and comparisons between the groups found that when contrasted with non-offenders, the child sexual molesters had a significantly higher level of schemas from the disconnection/rejection, impaired autonomy/performance, other directedness, and over vigilance/inhibition schema domains, whereas rapists endorsed significantly more schemas from the impaired autonomy/performance domain. When comparing between the two sexual offenders groups, the child sexual molesters group held significantly more schemas of pessimism than the rapist group. This provides evidence for sexual offenders having significantly more maladaptive schemas than non-offending counterparts, as well as there being differences within these schema profiles between the type of offence (i.e. between those who offend against children to those who offend against adults).

A study was carried out by Richardson (2005) to compare Early Maladaptive Schemas in a group of 54 adolescents (age range 13 to 19 years old) who had committed a sexual offence against either children, peer-aged or adult victims. All of the adolescents were taking part in a group-based treatment programme within a forensic mental health service for young people, however only seven of these had a diagnosed mental illness and were detained under the Mental Health Act 1983. The scores on the Young Schema Questionnaire (2nd edition; Young & Brown, 1994) differentiated between a 'clinical' group and a 'non-clinical group', based on the level of endorsement for each individual schema. The non-clinical group consisted of those who scored in the low ranges across all of the 16 maladaptive schemas. The result of this was that 74% of the whole group were defined to be within the clinical group, which included the seven with a diagnosed mental illness. This showed that many of the offenders had significant psychological difficulties in need of attention that may lie outside of the remit of offence-specific treatment, although only a small percentage had a diagnosed mental illness.

The results of the analyses from the above study showed that there were some identifiable differences between the Early Maladaptive Schema scores of those who offended against children and those who offended against a peer-aged or adult victim. It was found that there were certain significant differences between the two sub-groups, where the peer/adult offender group scored significantly higher mean scores on the following Early Maladaptive Schemas: 'Entitlement/Self-centeredness'; 'Insufficient self-control/Self-discipline'; and 'Emotion inhibition'. In general the peer/adult age offender group held schemas related to lacking discipline, self-control, a disrespect for rules, and emotional inhibition more so than the offenders with younger victims.

A different method of exploring schemas is drawing out 'Life Maps' which are visual autobiographies drawn up by the individual charting significant life events, including the sexual offence, and including their interpretation of the events as it happened at the time. Milner and Webster (2005) compared the Life Maps of rapists, child molesters and non-sexual violent offenders. It was found that the three groups showed different patterns of the schemas interpreted from the Life Maps. Rapists had significantly higher hostility to women and sexual entitlement than the other two groups, and child molesters showed a significantly higher sense of worthlessness than the other groups. A similar pattern was also found by Myers (2000), where rapists showed more distrust for women and a need for control related schemas, whereas child molesters had a more worthlessness and passive victim stance pattern to their schemas.

However, there is some contrary evidence to suggest that there are not such observable distinctions between the schematic profiles between sex offence type. Mann and Hollin (2007) found that after a content analysis of descriptions and explanations of individuals' sexual offences that there were not significant differences in nine out of 10 categories expressed for reasons of offending between rapists and child molesters. The only one that did significantly differ was 'intimacy seeking', which was offered more frequently by child molesters. The extent to which these categories can be identified as schemas is, however, questionable. It was stated that 'grievance' and 'need for respect/control' could be schemas, but the remaining categories would not necessarily fit into the schema definition. The two identified schemas were reported more frequently by rapists, so it was queried whether factors other than schema-driven thinking are more important in causing a child molestation sexual offence. The data from this research indicates that intimacy deficits have a greater role in child molestation than distorted thinking. However, it is plausible that there are some

schemas prevalent within child molesters that were not identified due to methodological shortcomings in assessment.

As well as using Life maps, Milner and Webster (2005) also used My Life questionnaire (version 1; Mann & Hollin, 2001). There were no significant differences between the rapists and child molesters on their scores using this questionnaire, but they collectively differed to violent offenders. This suggests that there is not a clear distinction between type of sex offence in respect to their schemas, however the profiles of sex offenders as a whole may be distinct from others. This could reflect a less specific instrument being used to assess for the schemas, but this lack of difference could also reflect certain methodological limitations. Firstly, there was a small participant number in each group (n=12) and homogeneity of variance was not met on one of the scales, so generalisability of findings is impaired. Secondly, both the sex offender groups had undertaken over 300 hours of CBT treatment for sexual offending, so therefore it is possible that genuine change had occurred during this treatment and so they may report lower levels of schema-related beliefs. This may have been significantly different if the measures were to have been administered pre-treatment.

Even though the research is growing, it can be seen from the above findings that there is some preliminary evidence to suggest that there may be differences between the schema profiles held between the sexual offenders that target adult victims, compared to those who offend against children. This is an important area to clarify, as if there is a difference between profiles then this could help us understand why people sexually offend against adults or children, as well as be useful for directing appropriate and effective therapy for these individuals.

1.7 Schemas and Mental Disorder

The Schema Therapy model (Young, 1990) proposes that early maladaptive schemas are at the core of personality pathology and psychological distress. It may therefore be assumed that individuals with a diagnosed mental illness or personality disorder would therefore hold more early maladaptive schemas compared to those that would fit into a non-clinical sample. This has in fact been found to be the case, where a strong association has been identified between early maladaptive schemas and higher levels of psychopathology (Pinto-Gouveia, Castilho, Galhardo & Cunha, 2006), where those within a clinical sample have a greater number of Early Maladaptive Schemas present when compared to a non-clinical sample.

Schema Therapy was initially developed for the use with those who have a personality disorder diagnosis, specifically Borderline Personality Disorder. There is extensive research supporting the identification and treatment of Early Maladaptive Schemas within those with Borderline Personality Disorder (e.g. Gliesen-Bloo, et al., 2007) and this has also extended to Narcissistic personality disorder (e.g. Behary & Dieckmann, 2011) hence Schema Therapy predominantly being used for the treatment of those with these disorders. Subsequent research has identified that other personality disorders also have distinct schema profiles (Jovev & Jackson, 2004).

There is, however, growing research to suggest that such schemas exist within other clinical populations also. Welburn, Coristine, Dagg, Pontefract and Jordon (2002) carried out an analysis of the scores of the Young Schema Questionnaire – Short Form (Young, 1998) and the Brief Symptom Inventory (Derogatis, 1993), and were able to identify specific schemas

that were significant predictors of anxiety, depression and paranoia. They found that *Vulnerability to Harm, Abandonment, Failure, Self-Sacrifice* and *Emotional Inhibition* were the biggest predictors of anxiety, whereas *Abandonment* and *Insufficient Self-control* predicted the presence of depression. The largest contributor to a presence of paranoia was that of *Mistrust/Abuse*. Hedley, Hoffart and Sexton (2001) identified certain early maladaptive schemas that were highly prevalent in those with Panic Disorder with Agoraphobia, specifically *Vulnerability to Harm*, and *Dependence/Practical Incompetence*. Those with Social Phobia have been found to have a specific schematic profile, which differentiates them from those with other anxiety disorders, and a non-clinical sample (Pinto-Gouveia et al. 2006).

When reviewing the application of this to a population more akin to that found in a secure forensic ward, Van Os (2000) found evidence suggestive of negative schemas playing a role in the development of psychosis. It has been proposed within a model of auditory hallucinations (Birchwood, Meaden, Trower, Gilbert & Plaistow, 2000) that negative schemas can also be instrumental in the development of such experiences via the route of negative childhood experiences involving social adversity that lead to negative schemas that include social humiliation and subordination. These in turn fuel voices and paranoia.

When exploring these propositions that schemas play a role within the development of psychosis, Bortolon, Capdevielle, Boulenger, Gely-Nargeot and Raffard (2013) found six early maladaptive schemas that were found to be significantly more represented in a clinical sample of (non-offending) patients with schizophrenia when compared to a non-clinical sample, after controlling for depression. These schemas were *Defectiveness/Shame, Failure*

to Achieve, Subjugation, Self-sacrifice, Emotional Deprivation and Social Isolation. The *Mistrust/Abuse* Schema was also found to specifically predict positive symptoms of psychosis, therefore highlighting a potential role of maladaptive schemas within psychosis. These findings may not be a surprise, given the plethora of research exploring negative childhood experiences of those with psychosis (e.g. Cohen, Palekar, Barker & Ramirez, 2012; Read, Van Os, Morrison & Ross, 2005), and the understanding of how early maladaptive schemas arise through core childhood needs not being met or violated.

It is of note that the above findings are all derived from non-sexual offending populations. There have been very few studies that have explored schemas within the offending population that also have a diagnosed mental illness or personality disorder. When reviewing these studies it was evident that there were some discrepancies between the results when compared to those above (non-sexual offenders). A contradictory finding arose from the research by Slazchic et al. (2014), as the three schemas that correlated most highly with offence supportive attitudes, were not the schemas that were most highly endorsed by the sample of mentally disordered sexual offenders. The authors found that Self-Punitiveness and Unrelenting Standards were the two highest scoring schemas. This differs from other patterns of Early Maladaptive Schemas from the non-mentally disordered sexual offender population. The authors proposed that this could be due to the high level of psychosis within the sample, and therefore these schemas reflecting the influence of mental disorder, specifically paranoia, that was not found in the non-mentally disordered sexual offending population. Therefore this is suggestive of when a sexual offender has the addition of a mental illness, different schemas are held from the ones that are directly linked to the offending behaviour (i.e. those that were most positively correlated with the offence supportive attitudes).

Even though the research of the presence and role schemas play within offending behaviour is in its infancy, the use and adaptation of Schema Therapy within a forensic setting is a growing field. Bernstein, Nijman, Karos, Keulen-de Vos, de Vogel and Lucker (2012) have found some promising effects of using Schema Therapy with forensic patients diagnosed with Borderline, Narcissistic, Antisocial and Paranoid personality disorders. In this pilot study, the authors used a random controlled design across seven Dutch forensic services to investigate the effectiveness of using Schema Therapy with this population. They found that the amount of leave (both supervised and unsupervised) was significantly higher in the treatment group, compared to those within the 'Treatment as usual' group, and that the scores on a clinical risk tool (Historical, Clinical and Risk management scheme, HCR-20; Douglas & Webster, 1999) improved more rapidly in the treatment group. These preliminary findings are suggestive of Schema Therapy being an effective treatment for reducing risk in this population.

The above findings are of relevance as the majority of previous research exploring schemas of sexual offenders has largely focussed on those within a non-clinical population, e.g. those within a prison setting. Given that those within a forensic service have a diagnosis of a mental illness or personality disorder, and these have been shown to have their own schematic profiles, there is a possibility that those within a forensic service could have a different schema profile. These differences in profiles could have a different explanatory power for their subsequent offences compared to those of their non-clinical peers. This could then suggest that there is a different schema structure leading to the propensity to commit a sexual offence between those with a mental illness and those without. This would have implications on the understanding and treatment of mentally disordered offenders.

1.8 Limitations within the literature

The majority of the studies investigating schemas or implicit theories within the sex offender population have been based upon those detained within a prison. Baker and White (2002) identified that sexual offenders constitute a significant group within the forensic psychiatric populations, i.e. those detained under the Mental Health Act 1983 (as amended by the 2007 act) that have also committed a criminal offence. It has been noted that there is a general paucity of research within those who have mental health difficulties and engage in deviant sexual practices (Drake & Pathé, 2004). The limited research on schemas and sexual offenders has suggested that this population also have maladaptive schemas (Lord & Perkins, 2014; Mannix, Dawson & Beckley, 2013; Richardson, 2005), however this has not been thoroughly explored. There is a potential for the symptoms of the mental illness to have a larger causal factor for their offending (e.g. command hallucinations in schizophrenia) rather than underlying schemas. In addition, more schemas relating to uncontrollability or lack of control may be more prevalent in this population, as their mental illness may be viewed as a reason for their offending, making it an external cause that they were not able to control.

The most common way to assess schemas has been through the use of interviews, and analysing the content of these to derive potential schemas. The use of self-report measures to attain schemas is not that widespread within this field of research. Self-report measures are an easier and more cost-effective way of identifying an individual's schemas, so if it is possible, it could be a valuable tool to use with this population and open to less rater-bias that may be present in those studies using interview content.

1.9 Rationale and aims for the research

The current research aims to further our understanding of schema profiles of mentally disordered sex offenders (MDSOs). Data will be collected from MDSOs over 6 NHS forensic inpatient services, from low security through to high security hospitals. Each participant will complete a Young Schema Questionnaire (Short form version 3, YSQ-S3; Young, 2005), My Life (version 2; Mann & Hollin, 2010) and have a brief assessment to identify offence and demographic details. The YSQ-S3 measures Early Maladaptive Schemas, and the My Life questionnaire has been found to be effective in identifying certain prevalent offending schemas within this population (Mann & Hollin, 2010). The type of offence of each participant (e.g. those who offend against adults or children) will be identified and the scores from the measures will be compared between the two groups with the aim of identifying any significant differences between them in either the Early Maladaptive Schemas or offending schemas. A correlational analysis will also be carried out in order to assess the relationship between Early Maladaptive Schemas and offending schemas. In order to evaluate whether the profiles significantly differ from those sex offenders without a mental illness, a comparison between the groups can take place using the data from Mann and Hollin's (2010) study.

There is evidence to suggest that the schema profiles of those who sexually offend against adults may be different to those who offend against children. This existing research is largely based however using populations that are detained within the Criminal Justice System and that do not have a mental health or personality disorder diagnosis. As outlined previously this could be an important difference and may have an impact on our understanding of, and therefore treatment for, said individuals that is different to the non-MDSO population.

The My Life v.2 questionnaire (Mann & Hollin, 2010) has not been widely used, so further use of this measure would be beneficial, especially using an MDSO sample. There has not been any attempt in the literature to review the correlation between schema measures within this population, so a clearer understanding on whether the measures used are comparable and accessing similar products will be a useful validating tool.

The benefit of this study is to enhance understanding of the existence and workings of schemas within this population. This may also help provide further guidance in assessment and treatment of such schemas within the population of MDSOs, rather than currently relying on the non-MDSO research (prison population). This is important, as the needs of the MDSOs may be in excess of, or different to, the offence-specific treatment programmes available to the non-MDSO groups.

Based upon the limited research in this field of sexual offending schemas outlined above the preliminary hypotheses for this research are:

- 1) There will be significant differences between the schema profiles of those MDSOs that offend against adults compared to those who offend against children. The adult victim profiles will have more prevalent schemas relating to control, entitlement and emotional inhibition, whereas the profiles of those who offend against children will more highly endorse schemas relating to feelings of worthlessness and being a victim themselves.
- 2) There will be a correlation between the two measures used (YSQ-S3 (Young, 2005) and My Life v.2 (Mann & Hollin, 2010)) around specific schemas: 'Dominance' with 'Impaired Limits' domain, and the 'Disadvantaged' with 'Disconnection and Rejection' domain, 'Impaired Autonomy and Performance' domain, and 'Other-directedness' domain.
- 3) The schema profiles of the MDSOs will be significantly different from those of the non-MDSOs (using published data). The MDSO population will have more schemas akin to clinical populations, such as Defectiveness and Social Isolation. Given the high rates of abuse and trauma in the research of those with schizophrenia, one could expect more 'Disadvantaged'-based schemas to also be present.

2. Method

2.1 Ethical Approval

In order to carry out this research project, an application for ethical approval was initially submitted to the National Research Ethics Service (NRES). A meeting was held with NRES to discuss the proposed project and for the researcher to answer any queries that were raised regarding any element of the project. After this meeting the feedback comments were addressed, and a favourable opinion for full ethical approval was granted by East Midlands Research Ethics Committee in April 2014 (see Appendix 6.1). Ethical approval was then sought and gained from the Ethics Committee at Royal Holloway, University of London (Appendix 6.10), and three NHS Research and Development (R&D) departments associated with the five initial services agreed to aide in data collection; London West Mental Health R&D, South West London and St Georges Foundation Trust R&D, and Noclor. A sixth R&D application was deemed necessary and sought at a later date. Approval letters and access letters can be seen in the appendices.

2.2 Design

This study adopted a questionnaire based cross-sectional, mixed design approach to explore the relationship between the schema profiles of those mentally disordered sexual offenders that offend against adults and those who offend against children. The questionnaires were used to attain the schemas, and the demographic and offence-related information was gathered through a brief interview and/or file review. Between group comparisons were carried out to explore any differences between the schema profiles of those mentally

disordered sexual offenders (MDSOs) against children and those against adult victims. Correlational design was carried out to assess the relationship between the two measures. Finally between group comparisons were carried out to identify if there were any differences in the schema profiles of the current sample of MDSOs and published data on non-MDSOs (i.e. sex offenders held within prison). Exploratory post-hoc analyses were then carried out to further explore any differences or relationships between the sample.

2.3 Participants

2.3.1 The sample

The sample consisted of 29 male inpatients that were being held at the time of data collection in a low, medium or high secure psychiatric hospital. The sample ranged in ages from 24 to 63 years (mean= 45.61, SD= 9.67). More information on the sample demographics is provided in Chapter 3. There was an overall recruitment uptake rate of 44.62%. 65 potential participants were approached and provided with the Participant Information Sheet (Appendix 6.13), and 29 consented to take part.

2.3.2 Inclusion and Exclusion Criteria

The Multi Disciplinary Teams (MDTs) were asked to consider the patients on their wards that fitted the following criteria;

- Men aged 18 to 65 years old.
- Who are held under the Mental Health Act, 1983 (as amended by the 2007 Act).
- Under conditions of low, medium or high security.
- Who have been convicted of a sexual offence (not necessarily their index offence) or have a well-documented history of sexual offending.

However they also had to not meet any of the following exclusion criteria;

- Active symptoms of mental illness to an extent that would distract or limit informed consent.
- Men whose behaviour is deemed too risky to take part in research (e.g. aggressive or inappropriate).
- A learning disability (e.g. IQ below 70).
- Insufficient comprehension/expression of English to understand/respond to the interview and questionnaires.

These criteria allow for an as homogenous sample as possible to be recruited. These were set also in order to minimise any potential risk to the participants and the researcher.

Theories of sexual offending differ for men with a learning disability to those without (e.g. Lindsay, 2005), therefore the exclusion criteria of IQ below 70 was used to again adhere to a homogenous sample.

There were a number of potential participants that were discussed within the MDT meetings when this research was raised that were not given the Responsible Clinician's (RCs) consent for the researcher to approach. This was due to varying reasons, including the team deeming the individual currently too unwell to approach, the individual not assessed as having capacity to consent themselves, the individual was in denial of their sexual offence, and research participation potentially damaging the individual's relationship with the MDT. This therefore shows that the potential pool of participants was greater than that identified in the research.

2.3.3 Recruitment

Participants were recruited from six secure services in and around the London area. These varied from low security, through medium to high security services. Clinical or Forensic Psychologists were identified within each service and approached to act as site supervisors for each individual service. Prior to accessing these services, honorary contracts were applied for as well as the researcher being required to complete a security induction and key training session. This was carried out within three of the six services. The remaining three services preferred the researcher to be escorted around the wards and to the participants, and so therefore key training was not required.

Once these formalities had been completed, the researcher either attended an MDT meeting or contacted the ward managers and RCs to discuss the research project and to ask the MDT to consider the patients on their wards that fit the above criteria. The RCs consent

was then sought to approach each of these identified participants. See appendices for copies of the RC Information Sheet and Consent Forms (Appendix 6.11 and 6.12 respectively).

Those who had been given consent by the RC were then approached on the wards by the researcher and spoken to in a private interview room on the ward. The Participant Information Sheet was given to the individual, which outlined the aims of the research and what it would entail. A discussion was had around confidentiality, consent and anonymity. Participants were given the opportunity to ask questions or raise any concerns. They were all provided with at least 24 hours to consider taking part before the researcher re-approached them to answer any queries and to seek written informed consent if they agreed to take part. A convenient time for the participant, researcher and ward was then arranged for the researcher to return and carry out the data collection component.

2.3.4 Power Considerations

Due to the limited number of studies of schemas in MDSOs, estimating an effect size is therefore difficult. Mann and Hollin (2010) was identified as the closest study on which to base the effect size calculation as they examined offence schemas in a prison population, i.e. offending schemas with no mental illness, using the My Life questionnaire (version 2). They administered the questionnaire to men in a prison convicted for rape, child molestation, non-sexual offence, and to prison guards (as the non-offending control group). They then measured the presence of the schemas and compared them between these groups. In order to identify the effect size, Cohen's d was calculated using the following formula: $\frac{\bar{x}^1 - \bar{x}^2}{S}$

As there were 3 offending groups (rapists, child molesters with female victims, child molesters with male victims) the average mean score was calculated for \bar{x}^1 , which created an overall mean of 70.77 for the offending group. The non-offending mean (prison guards) (\bar{x}^2) was 53.43. The average standard deviation (S) was calculated in a similar fashion. Offending standard deviation equated to 21.24 (19.69, 22.5 and 21.52), and the non-offending standard deviation was 15.87. As these two standard deviations were different, an S – average was required. This was calculated with the following formula;

$$S^1 + S^2 / 2$$

$$S - \text{average} = 18.56$$

Therefore the overall calculation was as follows;

$$70.77 - 53.43 / 18.56 = 0.93$$

The effect size estimated is large according to Cohen's conventions. Therefore using the convention of power set to 0.8 and alpha at 0.05 (Cohen, 1992), with an expected large effect size, approximately 26 participants per group (offence type) were needed, therefore 52 MDSOs in total to allow for cross group analyses.

There has been no study that has looked at the correlation between offending schemas and Young's early maladaptive schemas, therefore there is no basis to calculate effect size. On the basis a medium to large effect size is predicted, with alpha set to 0.05 and power at 0.8 (Cohen, 1992), a sample between 28 and 85 will be needed. The previous stated sample size of N=52 will therefore fit in well with this.

2.4 Measures

2.4.1 Young Schema Questionnaire – Short Version 3 (YSQ-S3; Young, 2005)

The YSQ-S3 was used to assess for Early Maladaptive Schemas (Appendix 6.17). These have been described as:

‘a broad, pervasive theme or pattern, comprised of memories, emotions, cognitions, and bodily sensations, regarding oneself or one’s relationships with others, developed during childhood or adolescence, elaborated throughout one’s lifetime, and dysfunctional to a significant degree’
(Young, Klosko & Weishaar, 2003, p.7).

This measure consists of 90-items and requires the individual to self-report to what degree each statement describes them using a 6 point Likert scale, from 1 (completely untrue of me) to 6 (described me perfectly). The scale assesses for 18 early maladaptive schemas that have been grouped into 5 domains. These have been described in detail within Chapter 1 (section 1.4.1).

Young initially developed a 205-item questionnaire assessing early maladaptive schemas, named Schema Questionnaire (Young, 1990). The internal consistency and test-retest reliability of this original questionnaire was assessed as adequate in both student and clinical samples (Lee, Taylor & Dunn, 1999; Schmidt, Joiner, Young & Telch, 1996). The questionnaire has undergone development and been revised a number of times. A short form version has been designed (YSQ-S; Young, 1998) due to the length of time in administering the long form (YSQ-L). The YSQ-S has been found to be broadly comparable to the long form version (Waller, Meyer & Ohanian, 2001) and the initial 15-factor structure of

the YSQ-S has been identified in clinical samples (Hoffart et al., 2005; Welburn, Coristine, Dagg, Pontefract & Jordan, 2002). Furthermore, studies have demonstrated the internal consistency to be between acceptable and very good ($\alpha > .70$) for both the overall YSQ-S and its subscales (Waller et al., 2001; Welburn et al., 2002). The YSQ-S3 has been translated and validated in different languages (e.g. Kriston, Schafer, Jacob, Harter & Holzel, 2013; Trip, 2006).

This measure was used in this research for a number of reasons. Firstly, the majority of the relatively little research there is on MDSOs and schemas has focussed on offending schemas or implicit theories (e.g. Ward & Keenan, 1999; Polaschek & Ward, 2002) that are sexually themed, and not on the more general schema assessment of early maladaptive schemas. The YSQ have been used more commonly in other clinical populations. It was therefore felt that to build up the understanding of this populations early maladaptive schemas could be beneficial for clinicians, researchers and theorists in this field. It could also aide with comparisons with other groups, clinical and non-clinical. The majority of research within this area is done using qualitative approaches. It was therefore thought that with using a quantitative measure this would enhance the recruitment number within the relatively limited population sample of MDSOs, as well as exploring the applicability of using such measures and approaches within this field. The short form of the questionnaire was chosen over the long form due to the reduced time in its administration, as well as its comparable psychometric properties (Waller, Meyer & Ohanian, 2001).

2.4.2 My Life – Version 2 (Mann & Hollin, 2010)

The 'My Life (version 2)' questionnaire (Mann & Hollin, 2010) (Appendix 6.18) was used to assess for offending schemas. This is a 32-item self-report questionnaire based upon a qualitative study of sexual offenders' explanations for their offending (Mann & Hollin, 2007). Each item is a statement of general beliefs about the self, the world and others. The questions are loaded onto two factors, one measuring themes of punishment, power, control, violence and revenge ('Dominance'), and the other reviewing how the individual sees himself as being let down, mistreated by others, and not receiving help from others when it was needed ('Disadvantaged'). These two categories are considered to be overarching modes that contain different schemas within them, e.g. Dominance includes a need for respect, and a desire for revenge; Disadvantaged includes beliefs about one being damaged, as well as being controlled by the past.

The individual records how much they believe the statement reflects their beliefs or experiences on a 5-point Likert scale, from 1 (very unlike me) to 5 (very like me). Internal consistency for this measure was found to be excellent ($\alpha = .928$), as was the internal consistency for the two-factor scales within the questionnaire ('Disadvantaged' $\alpha = .903$; 'Dominance' $\alpha = .903$). Test-retest reliability was found to be greater than the minimum accepted level of .7 recommended by Kline (2000), for both factors and for the whole scale (.810 (Disadvantaged), .757 (Dominance), .838 (whole scale)). A highly significant construct validity was found ($p < .0001$) for the total score of the measure between the sexual offending groups and control groups of violent non-sexual offenders and non-offenders. Concurrent validity was assessed by correlating the My Life scores with other psychometric scales. Correlations above .3 were taken to represent meaningful concurrent validity (Kline,

2000). The Disadvantaged scale correlated significantly with 8 scales (all $p < .0001$). These scales included Self-esteem ($r = -.47$), Impulsivity ($r = .36$), Sexual Entitlement ($r = .33$) and Women are deceitful ($r = .42$) scales. The Dominance scale correlated significantly with two scales; Aggressiveness ($r = .40$, $p < .0001$) and Sexual Entitlement ($r = .36$, $p < .0001$).

This measure was chosen as previous research on offending schemas, or implicit theories, has all been through qualitative assessment, or through the interpretation of attitude questionnaires. It is therefore a new approach to see whether offending schemas can effectively be assessed through this new methodological approach. This measure is the first identified validated measure of offending schemas. It has not been extensively used in research, and not at all with those offenders outside of the prison service, i.e. those within secure psychiatric settings and who have been given a diagnosis of a mental illness or personality disorder. Therefore a potentially useful further outcome of this research will be to explore the application and use of this measure within this relatively under-researched mentally disordered offender population.

2.5 Informal Interview

Both demographic and offence-related information was sought from the individual within a brief interview. It was felt that conducting a brief interview could help with engagement and rapport. The demographic information required was date of birth, ethnicity, relationship status, diagnoses, length of time in secure settings (both prison and hospital) and psychological treatment had to date (specifically if there have been any work on sexual

offending). The offence-related information that was collected reviewed the individual's forensic history, and more detailed information about the sexual offences that they had committed, including number of offences, gender of victim(s), age of victim(s), and relationship to victim(s). For a skeleton guide of the semi-structured interview schedule see appendix (Appendix 6.19).

All information was verified through reviewing the participant's case files. If the participant did not feel able to or want to talk about these topics the case file review was used to gather the information and replaced the interview component of the data collection. This was only carried out for one individual.

2.6 Post-hoc measures

The information gathered within the informal interview (or medical file review) allowed for a prediction of their current level of risk by using the Risk Matrix 2000 (RM2000/S; Hanson & Thornton, 2000). This is a 'statistically-derived risk classification process' (Thornton, 2007), which uses certain variables that have been found to have an effect on an individual's likelihood of re-offending. The variables that are used to create a risk category for sexual offending are; age (at present or at time of predicted release), number of court appearances for a sexual crime, number of court appearances for any offence, whether the sexual offence(s) included a male victim, the relationship to the victim, whether the individual has ever been married (or lived in a marriage-like relationship for >2 years), and whether there have been any instances of a non-contact sexual offence. The matrix provides a final score

(0-6) that then denotes which risk level classification that individual falls into. These categories are; Low risk, Medium risk, High risk, and Very High risk.

This measure of risk was developed using non-MDSO population, and therefore does not incorporate any indication of mental illness as a risk factor. The predictive accuracy of this measure has been tested on numerous samples of adult males serving prison sentences for sexual offences, and has a ROC AUC statistic of 0.75 for recidivism within 16-19 years follow-up (Thornton, 2007). Coefficients above 0.7 are indicative of moderate predictive accuracy. Hanson and Mourton-Bourgon (2009) used a *d*- statistic as the index of predictive accuracy, and found that this instrument ($d=0.82$) is comparable to that of other actuarial risk instruments, such as Static-99 (Hanson & Thornton, 1999) ($d= 0.70$), and the Rapid Risk Assessment for Sex Offender Recidivism (RRASOR; Hanson, 1997) ($d=0.59$).

2.7 Procedure

Prior to a participant being approached the researcher discussed the individuals current mental state with a member of the nursing staff on shift to ensure he was safe to be approached on that occasion. After having the time to consider whether they would like to participate in the research and given the opportunity to raise any concerns or ask any questions, informed written consent was obtained from the participants (Appendix 6.14). It was re-iterated to the participants that the research had no implications to their clinical care, all aspects of the research were anonymised so nothing could be identified to themselves, and that they could withdraw at any time from the study.

The collection of data was carried out individually in a quiet room with the researcher present. The interview was carried out first to help with engagement. The YSQ-S3 was then administered, followed by the My Life (v.2). Both of these questionnaires were completed independently by the participant, with the researcher present to answer any questions that arose. Two participants preferred the researcher to read out the questions to them. For both of these cases this was done, however the individuals marked their responses onto a separate questionnaire form, so as not to increase the likelihood of social desirability within their responses. The process took a maximum of one hour and 30 minutes, however the majority of the individuals completed this under an hour. Even though a break or splitting the testing session into two was offered, only one wished to do this as our meeting coincided with a scheduled cigarette break for the ward. The remainder of the participants were able to concentrate and remain engaged for the process to carry it out within one sitting. The researcher was always present for the completion of the questionnaires to ensure that the individual did not collaborate with others to answer the questions, or to allow too much time to review the questionnaire to reduce the opportunity for impression management and portraying themselves in either a more positive or negative light than reality.

At the completion of the questionnaires a debrief sheet was given to the participant (Appendix 6.15) that explained the purpose of the study and how their data was going to be handled. They were provided with information about who to contact if they were distressed or had concerns/questions regarding the research after the data collection session. They were also given the opportunity to receive a summary feedback of the results after its completion. Each participant was given £10 to compensate them for their time. The process of giving the participant money was witnessed by a member of staff (Appendix 6.16). Within

low secure settings this could be given directly to the individual witnessed by a member of staff, within the medium secure settings this could also usually be given directly to the patient, but agreed with the nursing staff prior to this and was dependent on the amount of money that individual had on them at that time. If this was over £10 (as each patient had a maximum of £20 on them at one time) then the money would go into the patient's locked drawer within the nursing office. Within the high secure settings no money is allowed to be given directly to patients. Therefore in these instances the £10 was paid into the patient's bank account through the 'Patient's Cash' department.

An electronic note was then input onto the medical notes of each participant to inform the clinical team that they had completed the research and that they were in receipt of £10. This was done to ensure that the whole team were aware of their involvement and that they may have extra money on them (if not in high security).

3. Results

3.1 Data Analysis Strategy

Demographic and offence related information was collected and analysed to allow for the description of the sample recruited. This also formed the basis for the between group comparison variables. In order to address the different research questions, a variety of statistical methods were used as appropriate. These are outlined in more detail within the respective research question sections below. Testing for normality, skewness and kurtosis for the variables was carried out first in order to identify whether parametric assumptions had been met. These would then further direct the tests selected to analyse the data. The z-skew and z-kurtosis scores can be seen in the appendices (Appendix 6.20 and 6.21).

3.2 Data Entry

The data was entered and analysed using SPSS 21. All information was screened to identify any potential missing data. It was found that there was missing demographic or offence related information for 17 participants. This was either due to the participant not willing to give certain information, or that they were uncertain of the correct details. This was obtained later from their medical files. Consent to access this information was sought prior to the commencement of any research activity on the Participant Consent Form (Appendix 6.14). There was no information missing on any of the My Life questionnaires. One participant had missed out 2 questions from the Young Schema Questionnaire –Short Form 3 (YSQ-S3). In accordance with the scoring guide for this questionnaire the 2 omitted scores were given the average of the remaining scores that made up that particular schema. For

instance, if one question from the 'Emotional Deprivation' schema was missing, then the scores given for the other four questions for this schema were averaged and this was the score attributed to the missing question.

3.3 Demographics and Characteristics of the Sample

Descriptive statistics were produced for the sample prior to commencing any statistical analyses. These were based upon demographic information, offence-related information and any other relevant characteristics obtained. Due to the small sample size ($n < 50$), frequency data is reported rather than percentages.

3.3.1 Sample Demographics

The sample consisted of 29 men detained under the Mental Health Act 1983 (as amended by the 2007 Act) within secure hospitals in and around London. The participants ranged from 24 to 63 years of age (mean = 45.21, SD = 9.67). The mean ages of the current sample can be seen in comparison to other analogous samples in Table 1 below. It can be seen that in general those who offend against children tend to be older than the group that offend against adults. However this was not true for the current sample.

Table1: Mean ages of the current sample and samples from comparable groups from published data.

Sample	Adult victims Mean (SD) (n)	Child victims Mean (SD) (n)	Total sample Mean (SD) (n)
Current sample (MDSO)	46.14 (10.81) (21)	42.75 (5.52) (8)	45.21 (9.67) (29)
Szlachcic et al. (2014) (MDSO)	-	-	37.32 (12.43) (31)
Moulden et al. (2014) (MDSO)	42.95 (13.76) (60)	45.85 (13.15) (48)	-
Moulden et al. (2014) (non-MDSO)	36.94 (9.48) (17)	50.71 (15.13) (24)	-
Carvalho & Nobre (2014) (non-MDSO)	33.8 (9.34) (32)	38.3 (9.61) (33)	-
Mann & Hollin (2010) (non-MDSO)	34.86 (11.17) (127)	43.91 (11.56) (152)	41.77 (13.00) (279)
Milner & Webster (2005) (non-MDSO)	36.7 (6.3) (12)	39.8 (11.7) (12)	-

MDSO= mentally disordered sexual offender

The mode self-described ethnicity was White British (10). Four men described themselves as Black British, and a further four labelled themselves as Black African. Three participants described their ethnicity as Afro-Caribbean. Two men defined themselves as White Irish, and one man reported to be Asian. The remaining five men labelled themselves as 'Mixed'. Two of these described having mixed Black and White parentage, one as mixed White and Asian, one described an Irish and Indian background, and the final participant described a mixed White ethnicity of European descent.

In regards to relationship status, the majority of the sample reported to be single (n=21). Four men described themselves to be in a relationship, two were separated from their partners, one was divorced, and one person declined to provide this information (and his current status was not identifiable within his medical records).

3.3.2 Psychiatric Characteristics

At the time of data collection the majority of the sample were being held within medium security (n=14). Eight of the men were detained within low security, and the remaining seven were under high security.

Within the sample, sixteen men had a primary diagnosis of a mental illness alone. Five had a diagnosis of personality disorder alone, and the remaining eight had a co-morbid mental illness and personality disorder diagnosis. Out of those 24 men with a mental illness

diagnosis, the most common was that of paranoid schizophrenia (n=21). Dissocial/antisocial personality disorder and emotionally unstable/borderline personality disorder were the two most common diagnoses from those with a personality disorder (n=8 for each diagnosis).

Table 2 provides a comprehensive breakdown of the diagnoses for the sample.

Table 2: Diagnoses of the participants

Primary Diagnosis	Frequency
Mental illness alone	16
Personality disorder alone	5
Co-morbid mental illness and personality disorder	8
Total	29
<hr/>	
Mental illness alone	
Paranoid schizophrenia	10
Schizoaffective disorder	3
Bipolar affective disorder	1
Paranoid schizophrenia and Bipolar affective disorder	2
Total	16

Personality disorder alone	
Antisocial personality disorder ¹	2
Antisocial personality disorder ¹ and Borderline personality disorder ²	3
Total	5
Co-morbid mental illness and personality disorder	
Paranoid schizophrenia and Antisocial personality disorder ¹	4
Paranoid schizophrenia and Borderline personality disorder ²	3
Paranoid schizophrenia and Schizoid personality disorder	1
Total	8

¹Antisocial and Dissocial personality disorders have been collapsed into one category

²Borderline and Emotionally unstable personality disorders have been collapsed into one category

3.3.3 Forensic Characteristics

The length of stay in a secure hospital ranged from 3 months to 26 years. The mean length of stay in secure hospitals (not necessarily the same hospital) was 10.12 years (SD= 8.01).

The total length of time spent in secure settings (hospitals and prisons) ranged from 1 year to 26.5 years, where the mean was found to be 13.27 years (SD= 8.01).

The frequency of the number of convictions held by the sample can be seen within Table 3. The total convictions of each individual ranged from 1 to 47 (mean=13.14 SD=13.46). However, 58.6% (n=17) had less than 10 convictions. The total number of sexual convictions ranged from 1 to 40 (mean=3.86, SD=7.21). The majority (89.7%, n=27) had 5 or less sexual convictions. Table 4 provides the frequency for total sexual convictions of the sample.

Table 3: Frequency of total convictions

Total number of convictions	Frequency
1	3
2	1
3	2
4	2
5	1
6-10	8
11-20	7
21-30	0
31-40	3
>40	2
Total	29

Table 4: Frequency of sexual convictions

Total number of sexual convictions	Frequency
1	12
2	5
3	3
4	4
5	2
>5	3
Total	29

There was a variety of sexual offences that were committed. The most frequent conviction was that of rape (n=28). This category included vaginal, oral, buggery and digital penetration subtypes of rape. Table 5 outlines the type of sexual conviction and the frequency of which these were committed within the sample. The participant with 40 sexual convictions has not been included within this table as it skewed the frequencies. However, this participant had 40 convictions for indecent assault, gross indecency with a child, and breaching sexual offences prevention order.

Table 5: Frequency of the type of sexual offence

Sexual offence conviction	Number of participants that had a conviction	Frequency
Rape	15	28
Indecent assault	7	8
Attempted rape	6	8
Indecent exposure	3	4
Sexual assault	7	15
Kidnap with intent to rape	1	1
Murder/manslaughter with sexual elements	1	3
Trespassing with intent to commit a sexual offence	2	4
Sexual harassment	1	1
Total	-	72

It is of note that within the brief assessment component of data collection, as well as reviewing medical files, there were considerably more offences that were committed (both sexual and non-sexual) that did not result in a conviction. It was deemed inappropriate to include these due to inaccuracies in reporting and to ensure a standardised measure.

The sample consisted of 21 men that sexually offended against adults (over the age of 16) only, five men that sexually offended against children only, and three men that had sexually offended against both adults and children. The majority of the participants had offended against adult females (n=23), seven had committed a sexual offence against a female child, there was one conviction against an adult male, and three participants had sexually offended against male children. In regards to the relationship to the victim, 18 offended against those that they did not know (strangers), and the remaining 11 offended against people that they knew. Out of these 11, four of the participants offended against their partner or ex-partner, four offended against a friend or peer, one person offended against a member of their family and two were against 'other' relationship.

Given that these men are currently being held within a secure hospital, and many of them have spent a considerable amount of time in such settings, it was expected that a large proportion of them would have carried out some therapeutic work on their sexual offending. It was found that the majority (n=24) had completed or were currently still involved in sexual offending work. In comparison to individual work with a therapist, group work was more common where 22 of the men had completed at least one group focussing on sexual offending. Figure 2 below demonstrates this information further.

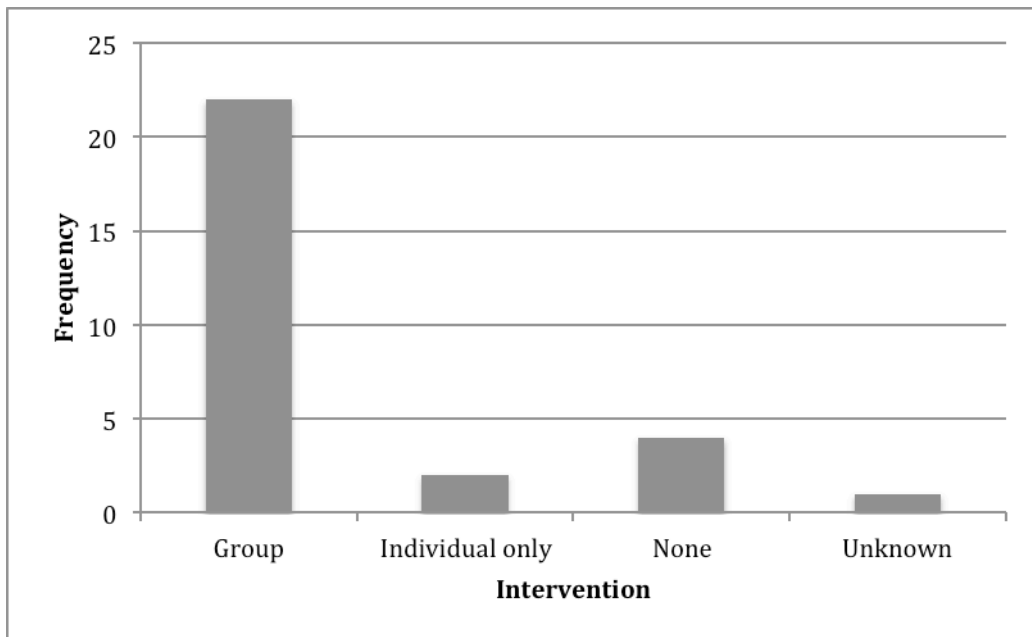


Figure 2: Interventions for sexual offending

Many of the participants who had completed or were currently in groups also had individual psychology sessions. These were reported to also include work exploring their offences. The figure above does not include the number of men who have also had individual work as well as group work.

3.4 Data Screening

Given that the hypotheses were outlined to compare the two separate groups of offenders (those who offend against adults and those who offend against children) there was not an expectation to have a subgroup of those who offended against both. It was decided to

categorise these three men into the group with those who had offended against children. This is in accordance with a previous study (Moulden, Chaimowitz, Mamak & Hawes, 2014) as well as fitting with their index offence. Within this subgroup, two of the men's index offences were against children. The third had two counts of sexual offences as their index offence (one against an adult and one against a child) however they had previous charges of offences against children, and none against adults. This resulted in $n=21$ in the adult victim group, and $n=8$ in the child victim group. Separate analyses for each statistical test took place that included this 'mixed victim' group in the larger subgroup (those who offended against children), as well as tests of them as a distinct group to see if there was any significant difference found. The statistical tests report both of these options.

Normality tests have little power to reject the null hypothesis of normality in small sample sizes, and so therefore these samples often pass the normality tests (Ghasemi & Zahediasl, 2012; Oztuna, Elhan & Tuccar, 2006). It was therefore decided that for those comparisons that included the groups where $n < 10$ that non-parametric alternatives would be used. Variables that were continuous and were to be considered for parametric tests (i.e. when the analysis included only samples where $n > 10$) were tested for normality of distribution. Histograms as well as analysing the skew and kurtosis were used for this. A table of the skew and kurtosis values can be seen in the Appendix (Appendix 6.20 & 6.21). It was found that three variables were not normally distributed within the group of offenders against adults. These variables were positively skewed ('Vulnerability to Harm or Illness', 'Enmeshment' and 'Pessimism/Worry' Early Maladaptive Schemas). Three variables within the whole sample were also found not to be normally distributed. These were 'Failure to Achieve', 'Vulnerability to Harm' and 'Enmeshment'. It was decided to use non-parametric alternatives when using these variables within analyses.

3.5 Descriptive Analysis of the Data

3.5.1 Young Schema Questionnaire – Short Version 3 (YSQ-S3; Young, 2005)

Separate analyses took place to identify the means and standard deviations for the individual Early Maladaptive Schemas and Schema domains of the YSQ-S3. This was carried out for the whole sample as well as separating them into the groups based upon whether their victim(s) were adults or children (see Table 6). It can be seen that 'Unrelenting Standards' was the highest scoring schema for the total sample as well as for the group of offenders against adults. The group that contained those who offended against children had 'Admiration/Recognition-seeking' and 'Pessimism' as the most highly endorsed schemas, as did the group that contained only those who offended against children (taking out the subgroup of those who offended against both). For this subgroup alone, the highest scoring schemas were that of 'Pessimism' and 'Self-Punitiveness'.

The internal consistency for the YSQ-S3 was found to be excellent for the total sample ($\alpha=0.96$) as well as for the subgroup that offended against children ($n=8$) ($\alpha=0.94$) and for those that offended against adults ($n=21$) ($\alpha=0.97$).

Table 6: YSQ-S3 mean scores and standard deviations for the Early Maladaptive Schemas and Schema domains

Early Maladaptive Schema	Total sample n=29 Mean (SD)	Offence against adults n=21 Mean (SD)	Offence against children n=8* Mean (SD)	Offence against children only n=5 Mean (SD)	Offence against both adult and child n=3 Mean (SD)
Abandonment/ Instability	13.03 (5.56)	13.10 (6.03)	12.88 (4.42)	13.00 (5.20)	12.67 (3.79)
Mistrust/Abuse	14.10 (6.26)	15.14 (6.15)	11.38 (6.09)	9.60 (5.13)	14.33 (7.51)
Emotional deprivation	13.03 (5.25)	13.95 (5.56)	10.62 (3.58)	11.00 (3.08)	10.00 (5.00)
Defectiveness/Shame	11.93 (5.34)	12.67 (6.12)	10.00 (3.12)	9.00 (2.92)	11.67 (3.21)
Social Isolation/Alienation	13.93 (6.53)	14.86 (6.71)	11.50 (5.71)	9.80 (6.02)	14.33 (4.73)
<i>Disconnection & Rejection Domain</i>	<i>66.03 (21.97)</i>	<i>69.71 (22.82)</i>	<i>56.38 (17.20)</i>	<i>52.40 (15.65)</i>	<i>63.00 (21.00)</i>
Incompetence/ Dependence	12.72 (4.98)	12.48 (4.48)	13.38 (6.44)	9.60 (4.93)	19.67 (1.15)
Vulnerability to harm/illness	11.38 (6.22)	11.62 (6.87)	10.75 (4.40)	8.20 (3.27)	15.00 (1.73)
Enmeshment	9.69 (5.33)	10.00 (5.73)	8.88 (4.32)	10.40 (4.72)	6.33 (2.31)
Failure to achieve	12.34 (5.51)	12.95 (5.95)	10.75 (4.03)	10.60 (4.98)	11.00 (2.65)
<i>Impaired Autonomy & Performance Domain</i>	<i>46.14 (16.71)</i>	<i>47.05 (17.96)</i>	<i>43.75 (13.66)</i>	<i>38.80 (15.63)</i>	<i>52.00 (1.00)</i>
Entitlement/ Grandiosity	13.34 (6.25)	14.24 (6.52)	11.00 (5.13)	12.60 (5.59)	8.33 (3.51)
Insufficient self- Control/Discipline	13.34 (5.05)	13.90 (5.42)	11.88 (3.83)	10.60 (4.45)	14.00 (1.00)

<i>Impaired Limits Domain</i>	26.69 (10.09)	28.14 (10.75)	22.88 (7.34)	23.20 (9.52)	23.33 (2.52)
Subjugation	12.48 (4.88)	12.10 (5.30)	13.50 (3.66)	12.00 (3.94)	16.00 (1.00)
Self sacrifice	15.10 (5.51)	15.71 (5.93)	13.50 (4.07)	13.00 (4.12)	14.33 (4.73)
Admiration/ Recognition-seeking	14.48 (5.30)	13.90 (4.97)	16.00 (6.19)	18.20 (6.94)	12.33 (2.31)
<i>Other Directedness Domain</i>	42.07 (11.46)	41.71 (12.41)	43.00 (9.17)	43.20 (12.03)	42.67 (2.08)
Pessimism/Worry	13.24 (5.46)	12.57 (5.73)	15.00 (4.50)	13.20 (4.60)	18.00 (2.65)
Emotional Inhibition	13.58 (6.56)	14.57 (7.11)	11.00 (4.14)	10.40 (2.70)	12.00 (6.56)
Unrelenting Standards	15.62 (5.77)	16.62 (6.14)	13.00 (3.82)	13.60 (4.34)	12.00 (4.00)
Self-Punitiveness	14.31 (5.83)	13.86 (5.77)	15.50 (6.21)	13.80 (5.72)	18.33 (7.09)
<i>Over-Vigilance & Inhibition Domain</i>	56.76 (18.24)	57.62 (19.74)	76.00 (14.44)	51.00 (12.88)	60.33 (17.79)
<i>Total</i>	257.69 (66.35)	244.24 (71.57)	220.50 (50.04)	208.60 (54.48)	240.33 (43.41)

*This group contained those who offended solely against children, and those who offended against both adults and children

A visual representation of the mean schema scores can be seen in Figure 3 below, where the total sample scores are compared with data from an equivalent population (Szlachcic et al. 2014). It is evident that both samples are largely similar in their profiles. Both datasets include those who offend against adults and children. Confidence intervals of 95% can also be seen for each schema.

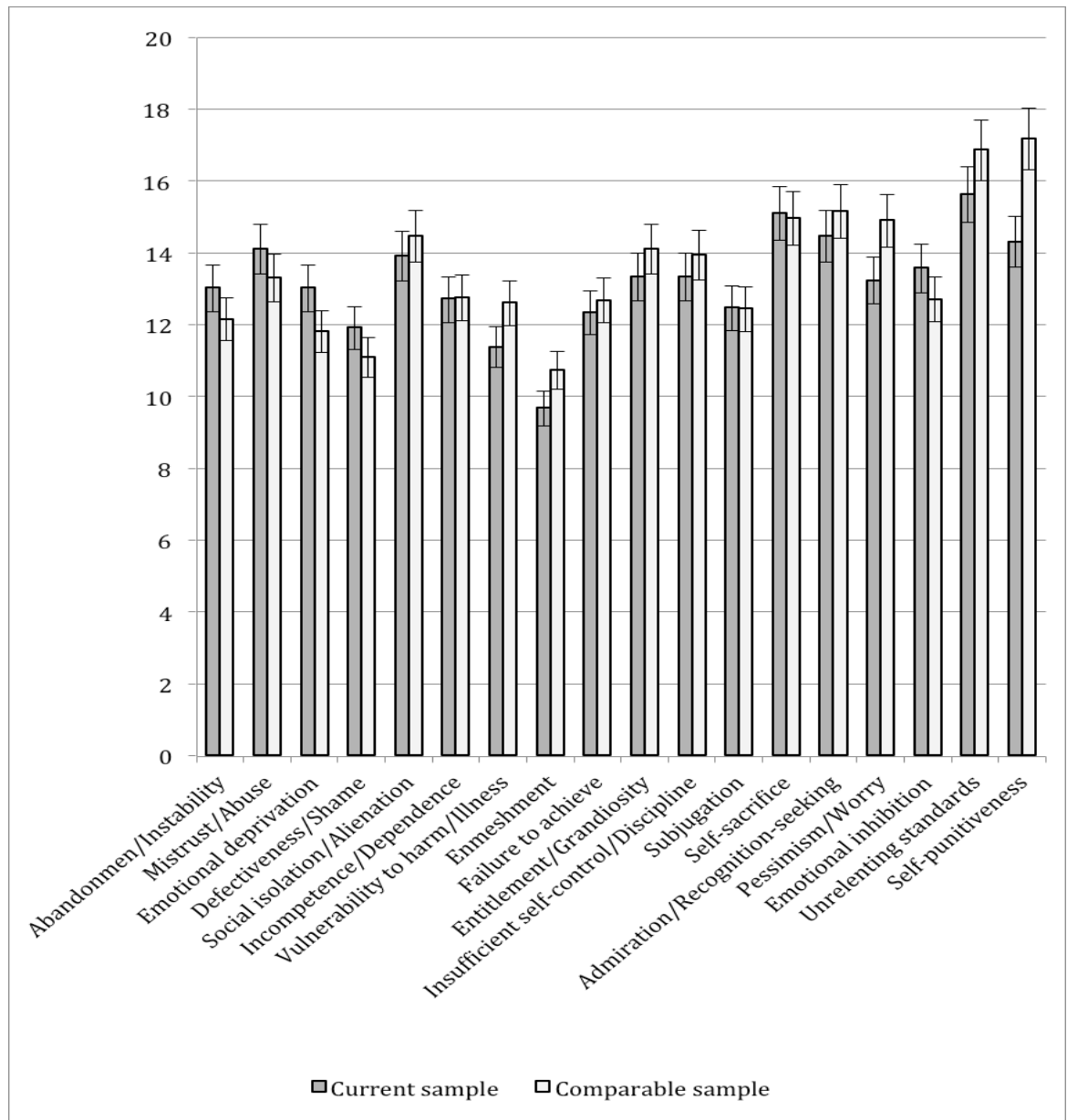


Figure 3: Comparison of Early Maladaptive Schema scores of current sample with equivalent population.

Figure 4 demonstrates the difference between schema domain endorsement between the groups within this sample. It can be seen from this bar chart that the one domain where the groups scored similarly on was 'Other Directedness'. There was more of a spread of mean scores between the groups within the other domains, specifically 'Disconnection and Rejection' and 'Impaired Limits'. Within both of these the group that contained those who offended against adults scored higher than the others. It should be noted that adjusted means (the mean of the mean domain scores) were used rather than the mean of the total domain scores, which are reported in Table 6, to control for the different amount of schemas within the different domains. This allows for easy comparison across domains. 95% confidence intervals have also been included for comparison.

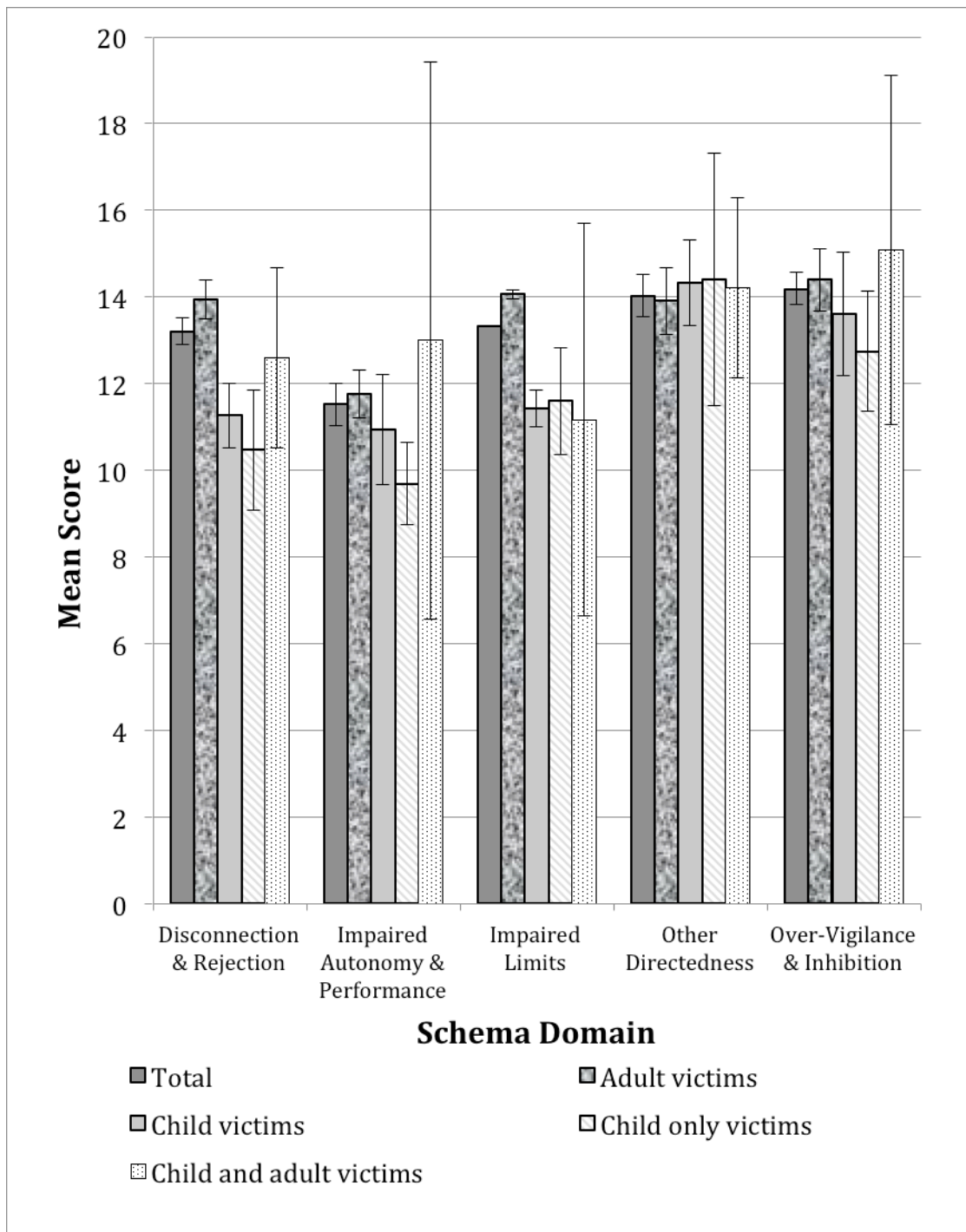


Figure 4: Mean schema domain scores on the YSQ-S3 of the total sample and the groups.

3.5.2 My Life (version 2) (Mann & Hollin, 2010)

The means of the two offending schemas as measured within the My Life questionnaire can be seen in Table 7 below. Due to the limited use of this questionnaire within the literature there is no directly comparable group to compare the means. It can be seen that the whole sample, as well as each group, scored higher on the 'Disadvantaged' schema compared to the 'Dominance' schema. This was particularly noted within the group that contained those who have offended against adults.

The internal consistency for the My Life measure was calculated for this sample. It was found to be excellent for the total sample ($\alpha = 0.91$) and for those that offended against adults ($n=21$) ($\alpha = 0.93$) and good for those that offended against children ($n=8$) ($\alpha = 0.84$).

Table 7: Means and standard deviations for the My Life offending schemas.

Sample	Schema	Mean	SD
Total (n=29)	Disadvantaged	49.59	10.09
	Dominance	42.48	12.75
Offenders against adults (n=21)	Disadvantaged	51.19	10.75
	Dominance	42.95	12.16
Offenders against children (n=8)	Disadvantaged	45.38	7.05
	Dominance	41.25	15.01
Offenders against children only (n=5)	Disadvantaged	44.60	2.97
	Dominance	39.00	18.95
Offenders against adults & children (n=3)	Disadvantaged	46.67	12.34
	Dominance	45.00	6.08

3.6 Analyses

The analyses carried out will now be described by research hypothesis. Given the limited power of the study and the small sample size, in particular within the group of offenders against children, the interpretation of the results should be done with caution.

3.6.1 Hypothesis 1

'There will be significant differences between the schema profiles of those mentally disordered sex offenders (MDSOs) that offend against adults compared to those who offend against children. The adult victim profiles will have more prevalent schemas relating to control, entitlement, and emotional inhibition, whereas the profiles of those who offend against children will more highly endorse schemas relating to feelings of worthlessness and being a victim themselves.'

To address the first hypothesis Mann Whitney tests were carried out (due to small sample size in comparable groups) to compare the mean Early Maladaptive Schema scores, mean schema domain scores, and mean offending schema scores between the two groups. Kruskal-Wallis tests were also carried out to assess for any statistical difference when dividing the sample into the three groups. The analysis for the basis of two groups will be discussed first, followed by the analysis for the three groups.

In accordance with the hypothesis, certain schemas were selected for the comparisons between the groups. These were Entitlement/Grandiosity, Emotional Inhibition, Unrelenting Standards (Early Maladaptive Schemas), and Dominance (offending schema), which were predicted to be higher amongst the group that offended against adults.

Defectiveness/Shame, Failure to Achieve, Subjugation, Self-Sacrifice, Admiration/Recognition-Seeking (Early Maladaptive Schemas) and Disadvantaged (offending schema), which all include the notion of worthlessness and being a victim and so therefore predicted to be higher amongst those who offended against children.

When reviewing the raw data of the schemas (Table 6 and 7) it is observed that those who offended against adults had scored higher than the comparison group on all the expected schemas. However after carrying out Mann-Whitney tests significant statistical differences were not found. This process was repeated using the selected schemas that were expected to be higher amongst those who offended against children. It was observed by looking at the data on Tables 6 and 7 that the expected outcomes only occurred for two of the six selected variables. These were Subjugation and Admiration/Recognition-Seeking. This therefore meant that for the remaining four variables, those offenders with adult victims scored on average higher than the child victim offenders. Again, any differences identified were not statistically significant. Table 8 below provides the values, significance and effect sizes of each of the Mann-Whitney analyses.

Table 8: Mann-Whitney tests comparing schemas between those who offended against adults and those who offended against children.

Schema (variable)	Test Statistic (U)	Significance (p)	Effect size (r)
Entitlement/Grandiosity	59.50	0.231	-0.22
Emotional Inhibition	60.00	0.240	-0.22
Unrelenting Standards	57.00	0.187	-0.25
Dominance*	82.50	0.942	-0.01
Defectiveness/Shame	66.50	0.391	-0.16
Failure to Achieve	68.50	0.447	-0.14
Subjugation	70.50	0.508	-0.12
Self-Sacrifice	70.00	0.508	-0.12
Admiration/Recognition-Seeking	66.50	0.392	-0.16
Disadvantaged*	53.50	0.136	-0.28

* From My Life questionnaire

It was deemed important to assess the data when split into three groups, as it may have been possible that the small subgroup of those who have offended against both adults and children could be skewing the other groups' data, making them less distinct from each other. Therefore a Kruskal-Wallis test was carried out to identify if there were any significant differences between the three groups of the selected variables. It was found that none of the variables were significantly different between the groups. The significance levels for the selected variables were as follows; Entitlement/Grandiosity ($\chi^2 (2) = 2.56, p = 0.279$), Emotional Inhibition ($\chi^2 (2) = 1.61, p = 0.448$), Unrelenting Standards ($\chi^2 (2) = 1.92, p = 0.383$), Dominance ($\chi^2 (2) = 0.61, p = 0.737$), Defectiveness/Shame ($\chi^2 (2) = 1.64, p = 0.440$), Failure to

Achieve ($\chi^2(2) = 0.64, p = 0.728$), Subjugation ($\chi^2(2) = 1.98, p = 0.371$), Self-Sacrifice ($\chi^2(2) = 0.64, p = 0.728$), Admiration/Recognition-Seeking ($\chi^2(2) = 2.30, p = 0.316$), and Disadvantaged ($\chi^2(2) = 2.81, p = 0.245$). As there was no significant difference between the groups it was not necessary to carry out post-hoc analyses to identify where these differences lay.

A further Kruskal-Wallis test was carried out that compared the mean scores of all the schemas (including the 18 Early Maladaptive Schemas and the two offending schemas) across the three groups to see if any of them were found to be significantly different between the groups. It was found that the significant differences prior to corrections highlighted one schema that held a significant difference between the groups. This was Dependence/Incompetence schema ($\chi^2(2) = 7.42, p = 0.024$). By carrying out post-hoc Mann-Whitney tests on this variable, it was possible to identify where the significant differences lay. There was a significant difference between the group that offended against both adults and children with the group that offended solely against adults ($U = 7.50, p = 0.036, r = -0.43$) and those who offended solely against children ($U = 0.00, p = 0.024, r = -0.80$).

Given the large amount of analyses that were being carried out within the overall Kruskal-Wallis test, this increased the chance of producing a type 1 error. Bonferroni corrections were therefore used to conservatively adjust for such chances. After adjusting for the corrections, which restricts the p value ($p = 0.05/60$ (18 Early Maladaptive Schemas and 2 offending schemas being compared across 3 groups) = 0.0008) the finding did not remain significant. Any interpretation of these results should therefore be taken with extreme caution due to the small sample sizes of the groups, in particular within the group that contained those who offended against both adults and children ($n = 3$).

3.6.2 Hypothesis 2

'There will be a correlation between the two measures used (YSQ-S3 (Young, 2005) and My Life v.2 (Mann & Hollin, 2010)) around specific schemas; 'Dominance' with 'Impaired Limits' domain, and the 'Disadvantaged' with 'Disconnection and Rejection' domain, 'Impaired Autonomy and Performance' domain, and 'Other-directedness' domain.'

In order to explore the outcome of this hypothesis a correlational design was adopted to assess the relationship between the scores of the offending schemas with the identified schema domains, as well as between the individual schemas held within these domains. This was carried out for the whole sample, for those who offend against adults/children/only children/both adults and children where appropriate or possible given the parametric restrictions of the small sample sizes in the groups.

The analyses that were highlighted within the hypotheses are described below. Bonferonni corrections were not applied to these analyses as they were *a priori* predictions of specific relationships. Pearson's correlations were used for those variables where parametric assumptions were met (for the whole sample and for the group that offended against adults). Kendall's correlations were used for those variables where parametric assumptions were not met. This was used in place of Spearman's correlation due to the smaller dataset. However, multiple regressions were used when exploring the relationship between the individual schemas within a domain and an offending schema. Prior to completing any multiple regressions the assumptions for such tests were checked. Three diagnostic tests were employed for each regression model. All assumptions were met and the models were considered to be generalisable and a good fit of the observed data. Cook's distances were all found to be less than 1, which indicated no significant outliers within the data (Cook &

Weisburg, 1982). Variance Inflation Factors, which is a measure of multicollinearity, all had values less than 10 suggesting there is not a strong linear relationship between the independent (predictor) variables (Myers, 1990). The standardised residuals indicated that the models were an acceptable fit of the sample data (i.e. 95% of z scores were between -1.96 and +1.96, 99% of z scores were between -2.58 and +2.58, and 99.9% of scores were between -3.29 and +3.29).

3.6.2.1 Relationship between 'Dominance' offending schema and 'Impaired Limits' schema domain.

Pearson's correlation found that there was a significant positive correlation between the Dominance schema, and the Impaired Limits schema domain. Table 9 shows these associations for the differing samples.

Table 9: Correlation between Dominance schema and Impaired Limits schema domain

Sample	Correlation (r value)	Significance (p value)
Total (n=29)	0.698 ⁺	<0.001
Adult victims (n=21)	0.671 ⁺	<0.001
Child victims (n=8)	0.764*	0.009
Child only victims (n=5)	0.949*	0.023
Both Child and Adult victims (n=3)	0.333*	0.602

⁺Pearson correlation

*Kendall correlation

This shows that the relationship between the Dominance schema and the Impaired Limits domain as a whole is significant to $p < .001$ within the whole sample and within the group that offended solely against adults. Those who offended against children showed a significant relationship between the two variables to $p = 0.009$. For those who offended solely against children, there is still a positive correlation, to a significance of $p < .05$. There was not a significant correlation found for those who offended against both adults and children.

When exploring this further, the standard multiple regressions showed that the individual schemas within the Impaired Limits domain accounted for a significant proportion of the variance within the Dominance schema to differing degrees between the groups. These two Early Maladaptive Schemas accounted for a significant amount of variance within the Dominance schema for the whole sample ($R^2 = 0.49$, adjusted $R^2 = 0.45$; $F(2,26) = 12.39$, $p < 0.001$). The partial regression coefficients showed that Entitlement/Grandiosity had a slightly higher significant contribution to the Dominance schema ($B = 0.81$, $\beta = 0.4$, $t(26) = 2.29$, $p = 0.031$), and Insufficient Self-Control, although still significant, had a slightly lower contribution ($B = 0.98$, $\beta = 0.39$, $t(26) = 2.24$, $p = 0.034$).

It was found within the group that contained those who had offended against adults that Entitlement/Grandiosity and Insufficient Self-Control schemas accounted for 45% of the variance of the Dominance schema ($R^2 = 0.45$, adjusted $R^2 = 0.39$; $F(2,18) = 7.39$, $p < 0.005$). However, neither of these two variables (Entitlement/Grandiosity and Insufficient Self-Control schemas) were independently significantly associated with the Dominance schema (Entitlement/Grandiosity; $t(18) = 1.72$, $p = 0.103$; Insufficient Self-Control; $t(18) = 1.64$, $p = 0.118$). In the group that had offended against children, the two schemas accounted for 85%

of the variance of the Dominance outcomes ($R^2 = 0.85$, adjusted $R^2 = 0.79$; $F(2,5) = 14.37$, $p = 0.008$). The partial regression coefficients showed that both Entitlement/Grandiosity ($B = 1.61$, $\beta = 0.55$, $t(5) = 3.02$, $p = 0.029$) and Insufficient Self-Control ($B = 2.28$, $\beta = 0.71$, $t(5) = 3.2$, $p = 0.024$) both had significant independent associations with the Dominance variable.

A multiple regression for the two remaining groups (those who offended solely against children, and those who offended against both adults and children) was not carried out due to the low power within these groups, and therefore not meeting parametric assumptions, which is required for this test.

3.6.2.2 Relationship between 'Disadvantaged' offending schema and 'Disconnection and Rejection' schema domain.

The output of the Pearson and Kendall correlations between the two variables can be seen in Table 10, which breaks down the significance of the relationship dependent on the different sample tested. The correlation for the group that offended against both adults and children did not output any results. The correlation was found to be significant for the remaining groups, with the exception for those who solely offended against children.

Table 10: Correlation between Disadvantaged schema and Disconnection and Rejection schema domain.

Sample	Correlation (r value)	Significance (p value)
Total (n=29)	0.577 ⁺	0.001
Adult victims (n=21)	0.502 ⁺	0.020
Child victims (n=8)	0.618 [*]	0.034
Child only victims (n=5)	0.316 [*]	0.448
Both Child and Adult victims (n=3)	-	-

⁺Pearson correlation

^{*}Kendall correlation

A standard multiple regression was then utilised to explore the contribution of the specific schemas within the Disconnection and Rejection domain on the Disadvantaged schema. This was only carried out for the whole sample and for the group that consisted of those who offended against adults. This is because normality of distribution is unreliable in small sample sized groups, and therefore a multiple regression cannot be used for non-normally distributed data.

It was found that the five schemas that make up the Disconnection and Rejection domain (Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation, Defectiveness/Shame, and Social Isolation/Alienation) accounted for a significant amount of variance in the Disadvantaged schema ($R^2 = 0.52$, adjusted $R^2 = 0.41$; $F(5,23) = 4.94$, $p = 0.003$) within the whole sample. The partial regression coefficients showed that Mistrust/Abuse schema had a significant unique contribution to the Disadvantaged schema ($B = 1.11$, $\beta = 0.69$, $t(23) = 2.85$,

p= 0.009). The remaining four schemas were not independently associated with the Disadvantaged schema (Abandonment/Instability (t(23)= -1.33, p= 0.196); Emotional Deprivation (t(23)=0.795, p= 0.435); Defectiveness/Shame (t(23)= 0.01, p= 0.990); and Social Isolation/Alienation (t(23)= 0.56, p= 0.579)).

When applying this to the group that offended against adults, it was found that the independent variables (the five schemas within the Disconnection and Rejection domain) did not account for a significant proportion of the variability of the Disadvantaged schema ($R^2= 0.45$, adjusted $R^2= 0.27$; $F(5,15)= 2.49$, $p= 0.078$).

3.6.2.3 Relationship between 'Disadvantaged' offending schema and 'Impaired Autonomy' schema domain.

Pearson or Kendall correlations were carried out for the comparisons for these analyses dependent on whether normality assumptions were met. See Table 11 below for the results of these tests.

Table 11: Correlation between Disadvantaged schema and Impaired Autonomy schema domain.

Sample	Correlation (r value)	Significance (p value)
Total (n=29)	0.584 ⁺	0.001
Adult victims (n=21)	0.636 ⁺	0.002
Child victims (n=8)	0.357*	0.216
Child only victims (n=5)	0.600*	0.142
Both Child and Adult victims (n=3)	0.353*	0.602

⁺Pearson correlation

*Kendall correlation

Multiple regressions are not recommended to be carried out on data that is not normally distributed. Despite three out of the four schemas that make up the Impaired Limits domain were found to not be normally distributed when reviewing the whole sample (Vulnerability to Harm, Enmeshment/Undeveloped Self, and Failure to Achieve) and two out of the four were also found not to be normally distributed when reviewing the group of those who offended against adults (Vulnerability to Harm, and Enmeshment/Undeveloped Self) it was decided that multiple regressions should be carried out for these groups, purely to identify any relationships rather than to draw conclusions. However, Cook's distances were found to be in excess of 1 (1.886) for the group that offended against adults so the multiple regression was carried out for the total sample alone. It was found that the four schemas that constitute the makeup of the Impaired Autonomy domain accounted for a significant proportion of the variance of the Disadvantaged schema for the whole sample ($R^2 = 0.41$, adjusted $R^2 = 0.32$; $F(4,24) = 4.22$, $p = 0.01$). Enmeshment/Undeveloped Self however was the

only significant partial coefficient that had a significant unique contribution to the variance ($B= 0.73$, $\beta= 0.38$, $t(24)= 2.32$, $p= 0.029$).

3.6.2.4 Relationship between ‘Disadvantaged’ offending schema and ‘Other-Directedness’ schema domain.

The final predicted significant relationship was that of Disadvantaged and the Other-Directedness schema domain. Table 12 shows the outcome of the correlation tests run between these variables.

Table 12: Correlation between Disadvantaged schema and Other-Directedness schema domain

Sample	Correlation (r value)	Significance (p value)
Total (n=29)	0.360 ⁺	0.055
Adult victims (n=21)	0.428 ⁺	0.053
Child victims (n=8)	0.071*	0.805
Child only victims (n=5)	0.200*	0.624
Both Child and Adult victims (n=3)	-	-

⁺Pearson correlation

*Kendall correlation

No relationship was found between the two variables for the group that offended against both adults and children. This is likely to be due to the very small sample size (n=3). The relationship between the variables were also not found to be significant for the other groups

either. Multiple regressions were not carried out to further explore the contribution of the individual schemas within Other-Directedness domain to that of the Disadvantaged schema as the overall correlations were found to be insignificant.

3.6.3 Hypothesis 3

'The schema profiles of the MDSOs will be significantly different from those of the non-MDSOs (using published data). The MDSO population will have more schemas akin to clinical populations, such as Defectiveness and Social Isolation. Given the high rates of abuse and trauma in the research of those with schizophrenia, one could expect more 'Disadvantaged'-based schemas to also be present.'

In order to investigate this hypothesis, published data that has used the specific schema measures that have been employed within this research were the basis of comparison. The published article from which the comparison will take place for the YSQ-S3 was carried out within a prison population of sexual offenders (Carvalho & Nobre, 2014). The data for which the My Life questionnaire will be compared is also from a prison population of sexual offenders (Mann & Hollin, 2010).

One sample t-tests were carried out using the published means as the 'test-value' for the comparison. Descriptive statistics for the data can be seen in Table 13 and 14. It was not possible to carry out non-parametric comparisons with the published data, therefore

parametric t-tests were used for the group who had offended against children (n=8) purely for exploratory purposes, however limitations of this will be discussed within the Discussion section. The subgroup of those who had offended against both adults and children were not used in these analyses given the very small sample size of this particular group (n=3) and therefore the extreme limitations this puts on parametric assumptions being met. They have been collapsed into the group that have offended against children for these analyses.

The mean age of the offenders against adults within the current sample (n=21) was 46.14 years (SD= 10.81), and for those who offended against children (n=8) was 42.75 years (SD=5.52). Whereas within the prison sample used for the YSQ-S3 measure, the offenders against adult victims (n= 32) this was 33.8 years (SD= 9.34) and for those who offended against children (n=33) was 38.3 years (SD= 9.61). For the non-MDSO population used for the My Life questionnaire, the mean age of those who offended against adults was 34.86 years (SD= 11.17), and for those who offended against children (female child victims only, n=152) was 43.91 years (SD= 11.56). The difference in age between the groups for the adult victims were significantly different for the YSQ-S3 group ($t(51)= 4.34, p<0.0001$) and the My Life group ($t(146)= 4.31, p<0.0001$). The MDSO adult victim group was significantly older than the two comparison groups. The MDSO child victim group was not significantly different to the comparison groups based on age.

Table 13: Descriptive statistics of the t-tests comparing current sample schema scores and published data schema scores for those who have offended against adults

Schema	MDSO mean score (n=21)	Non-MDSO mean score (n=32)	t(20)	p
Abandonment/Instability	13.10 (6.03)	16.10 (0.90)	2.28	0.034 ^a
Mistrust/Abuse	15.14 (6.15)	14.07 (0.79)	0.80	0.433
Emotional Deprivation	13.95 (5.56)	11.26 (0.93)	2.22	0.038 ^a
Defectiveness/Shame	12.67 (6.12)	11.37 (0.89)	0.97	0.343
Social Isolation/Alienation	14.86 (6.71)	12.70 (0.95)	1.47	0.156
Dependence/Incompetence	12.48 (4.48)	13.41 (0.89)	-0.96	0.351
Vulnerability to Harm	11.62 (6.87)	16.56 (0.99)	-3.29	0.004 ^a
Enmeshment	10.00 (5.73)	14.88 (0.94)	-3.91	<0.001 ^b
Failure to Achieve	12.95 (5.95)	13.17 (0.99)	-0.17	0.869
Entitlement/Grandiosity	14.24 (6.52)	-	-	-
Insufficient Self- Control/Discipline	13.90 (5.42)	-	-	-
Subjugation	12.10 (5.30)	12.23 (0.81)	-0.18	0.908
Self-Sacrifice	15.71 (5.93)	17.13 (1.48)	-1.09	0.287
Admiration/Recognition-	13.90 (4.97)	14.80 (1.03)	-0.83	0.419

Seeking				
Negativity/Pessimism	12.57 (5.73)	15.78 (0.96)	-2.57	0.018 ^a
Emotional Inhibition	14.57 (7.11)	14.79 (0.95)	-0.14	0.889
Unrelenting Standards	16.62 (6.14)	18.27 (0.93)	-1.23	0.232
Punitiveness	13.86 (5.77)	17.22 (0.74)	-2.67	0.015 ^a
(n=127)				
Disadvantaged*	51.19 (10.75)	42.50 (11.60)	3.71	<0.001 ^b
Dominance*	42.95 (12.16)	37.25 (11.58)	2.15	0.044 ^a

* From My Life questionnaire

MDSO= mentally disordered sexual offender (i.e. current sample)

Non-MDSO= non-mentally disordered sexual offender (i.e. comparison sample in prison)

^a Significant at the .05 level

^b Significant after Bonferroni corrections ($p=0.05/18 = 0.003$)

It can be seen from the above table that there were eight schemas found to be significantly different between the two groups. When Bonferroni corrections were used, the number of schemas that remained significant was two (Enmeshment and Disadvantaged). The Enmeshment was found to be significantly higher within the non-MDSO population, whereas the Disadvantaged schema was found to be higher within the MDSO population. The published article for the YSQ-S3 comparisons (Carvalho & Nobre, 2014) did not report the mean schema scores for the individual schemas within the Impaired Limits domain, as these were not found to be significantly different between their groups (non-offenders, rapists,

child sex molesters). Therefore it was not possible to compare the current sample with that of the non-MDSO published data for the group that offended against adults or for those who offended against children.

From reviewing Table 14, below, it can be seen that nine of the schemas were found to be significantly different between the current MDSO sample and the published non-MDSO sample. After carrying out Bonferroni corrections, two of these schemas remained significant. These were Unrelenting Standards and Vulnerability to Harm. These were both found to be more highly endorsed within the non-MDSO (prison) sample. It is of note that the non-MDSO population scored higher on all of the YSQ-S3 schemas compared to the MDSO sample within the group that offended against children. Also, the standard deviations for the non-MDSO sample were much smaller than the MDSO sample within the YSQ-S3.

Table 14 Descriptive statistics of the t-tests comparing current sample schema scores and published data schema scores for those who have offended against children

Schema	MDSO mean score (n=8)	Non-MDSO mean score (n=33)	t(7)	p
Abandonment/Instability	12.88 (4.42)	17.58 (0.90)	-3.01	0.020 ^a
Mistrust/Abuse	11.38 (6.09)	17.27 (0.79)	-2.74	0.029 ^a
Emotional Deprivation	10.62 (3.58)	14.50 (0.93)	-3.06	0.018 ^a
Defectiveness/Shame	10.00 (3.12)	12.25 (0.89)	-2.04	0.080
Social Isolation/Alienation	11.50 (5.71)	13.29 (0.95)	-0.89	0.404
Dependence/Incompetence	13.38 (6.44)	13.48 (0.94)	-0.05	0.964
Vulnerability to Harm	10.75 (4.40)	18.56 (1.04)	-5.02	0.002 ^b
Enmeshment	8.88 (4.32)	15.02 (0.99)	-4.02	0.005 ^a
Failure to Achieve	10.75 (4.03)	12.85 (1.04)	-1.48	0.184
Entitlement/Grandiosity	11.00 (5.13)	-	-	-
Insufficient Self- Control/Discipline	11.88 (3.83)	-	-	-
Subjugation	13.50 (3.66)	14.59 (0.81)	-0.84	0.428
Self-Sacrifice	13.50 (4.07)	18.61 (1.48)	-3.55	0.009 ^a
Admiration/Recognition-	16.00 (6.19)	17.43 (1.03)	-0.65	0.534

Seeking				
Negativity/Pessimism	15.00 (4.50)	20.14 (0.96)	-3.23	0.014 ^a
Emotional Inhibition	11.00 (4.14)	16.97 (0.95)	-4.08	0.005 ^a
Unrelenting Standards	13.00 (3.82)	20.78 (0.93)	-5.77	<0.001 ^b
Punitiveness	15.50 (6.21)	19.44 (0.71)	-1.79	0.116
(n=152)				
Disadvantaged*	45.38 (7.05)	42.73 (12.92)	1.06	0.324
Dominance*	41.25 (15.01)	35.39 (10.47)	1.10	0.306

* From My Life questionnaire

MDSO= mentally disordered sexual offender (i.e. current sample)

Non-MDSO= non-mentally disordered sexual offender (i.e. comparison sample in prison)

^a Significant at the .05 level

^b Significant after Bonferroni corrections ($p=0.05/18 = 0.003$)

3.7 Post-hoc analyses

Post-hoc analyses were carried out to further investigate the relationship of the schema profiles and other key variables that were collected. It is to be noted again however that the interpretation of these results should be done with caution due to the small sample sizes and limited power of the study. These analyses were primarily for exploratory purposes.

3.7.1 Schemas and relationship to victim

The total sample was split into two groups based upon their relationship to their victim(s), i.e. whether they knew their victim (n=11) or if they were a stranger (n=18). Descriptive statistics were produced for the two groups, which can be seen in Table 15 below. Those who sexually offended against someone that they knew (n=11) were aged between 26 and 60 (mean= 44.18, SD= 10.18). The age range for those who offended against strangers (n=18) was from 24 to 63 (mean= 45.83, SD= 9.59).

In order to explore if there are any differences in the schema profiles of those who offend against someone that they knew and those who offend against strangers independent measure t-tests were carried out. Normality, skew and kurtosis were examined first, and it was found that only two variables were found not to be normally distributed. These were Vulnerability to Harm schema for the group that knew their victim(s) (z-skew= 2.89), and Abandonment/Instability schema for the group that offended against strangers (z-skew= 2.95). Non-parametric tests (Mann Whitney tests) were therefore used when these variables were looked at.

Table 15: Descriptive data for those who offended against strangers and those who offended against known victims.

Schema	Known victim(s) n=11		Stranger victim(s) n=18	
	Mean	SD	Mean	SD
Abandonment/Instability	13.55	4.93	12.72 ⁺	6.03
Mistrust/Abuse	12.45	5.61	15.11	6.58
Emotional Deprivation	11.36	3.70	14.06	5.88
Defectiveness/Shame	11.64	4.99	12.11	5.98
Social Isolation/Alienation	11.36	6.09	15.50	6.45
Dependence/Incompetence	10.27	2.83	14.22	5.47
Vulnerability to Harm	8.64 ⁺	4.46	13.06	6.66
Enmeshment	8.82	4.21	10.22	5.96
Failure to Achieve	10.18	4.33	13.67	5.84
Entitlement/Grandiosity	11.36	5.08	14.56	6.71
Insufficient Self-Control/Discipline	11.18	4.83	14.67	4.84
Subjugation	11.36	4.99	13.17	4.83
Self-Sacrifice	16.00	4.94	14.56	5.89
Admiration/Recognition-Seeking	12.00	4.98	16.00	5.03

Negativity/Pessimism	9.91	2.98	15.28	5.68
Emotional Inhibition	10.82	4.12	15.28	7.27
Unrelenting Standards	14.09	5.56	16.56	5.85
Punitiveness	12.09	4.76	15.67	6.13
Disadvantaged*	47.91	8.26	50.61	11.17
Dominance*	37.36	9.78	45.61	13.57

*From My Life Questionnaire

+Not normally distributed

It was identified that three variables were significantly different between the groups. Dependence/Incompetence schema was found to be significantly different between the groups. Separate variance estimates were used as homogeneity of variance assumptions were not met ($F=10.11$, $p=0.004$). It was found that the group that offended against strangers endorsed this particular schema significantly more ($t(27)=-2.55$, $p=0.017$). A significant difference within the independent measure t-test for the Emotional Inhibition schema was identified. The homogeneity of variance assumptions were not met ($F=8.25$, $p=0.008$), and the group that offended against strangers had a mean score significantly higher than the group of offenders who knew their victim ($t(27)=-2.106$, $p=0.045$) for this schema. A Mann Whitney test was carried out comparing the mean scores of the Vulnerability to Harm schema as one group (known victims) did not meet parametric assumptions of normality. Within this test it was found that those who offended against strangers again scored significantly higher on this schema than the comparing group

($U=53.0$, $p=0.038$). All other variables were not found to be significantly different between the groups.

Given the large amount of analyses being carried out, this increases the chance of a type 1 error, where a significant result is found that does not actually exist. Therefore to control for this Bonferroni corrections were subsequently carried out which restricts the p value ($p=0.05/20$ (number of variables) $=0.0025$). With this conservative restriction put in place none of the variables were found to be significantly different between the two groups.

3.7.2 Schemas and diagnosis

A comparison between those men who had a diagnosis of a mental illness ($n=24$) and those who purely had a personality disorder diagnosis ($n=5$) was carried out. Those that have a diagnosis of mixed personality disorder and mental illness were collapsed into the group with those with a mental illness alone. A breakdown of the diagnoses can be seen in Table 2 (p.65). Descriptive statistics for these groups can be seen below in Table 16 below. The participants within the mental illness group had an age range of 24 to 63 (mean= 44.38, SD= 10.02). Five of these men were being held within high security, 11 were within medium security, and eight within low security. The mean length of stay within secure hospital was 10.05 years and within secure settings (hospitals and prisons) was 12.89 years. For those within the group that had a diagnosis of solely a personality disorder, the ages ranged from 41 to 60 (mean= 49.2, SD= 7.33). Two of these men were being held within high security, and the remaining three were in medium security. This group had an average of 10.45 years within secure hospitals and 15.1 years within secure settings all together.

Given that one of the groups had a total of less than 10 (personality disorder group), non-parametric tests were deemed most appropriate to be carried out. Therefore Mann-Whitney tests were administered to compare the means of the schemas between those who have a mental illness diagnosis, and those who have a personality disorder diagnosis.

Table 16: Descriptive statistics of those with a mental illness diagnosis and those with purely a personality disorder diagnosis

Schema	Mental illness n=24		Personality disorder n=5	
	Mean	SD	Mean	SD
Abandonment/Instability	11.75	4.37	19.20	7.01
Mistrust/Abuse	13.58	5.44	16.60	9.74
Emotional Deprivation	13.29	5.65	11.80	2.68
Defectiveness/Shame	11.42	4.83	14.40	8.44
Social Isolation/Alienation	14.13	6.87	13.00	5.05
Dependence/Incompetence	12.38	4.69	14.40	6.58
Vulnerability to Harm	10.71	5.34	14.60	9.56
Enmeshment	10.33	5.58	6.60	2.30
Failure to Achieve	12.21	4.59	13.00	9.54
Entitlement/Grandiosity	14.08	6.51	9.80	3.35

Insufficient Self-Control/Discipline	14.13	5.14	9.60	2.30
Subjugation	12.38	5.07	13.00	4.30
Self-Sacrifice	14.29	5.43	19.00	4.47
Admiration/Recognition-Seeking	15.04	5.57	11.80	2.77
Negativity/Pessimism	12.75	4.27	15.60	9.76
Emotional Inhibition	13.17	6.59	15.60	6.73
Unrelenting Standards	15.38	6.27	16.80	2.17
Punitiveness	13.54	4.11	18.00	10.98
Disadvantaged*	49.96	10.77	47.80	6.46
Dominance*	44.17	12.57	34.40	11.41

*From My Life Questionnaire

All schema variables were compared between the groups. It was found that the mean scores on the Abandonment/Instability schema were significantly higher within the personality disorder group ($U=17.5$, $p=0.014$, $r=-0.46$). The mean scores on the Insufficient Self Control ($U=26.5$, $p=0.052$, $r=-0.36$) and Self-Sacrifice ($U=27$, $p=0.056$, $r=-0.35$) were also very close to being significantly different between the two groups.

In order to prevent type 1 errors occurring Bonferroni corrections were subsequently put in place. This resulted in a p value requiring to be below 0.0025 to remain significant.

Therefore with these corrections in place, no variables were found to be significantly different between the two groups.

3.7.3 Schemas and number of sexual convictions

In order to identify if there is a relationship between the schema scores and number of sexual convictions, a correlational analysis was carried out. As the number of sexual convictions was positively skewed ($z\text{-skew} = 11.07$), non-parametric correlational analyses (Kendalls correlation) were carried out between the variables (number of sexual convictions and individuals schemas). It was found that the only schema that reported to have a significant correlational relationship with the number of convictions was Failure to Achieve ($r = -0.312$, $p = 0.032$). This shows that there is a negative correlation between these two variables, so as the number of convictions increases the lower the score on this specific schema. However, after controlling for Bonferroni corrections ($p = 0.0025$) this finding no longer remains significant.

3.7.4 Schemas and treatment received

The sample was categorised into those that had received (or are receiving ongoing) psychological treatment for sexual offending ($n = 24$), and those that had not received any intervention work ($n = 5$). See Figure 2 (p.71) for the breakdown of the type of intervention (group or individual only). The one participant where this information was unknown was collapsed into the group that contained those that had not received any sexual offending intervention work as it was felt that even if the individual could not remember or wish to disclose, then there would be mention of specific treatment within their media files, which

none was found. The group that had received some form of intervention had an age range from 24 to 60 (mean= 43.83, SD= 9.46), whereas the group that had not received any intervention for sexual offending had an age range from 42 to 63 (mean=51.8, SD= 8.61). The group that had received treatment had a slightly mean longer stay within hospital (10.58 years) and secure settings (13.51 years) compared to the no-treatment group (7.9 years and 12.1 years respectively).

As there was a small sample size within the group that had not received any interventions for sexual offending (n=5) it was deemed most appropriate to administer non-parametric tests as normal distribution within groups with small sample sizes is unreliable. Therefore in order to compare the means of the schema scores between the two groups, Mann-Whitney tests were carried out. It was found from these that there were no significant differences between the groups for any of the schemas. Given this finding, no further corrections were carried out to counteract the possibility of a type 1 error being found due to the large amount of analyses being run simultaneously.

3.7.5 Schemas and risk category

The Risk Matrix 2000 (RM2000/S; Hanson & Thornton, 2000) was used as a measure of level of risk. The output of the RM2000/S provides a score that will fall into one of four categories; those of low risk, medium risk, high risk and very high risk of re-offending. A comparison between the schema scores and the risk category was carried out to assess if there were significant differences between the groups. Key variables of the groups are

shown within Table 17. Descriptive statistics of the groups are provided within Table 18 below.

As two of the groups had very small sample sizes normality of distribution could not be tested, therefore non-parametric tests were used to initially compare the means of the scores. As there were four groups (the four risk categories) a Kruskal-Wallis test was carried out to examine whether any significant differences were found between the groups.

Table 17: Variables of the risk categories

Variable	Low risk n=2	Medium risk n=13	High risk n=12	V. High risk n=2
Mean age (SD)	49.5 (0.71)	46.04 (10.36)	44.5 (10.32)	39.5 (6.36)
Freq. of MI diagnosis	1	9	5	1
Stay in hospital	22	7.88	10.58	10
Stay in security*	23.75	11.04	13.73	14.5

MI=mental illness alone

*Stay in security= time (in years) spent in secure hospital and prison

Table 18: Descriptive statistics of the risk categories

Schema	Low risk mean rank	Med. risk mean rank	High risk mean rank	V. High risk mean rank
Abandonment/Instability	23.25	14.58	12.92	22
Mistrust/Abuse	17	14.81	15.75	9.75
Emotional Deprivation	14.25	14.35	15.54	16.75
Defectiveness/Shame	24.5	13.23	15.38	14.75
Social Isolation/Alienation	12.5	15.81	15	12.25
Dependence/Incompetence	17.25	12.42	17.46	14.75
Vulnerability to Harm	17.5	11.73	18.21	14.5
Enmeshment	13.5	15.92	13.25	21
Failure to Achieve	21	15.46	14.46	9.25
Entitlement/Grandiosity	13.75	16.69	13.5	14.25
Insufficient Self-Control/Discipline	13.5	16.08	14.58	12
Subjugation	11.25	14.62	14.79	22.5
Self-Sacrifice	24.5	14.19	13.54	19.5
Admiration/Recognition-Seeking	6	18.08	12.21	20.75
Negativity/Pessimism	12.5	14.15	16.67	13

Emotional Inhibition	13.75	13.42	16.54	17.25
Unrelenting Standards	14.25	13.62	15.54	21.5
Punitiveness	12.25	13.27	16.58	19.5
Disadvantaged*	20	12.81	16.54	15
Dominance*	9.5	15.38	15.83	13

*From My Life questionnaire

The results of the Kruskal-Wallis test did not identify any significant differences between the groups on their schema scores. Given that no variables were found to be significant, Bonferroni corrections or further post-hoc tests to identify where the difference lay between the groups were therefore not administered.

4 Discussion

4.1 Overview

The results of the current study suggest that the profiles between the two groups (those who sexually offended against adults and those who sexually offended against children) are not too dissimilar within this population (mentally disordered sexual offenders). It was found that the two schema measures used do significantly positively correlate on certain scales, suggesting that both are accessing and assessing similar constructs. Finally there are some differences between the mentally disordered sexual offenders (MDSOs) and the non-MDSOs (i.e. the prison population) in regards to their schema profiles, which have some specific implications. It should be noted that this is the first study to compare the schema profiles between the types of offenders within an MDSO population, and one of very few studies exploring schemas in any respect within MDSOs. This will hopefully provide a basis for further exploration into the role that schemas play within sexual offending in those who have a mental illness or personality disorder.

The main findings of the current study will be discussed in further detail within this section, with reference to the available literature. Given the small sample size of the groups, and the resulting low power achieved, the individual results are not able to be interpreted with certainty, and so therefore patterns will be identified within the data. These will be explored in further detail and the implications of these discussed. Limitations of the research and possible future research will be highlighted throughout.

4.2 Comparison of Schema Profiles between those who offend against adults and those who offend against children

The primary research question within this study was to identify any differences within the schema profiles of those MDSOs who offended against children and those who offended against adults. It can be seen from section 3.6.1 that none of the expected schemas were found to be significantly different between the groups. There was a trend noticed however, where in general the offenders with adult victims did score more highly on the predicted schemas, but this did not reach a level of significance. There are a number of reasons for why these findings were not significant which are discussed below. It is felt that the most substantial cause of this may be due to the lack of power achieved. The power analysis suggested 26 participants within each group (those who offended against adults, and those who offended against children), however this sample contained 21 individuals who had committed their sexual offence against an adult, and eight that had offended against children. It is possible that with a greater number of participants in each group (especially within the group that offended against children) that these differences may have reached significance.

4.2.1 Schemas predicted to be higher within those who offended against adults

No significant differences between the groups were found, however the schema that had the highest level of significance between these groups was that of Unrelenting Standards/Hypercriticalness ($p=0.187$), which, as can be seen, was not particularly close to

reaching significance. This suggests that the two groups may not be as distinctly different as hypothesised.

Sexual entitlement has been found to be highly prevalent within a 'rapist' population (Beech, Ward & Fisher, 2006; Polaschek & Gannon, 2004; Polaschek & Ward, 2002). The Entitlement/Grandiosity schema was thought to be the most related to this concept. Even though this schema was found to be higher within the adult victim group within the current study, this was not significantly higher than the group that offended against children. Interestingly, sexual entitlement has also found to be high within a 'child molester' population (Ward & Keenan, 1999; Marziano et al. 2006). This could therefore explain the non-significant difference for this schema as both groups endorse these beliefs. It is also unclear whether the more general entitlement beliefs that are captured within this schema are directly related to sexual entitlement, or whether they are distinct concepts (Pemberton & Wakeling, 2009). This could then also further limit any differences being found between the groups.

The Dominance schema from the My Life questionnaire was also expected to be higher amongst those who offended against adults given that those high on this scale seek admiration and control over others (Mann & Hollin, 2010). Again, this was found to be marginally higher within this group. There is a possibility that those who offend against children also hold these beliefs and desires highly, however a difference in sexual attraction of the offender, or their perceived ability to control adults may be the differing factor, rather than the desire or belief itself.

4.2.2 Schemas predicted to be higher within those who offended against children

Interestingly, the majority of the selected schemas that were predicted to be higher within the child victim group were actually found to be higher within the adult victim group. The focus of the schemas that were thought to be higher within the child victim group were those of feeling worthless and being a victim themselves. The two that were found to be higher within this group however were Subjugation and Admiration/Recognition-Seeking, both within the Other-Directedness domain. It is of note that none of the differences were found to be significant. This again, is likely to have been impacted by the small sample sizes within the groups, limiting the power.

It is possible that the disparity between the prediction and the outcome could be due to the fact that the whole sample had a diagnosed mental illness or personality disorder. The predictions were based upon data available in the literature that explored schemas within the non-MDSO population, largely from a prison population where mental illness or personality disorder diagnoses were not accounted for (albeit personality disorder is likely to be present in a majority of those within the prison sample, Singleton, Meltzer, Gatward, Coid & Deasy, 1998). Specifically looking at the schemas identified, feelings of worthlessness and being a victim may all be present within a clinical population due to the evidence of a higher level of abuse and trauma within the histories of those with a diagnosis (Richardson, 2005; Craissati et al., 2002) and therefore will apply to those who offend against adults also within this clinical sample. This would therefore skew the data, and not lead to any distinct differences between the groups as both have individuals with diagnoses of a mental illness and/or a personality disorder.

4.3 Correlation between the two measures of schemas

The second research question was exploring the relationship between the two schema measures used. There was a significant positive correlation found for all the hypothesised relationships between the specific schema domains and the two My Life schemas when using the data for the total sample. This is with the exception of the correlation between Disadvantaged schema and Other-Directedness schema domain, which was found to be very close to significance. There was not a significant relationship found between any of these correlations within the group that contained those who had offended against both adult and children. There is a strong possibility that this is due to the small participant number within this group (n=3), which therefore severely restricts the power and interpretations that can be made from the results.

When exploring the correlations for the sub-groups, it was found that those who offended against adults had significant positive correlations between Dominance and Impaired Limits; Disadvantaged and Disconnection and Rejection, as well as between Disadvantaged and Impaired Autonomy. For those who had offended against a child (n=8), the schema scores significantly and positively correlated between Dominance and Impaired Limits, and Disadvantaged and Disconnection and Rejection. Those who had solely offended against children (n=5) had a significant positive correlation for only one of the correlations; Dominance and Impaired Limits.

The positive correlations found show that there is a relationship between the two measures, which is suggestive of them both accessing and measuring similar constructs.

The relationship between Dominance and Impaired Limits domain was significant for the whole sample as well as for all of the sub-groups within it (with the exception of the group that contained those who had offended against both adults and children). Those who score highly on Impaired Limits schemas tend to show deficiencies with their internal limits, and respect and responsibility to others (Young et al. 2006). This therefore corresponds with that of the Dominance schema, where an individual high on this schema shows traits of wanting people to admire them and essentially be subservient to their wishes and desires. It was found that the two schemas that constitute the Impaired Limits domain (Entitlement/Grandiosity and Insufficient Self-Control) accounted for a greater proportion of the variance of the Dominance score within the group that offended against children (n=8), compared to those who offended against adults (n=21). This could be resultant of limited power, specifically within the child victim group, however could also suggest that there are more confounding variables for the adult victim group than for the child victim group in relation to the Dominance schema.

It was expected that there would be a positive correlation between Disadvantaged schema and the Disconnection and Rejection schema domain, as those high on either measure show beliefs regarding being mistreated, let down or harmed by others. The Disadvantaged schema relates to a belief that these negative experiences within an individual's past directly led them to "doing bad things" (Mann & Hollin, 2010). Within the whole sample, the only specific schema within the Disconnection and Rejection domain that accounted for a significant proportion of the variance of the Disadvantaged measure was that of Mistrust/Abuse. This therefore indicates that the specific element held within this schema (over the others that make up the domain; Abandonment/Instability, Emotional Deprivation, Defectiveness/Shame, and Social Isolation/Alienation) was more predictive of a score on the

Disadvantaged schema. The Mistrust/Abuse schema indicates an expectation that others will hurt, abuse or manipulate them, whereas the other four schemas are focussed more towards the unreliability of others and a feeling that they themselves are defective and different from others. It is therefore understandable how this specific schema is more highly related to the Disadvantaged schema.

The Impaired Autonomy domain is characterised by an overall feeling of inability to separate and function independently from others (Young et al. 2006). This was felt to correlate positively with the Disadvantaged schema as this schema was found to correlate highly with measures of low self-esteem and an external locus of control (Mann & Hollin, 2010), which would theoretically fit with Impaired Autonomy. There was a positive correlation found between these two constructs for the whole sample and for the group that offended against adults. The other subgroups did not reach significance in their correlation. Partial coefficient correlations found that Enmeshment/Undeveloped self was the only significant singular schema from the Impaired Autonomy domain to account for a significant proportion of variance. This is possibly because this schema relates directly to an inability to develop one's own self-identity and direction for oneself. Interestingly, this schema is developed more within those whose parents are very controlling, abusive or over-protective (Young et al. 2006). This could therefore explain this association, where those who have had overly close (be it in an abusive, controlling or protective way) relationships with care givers feel let down or mistreated by others (indicative of the Disadvantaged schema).

The final correlation assessed was that of Disadvantaged and Other-Directedness. There was not a significant correlation found between these variables however. This could be due to

the fact that as the focus of the Other-Directedness domain is towards meeting others needs at the expense of their own is not as significant or relevant to these individuals. This is understandable given that the offences committed are arguably in order to gratify their own needs over those of the victim (the other). These feelings are not as closely linked with feeling let down or mistreated than with Disconnection and Rejection and Impaired Autonomy schema domains.

4.4 Comparison of MDSOs schemas with non-MDSOs schemas

The third research question of the current study was to explore the differences in schema profiles between those inpatients that are being held within secure hospitals under the Mental Health Act 1983 (as amended by the 2007 act) compared to those sexual offenders within a prison setting. This was carried out to assess whether the profiles are significantly different. If this was the case then this could be due to the mental illness diagnosis or personality disorder. It was found that there were some significant differences between the two groups on certain schemas.

Within the *a priori* predictions, the schemas that were predicted to be significantly higher amongst the MDSO population were; Disadvantaged, Defectiveness and Shame, and Social Isolation. It was found that this was only true for the Disadvantaged schema within the group that offended against adults. This group also scored higher than the non-MDSO population on Defectiveness and Shame, and Social Isolation schemas, however this was not to a significant degree. These non-significant results could be a result of the reduced power

from the small sample sizes within the current MDSO groups. Contradictory to predictions, the MDSOs against children group scored lower on the Defectiveness and Shame, and Social Isolation schemas compared to the non-MDSO population, but non-significantly higher on the Disadvantaged schema. This again is likely to have been impacted on by the small number of participants recruited within the MDSO group. Further possible reasons for this are discussed later within this section.

The unexpected results for the Defectiveness and Shame, and Social Isolation schemas within the MDSO population could have arisen due to a number of reasons. It has been suggested (Drake & Pathé, 2004; Sahota & Chesterman, 1998a) that there are a variety of causal links between mental illness and sexual offending. A proportion of mentally ill offenders were found to have committed their offence due to direct and specific acute psychiatric symptoms (such as hallucinations or delusions), some were influenced by more indirect symptoms (such as disinhibition and chaotic thinking). There were also those who had offended outside of their mental illness, in which case suggests no link between mental illness and sexually offending for these individuals. It is therefore possible that the MDSO population would include those who offended due to psychiatric symptoms. This would perhaps then have an impact on their attribution and locus of control of their behaviour. If this was seen to be a more external attribution then this would have less impact on their Defectiveness and Shame, and Social Isolation schemas as would protect them from any internal judgements about themselves. Given that locus of control was not assessed within the current study, further exploration to examine this link would be necessary to identify whether a more external locus of control within the MDSO population that offended when mentally unwell has an impact on their feelings of being 'different' and 'inferior' to others that these schemas assess.

Interestingly, the group that offended against children within the current clinical population all scored lower than the child offending group within the prison setting on the Young Schema Questionnaire – Short form version 3 (YSQ-S3). It was found that some of these were significant differences. Again, there could be a number of reasons for this. The access to treatment is a possible influential factor. It was not possible within the realms of this research to explore the extent of treatment opportunities the individuals had if they had spent any time within prison, however it was seen that the majority (n=24) had (or were currently having) specific treatment focussing on their sexual offences. This could therefore be a possible reason for this difference between MDSOs and non-MDSOs, where those non-MDSOs had less treatment focussing on their sexual offending and therefore their schemas not being addressed or adjusted. The published data did not comment or record on whether the participants had received any treatment, and therefore could not be controlled for. This may result in a higher level of maladaptive schema endorsement within the non-MDSO population, which was found from this research. This would require further exploration to delineate the role of treatment on reducing sexual offenders' schemas.

There were certain schemas found to be significantly higher within the non-MDSO population. Enmeshment was found to be higher within both the non-MDSO comparison groups compared to the two MDSO groups within this sample (even though this remained to be significant only within the group that offended against adults after Bonferroni corrections). This could be suggestive of more of an attachment style difficulty that is associated with sexual offending, rather than the mental illness or personality disorder having a causal link, as discussed previously. Vulnerability to Harm was also found to be significantly higher within both non-MDSO groups (however only remained significant after Bonferroni corrections within the offenders with child victims). This could be a result of the

current situation they are in, where those in prisons may feel currently more at risk compared to those within a hospital. This could therefore reflect a state association, rather than a trait association. Further research exploring this link could be beneficial to identify such associations, which would help us understand the role of such schema within the offending behaviour.

When reviewing the output from the comparisons between the groups on the My Life questionnaire, it is evident that both the MDSO groups scored higher on both of the schemas within this questionnaire. It has been discussed earlier why it was expected to see the Disadvantaged schema to be higher within the MDSO population, however higher scores of the Dominance schema have not been explored. Neither of the MDSO groups scored significantly higher than the non-MDSO groups on this schema after Bonferroni corrections, so the difference could be due to the lack of power used, or the tests used to identify the difference (this is discussed in more detail below). The Dominance schema captures the beliefs regarding power, control, revenge and wanting respect from others. This suggests that the MDSOs endorse this more so than the non-MDSO population, which given previous discussion around the role of mental illness within sexual offending and this occurring during their mentally unwell state, would be expected to be lower within this group. It could reflect, however, that the MDSOs are still currently unwell, and therefore have these beliefs and attitudes that are less present within the non-MDSO population.

Overall, given the evidence of a higher endorsement of early maladaptive schemas within a clinical population (Bortolon et al., 2013; Pinto-Gouveia et al., 2006), it is possible that this could, to some extent, explain this difference between the groups. Therein, the addition of a

mental illness or personality disorder could bring about a difference in schema profiles. There is also research to suggest that there is a substantial proportion of offenders within prisons that have serious mental illnesses and/or personality disorder (Fazel & Danesh, 2002). The illnesses of these individuals may be able to be managed within prison, or not as severe so as to require specific hospital treatment, and hence remain in prison. Therefore this may suggest a degree of overlap between the two populations, which would have implications on differences being found. This information was not available within the published data, and so could therefore not be controlled for.

It should be noted that there were significant differences between the MDSO group, and the compared non-MDSO groups from the published data. The MDSO adult victim group were significantly older than those of the non-MDSO populations. This therefore limits the ability to reliably compare the groups, as any differences found could be due to this rather than actual differences within the separate groups themselves. It was also not possible to attain the clinical demographics of those within the published data, so it could therefore be that a certain percentage of the non-MDSO population had a mental illness diagnosis, and therefore not making them distinct groups.

Despite parametric assumptions not being met for these comparisons, parametric tests were used to compare the means between the groups (t-tests) as it was not possible to input external data (the data from the published articles) into non-parametric tests (Mann-Whitney tests) using SPSS. This therefore has some implications on the results and any conclusions drawn from them. Parametric tests are more robust and assume normality between the two samples. By using non-parametric tests, this may have resulted in more

differences to be found between the groups as they are less robust and require a lower power.

4.5 Post-hoc analyses

A number of post-hoc analyses took place to identify any association with sexual offending on a number of other variables. These were exploratory in nature, and not necessarily built upon theoretical underpinnings. Certain schemas were found to be significantly higher within the group who offended against people that were not known to them (strangers; n=18) compared to those who knew their victim (n=11). These were Dependence/Practical Incompetence, Vulnerability to Harm, and Emotional Inhibition. There is not a clear understanding why these would be more prevalent within this subgroup of the sample. This could be a type 1 error, where a significant finding was found despite a pattern not really existing. This could also be a result of the low power and sample sizes not accurately representing the whole population.

Woods and Porter (2008) identified that sexual offences against strangers were more likely to include violent and hostile behaviour, compared to those with known victims, which included a less violent, more personal and compliance-gaining approach. This may therefore go some way to explaining the increase in Emotional Inhibition, where people high on this schema go to extreme lengths to control their emotions for fear of losing control. This 'loss of control' may have happened at the time of the offences opportunistically against a stranger, so have high awareness or anxiety regarding this and further strengthening this

schema. It would be interesting to explore these findings further however to see if there is an association between people with a higher degree of emotional control, fear of harm or a perceived lack of personal ability and their choice of victim.

There were three schemas that were found to be significantly different (or approaching significance) between those who have a mental illness diagnosis (n=24) compared to those with a personality disorder (n=5). These were Abandonment/Instability, Insufficient Self-Control and Self-Sacrifice. Those with a purely personality disorder diagnosis scored higher on Abandonment/Instability and Self-Sacrifice, and scored lower on Insufficient Self-Control compared to their counterparts with a mental illness diagnosis. Bortolon et al. (2013) examined the Early Maladaptive Schemas within a population of (non-offending) patients with schizophrenia. The authors used an earlier version of the YSQ, which did not include Insufficient Self-Control, therefore it was not possible to compare this to a similar group, however as this schema is related to a difficulty in inhibiting emotions, it is understandable how this could be higher within the mental illness group, given that emotional disinhibition and dysregulation is prevalent within those with paranoid schizophrenia (Haralanova, Haralanov, Beraldi, Möller & Hennig-Fast, 2012).

The two schemas that were higher amongst those within the personality disorder group refer to an instability in relationships and a tendency to put others' needs first. These are both inter-relational aspects, and therefore understandable how they could be more prevalent within those with a solely personality disorder diagnosis, where interpersonal difficulties is a core characteristic of those with a personality disorder as outlined within the

Diagnostic and Statistical Manual of Mental Disorders (5th edition; DSM V; American Psychiatric Association, 2013).

There were no significant differences found between the risk categories of the patients within the sample. Even though non-significant, some general patterns can be seen to emerge within the raw data. For example in general as the risk level increased, endorsement in the following schemas also increased; Emotional Deprivation, Subjugation, Emotional Inhibition, Unrelenting Standards, Punitiveness. The latter four schemas constitute the Over-Vigilance and Inhibition domain. This domain involves schemas that relate to the excess focus on controlling, suppressing or ignoring one's emotional experiences. Therefore this may be suggestive of those higher at risk having a tendency to want to control their emotions to meet rigid internal rules. This is supported by a heightened Emotional Deprivation schema score with increasing risk level, as this schema refers to the belief that others will not or are not able to meet their emotional needs, and therefore a potential need to over-control them themselves. It should be stressed again however, that these were not significant findings, and with very small sample sizes in the two extreme categories (low risk (n=2) and very high risk (n=2)). This therefore causes a problem with the drawing of any firm conclusions. It could be suggested that this requires further exploration to extrapolate any links between emotional control and sexual offending, possibly with a focus on risk level of offenders.

4.6 Sample

There is very little research on sexual offenders who also have a mental illness or personality disorder (Drake & Pathé, 2004; Harris, Fisher, Veysey, Ragusa & Lurigio, 2010). Therefore this study adds to this small literature, as well as being the first to compare schema profiles between offence types within this subgroup of sexual offenders. It should be highlighted that this sample only included male sex offenders, and therefore cannot be generalised to the growing field of interest in female sex offenders (Cortoni & Gannon, 2011), or adolescent sexual offenders, given the different personal and offence characteristics identified between these groups and male sexual offenders (Gannon, Rose & Ward, 2008; Richardson, 2005). Further research exploring these different groups could be beneficial to identify any similarities or distinct differences between them to aid our understanding of the developmental path or causal factors for such offending behaviour.

4.6.1 Demographics

The current sample had a wide age range (24-63), with an average age of 45.21 years (SD=9.67). Table 1 highlights the mean ages of comparable samples, both MDSOs and non-MDSOs. It can also be seen within section 3.6.3 that when divided into the offence type group (i.e. those who offended against adults and those who offended against children) the adult victim group were found to be significantly older than the comparison groups used for hypothesis 3. These comparison samples were drawn from a prison population (non-MDSO). The offenders against children were not found to be significantly different from the comparison groups, however, as previously mentioned, it is possible that the small sample size of this particular group may have had an impact on this non-significant result.

Szlachcic et al. (2014) had a comparable sample of MDSOs. The mean age of their sample was found to be 37.32 years (SD= 12.43), which was found to be significantly different from the current sample ($t(58) = 2.73, p=0.008$). However, Moulden et al. (2014) had a sample of MDSOs that did not differ significantly from the current sample. Mannix et al. (2012) had a sample of 12 MDSOs convicted of child sexual abuse who had a mean age of 45.3 years (SD= 9.69), which again did not differ from the current sample of this subgroup. Overall it appears that mean ages are mixed for non-MDSO populations, however the sample in the current study does not seem to be significantly different from most published groups.

When reviewing other studies using non-MDSO population, it can be seen from Table 1 (p.63) that the current sample adult victim MDSO population is significantly older than the non-MDSO adult victim groups. Whereas, the child victim non-MDSO groups do not significantly differ in age compared to the current sample. In general it appears that on average those who offend against adults tend to be younger than those who offend against children, however this was not the case for the current sample, where the reverse was true. Therefore, overall it appears that the current sample is significantly older in comparison to non-MDSO groups (specifically those who offend against adults), however from the literature it appears to be a heterogeneous group in regards to ages. It should be noted that the age calculated was at the time of data collection, rather than at index offence or first sexual offence, which may be reliably different between the two groups.

A variety of ethnicities were recorded within the current sample. The majority were from ethnic backgrounds ($n=19$), which included Black (British, African and Afro-Caribbean) Asian, White Irish, and Mixed. The remainder labelled themselves as White British ($n=10$). This is

comparable to other studies, which have also identified a high representation of ethnic minorities within their samples (e.g. Chesterman & Sahota, 1998b; Craissati & Hodes, 1998; Szlachcic et al. 2014;). This finding has also been recognised with inpatients of forensic hospitals overall (i.e. not solely sexual offenders), general psychiatric hospitals and within prisons (Bhui, Stansfeld, Hull, Priebe, Mole & Feder, 2003; Rutherford & Duggan, 2007; Singh, Greenwood, White & Churchill, 2007).

There have been many suggested reasons for this increased level of ethnic minorities detained under the Mental Health Act 1983 (as amended by the 2007 Act), which include cultural differences in regards to stigma of mental health and therefore a delay in seeking help (and consequential increase in severity of symptoms at time of presentation to services) (Harrison, Holton, Neilson, Owens, Boot & Cooper, 1989), higher rates of mental illness within certain ethnic minorities (Lewis, Croft-Jeffreys & David, 1990), entrenched racism within mental health services and psychiatry (Littlewood & Lipsedge, 1997), and services seeming inaccessible and inappropriate to ethnic minorities (Cochrane & Sashidharan, 1996). However, Singh et al. (2007) found that these to be largely unsupported. Therefore, the reason for the common finding of the overrepresentation of ethnic minorities remains unclear. The geographical locations of the services are also likely to have an impact on this finding.

The current research also found evidence to suggest that the relationship statuses of the men within this sample did not significantly differ from those of comparable samples (e.g. Moulden et al. 2014; Szlachcic et al. 2014). The majority of men recruited labelled themselves as single with no significant relationships in the past. Moulden et al. (2014)

found a significant proportion of their MDSO sample to be single. These findings were significantly different from the authors' non-MDSO population, where the majority were not single.

4.6.2 Heterogeneity

As well as being ethnically diverse, the sample was also found to be heterogeneous with regards to a number of other factors, including psychiatric diagnoses, sexual offence, and victim choice. This heterogeneity appears to be intrinsic within this population, as has been described by other researchers within the field (e.g. Baker & Beech, 2004). The analyses carried out in the current study allowed for the inclusion of a wide range of variables, however this also highlighted the possibility of confounding variables having an impact on the output and interpretation of these analyses.

The inclusion and exclusion criteria of previous studies have varied when exploring this population (Hughes & Hebb, 2005), which can result in a limit to the extent this study can be compared to others. The current study used a broad definition of mental disorder, which included those with a personality disorder diagnosis. An exclusion criterion of those with mental impairment, i.e. those with an IQ of below 70, was used. This was based upon the finding of sexual offending within this population to possibly be due to different underlying causal pathways compared to those without an intellectual disability (Lindsay, 2005). Therefore schemas may not be as prevalent or causal in nature within that population. It was decided to include those with a personality disorder as a high co-morbidity rate has been identified within this population (Tyrer & Simmonds, 2003; Zimmerman, Rothschild &

Chelminski, 2005), as well as it reflecting the composition of this population within forensic settings. Five men with a sole diagnosis of personality disorder were recruited within the current study. It is therefore possible that the inclusion of these men may have diluted the impact of mental disorder on the results. However, it can be seen from section 3.7.2 that there were no differences found between these two groups on the basis of their schemas. Again, this could be an artefact of the limited sample sizes and power of these two groups. Further research exploring any differences in the schemas of those with a mental illness and those with a personality disorder in forensic settings could be beneficial to further understand if these are two distinct groups on the basis of their sexual offending.

The definitions of sexual offending that have been used in the inclusion criteria have also varied within previous studies. Many studies have only included those whose index offence was a sexual offence (e.g. Smith, 2000; Smith & Taylor, 1999). Other studies have included those with a sexual offence that may not necessarily be their index offence (e.g. Mann & Hollin, 2010), and others have included problematic sexual behaviour (e.g. Hughes & Hebb, 2005; Szlachcic et al. 2014). It was found when discussing potential research participants within multi-disciplinary teams that a number of men did not have a sexual offence conviction for a number of reasons (including charges not being pressed, being detained in hospital when offence took place). Therefore those with a *“well documented history of sexual offending”* were included in order to capture these men. This has the possibility of diluting the sample to include those who do not have a conviction, and therefore skewing the data, however it was felt that this is a more representative sample of a forensic MDSO population, and those who would be referred for sexual offending treatment work. This therefore makes the sample more generalisable within the population, rather than restricting it to those whose index offence is a sexual crime only.

The vast majority of research on MDSOs has separated those who have offended against adults and those who have offended against children. Baker and Beech (2004) report a high proportion of mixed victim type (i.e. both adult and children) within the samples of those sexual offenders with a mental illness, personality disorder, and/or learning disability. It is unclear from previous published articles whether this subgroup have been excluded, controlled for, or categorised in a different way. This could be a potential confound within previous research if it has not been assessed or controlled for. This study categorised those who had offended against both into the child victim group (as also done by Moulden et al. 2014), as well as keeping them as a separate group for the analyses. There were limitations with this however given the extremely small sample size of those who offended against both (n=3).

4.6.3 Sample size

It is important to note that the current study had a limited sample size. This resulted in restricted power, which has implications on the ability to detect differences of the schemas between the groups. Therefore, in order to minimise the possibility of type two errors, trends within the data were highlighted within the results section, as well as any significant differences. The group of participants who had offended against children was noted to be particularly small (n=8). It was anecdotally noted that there was more prevalence of those who offended against children to be held within prisons rather than hospitals. This finding is unclear and data to support or reject this was not found. However, as there was a lower rate of recruited offenders against children within the current study, it is possibly a true reflection. It has been noted that there is a general paucity of research in those men who are mentally ill and sexually offend against children (Short, Lennox, Stevenson, Short &

Shaw, 2012). This could be due to a severe lack of men that fall into this category. This could be for a number of hypothesised reasons. For example, there could be different contributing factors for the offence against children compared to adults, such as attachment difficulties and paraphilias, which may be viewed as more integral, and therefore this may not meet the requirements for sectioning under the Mental Health Act. There also may be a higher level of shame related to sexually offending against children, and therefore less desire to take part in research. This therefore could mean that the number of this group within the hospital settings may be higher than it appears from this sample. Further research is required to explore this potentially prevalent pattern, and to identify the reasons for such differences.

It should be recognised that the power for the current study was based upon research that compared different groups to those that were used in this study (i.e. those sexual offenders without a mental illness, and compared to non-sexual offenders). This therefore has limitations, in such that the applicability of the measures (and therefore the power assumed from these measures) may not be appropriate for this group. The power analysis was based upon a sexual offending group and non-sexual offending group, whereas this research aimed to identify differences between subgroups of sexual offenders and therefore may not be sensitive enough to identify group differences with a power based upon an experimental group (sexual offenders) and control group (non-sexual offenders). However, as there is a great deficit in published research on schemas in sexual offenders with mental illnesses, this study selected the cited study as this was identified to be the closest in application and one of very few studies that have utilised the less commonly used questionnaire, My Life questionnaire, and therefore more likely to have provided a more conservative power estimation than if it were to be based upon the well-validated Young Schema Questionnaire.

Despite the limited power, this sample is one of the largest within this population, so the study helps to increase our understanding of this under-researched subgroup of offenders.

4.6.4 Sampling method

There are a number of biases identified within the sampling method. It was noted in discussions with multidisciplinary teams that the pool of participants was larger than those approached. The reasons for the whole pool not being approached was largely due to the teams being reluctant to approach certain suitable participants due to engagement or stigma factors (e.g. the participants unwilling to view themselves as having sexually offended). As a consequence, this reduced the total number that was approached to take part. Additionally, self-selection biases took place in those who were approached to take part. There could be significant differences between those that agreed to take part, and those that did not. It was not possible to get any information about the group that were not approached or did not give consent to take part, and so therefore it was not possible to identify any specific differences. However, as mentioned previously, this difference in group sizes could be due to the type of sexual offence committed (e.g. those offenders against children potentially less willing to take part), but could also reflect more intrinsic differences between those who consented and those who did not. It is possible, for instance, that those who did not consent could hold more antisocial tendencies than those who took part. This therefore has implications on the ability to generalise the findings, as the sample may not wholly represent the MDSO population.

Certain factors were not formally tested, such as testing for a learning disability. This exclusion criterion was based upon the clinical teams' knowledge and judgement of the individuals. Therefore, it is possible that there may be certain participants who would have met criteria for a learning disability, but as they may have not been accurately assessed or diagnosed, were therefore approached to take part.

Those with acute active symptoms of mental illness that would limit their ability for informed consent were not included in the participant pool. It was noted subjectively that a number of the participants presented with ongoing symptoms of mental illness. This may have had an impact on their willingness to engage with the research and/or researcher. This could have resulted in certain people less likely to take part, or may have had an impact on their honesty within the self-report measures. Residual paranoia, for instance, may have increased their guardedness and engagement in impression management. This may have therefore resulted in an under-representation of schemas. A number of actions were put in place in order to minimise the impact of this however. For instance; the provision of the participant information sheet that outlines who the data will be available to and what will happen with the data, further explanation within the consent form, as well as presenting in a non-judgemental and accepting manner were routinely done with each participant. Therefore ongoing mental illness symptoms could be a confounding factor within the current study, however this is likely to be a challenge in any research that invites those with mentally ill patients to take part.

4.7 Role of mental illness within sexual offending

Theories of sexual offending have typically been based upon research involving non-MDSOs (e.g. Finkelhor, 1984; Marshall & Barbaree, 1990; Ward & Siegert, 2002). In response to these and to explore if these models are also applicable to those mentally ill individuals who sexually offend, Sahota and Chesterman (1998b) found that there were similarities between the psychosexual profiles of MDSOs and non-MDSOs, with an apparent overlap in their motivation to offend. However, there have been subsequent proposals of typologies of MDSOs that explore the role mental illness can play within the sexual offence discussed below.

Sahota and Chesterman (1998a) divided sex offenders with schizophrenia into four broad categories: 1) those who sexually offend as a result of specific psychotic symptoms, such as hallucination or delusions; 2) those who sexually offend as a result of general psychiatric symptoms, including chaotic thinking, arousal and disinhibition; 3) those who sexually offend as a result of negative symptoms of psychosis, e.g. social isolation and emotional blunting; and 4) those whose sexual offending is unrelated to their illness. This provides a good framework to understand the pathways to sexual offending in those with a mental illness.

Drake and Pathé (2004) built upon this model to highlight different risk factors that may be instrumental to a greater or lesser degree in MDSOs propensity to sexually offend. The authors again proposed four categories: 1) Those with a *pre-existing paraphilia*, where those MDSOs have sexually offended prior to the onset of their mental illness, and therefore the illness may be a coincidental addition; 2) Those whose *sexual deviance arose from factors*

specific to their illness e.g. positive symptoms (hallucinations or delusions), disinhibition and/or impulsivity, negative symptoms (social withdrawal, cognitive deterioration); 3) Those who exhibit *deviant sexual behaviour in the context of a broader range of antisocial behaviours*, where individuals have antisocial traits predating their mental illness, and that their offending behaviour are enacted within a sexual way rather than a paraphilic basis; and 4) Those where *factors other than pre-existing pathology or the influence of mental illness* are integral to their offending, which may include brain injury, dementia or substance misuse. It can be seen that those outlined within group one are theoretically the most akin to the non-MDSO population.

These theories outline possible pathways to sexually offending within the MDSO population. They are useful frameworks to consider potential causal or risk factors that underlie sexually offensive behaviour. With this in mind, those that would fall into the different categories are likely to have different motivations and explanations for their offending, and therefore schema profiles may differ between them. It could be expected that those within group one could have a schema profile more similar to that of the non-MDSO population, whereas other categories may have separate and distinct profiles. This may go some way to explaining the non-significant differences between the groupings used within this study, as the sample may have included participants from across these groups. As the current study did not identify which group each participant fell into, future research could explore this link more to see if those in the different categories or groups have significantly different schema profiles.

4.8 Schema measures

The Young Schema Questionnaire – Short form version 3 (YSQ-S3) is a widely validated measure that has been translated and validated in numerous languages (e.g. Kriston et al. 2013; Lyrakos, 2014). This measure has been used with a wide variety of clinical and non-clinical groups, however it was noticed that there was a lack of comparable groups to the current sample. The one study that has used this measure with a MDSO population (Szlachcic et al. 2014) was used to compare the findings. As can be seen within Figure 3 (p.76), the current sample was very similar to that of the comparable sample in regards to the endorsement of certain schemas. The Over-Vigilance and Inhibition, and Other-Directedness domains were the highest scoring domains for both samples. Szlachcic et al. (2014) found Self-Punitiveness and Unrelenting Standards to be the most highly endorsed schemas, whereas within the current sample, Unrelenting Standards, and Self-Sacrifice were the highest two, and Self-Punitiveness scoring fourth highest. This research therefore adds to the very limited YSQ-S3 data available within this population.

The My Life questionnaire has been less widely used within research, and it appears only within the non-MDSO population. Therefore this study provides the first dataset available for this measure within the MDSO population.

It can be seen that the internal consistencies identified for the two measures within this sample were all excellent for the total sample, and for the subgroups of those that offended against adults and those that offended against children (with the exception of the group that offended against children when using the My Life questionnaire, which demonstrated 'good'

internal consistency). This therefore demonstrates that the items on the questionnaires are successfully measuring the same construct, for the total sample and for the subgroups. This suggests that they are reliable measures that can be used with this population.

Given that schemas are thought to be affecting information processing at an unconscious level (Beck, 1996) it could be suggested that self-report measures are not a reliable way to assess schema-level cognition. Even though schemas are assumed to represent unconscious processes, schema therapy suggests that in order for schema change these can be brought under conscious control and awareness (Young, Klosko & Weishaar, 2003). However, Gannon (2009) proposes that *"the accuracy of self-reported cognitive products is highly reliant upon the motivation of the individual to report their internal processes honestly, and their ability to accurately introspect on their cognitive functioning"* (p.228). There was variability in the participants' abilities to complete the schema questionnaires qualitatively noted. This could reflect a difference in their cognitive abilities, or their level of insight or motivation to self-reflect. Therefore there could be an inconsistency in the accessibility of individual's schemas.

As well as there being variability in accessibility of schemas, research has also suggested that there is variability in individuals' schemas over time within this population (Baker & Beech, 2004). The authors found that sexual and violent offenders self-reported early maladaptive schemas varied over a three-week period, more so than a non-offending population. This was considered to be influenced by the disorganised attachment style within the sample. This is because this style of attachment may have multiple and contradictory internal working models of others and the self, and only one of these models can be accessed

consciously at one time. This would result in unreliable self-reporting of early maladaptive schemas if different models are being accessed at different times.

In addition to this, reporting of early maladaptive schemas has been found to vary in accordance to mental state. Zuroff, Blatt, Sanislow, Bondi and Pilkonis (1999) suggested a state-trait vulnerability model, which stipulates that individuals possess stable structures that fluctuate in their accessibility dependent upon mood. This proposition has been supported by clinical research where early maladaptive schemas were measured in a sample of depressed individuals, and the scores were compared to a sample of previously depressed people, and those who have never experienced depression (Wang, Halvorsen, Eisemann & Waterloo, 2010). The authors found that certain schemas were found to be stable across time and mood, whereas others were more state dependent.

In the current study, attachment style, mood and depression were not explicitly assessed, and therefore no exploration of these factors could be carried out, or controlled for. This therefore highlights a possible limitation of the results, where the level of awareness or conscious access the participants had to their schemas may have implications on the output and therefore analyses.

Concern around social desirability is often highly reported within research of sexual offenders given the social stigma associated with their offence (Tan & Grace, 2008). There has been mixed evidence of the use of socially desirable responding within previous research on sexual offenders (Carvalho & Nobre, 2014; Gudjonsson, 1990; Mann & Hollin,

2010). Tan and Grace (2008) argue that socially desirable responding within this population is somewhat inconclusive. Szlachcic et al. (2014) used a specific measure to assess for social desirability (Paulhus Deception Scale; Paulhus, 1999) within their research, and found that only two of the 31 MDSO participants were found to be answering in a favourable way to a significant degree. No measure of social desirability was used within the current research given this low number, as well as in an attempt to reduce the length of time required for each participant to take part with the aim to increase the sample size. There is, therefore, a possibility that the current sample were subject to a certain degree of desirable responding which would have implications on the level to which they endorsed certain (or all) schemas. In order to try to minimise this, the confidentiality and anonymity process was emphasised prior to completing the questionnaires as well as each participant being assessed individually and privately.

Given the lack of significant differences found between the subgroups of offenders when using the two measures, it is possible that the questionnaires were not sensitive enough to show group differences. This could suggest that there are differences within the schema profiles of those sexual offenders that offend against children and those that offend against adults however the differences may be more subtle than that can be identified in the existing measures used within this research, which were developed for different populations. More specific measures may therefore be required for this specific subgroup of sexual offenders with a mental illness.

4.9 Sexual offender treatment

It was found that the current sample had been detained within hospital for a significantly longer amount of time than the comparison sample within Szlachcic et al. (2014). The mean length of stay for this sample was 10.12 years (SD=8.01), whereas the comparable sample had a mean stay of 4.65 years (SD=6.79). This could therefore explain to some extent the considerable difference in the total number of participants not having received any form of psychological treatment for their sexual offending (either group, individual, or both) between the two samples (no treatment n=4 in current sample, n=11 in comparison sample).

It is not possible to identify the extent to which the samples in the published data of the non-MDSO populations had received any psychological treatment for their sexual offending. Therefore a possible limitation of the results could be that as the majority of this sample had received some form of psychological treatment, this in itself could have impacted on the schemas within the individual participants. Therein, treatment could directly or indirectly influence the schema profiles of the individuals. This would then not express the schemas that may have contributed towards the sexual offending behaviour to take place initially as these may have been adjusted throughout the treatment. This would have an impact on the ability to distinguish any differences between the groups (either between those who offend against adults and those who offend against children, or between MDSOs and non-MDSOs).

Even though no significant difference between schema endorsements was found between those who had received treatment and those who had not within this sample, the small

sample size within the 'no-treatment' group (n=5) restricts the power and therefore likelihood of finding any differences. In order to overcome this confounding variable and to identify whether the 'true' schema profiles of MDSOs differ between those who offend against adults and those who offend against children, the questionnaires would need to be administered to those who have been newly admitted (so therefore closer to the time of the offence) and not received any treatment regarding their sexual offending (so the therapeutic benefit of treatment would not have adjusted their schemas).

4.10 Clinical Implications

The findings from this research have clinical implications on our understanding of those with a mental illness who sexually offend, as well as the treatment offered to these individuals. Firstly, although further research is required due to the limited sample size within this study, it appears that there may be some differences of the MDSO schema profiles between those who offend against children and those who offend against adults. Although these differences were not significant within this dataset, there were trends within the data that supported the hypotheses. This is suggestive of there possibly being differences at a schema level. However, it would be important to use the schemas to develop individualised formulations, rather than presume certain characteristics based upon their choice of victim or other variables. Overall, the implications of this is that schemas may be useful within the whole therapeutic process; assessment stage (to underlie specific schemas prevalent), the formulation stage (to help understand why the sexual offence may have occurred and what may be maintaining future risk of re-offending), the intervention stage (as they would highlight the main areas that may need to be addressed within therapy), as well as the

evaluation process (where assessing schemas may be used to identify change or therapeutic direction).

Given that sex offender treatment for those within forensic mental health settings are derived from treatment programmes for non-MDSO populations, these findings suggest that there may be some benefit in adjusting these to accommodate the MDSO population.

Although the findings within this study identified key factors that overlap with the non-MDSO population, there were also some findings that differentiate the two groups.

Therefore Sex Offender Treatment Programmes (SOTPs) that are delivered to non-MDSOs should be adapted to accommodate for cognitive and symptom related difficulties for the MDSOs, such as impulse control, emotion regulation and symptom management. Addressing the role their mental illness played within their offending would also be a key factor for this group.

The treatment of offenders (including sexual offenders) within the criminal justice system is often based upon the Risk, Need Responsivity model (Andrew, Bonta & Hoge, 1990; Andrew & Bonta, 2010). However, it has been highlighted that the ethos and focus of the criminal justice system differs to that of mental health services, where a focus on rehabilitation and care is more prominent (Harris, Fisher, Veysey, Ragusa & Lurigio, 2010). Ward and Stewart (2003) criticised the Risk, Need Responsivity model for its sole focus on criminogenic needs, and therefore developed the Good Lives Model as an alternative. This model has a focus on recovery and the enhancement of offenders' abilities to obtain primary human goods, as well as risk reduction. It therefore is felt that the Good Lives Model corresponds with the philosophy of the mental health services more so than the criminal justice system, due to

promotion of recovery and well-being (Simpson & Penney, 2011). Initial research of using the Good Lives Model with MDSOs also appears promising (Barnao, Robertson & Ward, 2010; Gannon, King, Miles, Lockerbie & Willis, 2011). This model is therefore argued to be more compatible with mental health forensic services, over SOTPs (Barnao et al. 2010; Lord, 2014).

There was a small proportion of the current sample that had not received any treatment for their sexual offending. Even though it was found that these had been in hospital on average less time than those who had received treatment, it is an important aspect to consider and for mental health services to be aware of. There could be a number of reasons why this small selection of men had not received any specific sexual offence treatment, such as they may have been considered not to need it by the clinical team, they may have refused treatment themselves, or they may have been on a waiting list. It is not possible from the available information to identify the actual reasons, however highlights the importance for services to assess and address both mental health and criminogenic needs of their MDSOs.

This study was the first identified to use the My Life questionnaire with a MDSO population, and the second (after Szlachcic et al., 2014) to use the YSQ-S3. This is therefore a very new and developing area of research interest. It can be seen that these measures were appropriate and applicable to use, and may prove to be useful in the assessment of schemas within this population. However, as mentioned previously there requires further research to explore the stability of schemas within such a population where attachments are likely to be severely disrupted, as well as mental states being variable. Given the high correlations between the two measures this is suggestive of them accessing similar phenomena.

4.11 Conclusions

Being one of the first studies to explore schema level cognitions within a sample of MDSOs, this research adds to the very small pool of information for this population. Overall, there are some potential differences between those who offend against children and those who offend against adults. The differences were not significant within this study however, but trends within the data have been highlighted. Reasons for this non-significance have been raised, as well as areas that require further research to help us understand sexual offending in those with a mental illness. There is some indication of more general maladaptive schemas being important within this group, rather than solely sexually related schemas (Pemberton & Wakeling, 2009). The use of schema self-report measures appeared to be appropriate and may be a useful tool with this population.

There was overlap found between the MDSO population and non-MDSO population, but the results are indicative of MDSOs having different schema profiles to those non-MDSO profiles identified within the literature. It is likely that the addition of the mental illness or personality disorder will have impacted upon these profiles. Therefore it would be important for these considerations when planning and implementing treatments for this group.

Although it is appropriate to base treatment for this group on such programmes like SOTP from non-MDSO populations, there should be some adaptations made to account for the role of mental illness in their offending. It was also discussed the possible 'better fit' of the Good Lives Model treatment for this group within mental health services.

Although this study included what is thought to be a relatively representative sample of MDSOs, this also resulted in some inherent methodological limitations that have been discussed. These include heterogeneity within the sample, possible confounding variables, and the limited power as a result of a small sample size. Further research is therefore required to develop our understanding of sexual offending and the role mental illness plays within this.

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6. Appendices

6.1 National Research Ethics Committee Letter of Approval



Health Research Authority

NRES Committee East Midlands - Nottingham 1

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839695
Facsimile:

23 April 2014

Mr Michael Woodcock
41 Mervan Road
London
SW2 1DR

Dear Mr Woodcock

Study title:	Schema Profiles of Mentally Disordered Sex Offenders: A comparison between adult versus child victim offenders
REC reference:	14/EM/0154
IRAS project ID:	143914

Thank you for your letter of 21 April 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager, Miss Helen Wakefield, at nrescommittee.eastmidlands-nottingham1@nhs.net

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management

permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Evidence of insurance or indemnity	Gallagher Heath - Valid to 31.07.14	02 September 2013
Other: Investigator's CV	Michael Woodcock	
Other: Investigator's CV	Simone Fox	
Other: Confirmation of Payment Sheet	1.0	12 March 2014
Participant Consent Form: Responsible Clinician Consent Form	1.0	08 February 2014
Participant Consent Form	1.1	21 April 2014
Participant Information Sheet: Responsible Clinician Information Sheet	1.0	08 February 2014
Participant Information Sheet	1.1	21 April 2014
Participant Information Sheet: Debrief Sheet	1.1	21 April 2014
Protocol	1.0	13 February 2014
Questionnaire: Young Schema Questionnaire - Short Version (2005)	Validated	
Questionnaire: My Life (Version 2)	Validated	
REC application	143914/583312/1/946	20 March 2014
Response to Request for Further Information	Email	21 April 2014

Statement of compliance

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

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

14/EM/0154	Please quote this number on all correspondence
------------	--

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

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

Yours sincerely

pp 

Reverend Keith Lackenby
Vice Chair

Email: nrescommittee.eastmidlands-nottingham1@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Dr Andy MacLeod*
Ms Maria Tsappis, West London Mental Health Trust

6.2 National Research Ethics Committee Minor Amendment Approval Letter



Health Research Authority NRES Committee East Midlands - Nottingham 1

Royal Standard Place
Nottingham
NG1 6FS

Tel: 0115 8839697

21 May 2014

Mr Michael Woodcock
41 Mervan Road
London
SW2 1DR

Dear Mr Woodcock

Study title:	Schema Profiles of Mentally Disordered Sex Offenders: A comparison between adult versus child victim offenders
REC reference:	14/EM/0154
Amendment number:	1
Amendment date:	16 May 2014
IRAS project ID:	143914

Thank you for your letter of 16 May 2014, notifying the Committee of the above amendment.

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

Document	Version	Date
Notice of Minor Amendment		16 May 2014
Participant consent form [1]	1.2	13 May 2014

Statement of compliance

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

14/EM/0154:

Please quote this number on all correspondence

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Rachel Nelson', enclosed in a thin black rectangular border.

Ms Rachel Nelson
REC Assistant

E-mail: NRESCCommittee.EastMidlands-Nottingham1@nhs.net

Copy to: *Ms Maria Tsappis*

Dr Andy MacLeod

6.3 National Research Ethics Committee Substantial Amendment Approval Letter



Health Research Authority

NRES Committee East Midlands - Nottingham 1

Royal Standard Place
Nottingham
NG1 6FS

Tel: 0115 883 9428

13 January 2015

Mr Michael Woodcock
41 Mervan Road
London
SW2 1DR

Dear Mr Woodcock

Study title:	Schema Profiles of Mentally Disordered Sex Offenders: A comparison between adult versus child victim offenders
REC reference:	14/EM/0154
Amendment number:	22.12.2014
Amendment date:	22 December 2014
IRAS project ID:	143914

The above amendment was reviewed at the meeting of the Sub-Committee held on 13 January 2015.

Ethical opinion

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

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Notice of Substantial Amendment (non-CTIMP)		22 December 2014
Other [Debrief Sheet]	1.2	15 December 2014
Other [Confirmation of Payment Sheet]	1.1	15 December 2014
Other [Responsible Clinician Information Sheet]	1.1	15 December 2014
Other [Responsible Clinical Consent Form]	1.1	15 December 2014
Participant information sheet (PIS)	1.2	15 December 2014

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

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

Statement of compliance

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

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

14/EM/0154:	Please quote this number on all correspondence
--------------------	---

Yours sincerely



Reverend Keith Lackenby
Chair

E-mail: NRESCommittee.EastMidlands-Nottingham1@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to: Ms Maria Tsappis, West London Mental Health Trust
Dr Andy MacLeod

NRES Committee East Midlands - Nottingham 1

Attendance at Sub-Committee of the REC meeting on 13 January 2015


Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Ursula Holdsworth	Retired Staff Grade Community Paediatrician	Yes	
Reverend Keith Lackenby	Lay member	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Miss Nicola Kohut	REC Assistant

6.4 West London Mental Health Trust Approval Letter

West London Mental Health 
NHS Trust



Dr Hannah Crisford
Clinical Psychologist
West London Mental Health Trust
Three Bridges Medium Secure Unit
Uxbridge Road
Southall UB1

West London Mental Health Trust R&D Office
Medway Lodge
K Block 1st Floor
St Bernard's Wing
Uxbridge Road
Middlesex UB1 3EU

Tel: 020 8354 8738
Fax: 020 8354 8733
Email: rd.office@wlmht.nhs.uk

31 July 2014

Dear Dr Crisford

Re: Schema profiles of mentally disordered sex offenders: a comparison between adult versus child victim offenders
LREC Ref: 14/EM/0154
R&D Reference Number: CRIHW1401 (formerly WOOMW1401)

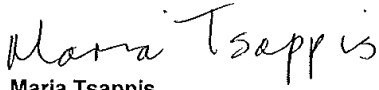
I am pleased to confirm that the above study has now received a full R&D approval, and you may continue your research in **West London Mental Health Trust**. May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Serious Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Research Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Research Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Research Ethics Committee and R&D Office as soon as possible.
- **Monthly/Annual Progress report:** you are required to provide us and the Research Ethics Committee with a progress report and end of project report as part of the research governance guidance.
- **Recruitment data:** if your study is a portfolio study, you are required to upload the recruitment data on a monthly basis in the website:
http://www.crncc.nihr.ac.uk/about_us/processes/portfolio/p_recruitment/
- **Amendments:** if your study requires an amendment, you will need to contact the Research Ethics Committee. Once they have responded, and confirmed what kind of amendment it will be defined as, please contact the R&D office and we will arrange R&D approval for the amendment.
- **Audits:** each year, West London Mental Health Trust selects 10% of the studies from each service we have approved to be audited. You will be contacted by the R&D office if your study is selected

for audit. A member of the governance team will request you complete an audit monitoring form before arranging a meeting to discuss your study.

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

Yours sincerely

A handwritten signature in black ink that reads "Maria Tsappis". The signature is written in a cursive style with a large, prominent 'M' and 'T'.

Maria Tsappis
Research Governance Officer

6.5 West London Mental Health Trust Letter of Access

West London Mental Health



NHS Trust



Mr Michael Woodcock
Trainee Clinical Psychologist
Dept of Clinical Psychology
Royal Holloway, University of London
Egham
Surrey TW20 0EX

West London Mental Health Trust R&D Office
Medway Lodge
K Block 1st Floor
St Bernard's Wing
Uxbridge Road
Middlesex, UB1 3EU

Tel: 020 8354 8738
Fax: 020 8354 8733
Email: rd.office@wlmht.nhs.uk

31 July 2014

Dear Mr Woodcock

Letter of access for research

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through **West London Mental Health Trust** for the purpose and on the terms and conditions set out below. This right of access commences on **31/07/2014** and ends on **23/09/2015** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to **West London Mental Health Trust** premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through **West London Mental Health Trust**, you will remain accountable to your employer **Camden & Islington NHS Foundation Trust** but you are required to follow the reasonable instructions of your nominated **research supervisor** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with **West London Mental Health Trust** policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with **West London Mental Health Trust** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take

reasonable care for the health and safety of yourself and others while on **West London Mental Health Trust** premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

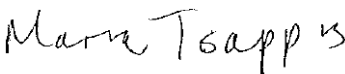
West London Mental Health Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you **MUST** stop undertaking any regulated activity immediately. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely



Maria Tsappis
Research Governance Officer

Letter of access appendix - List of projects

Study Title: Schema profiles of mentally disordered sex offenders: a comparison between adult versus child victim offenders R&D reference: CRIHW1401 (formerly WOOMW1401) REC reference: 14/EM/1401		
Study duration:	Start date: 31/07/2014	End date: 31/07/2015
Letter of access duration:	Start date: 31/07/2014	End date: 23/09/2015
<i>If any information on this document is altered after the date of issue, this document will be deemed INVALID</i>		

South West London and St. George's 
Mental Health NHS Trust

Mr Michael Woodcock
41 Mervan Road
Brixton
London
SW2 1DR

5 June 2014

Research and Development

R&D Director: Dr Robert Lawrence
c/o SECTION OF MENTAL HEALTH, PHSE
DIVISION
ST GEORGE'S, UNIVERSITY OF LONDON
CRANMER TERRACE
LONDON SW17 0RE

R&D Co-ordinator: Ms Enitan Eboda
E-mail: eeboda@sgul.ac.uk

Direct Line: 020 8725 3463
Fax: 020 8725 3538

Dear Mr Woodcock,

Research Title: Schema profiles of mentally disordered sex offenders: a comparison between adult versus child victim offenders
Principal Investigator: Mr Michael Woodcock
Project reference: PF593
Sponsor: Royal Holloway, University of London

Following various discussions your study has now been awarded research approval. Please remember to quote the above project reference number on any future correspondence relating to this study. I hereby confirm acceptance of minor amendment 1 (dated 16 May 2014) to your study, since you have gone through the correct channels to seek approval from the relevant bodies

Please note that, in addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, host site approval is subject to the following conditions:

In addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, you need to ensure the following:

- The Principal Investigator (PI) must ensure compliance with the research protocol and advise the host of any change(s) (eg. patient recruitment or funding) by following the agreed procedures for notification of amendments. Failure to comply may result in immediate withdrawal of host site approval.
- Under the terms of the Research Governance Framework, the PI is obliged to report any adverse events to the Research Office, as well as the REC, in line with the protocol and sponsor requirements. Adverse events must also be reported in accordance with the Trust Accident/Incident Reporting Procedures.
- The PI must ensure appropriate procedures are in place to action urgent safety measures.
- The PI must ensure the maintenance of a Trial Master File (TMF).

Terms and conditions of Approval, version 1.1 05/06/2014

- The PI must ensure that all named staff are compliant with the Data Protection Act, Human Tissue Act 2005, Mental Capacity Act 2005 and all other statutory guidance and legislation (where applicable).
- The PI must comply with the Trust's research auditing and monitoring processes. All investigators involved in ongoing research may be subject to a Trust audit and may be sent an interim project review form to facilitate monitoring of research activity.
- The PI must report any cases of suspected research misconduct and fraud to the Research Office.
- The PI must provide an annual report to the Research Office for all research involving NHS patients, Trust and resources. The PI must also notify the Research Office of any presentations of such research at scientific or professional meetings, or on the event of papers being published and any direct or indirect impacts on patient care. This is vital to ensure the quality and output of the research for your project and the Trust as a whole.
- Patient contact: Only trained or supervised researchers holding a Trust/NHS contract (honorary or substantive) will be allowed to make contact with patients.
- Informed consent: is obtained by the lead or trained researcher according to the requirements of the Research Ethics Committee. The original signed consent form should be kept on file. Informed consent will be monitored by the Trust at intervals and you will be required to provide relevant information.
- Closure Form: On completion of your project a closure form will be sent to you (according to the end date specified on the R & D database), which needs to be returned to the Research Office.
- All research carried out within South West London & St George's Mental Health NHS Trust must be in accordance with the principles set out in the Department of Health's Research Governance Framework for Health and Social Care 2005 (2nd edition).

Failure to comply with the conditions and regulations outlined above constitutes research misconduct and the Research Office will take appropriate action immediately.

Please note, however, that this list is by no means exhaustive and remains subject to change in response to new relevant statutory policy and guidance. If you have any queries regarding the above points please contact Enitan Eboda, R&D Co-ordinator, on 020 8725 3463 (St. George's), e-mail: eeboda@sgul.ac.uk.

Yours sincerely,



Dr Robert M. Lawrence
Research & Development Director
Chair, Research & Development Committee.

6.7 South West London and St. George's NHS Mental Health Trust Letter of Access

South West London and St George's **NHS**
Mental Health NHS Trust

Mr Michael Woodcock
41 Mervan Road
Brixton
London
SW2 1DR

5 June 2014

Research and Development

R&D Director: Dr Robert Lawrence
c/o SECTION OF MENTAL HEALTH, PHSE
DIVISION
HUNTER WING
CRANMER TERRACE
LONDON SW17 0RE

R&D Co-ordinator: Ms Enitan Eboda
E-mail: eeboda@sgul.ac.uk

Direct Line: 020 8725 3463
Fax: 020 8725 3538

Dear Mr Woodcock,

Honorary research contract issued by South West London and St George's Mental Health NHS Trust

I am pleased to provide you with a Letter of Access with South West London and St George's Mental Health NHS Trust. We will send a copy of the letter to your substantive employer.

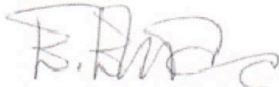
This letter will be effective immediately. Its duration is limited from 05 June 2014 to 4 July 2015. Please note that you cannot start the research until you have received a letter from us giving permission to conduct the project.

South West London and St George's Mental Health NHS Trust will not reimburse any expenses you incur unless subject to prior arrangement. Similarly, the Trust accepts no responsibility for damage to or loss of personal property, with the exception of small valuables handed to officials for safe custody.

Your Research Passport and Letter of Access may be subject to random checks carried out by NHS organisations within the lifetime of the project so accuracy of information is essential.

You are required to inform the Trust of any changes to the information provided on the Research Passport.

Yours sincerely,



Ms Enitan Eboda
Research & Development Coordinator.

6.8 Noclor Approval Letter 1 (East London NHS Foundation Trust)

noclor **NHS**
Research Support Service

Bedford House, 3rd Floor
125-133 Camden High Street
London, NW1 7JR

Tel: 020 3317 3045
Fax: 020 7685 5830/5788
www.noclor.nhs.uk

02 July 2014

Mr Michael Woodcock
Department of Psychology
Royal Holloway, University of London
Egham, Surrey
TW20 0EX

Dear Michael

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in **the trust(s) identified below**:

Study Title: Schema Profiles of Mentally Disordered Sex Offenders: A comparison between adult versus child victim offenders
R&D reference: 143914
REC reference: 14/EM/0154

This NHS Permission is based on the REC favourable opinion given on **23 April 2014** and the most recent amendment submitted to REC on 16 May 2014

Name of the trust	Name of current PI/LC	Date of permission issue(d)
East London NHS Foundation Trust	Dr Bradley Mann	02 July 2014

If any information on this document is altered after the date of issue, this document will be deemed INVALID

Yours sincerely,



Pushpsen Joshi
Research Operations Manager

Cc: Dr Bradley Mann, Local Collaborator
Dr Andy MacLeod, Sponsor Contact

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

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Serious Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Research Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Research Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Research Ethics Committee and R&D Office as soon as possible.
- **Monthly / Annually Progress report:** you are required to provide us and the Research Ethics Committee with a progress report and end of project report as part of the research governance guidance.
- **Recruitment data:** if your study is a portfolio study, you are required to upload the recruitment data on a monthly basis in the website:
http://www.crncc.nihr.ac.uk/about_us/processes/portfolio/p_recruitment/
- **Amendments:** if your study requires an amendment, you will need to contact the Research Ethics Committee. Once they have responded, and confirmed what kind of amendment it will be defined as, please contact the R&D office and we will arrange R&D approval for the amendment.
- **Audits:** each year, noclor select 10% of the studies from each service we have approved to be audited. You will be contacted by the R&D office if your study is selected for audit. A member of the governance team will request you complete an audit monitoring form before arranging a meeting to discuss your study.

6.9 Noclор Approval Letter 2 (Barnet, Enfield and Haringey NHS Foundation Trust)



1st Floor, Bloomsbury Building
St Pancras Hospital
4 St Pancras Way
NW1 0PE

Tel: 020 3317 3045
Fax: 020 7685 5830/5788
www.noclор.nhs.uk

16 December 2014

Michael Woodcock
Camden and Islington NHS Foundation Trust
Dept of Clinical Psychology
Royal Holloway, University of London
Egham, Surrey
TW20 0EX

Dear Michael,

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in **the trust(s) identified below**:

Study Title: Schema Profiles of Mentally Disordered Sex Offenders: A comparison between adult versus child victim offenders
R&D reference: 143914
REC reference: 14/EM/0154

This NHS Permission is based on the REC favourable opinion given on **23 April 2014** and the most recent amendment submitted to REC on 16 May 2014

Name of the trust	Name of current PI/LC	Date of permission issue(d)
Barnet Enfield & Haringey NHS Mental Health Trust	Dr Clare Conway	16 December 2014

If any information on this document is altered after the date of issue, this document will be deemed INVALID

Yours sincerely,

Pushpsen Joshi
Research Operations Manager

Cc: Dr Clare Conway, Local Collaborator
Annette Lock, Sponsor Contact
Judith Germuska, Barnet Enfield & Haringey NHS Mental Health Trust R&D Office Contact

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

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Serious Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Research Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Research Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Research Ethics Committee and R&D Office as soon as possible.
- **Monthly / Annually Progress report:** you are required to provide us and the Research Ethics Committee with a progress report and end of project report as part of the research governance guidance.
- **Recruitment data:** if your study is a portfolio study, you are required to upload the recruitment data on a monthly basis in the website:
http://www.crnc.nihr.ac.uk/about_us/processes/portfolio/p_recruitment/
- **Amendments:** if your study requires an amendment, you will need to contact the Research Ethics Committee. Once they have responded, and confirmed what kind of amendment it will be defined as, please contact the R&D office and we will arrange R&D approval for the amendment.
- **Audits:** each year, noclor select 10% of the studies from each service we have approved to be audited. You will be contacted by the R&D office if your study is selected for audit. A member of the governance team will request you complete an audit monitoring form before arranging a meeting to discuss your study.

6.10 Royal Holloway, University of London Ethics Approval Letter (email)

2014/054 Ethics Form Approved

Psychology-Webmaster@rhul.ac.uk

Thu 15/05/2014 16:25

To:

nxjt017@rhul.ac.uk;

Fox, Simone;

Cc:

PSY-EthicsAdmin@rhul.ac.uk;

Leman, Patrick;

Lock, Annette;

umjt001@rhul.ac.uk;

Application Details: View the form click [here](#) Revise the form click [here](#)

Applicant Name: **Michael Woodcock**

Application title: **Schema Profiles of Mentally Disordered Sex Offenders**



[NHS Trust logo]

Dr [Insert RC's Name]

[Insert RC's Occupation]

Dear Dr [Insert RC's Name],

Re: Major Research Project – Schema profiles of mentally disorders sex offenders.

RESPONSIBLE CLINICAN INFORMATION SHEET

I am a Trainee Clinical Psychologist studying at Royal Holloway, University of London. As part of my training I am required to complete a Major Research Project for which I am interested in exploring schema profiles of mentally disordered sexual offenders.

The investigation and treatment of sexual offenders has typically focused upon cognitive distortions, defined as a belief system which supports sexual offending, including justifications, judgements and rationalisations (Abel et al, 1984). Whilst a number of researchers have investigated the content and role of cognitive distortions in sexual offending, few have looked at the mechanisms through which they are generated. Ward (2000) argues that cognitive distortions may be the product of underlying schema, termed "*implicit theories*". If this is the case, it may be more effective to focus treatment at an offender's underlying schemas rather than cognitive distortions.

There are different types of schemas within the psychology literature. Young identified 18 dysfunctional, broad and pervasive themes that characterise the individual and their relationship with others. These were labelled Early Maladaptive Schemas (EMSs) (Young, 1990). Offending schemas were developed as EMSs were not descriptive or specific enough to capture and explain offending behaviour (Ward, 2000). These reflect the underlying structures that attempt to explain the situations in which people commit such societal norm-breaking behaviours. A number of researchers have contributed to the offending

schema field, resulting in a less unified collection as that of the EMSs. The presence of both EMSs and offending schemas have been identified within sex offenders who do not have a mental health diagnosis (non-MDSO) (Richardson, 2005; Milner & Webster, 2005).

The investigation of schemas in sexual offenders is arguably still in its infancy and the investigation of sexual offending amongst men with severe mental illness generally, has been even more neglected. There appears to have been an unsupported assumption that sexual offending in men with severe mental illness arises primarily as a result of their mental state. This large gap in the literature highlights the importance of investigating sexually offending in men with severe mental illness, and in developing appropriate treatments.

This study will therefore aim to add to the small literature available that investigates the schemas of sexual offenders with mental illness. The study will explore whether there are specific schema profiles dependent on a number of variables of the sex offender, such as type of offence, relationship to the victim and primary diagnosed mental illness. The study has been reviewed and received a favourable opinion from the East Midlands Research and Ethics Committee and [insert specific trust] R&D.

Following the receipt of consent, participants will be asked to complete a short interview to collect demographic and offence related information, which will later be corroborated through a file review. Participants will then be asked to complete the Young Schema Questionnaire – Short Form (YSQ-S3; Young & Brown, 2003) which is a 75 item self-report measure designed to assess Early Maladaptive Schemas, using a 6 point Likert scale. Subsequently the 'My Life' version 2 questionnaire (Mann & Hollin, 2010) which examines the presence of offending schemas. In total the assessments will take approximately 1.5 hours to complete. As an incentive to take part participants will be given £10 to compensate for the time they give.

Please note that all information collected as part of the research protocol will be kept confidential and held purely for research purposes. However should information be disclosed which suggests a risk, either to the participant themselves or to anyone else, this would need to be shared with yourself, after which responsibility for further investigation and proceedings will lie with the care team. Similarly it is possible that given the personal nature of some of the questions asked, participants may experience some embarrassment or distress. Every effort will be made to minimise this and participants will be informed of the nature of the assessments prior to consent. Should participants become distressed the assessment will be suspended, immediate support offered and information regarding the participant's mental and emotional state fed back to nursing staff.

I would therefore like to ask permission to invite patients under your care to take part in this study. I would be grateful if you would discuss this with the rest of your care team and identify those who may be appropriate to approach.

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> - Men aged 18 to 65 years old - Who are held under the Mental Health Act, 1983 (as amended by the 2007 Act) - Under conditions of low, medium or high security - Who have been convicted of a sexual offence (not necessarily their index offence) or have a well-documented history of sexual offending. 	<ul style="list-style-type: none"> - Active symptoms of mental illness to an extent that would distract or limit informed consent - Men whose behaviour is deemed too risky to take part in research (e.g. aggressive or inappropriate) - A learning disability (e.g. IQ below 70) - Insufficient comprehension/expression of English to understand/respond to the interviews and questionnaires

If you would be happy for any of your patients who meet the inclusion/exclusion criteria above to take part, I would be grateful if you would read and sign the consent form enclosed and list the patients' names in the table. Please return these to [Site Psychologist's Name]. I have also included a copy of the Participant Information Sheet and Participant Consent Form for your information.

If you have any questions about the study or would like further information please feel free to contact me by email at michael.woodcock.2012@live.rhul.ac.uk.

Kind Regards

Michael Woodcock

Trainee Clinical Psychologist

Royal Holloway, University of London



[NHS Trust logo]

RESPONSIBLE CLINICAN CONSENT FORM

Major Research Project – Schemas and cognitive distortions in mentally disorders sex offenders

I, _____ give consent for Michael Woodcock to approach the patients who I have identified and who consent to participate in the above research project. I give consent for Michael Woodcock to access their medical notes to obtain details relevant to the research and to test participants on weekdays, evenings and weekends as appropriate.

I have read the information sheet provided and therefore understand that after giving consent participants will be asked to complete a short interview to collect demographic and offence related information. Following this, participants will be asked to complete two questionnaires. In total this will take approximately 1 hour and 30 minutes. As an incentive to take part participants will be given £10 for their time.

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> - Men ages 18 to 65 years old - Who are held under the Mental Health Act, 1983 (as amended by the 2007 Act) - Under conditions of low, medium or high security - Who have been convicted of a sexual offense (not necessarily their index offence) or have a well-documented history of sexual offending. 	<ul style="list-style-type: none"> - Active symptoms of mental illness to an extent that would distract or limit informed consent - Men whose behaviour is deemed too risky to take part in research (e.g. aggressive or inappropriate) - A learning disability (e.g. IQ below 70) - Insufficient comprehension/expression of English to understand/respond to the interviews and questionnaires

I have reviewed the inclusion/exclusion criteria above and confirm that I am the Responsible Clinician for the following potential participants.

Patients:

Name	Ward

SIGNED _____

DATE _____

(Please return this consent form to [Insert Site Psychologists Name].)



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PARTICIPANT INFORMATION SHEET

Major Research Project – Schema profiles of mentally disordered offenders with a sexual offending history.

I would like to invite you to take part in a research project. Before you decide if you want to take part it is important that you understand what the research will involve and why it is taking place. Please take time to read the following information and feel free to ask any questions you may have.

The Study:

My name is Michael Woodcock and I am conducting a study as part of my doctorate in Clinical Psychology at Royal Holloway, University of London. The research hopes to increase our understanding of the relationship between the way people view the world, themselves and other people, and views about sex in men who have a history of sexual offending.

The research has been reviewed and given a favourable opinion by the East Midlands Research Ethics Committee which aims to ensure the research respects your rights, welfare and dignity.

Why have you been asked to take part?

A number of patients within secure units in London and the surrounding areas are being invited to participate. I am interested in talking with people who have a history of sexual offending.

What will you be asked to do?

The research involves completing two questionnaires and a brief assessment interview with Michael Woodcock. These will begin with some background questions and then move on to questions about how you view the world, yourself and other people. Some of the questions will be about your views about sex. All together this

might take up to 1 hour and 30 minutes. However you can ask for breaks or complete the assessment in more than one session. I understand that some of the questions may be quite personal and may be hard to talk about. You are free to withdraw from the research at any time and you will be offered support if participation causes any distress.

Anyone who decides to take part in the research will be given £10 in order to compensate them for their time.

Who will have access to your information?

All information will be confidential and kept only for research purposes. All questionnaires and information sheets will have your name removed and given a number instead, in order to keep them anonymous. The results may be published in a journal or presented at a conference, but this will not include any personal details and no one will know you have taken part.

However, if during the assessment interview or during the completion of the questionnaires you inform me that you are in danger or that you are putting someone else in danger, I would have to inform your Responsible Clinician. Also if you became distressed during the research I would inform nursing staff or other professionals on your care team to make sure you were given the appropriate support.

Will taking part effect your treatment?

If you decide to take part in the research this will not affect the treatment you receive in hospital. However it is hoped that the results of the study may help to improve the treatment given to men in hospital who have a history of sexual offending.

What happens if you decide not to take part?

It is your decision whether you want to take part in the research. If you decide you do not want to take part this will not affect the treatment you receive in hospital or any decisions made about your care. You can also decide to withdraw at any time during or after completing the assessment and interview. If this were to happen your data collected up to that point will still be used as it would be impossible to trace your data due to the anonymisation process that is being used.

What happens next?

If you decide that you would like to take part in the research, you will be asked to sign a consent form. The consent form will ask permission to collect some background information from your medical files as well as showing that you agree to

take part. A convenient time/s will then be arranged, to meet and complete the interview and questionnaires.

Where can you get more information?

If you would like to ask any questions or find out more information about the research, please contact one of the psychologists or [site Psychologist's name] who will ask me to get in contact with you. Alternatively, if you have been given one of these Information Sheets I will be attempting to meet up with you in the near future, so you could ask me questions then. If you have any complaints about this research project then please raise these with me or speak to your Responsible Clinician who will get in touch with me.

Thank you for reading this information and for considering taking part in the research.

Michael Woodcock

Trainee Clinical Psychologist

Royal Holloway, University of London



[NHS Trust logo]

Participant Consent Form

Major Research Project: Schema profiles of mentally disordered offenders with a sexual offending history

Researcher: Michael Woodcock, Trainee Clinical Psychologist

Please initial box

- 1) I confirm that I have read and understand the information sheet for the above research and have had an opportunity to consider the information and ask questions I may have.
- 2) I understand that it is my decision to take part and that I can withdraw at any time, without this affecting the treatment I receive in hospital or any decisions regarding my care.
- 3) I give permission for Michael Woodcock to access my medical records to gather some background information relevant to the research project.
- 4) I understand that my data and relevant information from my medical notes may be looked at by the researcher and other individuals employed by Royal Holloway University of London and the NHS as relevant to the research. I give permission for these individuals to have access to my data.
- 5) I understand that my Responsible Clinician will be informed that I am taking part in this research project.
- 6) I understand that if I disclose any information regarding my own safety or the safety of others to the researcher, then this will have to be passed onto my Responsible Clinician
- 7) I agree to take part in this research project.

NB This consent form will be kept separately to your responses

Name of Participant:

Signature:

Date:

Researcher:

Signature:

Date:



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DEBRIEF SHEET

Major Research Project – Schema profiles of mentally disordered offenders with a history of sexual offending.

I would like to thank you for your participation in this study.

Purpose of the study

The purpose of this study is to explore the way in which people with a history of sexual offending view the world, themselves and others around them. This is important as it helps clinicians in starting to understand why people may commit such offences and will hopefully guide treatment in a more effective way to help these individuals.

Procedure

The process of the study included asking a number of men who have a history of sexual offending to complete two questionnaires, as well as have a brief discussion with the researcher about their offence(s) and other potentially important factors such as diagnosed mental illness or treatment that you may have already gone through. The results of the questionnaires were then reviewed and analysed. The scores were compared between those who have a history of sexual offending against children to those against adults.

Support

I understand that the topics covered within the questionnaires are of a sensitive nature. If you were upset or distressed after taking part in this study then please speak to your Responsible Clinician, who will be aware that you have taken part. If you would like to make a complaint about the study or how it was conducted, then

please also pass this onto your Responsible Clinician who will then forward this onto me if required.

Further Information

If you have any questions about the study or you would like to have a copy of the results, please contact your Responsible Clinician, or a member of the Psychology department, who will then get in touch with me. I will then be able to answer any of your questions or provide you with a summary of the findings.

Thank you again for your participation in this study.

Michael Woodcock

Trainee Clinical Psychologist

Royal Holloway, University of London



[NHS Trust logo]

CONFIRMATION OF PAYMENT SHEET

Major Research Project – Schema profiles of mentally disordered offenders with a history of sexual offending.

This is a sheet to confirm that you have received payment for taking part in the above study.

I confirm that Michael Woodcock (Trainee Clinical Psychologist) has given me, _____, the £10 that was agreed for taking part in the study. This has been witnessed by _____ (name), _____ (role). This will be kept by the nursing staff until I am able to/want to use it for myself.

Please sign below:

Date:

Participant:

Witness:

Researcher:

Michael Woodcock

Trainee Clinical Psychologist

Royal Holloway, University of London

6.17 Young Schema Questionnaire – Short Form version 3 (YSQ-S3; Young, 2005)

Not included due to copyright restrictions

My Life (Version 2)

Instructions

Please read the statements below. Each statement represents a belief about life, or is a statement about an experience that some people have had in their life. For each statement, please circle the number on the scale provided, to show how similar this statement is to your own views about life or the experiences you have had.

1. When others treat me badly, they deserve some sort of punishment.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

2. When I've done bad things it's because I've been shutting out the problems of the past.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

3. I would like to show people that I am more powerful than they think.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

4. Other people don't understand my feelings about life.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

5. I would like to be famous

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

6. When people don't respect me I feel a need to show them they're wrong.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

7. I've had more pain and loss in my life than most people.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

8. I like it when people do what I want them to do.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

9. In my life, I've often needed to talk about my problems but I've not had the opportunity.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

10. People who threaten me need to be shown that they can't get away with it.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

11. Violence is sometimes the only way to sort everything out.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

12. I haven't had what I deserve in life.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

13. I've had no help in life.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

14. I have felt powerless in much of my life.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

15. Any bad things I've done are usually because of the things that have happened to me in my life.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

16. I wish I got the last word more.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

17. People have often tried to cheat me in my life.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

18. There are people in life that I want to get back at.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

19. Sometimes I've done bad things because of my emotional problems.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

20. I can change people's minds.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

21. I have problems because of the things that have happened to me in my life.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

22. Bad things always happen to me.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

23. Sometimes I feel detached from myself in life, as if I'm not in control.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

24. I want to look tough in the eyes of others.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

25. Some people that I have hurt deserved it.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

26. I don't like to take no for an answer in life.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

27. When I want sex, I feel I should be able to have it.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

28. Women are mainly responsible for the hurt that I feel in my life.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

29. I would like to be a hero.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

30. It's a change when I get what I want in life.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

31. People in my life have made me feel inadequate.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

32. When I get angry I want to get back at people.

5	4	3	2	1
Very like me	Quite like me	Neither like nor unlike me	Quite unlike me	Very unlike me

6.19 Semi-structured interview skeleton schedule

Date	
Patient number	
Date of birth / Age	
Ethnicity	
Relationship status	
Current security level	
Length of time of current stay	
Previous admissions (hospital) and length. Time spent in prison	
Diagnosis/es	
Offence(s) (type, number of sexual offences, when they occurred etc.)	
Victim (age, gender, relationship to participant etc.)	
Previous convictions (sexual and non-sexual)	
Psychological treatment received (current or previous, individual or group etc.)	

6.20 Skew and Kurtosis table for YSQ-S3 for the whole sample and sub-groups

Early Maladaptive Schema	z-skew; z-kurtosis				
	Total sample n=29	Offence against adults n=21	Offence against children n=8 ⁺	Victims were strangers n=18	Victims were known n=11
Abandonment/ Instability	2.53; 1.35	2.28; 1.29	0.90; -0.96	2.95*; 1.62	-0.18; -0.68
Mistrust/Abuse	0.76; -0.93	0.49; -0.74	1.11; -0.59	0.55; -0.9	0.23; -0.98
Emotional deprivation	1.33; 0.75	0.82; 0.42	-0.25; -0.77	0.68; 0.15	-0.03; -0.8
Defectiveness/ Shame	2.32; 1.09	1.59; 0.46	-0.5; -0.82	2.12; 1.3	1; -1.13
Social Isolation/ Alienation	0.85; -1	0.53; -0.96	0.65; -1.03	0.25; -0.89	1.45; 0.57
<i>Disconnection & Rejection Domain</i>	1.05; -0.87	0.57; -0.86	0.79; -1.14	0.64; -0.93	0.4; -0.91
Incompetence/ Dependence	1.03; -1.07	1.51; 0.29	-0.06; -1.29	-0.11; -1.22	-0.07; 0.39
Vulnerability to harm/illness	3.14*; 1.45	2.80*; 1.19	-0.29; -0.98	2.17; 1.11	2.89*; 1.77
Enmeshment	3.10*; 1.25	2.59*; 1.04	1.84; 1.32	2.54; 0.98	1.12; -0.72
Failure to achieve	2.60*; 1.31	2.09; 1.03	0.76; 0.36	2.13; 1.06	1.08; -0.16
<i>Impaired Autonomy & Performance Domain</i>	1.67; 0.32	1.44; -0.17	0.44; -0.88	1.07; -0.54	0.74; -0.93
Entitlement/ Grandiosity	1.20; -0.93	0.78; -0.99	0.85; -0.6	0.5; -0.98	1.25; -0.35
Insufficient self- Control/Discipline	1.01; -0.63	0.65; -0.79	0.14; -0.55	0.56; -0.4	1.59; 1.03

<i>Impaired Limits Domain</i>	1.11; -0.83	0.46; -0.94	1.46; 1.32	0.55; -0.88	1.54; 1.06
Subjugation	0.02; -1.09	0.58; -1.06	-2.04; 1.1	-0.37; -0.88	0.58; -0.78
Self sacrifice	1.74; -0.71	1.41; -0.96	-0.33; -1.14	1.96; -0.15	0.52; -0.41
Admiration/ Recognition- seeking	0.97; -0.97	0.59; -1.09	0.63; -0.71	0.69; -0.84	1.37; -0.52
<i>Other Directedness Domain</i>	0.61; -0.33	1.18; -0.57	-2.74*; 1.82	0.1; 0.73	1.2; 0.59
Pessimism/Worry	2.12; 1.42	2.88*; 1.78	-1.4; 1.1	1.13; 1.26	0.12; -0.74
Emotional Inhibition	1.52; -0.86	0.84; -1.08	0.58; -0.32	0.5; -1.14	0.76; 0.7
Unrelenting Standards	1.57; 0.19	1.07; -0.76	-0.82; -0.65	0.86; 0.18	1.97; 1.26
Self-Punitiveness	2.12; 0.96	2.45; 1.43	0.42; -0.4	1.78; 0.72	0.73; -0.75
<i>Over-Vigilance & Inhibition Domain</i>	1.43; 0.68	1.41; 0.31	-0.86; 0.82	0.64; 0.42	0.42; 0.48

+ = This group contained those who offended solely against children, and those who offended against both adults and children

* = Not normally distributed ($z > 2.58$).

6.21 Skew and Kurtosis table for My Life questionnaire for the whole sample and sub-groups

My Life Schema	z-skew; z-kurtosis				
	Total sample n=29	Offence against adults n=21	Offence against children n=8 ⁺	Victims were strangers n=18	Victims were known n=11
Disadvantaged	0.4; -0.29	-0.11; -0.46	-0.26; 0.85	0.16; -0.39	-0.08; -0.63
Dominance	0.51; -0.61	1.12; -0.47	-0.33; -0.51	-0.11; -0.56	0.09; -0.74

+ = This group contained those who offended solely against children, and those who offended against both adults and children.