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Attributions and Paranoid Delusions

With Research Portfolio Part I

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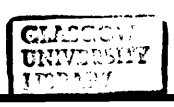

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Attributions and paranoid delusions: a review.

The following review considers the contribution of psychological research to the understanding of delusions. In particular, the paper focuses on the cognitive processes involved in the formation and maintenance of delusional beliefs. Indeed there is growing evidence that persecutory delusions are characterised by a particular cognitive set whereby negative events are externally attributed to factors other than self. The theoretical and clinical implications of these findings will be discussed with reference to the need for further research and investigation.

Traditional psychiatric approaches to the study of psychosis are based on the classification of syndromes through identifying the characteristic presentations of patterns of symptoms in psychotic disorders. However, in recent years the development of cognitive approaches to psychosis has enabled researchers to study the individual symptoms using cognitive models. Persons (1986) has highlighted several benefits of symptom-focused studies, one of which is the advance of theoretical understanding. As practitioners aim to use theoretical understanding as the basis for treatment approaches, its advance ought also to inform and enhance treatment. A second benefit suggested by Persons, is the recognition that clinical phenomena and normal phenomena can be viewed as existing on a continuum, rather than as two dichotomous categories. In the case of delusions, authors have debated for some time on this issue. Some argue that delusions are abnormal beliefs isolated entirely from reality and normal beliefs (for example, Jaspers, 1913, 1963 and Berrios, 1991). Others maintain that delusions are one dimension on a 'belief continuum' (for example, Strauss, 1969, 1991 and Spitzer, 1990), which potentially includes 'questionable beliefs', 'ingenious beliefs', 'religious phantasy' and delusions (Spitzer, 1990, p386). The latter argument has highlighted the importance of understanding the cognitive components that normal and delusional thinking might share. Kaney and Bentall advise that "...paranoid

thinking may be marked by particular cognitive characteristics which merit further investigation from the standpoint of psychological theories of normal belief acquisition" (1989, p197).

The following review firstly considers some of the conceptual issues surrounding delusions as a symptom of psychosis. Secondly, the contribution of attribution theory to the understanding of psychopathology is outlined and empirical studies of attribution in persecutory delusions are reviewed. Following this, depression and view of self in relation to paranoia are discussed. Finally, cognitive theories of delusions are outlined and possibilities for further study are suggested.

The concept of delusions

In a review of the conceptual history of delusions, Berrios (1991) states that the 'received view' of delusions has it roots in the 17th century with the work of Hobbes (1651, republished 1968) and Locke (1690, republished 1959), at a time when insanity and delusions were thought to be equivalent. In other words, having delusions meant being insane and being insane meant having delusions. Hobbes and Locke sought to explain why delusions contained wrong or bizarre content about self and world, given that all knowledge was based on experience. Berrios concludes from these authors that "the model inherited by the 19th century" includes the view that "delusions resulted from failures (caused by physical reasons) in the apparatus that served to acquire experiences. The system designed to process information was in order" (1991, p7). It was thought that brain lesions resulted in perceptual disturbances, which were experienced as hallucinations or delusions. This demonstrated a failure of the mechanisms that assist in acquiring experience. It was also thought to be true that the deluded person's capacity to reason was intact, indicating that they were able to process information efficiently. What followed in the 19th century argues Berrios, served to 'crystallise' the view of

delusions as 'wrong beliefs', in particular, the conceptual separation of knowledge and belief. Knowledge became indicative of scientific certainty and belief referred to subjective mental attitude. Therefore delusions could no longer be considered a form of knowledge since they contained no scientific content, but were redefined as conceptions or beliefs. Berrios, however reports as 'useless', the defining of delusions as beliefs, because individuals with delusions do not consider any hypotheses alternative to their delusion. This implies that search for alternative hypotheses features in other types of beliefs. However, several studies have shown that normal subjects will ignore or fail to critically scrutinise contradictory alternatives, but will readily accept evidence confirming their belief (e.g.: Wason & Johnson-Laird, 1972 and Lord, Lepper & Ross, 1979). Further, on the basis that the content of a delusion lacks information about the individual or his world, Berrios states that "delusions are likely to be empty speech acts... (and) are not the symbolic expression of anything" (1991, p12).

The distinction between knowledge and beliefs is interesting in the light of Cox and Cowling's (1989) investigation of beliefs in unscientific phenomena. 60,000 British adults were surveyed and it was found that 68% experience a belief in God, more than 50% in thought transference, more than 50% in fortune telling, more than 25% in ghosts and between ten and twenty five percent report beliefs in either reincarnation, horoscopes, devil or black magic. Stevenson (1983) also found that 10% of the population report extra-sensory experiences and 27% report experiencing paranormal communication.

In the early 20th century, the influential view of delusions is largely attributed to Jaspers (1913, 1963), who described delusions as having specific notable characteristics. In summary, Jaspers considered that delusions are held with certainty of conviction, are maintained despite contradictory evidence, have

impossible content and are based on a changed awareness of reality. (Jasper's account is reviewed in detail by Garety and Hemsley, 1994). The extent of Jasper's influence is observed in the continued use of his distinction between primary and secondary delusions. Primary delusions being those generated by their own aetiology and secondary delusions being the result of other anomalous experiences such as hallucinations.

The concepts proposed by authors such as Jaspers and Berrios are thought by some to have been a hindrance in the progress of our understanding of delusions. Bentall and Kinderman (1998) apportion blame to the 'prejudice' of traditional psychiatric explanations, for the lack of systematic psychological research into delusions. Jasper's concepts are criticised for having no empirical foundations (Garety & Hemsley, 1994); indeed evidence opposing Jasper's view is now emerging. Psychological interventions with delusional beliefs that consider contradictory evidence for the basis of the belief, show some degree of efficacy in shifting delusional conviction over time (e.g.: Kingdon & Turkington, 1994 and Chadwick & Lowe, 1990). Further, Berrios' statement that delusions are symbolic of nothing has been criticised on the basis that delusional content often reflects meaningful issues such as existential and social concerns (for example, Bentall, 1994 and Musalek, Berner & Katschnig, 1989).

In the light of this glimpse into history, it is interesting to observe how the 20th century psychological approach to delusions essentially turns the original idea of Hobbes and Locke on its head. Far from assuming 'the system designed to process information is in order', modern researchers have focussed their efforts on identifying potential information-processing anomalies associated with delusions. For example, Green and Neuchterlein (1994) found that individuals with schizophrenia have difficulties processing information from the iconic store. In

studies of probability testing, Hemsley & Garety (1986) observed reasoning deficits, which they argue are due to an inability to successfully use 'probabilistic information' in reality testing. Further, studies of attributional inference indicate an external bias for negative events and experiences (for example, Kaney & Bentall, 1989 and Bentall, Kaney & Dewey, 1991).

The changing view of delusions is reflected in modern definitions. Garety and Hemsley have drawn attention to the inadequacy of standard psychiatric definitions for delusions and suggest a more useful view is that delusions are one dimension of a belief continuum reflecting features such as belief strength and preoccupation (1994, p17).

The Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM IV) states that delusions are "erroneous beliefs that usually involve a misinterpretation of perceptions or experiences" (American Psychiatric Association, 1994, p275). The use of the term 'erroneous' is reflective of the historical and traditional psychiatric notion of delusions as 'wrong beliefs'. However, the statement 'misinterpretation of perceptions...' suggests a recognition that individuals may have information-processing difficulties associated with their delusion. DSM IV further acknowledges the difficulty of distinguishing between a delusion and a strongly held idea and suggests that the degree of conviction in the belief despite contradictory evidence is a useful measurement. The definition perhaps represents an attempt to accommodate the modern psychological approach to delusions and is viewed as a move forward from previous definitions.

Hints from 'normal' psychology: belief formation and attribution theory

Perhaps to understand what is viewed as pathological, it is necessary to return to what is known about the 'normal'. Hemsley and Garety (1986) considered the

formation of normal beliefs in an effort to understand delusional beliefs. They suggest that information processing in subjects with delusions will deviate from normality in that probability judgements are inefficient or dysfunctional. The authors differentiate the formation of beliefs from factors that maintain beliefs.

Belief formation

Frith (1979) has suggested that the initial formation of delusions may be attributed to unusual perceptual experiences, which were previously screened out of conscious awareness, but are now prominent in the individual's conscious processing. Essentially, this means that the experience is 'abnormal', but the belief is 'normal'. As Frith states, "delusions can be seen essentially as attempts to explain and understand, using entirely normal principles of reasoning and experience" the misperceptions which arise from heightened awareness (1979, p230). Stated more simply, Maher (1974) suggests that delusions are often rational explanations for abnormal experiences. Maher and Ross (1984) suggest that delusions develop secondary to anomalous experiences such as perceptual abnormalities. This conforms to the Jasperian notion of secondary delusions (Jaspers, 1913). Hemsley and Garety suggest that hallucinations may feature in the formation of delusions in that they "are data, often distressing and uncontrollable, for which an explanation must be found" (1986, p54). The individual experiencing hallucinations will infer a real source for their experience and this inference gives rise to a delusional belief.

Garety and Hemsley later describe an elaborate multi-factorial model of delusion formation stating that "delusions are clearly complex phenomena, and it is likely that a number of factors contribute to their formation and maintenance" (1994, p129). The model begins with the individual's *prior expectations*, based on past learning, affective state, cognition and personality. These expectations interact

with *current information,* which is assessed on a number of dimensions (for example, clear-ambiguous, common-unusual). If this new information or experience is rated, for instance, as common, external and neutral, it is *ignored.* Potentially an individual will search for confirmatory experience at this stage. Otherwise the perceptual and inferential *information processing style* will lead to a judgement and *belief* about the experience or event. Failure to utilise learning from past regularities leads to a mismatch between expectations and actual experience and causes *high arousal,* which in turn may exacerbate information processing biases. *Reinforcement* of the belief occurs as a function of affect reduction such as anxiety or depression. There are several stages of processing in the model, each reciprocal to preceding or subsequent stages in the formation of delusional beliefs. *(Original terminology in italics.)*

Belief maintenance

Hemsley and Garety (1986) suggest that the maintenance of delusions may be subject to the same processes that maintain normal beliefs. For example, the strength of a belief and its resistance to change may be similar in both delusional and normal belief systems. In this respect the authors turn to the conceptualisation of Fischhoff and Beyth-Marom (1983) on the evaluation of evidence relating to beliefs. Based on Bayes' theorem that the probability of knowledge, represented as hypotheses, is true, a belief conviction may change on the basis of new information. Derived from this, Fischhoff and Beyth-Marom have suggested several possible stages of hypothesis testing which may be faulty for the person with delusions. These stages include hypothesis formulation, assessment of prior odds, information search and acting on the belief. With hypothesis formulation, difficulties arise when the individual either fails to formulate a hypothesis or the hypothesis is not testable. Hemsley and Garety point out that patients frequently present with un-testable delusions such as prediction of future events. In the

assessment of prior odds, the possibilities of competing hypotheses are frequently not considered. The authors demonstrate this by noting that "deluded patients frequently tell interviewers that they have never considered the possibility of the falseness of their beliefs" (1986, p53). In terms of search for information, it is thought that patients will either fail to search or will search for only confirmatory evidence. The action output based on a belief appears to be consistent with that of action on normal beliefs. Invariably, acting on a belief is done with similar caution as found in normal subjects. The authors observe that for individuals with delusional beliefs a "striking feature is their remarkable lack of action congruent with apparently sincerely held beliefs" (1986, p54). However, this may also be attributable to patients perceived lack of control and sense of helplessness given the distress of their situation.

Hemsley and Garety concluded that a possible cause of delusions is an inability to efficiently test hypotheses with probabilistic reasoning. In a later study, these authors demonstrated such a deficit when patients with delusions failed to evaluate hypothesis when given probabilistic information (Huq, Garety & Hemsley, 1988). Bentall and Young (1996) suggest that underlying this deficit of probabilistic reasoning is a failure to integrate information over a time period, given that patients demonstrate normal reasoning when asked to 'academically' test hypotheses.

Further insight from normal psychology comes in the form of attributional inference in belief systems. Attribution theorists (e.g.: Heider, 1958; Kelley and Michela, 1980 and Hewstone, 1989) propose that individuals desire to explain the experiences and events which happen to them, based on a need to exercise control over their world. In attempting to make sense of the world as they experience it, individuals will assign a cause to an event which is either internal - from within and due to themselves, or external - from outwith themselves and due to other

people or circumstances. This is referred to as the internality of an attribution. An attribution can also be stable – likely to be present in the future, and global – influential in many areas of the individual's life.

Abramson, Seligman and Teasdale (1978) used the theory of social attribution as the basis for their 'learned helplessness' model of depression. This model proposes that depression is maintained by the tendency of depressed individuals to make excessively internal, global and stable attributions for negative events. In other words, a depressed individual will tend to blame themselves for negative events and experiences, and this attribution is enduring over time and across situations, thus perpetuating the depression and sense of hopelessness. Studies of attribution in depression have focussed on the globality and stability dimensions of attributional inference as predictors of depression. However, in studies of delusions, investigators have concentrated on the internality dimension of attributional inference.

Studies of attribution in individuals with persecutory delusions

Most of the systematic investigation into attributions and delusions has been reported by Bentall and his colleagues (Kaney & Bentall, 1989; Bentall, Kaney & Dewey, 1991; Kinderman, Kaney, Morley and Bentall, 1992; Young & Bentall, 1995; Bentall & Young, 1996). These authors have concentrated on comparing deluded patients, depressed patients and non-patient controls on measurements of social attribution.

Kaney and Bentall (1989) proposed that delusions, like depression, would have their own particular attributional style. From their clinical work, the authors had noted that the content of patients' delusions often reflected concerns about their social position and the behaviour of others towards them. Based on social

attribution theory (Hewstone, 1985) the authors predicted that patients with persecutory delusions would make external, global and stable attributions for negative events. The three groups (deluded, depressed and normal) were matched for age and gender. Deluded and depressed groups were matched for depression. Social attribution was assessed using the Attributional Style Questionnaire (Peterson, Semmel, von Baeyer et al, 1982). This questionnaire asks participants to state a possible cause for six negative events and six positive events. Subjects then rate the cause for the degree to which they believe it is (a) due to themselves or others (internality), (b) likely to be present in the future (stability) and (c) likely to affect other areas of their lives (globality). From the results, the authors suggest that individuals suffering from persecutory delusions "made excessively external attributions for negative events and internal attributions for positive events" (p191). Levels of depression were similar in both deluded and depressed groups, however deluded subjects showed an attributional bias, suggesting that this is specific to persecutory delusions and not depression.

A further study by Bentall, Kaney and Dewey (1991) investigated social reasoning of patients with persecutory delusions. The authors asked two questions: Do deluded individuals make abnormal attributions? And are they able to make use of the same information as nondeluded individuals? The results indicated that deluded subjects excessively attributed negative events to person, rather that circumstance or stimulus. This bias was also present in depressed subjects but to a lesser degree. Deluded subjects were also excessively certain about those ratings compared with depressed subjects. In other words, when something bad happens, they are likely to blame others and do so with extreme certainty. Despite this, they do appear to utilise the same information for their decisions as depressed and normal subjects. However, deluded subjects continued to attribute negative events to person despite poverty of information. They also attributed significantly more to

person for negative events than for positive events. From their findings the authors suggests that persecutory delusions may serve a protective function, but not necessarily against depression as has previously been argued (Zigler & Glick, 1988). They suggest that "persecutory delusions share some of the cognitive features of other psychotic symptoms such as hallucinations while at the same time being also related to depressive mental states" (p22). The external self-serving bias represents a form of self-deception with the function of preventing the individual becoming aware of their negative self-referent attitudes.

Kinderman, Kaney, Morley and Bentall (1992) report their observations of differences between deluded, depressed and normal subjects on internality ratings for self-attributions. Subjects suffering from persecutory delusions showed an 'exaggerated self-serving bias' on internality ratings for their own attributions in relation to hypothetical positive and negative events. These findings may reflect differences in the way deluded subjects make attributions about their own attributions. In other words, the causal attributions of individuals with persecutory delusions are similar to those of normal subjects, but the difference is in the evaluation of the attribution. Deluded subjects evaluate internal attributions for negative events as external. The authors suggest that "persecutory delusions reflect exaggerations of those cognitive biases found in ordinary subjects which normally have the function of protecting the individual from chronic feelings of low self-esteem" (p381).

Huq, Garety and Hemsley (1988) found that deluded subjects were over-confident regarding judgements made with less information than normal and psychiatric comparison groups. Based on these findings, Young and Bentall (1995) predicted that deluded subjects would show differences on focussing on a hypothesis and would respond differently to feedback. The results showed that deluded subjects

generated as many hypotheses as did depressed and normal subjects. However, they were less likely to adhere to their hypothesis when given positive feedback, but more likely to focus on their hypothesis with negative feedback. A subsequent study by Bentall and Young (1996) replicated these findings and the authors conclude that the difficulty for deluded subjects is not generating or knowing how to test hypotheses, but rather the accumulation of relevant information over a period of time to assist with hypothesis testing.

Depression, view of self and persecutory delusions

Kinderman (1994) used an emotional Stroop task to show that people with persecutory delusions have a specific attentional bias for self-referent information. Depressed subjects rated salient low self-esteem adjectives as self-descriptive. However, deluded subjects rated low self-esteem adjectives as significantly less descriptive regardless of their high salience. Kinderman suggests that "the self-serving biases... are absent when deluded patients are asked to make implicit rather than explicit judgements of causality. These observations would imply... a fragile self-concept and consequent abnormalities in the processing of information related to the self" (1994, p54). Bentall, Kinderman and Kaney (1994) found results demonstrating the absence of the self-serving bias using implicit measures to avoid activating self discrepancies. On an explicit measure of attribution, deluded subjects attributed negative events externally. However, on an implicit measure of attribution, they demonstrated an attributional bias similar to that of depressed subjects by internally attributing negative events.

In a more recent study, Kinderman and Bentall (1996) reported on self-concept and causal attributions in paranoid and depressed patients. The results indicated that paranoid individuals differed from depressed individuals in two respects. Firstly, they were highly consistent in their perceptions of self. Secondly, they showed

discrepancies between their own perceptions of self and believed parental perceptions of self. Specifically, paranoid individuals believed that their parents held more negative views of them compared with depressed individuals and nonpatient controls. The authors argue that these findings support the theory that persecutory delusions serve to maintain a positive self-concept.

Fear, Sharp and Healy (1996) investigated cognitive processing in individuals with a diagnosis of delusional disorder. They found that these individuals demonstrated a distinct attributional style of excessive external and stable attributions for negative events and internal bias for positive events, consistent with studies of persecutory delusions. However, subjects were not found to be depressed either overtly or covertly. The main symptoms of the subjects were delusions, with minimal other psychotic phenomena, suggesting that the attributional bias may be a feature associated with delusions specifically rather than psychotic presentation per se. Delusional content was varied and included grandiose delusions. The authors conclude "that delusions represent a unitary form irrespective of their content" (1996, p67).

Kinderman and Bentall (1997) found that in addition to the externalising bias, people with persecutory delusions also attribute excessively to person rather than circumstance. The bias of attributing positive events internally and negative events externally was true of non-patient controls as well as subjects with persecutory delusions. However, non-patient subjects attributed more to situation than to person.

Two cognitive models of paranoid delusions

On the basis of these findings, Bentall and his colleagues propose a cognitive model of paranoid delusions incorporating discrepancies in view of self and

attributional bias as key elements in paranoia (Bentall, Kinderman & Kaney, 1994 and Bentall & Kinderman, 1998). The model is derived from self discrepancy theory (Higgins, 1987) and takes the view that delusions have a functional significance. The function of the delusional belief is represented by a need to attribute blame for negative events to others in order to protect their self-esteem by reducing the discrepancy between ideal and actualised self. A brief outline of self discrepancy theory (SDT) sets the background for explaining Bentall's model.

Higgins (1987) proposes a theory of self that accounts for not one self-concept, but several. These are 'actual self' representing 'the person I am', 'ideal self' representing 'the person I would like to be' and 'ought self' representing 'the person I ought to be'. Higgins suggests that when events and experiences occur in a person's life, these concepts or views of self interact in a manner which causes discrepancy. There is empirical evidence to support the model in non-clinical populations. A study of students by Scott and O'Hara (1993) found that depression was associated with actual-ideal discrepancy and anxiety was associated with actual-ought discrepancies.

Bentall, Kinderman and Kaney (1994) found that paranoid individuals attend more to threats, which trigger negative actual-self representations. Thus when an individual apportions blame for bad events to others, it reduces the discrepancy between actual-self and ideal and ought self. However, it may also activate discrepancies between own self-view and others' view of self. The model is presented as a linear chain of events, beginning with a threat to the self, which activates an actual-ideal discrepancy. Resulting from this discrepancy, an external attributional biasing for negative events occurs which leads to either reduction in actual-ideal discrepancy or increased self-other discrepancy. Finally, an increased

discrepancy between self-view and other-view of self reinforces the external attributional bias.

In support of this model, Kinderman and Bentall (1997) found that individuals with persecutory delusions excessively attribute to person rather than situation. The authors suggest that "external – personal attributions for negative events increase the accessibility of actual self – actual other discrepancies" (1997, p344).

A second cognitive model of paranoid delusions is that proposed by Trower and Chadwick (1995) which expands on Bentall's model. Bentall and his colleagues have consistently identified an attributional bias whereby individuals suffering from persecutory delusions tend to externalise blame and perceive themselves as victims. In other words, the delusional belief of personal threat from others is viewed as undeserved and unjustified. Trower and Chadwick suggest that although this accounts for a percentage of individuals with paranoia, there exist a minority within this population who cannot be accounted for in Bentall's model. They have proposed a cognitive model of paranoia isolating persecutory and punishment as two distinct types of paranoia. In persecutory paranoia, individuals perceive others as bad and themselves as victims and they attribute blame to others. In punishment paranoia, individuals attribute blame to themselves, perceiving themselves as bad and others as justifiably punishing them.

Based on this model, Chadwick, Birchwood and Trower (1996) suggest an approach to assessment and treatment for these paranoid individuals. Chadwick and Trower (1996) reported a single-case study of punishment paranoia in which cognitive therapy was used to treat negative self-evaluative belief prior to challenging delusional beliefs. Conviction in the negative self-evaluative belief and in one of the delusional beliefs remained stable throughout the assessment and

weakened following the point of intervention. Simultaneously, depression became less severe. The therapeutic result was a reduction in emotional distress and behavioural disturbance previously associated with the beliefs.

Directions for further research

In summary, the re-conceptualisation of delusional phenomena as beliefs that share similar features with other beliefs has proved useful in improving the understanding of information-processing anomalies associated with delusions. From the review of studies of attributions in paranoid delusions, the following can be concluded. Individuals with persecutory delusions are prone to excessive external and personal attributional bias for negative events and experiences. This is thought to have a protective function for the individual's view of self. Levels of depression have been shown to be similar in both deluded and depressed groups, suggesting that the self-serving bias is specific to persecutory delusions and not depression. A study of individuals with delusional disorder and therefore a range of delusional content has replicated the external attributional inference for negative events suggesting that this bias is not content-specific. There is clinical, but as yet no empirical evidence suggesting that two subtypes of paranoia exist, punishment and persecutory, and that each have distinct attributional styles. An interesting question might be to determine whether there is empirical evidence of a particular cognitive style which may serve to support Trower and Chadwick's (1995) model of persecutory and punishment delusions.

Further, to date all previous studies have compared deluded subjects with depressed and non-deluded controls, therefore it is unknown whether the self-serving bias is present when delusions are remitted. Is the self-serving external attributional bias a state feature of persecutory delusions or is it a trait feature of individuals who experience persecutory delusions? This is an important issue for

the treatment of these individuals, not only for those who are currently delusional, but also for those who are prone to relapse and a return of delusional beliefs. If the attributional bias is a state feature of persecutory delusions it is potentially useful to monitor change in attributional style as a sign of relapse. Indeed, Birchwood (1995) suggests that an individual's attributions to explain emerging symptoms of early relapse will potentially accelerate or delay the onset of an acute episode. Therefore, psychological intervention for early relapse could be employed to target specific attributions responsible for the development and maintenance of persecutory delusions.

In conclusion, further study using a remitted delusional control group with a diagnosis of schizophrenia, rather than the traditional depressed and non-psychiatric comparisons would have the advantage of testing the theory with patients currently in remission as well as those who are symptomatic. This would provide the opportunity to consider whether the attributional style identified in previous research is stable and consistent over time, in the presence and absence of symptoms.

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Chapter Two

Attributions and paranoid delusions: a research proposal.

Written in accordance with Ayrshire and Arran Research and Ethics Committee submission guidelines.

Attributions and paranoid delusions: a research proposal

Application and Proposal to the Research and Ethics Committee

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1. Name and status of proposer.

Ruth Thomson, Trainee Clinical Psychologist

---

2. Address for correspondence.

Dept. Psychological Medicine,

Academic Centre,

Gartnaval Royal Hospital,

1055 Great Western Road,

Glasgow,

G12 OXH.

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3. Employing authority.

Greater Glasgow Community and Mental Health Services NHS Trust

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4. In which hospital(s) or other location will the study be undertaken?

Ayrshire and Arran Community Health Care Trust

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5. Title of project.

Attributional Style in Paranoid Delusions

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6. Has the proposed research been approved by any other committee of ethics? Give details.

The proposal has not been approved by any other ethics committee.

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7. Has the proposed or similar research been carried out in any other centre?

Attributional style in persecutory delusions has been studied systematically by Bentall and his co-researchers (mainly Liverpool). However, the particular cognitive theory in the proposed study distinguishes persecutory and punishment delusions as two distinct types of paranoid delusions. Although there is one reported single treatment case study of

punishment delusions by Chadwick (Southampton) and Trower (Birmingham) to date, there are no published systematic studies of attributional style in punishment delusions.

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8. Please give a summary of the project, including the question to be answered, the procedures to be used, the measurements to be made and how the data will be analysed.

Summary of the project

(a) Questions to be answered

The study will consider whether there are specific attributional styles evident in punishment or persecutory paranoia. It will do this by measuring the three dimensions of attribution theory - internality, stability and globality of attributions. The hypotheses are as follows: (1) On an explicit measure of attributional style individuals with persecutory delusions will demonstrate excessive external attributions for negative events in comparison to remitted and punishment paranoia groups. (2) On an explicit measure of attributional style individuals with punishment delusions will demonstrate excessive internal attributions for negative events in comparison with remitted controls. (3) On an implicit measure of attributional style no differences will be observed between persecutory, punishment and remitted groups.

(b) Procedures to be used

When a potential participant is referred, s/he will be issued with the information sheet and consent form to read and sign. If required, for the purpose of reducing anxiety or clarifying information, the principal researcher will be available to meet with participants prior to the study. Once the consents of the participant and his/her Responsible Medical Officer are obtained, the investigation will begin with a diagnostic interview (Structured Clinical Interview for DSM IV) which will last approximately an hour. At the second session, the brief Clinical Interview for Persecutory and Punishment Paranoia will be given. Following this, the subject will be asked to complete a short vocabulary test. The Pragmatic Inference Test, Attributional Style Questionnaire, Rosenberg Self esteem Questionnaire and the Hamilton Rating scale for Depression will then be administered. This session will again last about an hour. The measures used in the study are also clinical assessment tools yielding useful clinical material, such as severity of depressive symptoms or indicators of poor self-esteem. If it is agreeable to the participant, a follow-up appointment can be arranged with him/her and his/her keyworker or therapist to share such information, which may benefit the

treatment process. This means that participation in the study offers the opportunity for a psychological assessment to be available in addition to existing treatment or care.

(c) Measurements to be made

- The Structured Clinical Interview for DSM IV
- Clinical Interview for Persecutory and Punishment Paranoia
- The National Adult Reading Test
- The Hamilton Depression Scale
- The Pragmatic Inference Test
- The Attributional Style Questionnaire
- The Rosenberg Self-esteem Scale

Screening assessments

The **Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders 4th edition – Clinical Version** (First, Spitzer, Gibbon & Williams, 1997; American Psychiatric Association, 1994) is a semi-structured diagnostic interview for DSM IV Axis I diagnoses. The SCID is completed using one or more of the following sources of information: by interviewing the patient, his friends or family members, by interviewing health professionals or by examination of medical case records. It will be used as a diagnostic screening tool to ensure inclusion and exclusion criteria are adhered to. The **Clinical Interview for Persecutory and Punishment Paranoia** is a brief interview devised specifically for the present study to distinguish persecutory from punishment paranoia on the basis of the model proposed by Trower and Chadwick. The **National Adult Reading Test** (Nelson, 1982 and Nelson & Willison, 1991) is a standardised assessment of word-reading ability designed to provide an estimate of the pre-morbid intelligence of adults suspected of having intellectual deterioration. The NART will be administered to ensure that any differences between the groups on experimental variables cannot be accounted for by differences in verbal intelligence.

Research assessments

The **Hamilton Depression Scale** (Hamilton, 1960 & 1967) is a 21-item observer-rated measure of the severity of depressive symptoms. The **Pragmatic Inference Test** (Winters & Neale, 1985) is a disguised measure of attributional style which is presented as a memory test to avoid conscious response biasing. Subjects are required to listen to an audiotaped recording of twelve self-referent vignettes which have been derived from the Attributional

Style Questionnaire. The **Attributional Style Questionnaire** (Peterson, Semmel, von Bayer, Abramson, Metalsky & Seligman, 1982) will be administered as a measure of the three dimensions of attributional theory. Subjects are required to generate casual explanations for six negative and six positive hypothetical situations and rate the causes on bipolar rating scales. The **Rosenberg Self Esteem Questionnaire** (Rosenberg, 1965) is a standardised 10-item measure of global self-esteem. Subjects are required to rate the self-statements on a four-point scale.

(d) How the data will be analysed

Data will be analysed using the Statistical Package for Social Sciences (SPSS) database.

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9. Is the power of the study sufficient to answer the question that is being asked? Please indicate the calculations used for the required sample size, including any assumptions made.

A sample size of 10 in each experimental group is in line with the recommendations for carrying out appropriate analysis. Comparable studies also have similar sample sizes.

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10. What statistical tests will be applied to the results? Please give details of proposed methods.

The data yielded from the measures will consist of four main variables. A verbal intelligence score, an internality of attribution rating, a severity of depression score and a self-esteem rating. The data will be analysed using the independent t-test or Mann-Whitney test for significance between the variables.

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11. Scientific background to the study. Give a brief account of relevant research in this area with references.

Traditional psychiatric approaches to the study of psychosis have concentrated on syndromes classified by characteristic presentations of patterns of symptoms in psychotic disorders. However, in recent years the developments of cognitive approaches to psychotic disorders have enabled researchers to study individual symptoms such as hallucinations and delusions, using cognitive models. Outlined below are some of the more recent studies by Bentall and his co-researchers into the nature of delusions as a psychotic symptom. A brief description of attribution theory is given to clarify the theoretical background to the studies.

Attribution theory (e.g.: Heider, 1958; Kelley & Michela, 1980 and Hewstone, 1989) has developed from the observations of social psychologists of the way in which people explain the experiences and events which happen to them. The basic assumption of attribution theory is that people have a desire to explain and make sense of the world as they experience it. In doing so, they assign a cause to an event which is either internal (from within themselves) or external (from outwith themselves). This is referred to as the 'internality' - the extent to which the cause is internal (due to themselves) or external (due to other people or circumstances). A further dimension of the theory is the 'stability' of an attribution. This refers to the probability that the attribution will remain present in the future. And finally the 'globality' dimension indicates the degree to which a particular attribution influences other areas of the individual's life.

Abramson, Seligman and Teasdale (1978) used the theory of social attribution as the basis for their 'learned helplessness' model of depression. This model proposes that depression is maintained by the tendency of depressed individuals to make excessively internal, global and stable attributions for negative events. In other words, a depressed individual will tend to blame themselves for negative events and experiences, and this attribution is enduring over time and across situations, thus perpetuating the depression and sense of hopelessness. Studies of attribution in depression have focussed on the globality and stability dimensions of attributional inference as predictors of depression. However, in studies of delusions, investigators have concentrated on the internality dimension of attributional inference.

Kaney and Bentall (1989) report on their study of attributions in deluded and depressed patients. The groups were matched for age, gender and symptoms other than delusional beliefs. Results suggest that individuals suffering from persecutory delusions "made excessively external attributions for negative events and internal attributions for positive events" (p191). The authors suggest that paranoid thinking may be usefully investigated for cognitive characteristics similar to those evident in normal beliefs.

Bentall, Kaney and Dewey (1991) investigated social reasoning in persons with persecutory delusions. The results indicated that deluded subjects excessively attributed negative events to person, rather that circumstance or stimulus, and were excessively certain about those ratings compared with depressed subjects.

Kinderman, Kaney, Morley and Bentall (1992) report their observations of differences between deluded, depressed and normal subjects on internality ratings for self-attributions. Subjects suffering from persecutory delusions showed "an exaggerated self-serving bias" (p371) on internality ratings for their own attributions in relation to hypothetical positive and negative events. The authors suggest that these findings may reflect differences in the way deluded subjects make attributions about their own attributions.

Kinderman and Bentall (1996) reported a study of self-concept and causal attributions in paranoid and depressed patients with persecutory delusions. The results indicated that paranoid individuals differed from depressed individuals in two respects. Firstly, they were highly consistent in their perceptions of self. Secondly, they showed discrepancies between their own perceptions of self and believed parental perceptions of self. Specifically, paranoid individuals believed that their parents held more negative views of them compared with depressed individuals and non-patient controls. The authors argue that these findings support the theory that persecutory delusions serve to maintain a positive self-concept.

The above studies have identified an attributional bias whereby individuals suffering from persecutory delusions tend to externalise blame and perceive themselves as victims. Otherwise stated, the delusional belief of personal threat from others is viewed as undeserved and unjustified. Trower and Chadwick (1995), suggest that although this accounts for a percentage of individuals with paranoia, there exist a minority within this population whose delusional beliefs cannot be accounted for in Bentall's model. They have proposed a cognitive model of paranoia isolating *persecutory* and *punishment* as two distinct types of paranoia. In persecutory paranoia, individuals perceive others as bad and themselves as victims and they attribute blame to others. In punishment paranoia, individuals attribute blame to themselves, perceiving themselves as bad and others as justifiably punishing them. Based on this model, Chadwick, Birchwood and Trower (1996) suggest an approach to assessment and treatment for these paranoid individuals.

Chadwick and Trower (1996) reported a single-case study of punishment paranoia in which cognitive therapy was used to treat negative self-evaluative belief prior to challenging delusional beliefs. Conviction in the negative self-evaluative belief and in one of the delusional beliefs remained stable throughout the assessment and weakened following the point of intervention. Simultaneously, depression became less severe. The therapeutic

result was a reduction in emotional distress and behavioural disturbance previously associated with the beliefs. From the results of this treatment case study and their wider clinical experience, the authors suggest there is clinical evidence to support the model. However, it has yet to be tested empirically. The proposed study, therefore, seeks to determine whether there is empirical evidence of a particular cognitive style, which may serve to support Trower and Chadwick's (1995) model of punishment delusions (Hypothesis 2). In addition, the proposed study differs from the majority of reported studies in this field by using a remitted delusional schizophrenic control group rather than the traditional depressed and non-psychiatric comparisons. This has the advantage of testing Kinderman and Bentall's (1996) theory with patients currently in remission as well as those who are symptomatic. This enables investigation into whether the external attributional bias observed in persecutory delusions is a state feature of those delusions or a trait feature of individuals who experience persecutory paranoia (Hypotheses 1 & 3).

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12. Please state whether there are any expected benefits to patient care and if so summarise.

The results of the study will lead to an improved theoretical understanding of the cognitive processing which occurs in paranoid delusions. This in turn will aid clinicians in their assessment and treatment of individuals suffering from paranoid delusions.

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13. Please state the likely duration (a) of the project itself and (b) for individual patients.

(a) The likely duration of the project is from August 1996 - July 1997.

(b) The likely duration for individual patients is two 60 minute and one 30 minute sessions over a period of 2-3 weeks. The first is an interview session, the second session is for administering the research measures and the third is to provide feedback if desired.

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14. Please state who will have access to data and what steps will be taken to keep data confidential.

Ruth Thomson, principal investigator; Andrew Gumley, field supervisor; Paul Fleming, academic supervisor and where relevant in the interests of enhancing current treatment, the therapist or keyworker responsible for the participant. Individual data profiles will be kept in a locked filing cabinet. Data entered on the SPSS database will be unidentifiable as specific to particular individuals.

15. Please give details of how consent is to be obtained. A copy of the proposed consent form along with separate patient information sheet, written in simple non-technical language must be attached to this proposal form.

The patient will be approached initially by his therapist or main keyworker. S/he will be asked to read the information sheet and sign the consent form. Clarification of information on the patient's involvement will be given if requested.

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16. Does the research involve additional invasive procedures over and above the normal treatment of the patient? If so are there any hazards associated with the procedure?

The research involves the administration of interview procedures and questionnaires that are additional to normal clinical assessment or treatment. However, hazards associated with these procedures are unlikely. In the unlikely event of a participant becoming distressed by such procedure (for example, reporting on past traumatic experiences of illness or hospitalisation), the interview procedure will be immediately suspended and appropriate clinical/ therapeutic action taken, either by the investigator or by referral to the keyworker.

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17. Please state any potential hazards to participants arising from the research, their estimated probability and the precautions taken to meet them.

There are no known potential hazards to participants arising from the research.

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18. Please describe any procedures which may cause discomfort or distress to participants, the degree of discomfort or distress entailed and their estimated probability.

Not applicable.

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19. Who are the proposed participants in the research (and controls if appropriate) and how are they to be selected? Please give details of age, sex, numbers involved and any other relevant details.

Subjects will be male or female, with an age range of 18-65 years. Subjects in the experimental groups will have a primary diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder or delusional disorder. Subjects will be those currently receiving psychological or psychiatric treatments. Experimental group one (n=10) will

comprise of subjects with punishment delusional beliefs. Experimental group two (n=10) will comprise of subjects with persecutory delusional beliefs. The control group (n=10) will comprise of subjects with schizophrenia whose persecutory delusional beliefs are remitted. Patients will be excluded from the study if (a) they have a learning disability, (b) they are known to be currently misusing alcohol or drugs, or (c) their symptoms had a known or suspected organic aetiology.

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20. Give the names, strengths, doses and route of administration of investigational drugs to be used.

Not applicable.

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21. Are the drugs used to be subject to the terms of a product licence, a Clinical Trial Certificate or a Certificate Exemption? Is an unlicensed product registered under the DDX scheme? Which ever is applicable, please provide documentary evidence.

Not applicable.

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22. Are the drugs used given in accordance with the product license, with the agreed protocol (in the case of CTX or DDX) or with the CTC?

Not applicable.

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23. Which manufacturer is organising the trial or supplying the investigational drugs?

Not applicable.

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24. If the trial is being undertaken in general practice and involves the supply of drugs, please state the arrangements made for storing, labelling and dispensing.

Not applicable.

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25. Are questionnaires to be used? If so a copy must be attached to this application form.

Questionnaires are enclosed with this application form.

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26. How is the project to be funded?

The research will be funded by the University of Glasgow Training Course in Clinical Psychology.

27. Please state any interests, i.e.: profit, personal or departmental, financial or otherwise, relating to the study. Details of payment per patient recruited and/or any other remuneration details must be included.

There are no financial interests relating to the study.

28. Will the research have revenue consequences for the NHS? If yes, please tick. Give details of revenue consequences.

Radiology	**Biochemistry**
Pharmacy	**Microbiology**
Haematology	**Pathology**
Nursing	**Medical Records**
Other _____	

The research will have no revenue consequences for the NHS.

29. Please attach other relevant material, for instance letters to subjects (which must be in non-technical language).

A copy of all relevant material is attached.

Date of submission	**Signature of principal investigator**
_____	_____

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Chapter Two Appendices

2.1 Information for Referrers

2.2 Patient Information Sheet

2.3 Consent Form

2.4 Clinical Interview for Persecutory – Punishment Paranoia

2.5 Pragmatic Inference Test

2.6 Attributional Style Questionnaire

2.7 Rosenberg Self Esteem Questionnaire

2.8 Hamilton Depression Scale

Appendix 2.1 Information for Referrers

Attributional Style in Two Types of Paranoid Delusions

Information for Referrers

Background to the study

The current study is an investigation into the attributional style associated with two types of paranoia: persecutory and punishment. Current research suggests that these types of paranoia can be differentiated on how the individual views themselves, and therefore how they attribute positive and negative events. More specifically, persecutory paranoia appears to be based on the belief that the behaviour of others is unjustifiably persecutory; whilst in punishment paranoia the behaviour of others is viewed as justifiable. This has profound implications for the presence of secondary morbidity such as poor self-esteem and depression. Clearly these are important factors for the day to day management and treatment of these individuals.

The study seeks to investigate these factors in persecutory and punishment subtypes of paranoid delusions.

Inclusion criteria

1. Diagnosis of psychotic disorder.
2. Presence of paranoid delusions.
3. Age 18-65.

Exclusion criteria

1. Organic aetiology.
2. Learning disability.
3. Alcohol misuse.

Measures

Structured Clinical Interview for DSM IV
Clinical Interview for Persecutory – Punishment Paranoia
National Adult Reading Test
Pragmatic Inference Inference Test
Attributional Style Questionnaire
Rosenberg Self Esteem Questionnaire
Hamilton Depression Scale

Procedure

Prior to inclusion in the study, consent will be sought from the patient and their Consultant Psychiatrist. Following consent, the patient will be see on two or three occasions for assessment. If the patient wishes, a further meeting can be arranged to give feedback on the results of the assessment with the keyworker or Consultant present.

For further information please contact:
Ruth Thomson, Trainee Clinical Psychologist. 01294 274 050

Appendix 2.2 Patient Information Sheet

Patient Information Sheet

THANK YOU FOR CONSIDERING BEING A PART OF THIS STUDY

Please read the information thoughtfully before you decide to take part. If you would like clarification, please ask the person who gave you this form.

Why have I been asked to take part?

You have been asked to take part because we are keen to discover how individuals with mental health difficulties feel and think about themselves. Having this information allows us to know how we can help individuals who have mental health problems.

What does the study involve?

In order to develop more effective therapies, it is important to discover how people think and how this might affect their feelings about themselves and others. You will be asked to meet with the researcher on two or three occasions.

At the first meeting you will be asked some questions about yourself and any mental health difficulties you have. This will last for about an hour. At the second meeting you will be asked some further questions about how you usually deal with various day to day situations which involve others. Again, this meeting will last about an hour.

If you wish, we can arrange to see a third time, to give you feedback on the questionnaires. The information you give for the study may benefit your treatment. Therefore we can also arrange to have your therapist or keyworker present at the third meeting. Information will not be shared with your therapist or keyworker unless you decide that is what you wish.

Does taking part in the study involve any risks to me?

Your participation in the study will not adversely affect your treatment in any way and involves no risk to you.

What happens to the information collected about me?

The information you give will be confidential and anonymous and will be used only for the purposes of this study. The information will not be shared with anyone else.

What if I decide to take part and then change my mind?

You may withdraw from the study at any time, should you decide you no longer wish to participate.

Appendix 2.3 Consent Form

Consent Form

Patients

(a) I have read the patient information sheet and I am willing to take part in this study.

(b) I would /would not like to have feedback on the questionnaires.

(c) I would /would not like my therapist /keyworker to be present when I have feedback on the questionnaires.

Name _____

Signature _____

Date_____

Responsible Medical Officer

I have read the information for referrers and I am willing for

_____ (name of patient) to participate on the study.

Name _____

Signature _____

Date_____

Appendix 2.4 Clinical Interview for Persecutory – Punishment Paranoia

Clinical Interview for Persecutory-Punishment Paranoia

Some people that I meet are troubled by fears that others are against them or want to harm them in some way.

Have you ever experienced this?

When was this?

What was happening?

Was it specific individuals who were troubling you?

Has there ever been a time when you've been anxious?

Were there particular stresses in your life around that time?

Do you remember how your were feeling?
(e.g.: did you ever feel angry with that person/ these people?)

Did you do anything about the situation (e.g. report to the police)

Do you remember how others reacted?

More recently, when you encountered this, how did you feel about others?

How did you feel about yourself?

Summarise and ensure information is correct.

Features of "poor me" persecutory	**Features of "bad me" punishment**
Focussed (specific to certain people)	Unfocussed (global, many people)
Undeserved (self as victim)	Deserved (self as bad)
Feels righteous indignation & anger	Feels anxious and transparent
Seeks revenge and confrontation	Avoidance behaviour

Appendix 2.5 Pragmatic Inference Test

Anglicised Version of the Pragmatic Inference Test.
Presented on audiotape.

Story #1

You decide to open your own dry cleaning shop in a small but growing town near the border. Your shop will be the only one of its kind for miles around. In the first year of business the town's population doubles and your business prospers. Your advertising campaign is a big success and reactions from your customers indicate that the cleaning is of good quality. Your gross sales exceed expectations. You wonder whether it would be to your advantage to open a chain of shops, so you go to the bank and apply for a loan. As you had hoped the bank approves the loan.

Story #2

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

Story #3

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

Story #4

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

Story #5

You and a colleague decide to go out one night for a bite to eat. You wonder whether you will have a good time since your colleague is a moody person. The night starts out badly when you forget to call a taxi for both of you and you also fail to make dinner reservations. You and the colleague wait for an hour at the restaurant and there is still no table. You both decide to go elsewhere for a meal. The food and service are unsatisfying at the other place, especially for the colleague. On the trip home the colleague asks you about how you were able to receive a recent promotion from the boss and mentions that no-one else in the office has received a promotion in over two years. The questioning indicates a hostile tone.

Story #6

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

Story #7

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

Story #8

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

Story #9

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

Story #10

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

Story #11

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

Story #12

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

Questionnaire

Instructions

Please read the following questions related to the stories you just heard.

Circle the letter beside the answer you think is correct.

Story #1

1. What kind of shop do you open?

A) Hardware

B) Dry cleaning

2. In what part of the country is the town located?

A) Birmingham

B) Carlisle

3. Where is the loan obtained?

A) Finance company

B) Bank

4. What is the reason for the success of your business?

A) You are a clever business person

B) You had no competition

Story #2

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

    A) Need advice

    B) Your friend is recruiting staff

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

    A) Six weeks

    B) Six months

3. **Why do you have trouble finding work?**

    A) Poor job record

    B) Poor job market

4. **What kind of job interests you?**

    A) A big company

    B) A small company

Story #3

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

A) Your appearance is generally perceived as worthy of a compliment

B) This person needs a favour from you

2. Why do you spend money on your appearance?

A) Self pride

B) You enjoy compliments

3. Who gives you the most compliments at work?

A) Same sexed people

B) Opposite sexed people

4. On what do you spend your money?

A) Shoes

B) Hairstyle

Story #4

1. **Who comes to you for advice?**

    A) Colleague

    B) Neighbour

2. **What is the nature of the problem?**

    A) Stealing

    B) Drinking

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

    A) Male

    B) Female

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

    A) This person is the type not to ask for advice

    B) You are inexperienced in this area

Story #5

1. **Where do you and the colleague go?**

   A) To a film

   B) To a restaurant

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

   A) Afternoon

   B) Evening

3. **Why does the colleague act hostile to you?**

   A) The person is jealous of you

   B) The person is angry that you forgot to call a taxi and make dinner reservations

4. **Who initiates the activity?**

   A) You

   B) The colleague

Story #6

1. **With whom do you have a date?**

    A) A close friend

    B) A new acquaintance

2. **Where do you go on the date?**

    A) To a film

    B) For dinner

3. **Why does the date go badly?**

    A) Your date was a boring person

    B) You were not interesting enough for the person

4. **Where did you go after the date?**

    A) For a drive

    B) Nowhere

Story #7

1. **Who starts the conversation with you?**

    A) A tourist

    B) A stranger

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

    A) You are friendly

    B) This person wants your help

3. **What are you doing when you are approached by this individual?**

    A) Reading a newspaper

    B) Reading a book

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

    A) Illness

    B) Deserted by family

Story #8

1. **Why is the party a success?**

    A) Your colleagues are in the mood to unwind

    B) You know how to throw a good party

2. **What is popular at the party?**

    A) The drink

    B) The food

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

    A) Christmas

    B) Summer

4. **Is the party well attended?**

    A) Yes

    B) No

Story #9

1. **Where do you give the speech?**

    A) A political convention

    B) A town hall meeting

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

    A) You were an ineffective speaker

    B) The second speaker took the less controversial viewpoint

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

    A) Someone tells you

    B) You witness it

4. **What is being discussed at the meeting?**

    A) Road repair

    B) Rubbish removal

Story #10

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

    A) No one

    B) Your spouse

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

    A) Manual

    B) Technical

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

    A) You have poor technical skills

    B) The boss wants you to leave to make room for a relative

4. **What shift do you work?**

    A) Day

    B) Night

Story #11

1. **What kind of course do you take?**

    A) English literature

    B) Writing

2. **Why do you take the course?**

    A) Compulsory

    B) Pleasure

3. **Why does your teacher like your paper?**

    A) You are a good writer

    B) Your viewpoints are similar to the teacher's

4. **Why do you choose to write about Fowles?**

    A) He is your favourite author

    B) The teacher tells you to

Story #12

1. **What type of income raise do you receive?**

    A) Bonus payment

    B) Wage increase

2. **How do you hear about the raise?**

    A) A memo

    B) Told personally

3. **Why do you get the raise?**

    A) Company wants to prevent further resignations

    B) You deserve the raise because of good performance

4. **Who else gets a raise?**

    A) No-one

    B) Everyone

THIS IS THE END OF THE QUESTIONNAIRE
THANK YOU.

Appendix 2.6 Attributional Style Questionnaire

Attributional Style Questionnaire

Directions

1. Read each situation and vividly imagine it is happening to you.
2. Decide what you believe would be the major cause of the situation if it happened to you.
3. Write this cause in the blank space provided.
4. Answer the three questions about this cause, by circling one number per question.
5. Go to the next situation and follow the same procedure.

YOU MEET A FRIEND WHO COMPLIMENTS YOU ON YOUR APPEARANCE.

1) Write down the one major cause. _____

2) Is the cause of your friend's compliment due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Totally due to me**

3) In the future when you are with your friend will this cause again be present?

Will never again be present	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Will always be present**

4) Is the cause something that just affects interacting with friends or does it also influence other areas of your life?

Influences just this particular situation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Influences all situations in my life**

YOU HAVE BEEN LOOKING FOR A JOB UNSUCCESSFULLY FOR SOME TIME.

5) Write down the one major cause. _____

6) Is the cause of your unsuccessful job search due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Totally due to me**

7) In the future when looking for a job will this cause again be present?

Will never again be present	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Will always be present**

8) Is the cause something that just influences looking for a job or does it also influence other areas of your life?

Influences just this particular situation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Influences all situations in my life**

YOU BECOME VERY RICH.

9) Write down the one major cause. _____

10) Is the cause of your becoming rich due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Totally due to me**

11) In your financial future, will this cause again be present?

Will never again be present	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Will always be present**

12) Is the cause something that just affects obtaining money or does it also influence other areas of your life?

Influences just this particular situation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Influences all situations in my life**

A FRIEND COMES TO YOU WITH A PROBLEM AND YOU DON'T TRY TO HELP THEM.

13) Write down the one major cause. _____

14) Is the cause of your not helping your friend due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Totally due to me**

15) In the future when a friend comes to you with a problem, will this cause again be present?

Will never again be present	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Will always be present**

16) Is the cause something that just affects what happens when a friend comes to you with a problem or does it also influence other areas of your life?

Influences just this particular situation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Influences all situations in my life**

YOU GIVE AN IMPORTANT TALK IN FRONT OF A GROUP AND THE AUDIENCE REACTS NEGATIVELY.

17) Write down the one major cause. _____

18) Is the cause of the audience reacting negatively due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Totally due to me**

19) In the future when giving talks will this cause again be present?

Will never again be present	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Will always be present**

20) Is the cause something that just influences giving talks or does it also influence other areas of your life?

Influences just this particular situation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Influences all situations in my life**

YOU DO A PROJECT WHICH IS HIGHLY PRAISED.

21) Write down the one major cause. _____

22) Is the cause of being praised due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Totally due to me**

23) In the future when doing a project will this cause again be present?

Will never again be present	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Will always be present**

24) Is the cause something that just affects doing projects or does it also influence other areas of your life?

Influences just this particular situation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Influences all situations in my life**

YOU MEET A FRIEND WHO ACTS HOSTILE TOWARDS YOU.

25) Write down the one major cause. _____

26) Is the cause of your friend acting hostile due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Totally due to me**

27) In the future when interacting with friends will this cause again be present?

Will never again be present	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Will always be present**

28) Is the cause something that just influences interacting with friends or does it also influence other areas of your life?

Influences just this particular situation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Influences all situations in my life**

YOU CAN'T GET ALL THE WORK DONE THAT OTHERS EXPECT OF YOU.

29) Write down the one major cause. _____

30) Is the cause of your not getting all the work done due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Totally due to me**

31) In the future when doing the work that others expect will this cause again be present?

Will never again be present	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Will always be present**

32) Is the cause something that just affects doing work that others expect of you or does it also influence other areas of your life?

Influences just this particular situation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Influences all situations in my life**

YOUR PARTNER HAS BEEN MORE AFFECTIONATE.

33) Write down the one major cause. _____

34) Is the cause of your partner being more affectionate due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Totally due to me**

35) In the future interactions with your partner will this cause again be present?

Will never again be present	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Will always be present**

36) Is the cause something that just affects how your partner treats you or does it also influence other areas of your life?

Influences just this particular situation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Influences all situations in my life**

YOU APPLY FOR A JOB OR COLLEGE PLACE THAT YOU WANT VERY BADLY AND YOU GET IT.

37) Write down the one major cause. _____

38) Is the cause of your getting the job or college place due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Totally due to me**

39) In the future when applying for a job or college place will this cause again be present?

Will never again be present	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Will always be present**

40) Is the cause something that just influence applying for a job or college place or does it also influence other areas of your life?

Influences just this particular situation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Influences all situations in my life**

YOU GO OUT ON A DATE AND IT GOES BADLY.

41) Write down the one major cause. _____

42) Is the cause of the date going badly due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Totally due to me**

43) In the future when dating will this cause again be present?

Will never again be present	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Will always be present**

44) Is the cause something that just influences dating or does it also influence other areas of your life?

Influences just this particular situation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Influences all situations in my life**

YOU GET A WAGE RISE.

45) Write down the one major cause. _____

46) Is the cause of your getting a wage rise due to something about you or something about other people or circumstances?

Totally due to other people or circumstances	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Totally due to me**

47) In the future on your job will this cause again be present?

Will never again be present	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Will always be present**

48) Is the cause something that just affects getting a wage rise or does it also influence other areas of your life?

Influences just this particular situation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Influences all situations in my life**

THIS IS THE END OF THE QUESTIONNAIRE
THANK YOU

Appendix 2.7 Rosenberg Self Esteem Questionnaire

Rosenberg Self Esteem Questionnaire

This is a short questionnaire to measure thoughts about yourself. Please indicate whether you strongly agree, agree, disagree, or strongly disagree with each statement by ticking the appropriate box.

	Strongly agree	**Agree**	**Disagree**	**Strongly disagree**
On the whole I am satisfied with myself				
At times I think I am no good at all				
I feel I have a number of good qualities				
I am able to do things as well as most other people				
I feel I do not have much to be proud of				
I certainly feel useless at times				
I feel I'm a person of worth at least equal with others				
I wish I could have more respect for myself				
All in all I am inclined to feel that I am a failure				
I take a positive attitude towards myself				

Appendix 2.8 Hamilton Depression Scale

Hamilton Depression Scale

Patient's Name _____ **Patient's Record Number** _____

Doctor _____ **Visit Number** _____

Date of Visit _____

Complete all items of the Hamilton Scale using the following assessment grades:

For scales marked 0 – 4
0 = Absent
1 = Mild or Trivial
2-3 = Moderate
4 = Severe

For scales marked 0 – 2
0 = Absent
1 = Slight or Doubtful
2 = Clearly Present

Item No.	Score	Symptom
1		**Depressed Mood (0-4)** Gloomy attitude, pessimism about the future. Feeling of sadness. Tendency to weep: 1 Sadness and/or mild depression 2 Occasional weeping and/or moderate depression 3 Frequent weeping and/or severe depression 4 Extreme symptoms
2		**Guilt (0-4)** Self-reproach, feels he has let people down. Ideas of guilt. Present illness is a punishment. Delusions of guilt. Hallucinations of guilt.
3		**Suicide (0-4)** Feels life is not worth living. Wishes he were dead. Suicidal ideas. Attempts at suicide.
4		**Insomnia, initial (0-2)** Difficulty falling asleep.
5		**Insomnia, middle (0-2)** Patient restless and disturbed during the night. Waking during the night.
6		**Insomnia, delayed (0-2)** Waking in early hours of the morning and unable to fall asleep again.
7		**Work and Interests (0-4)** Feelings of incapacity. Listlessness, indecision and vacillation. Loss of interest in hobbies. Decreased social activities. Productivity decreased. Unable to work. Stopped work because of present illness only.

Item no.	Score	Symptom
8		**Retardation (0-4)** Slowness of thought, speech, and activity. Apathy. Stupor: 1 Slight retardation at interview. 2 Obvious retardation at interview. 3 Interview difficult. 4 Complete stupor.
9		**Agitation (0-2)** Restlessness associated with anxiety.
10		**Anxiety, psychic (0-4)** Tension and irritability. Worrying about minor matters. Apprehensive attitude. Fears.
11		**Anxiety, somatic (0-4)** Gastrointestinal, wind, indigestion. Cardiovascular, palpitations, headaches. Respiratory, genito-urinary, etc.
12		**Somatic Symptoms, Gastrointestinal (0-2)** Loss of appetite. Heavy feelings in abdomen. Constipation.
13		**Somatic Symptoms, General (0-2)** Heaviness in limbs, back or head. Diffuse backache. Loss of energy and fatigueability.
14		**Genital Symptoms (0-2)** Loss of libido. Menstrual disturbances.
15		**Hypochondriasis (0-4)** Self-absorption (bodily). Preoccupation with health. Querulous attitude. Hypochondriacal delusions.
16		**Loss of weight (0-2)**
17		**Insight (0-2)** 2 Loss of insight. 1 Partial or doubtful loss. (Insight must be interpreted in terms of 0 No loss. patient's understanding & background.)
18		**Diurnal Variation (0-2)** Symptoms worse in morning or evening. (Note which)
19		**Depersonalisation and Derealisation (0-4)** Feelings of unreality. Nihilistic ideas. (Specify)
20		**Paranoid Symptoms (0-4)** Suspicious. Ideas of reference. Delusions of reference and persecution. Hallucinations, persecutory. (None of these with a depressive quality)
21		**Obsessional Symptoms (0-2)** Obsessive thoughts and compulsions against which the patient struggles.
TOTAL		

Explanatory Statement.

The following is a statement explaining the discrepancy between the research proposal and the research paper.

One of the original aims of the study was to investigate Trower and Chadwick's cognitive model of two subtypes of paranoia. These authors have proposed a model of paranoia isolating *persecutory and punishment* as two distinct types of paranoia. In persecutory paranoia, individuals perceive others as bad and themselves as victims and they attribute blame to others. In punishment paranoia, individuals attribute blame to themselves, perceiving themselves as bad and others as justifiably punishing them. The study set out to investigate whether there are specific attributional styles evident in punishment and persecutory paranoia by using measures of implicit and explicit attributions. Further, research by Bentall and his colleagues have shown that, in comparison to depressed and normal controls, individuals with persecutory delusions excessively externally attribute negative events to others. It is thought that this attributional bias serves the function of preventing individuals becoming aware of their own negative self-referent attitudes. It is remains unknown, however, whether this self-serving bias is present when delusions are remitted. Therefore, based on Bentall's findings and the model proposed by Trower and Chadwick, the predictions are: (1) On an explicit measure of attributional style individuals with persecutory delusions will demonstrate excessive external attributions for negative events in comparison to remitted and punishment paranoia groups. (2) On an explicit measure of attributional style individuals with punishment delusions will demonstrate excessive internal attributions for negative events in comparison with remitted controls. (3) On an implicit measure of attributional style no differences will be observed between persecutory, punishment and remitted groups.

In the process of data collection, it was discovered that individuals with punishment delusions were requiring approximately double the amount of time in the gathering of information. Essentially this was the result of the slow process of engagement prior to completion of measures. Their suspiciousness was perhaps confounded by more severe depressive or negative psychotic features. Alternatively, it may simply have been a feature of a more severe paranoid state. As there have been no experimental studies with this subgroup, the pragmatics of such a situation were not accounted for. Unfortunately, the time constraints for data completion dictated that this experimental group be dropped from the study. The focus of investigation became hypotheses (1) and (3) outlined above.

Therefore, the present study asks whether the self-serving external attributional bias is a state feature of persecutory delusions or a trait feature of individuals who experience persecutory delusions. The hypotheses are that: (1) on an explicit measure of attributional style individuals with persecutory delusions will demonstrate external attributions for negative events in comparison to remitted controls and (2) on an implicit measure of attributional style no differences will be observed between the delusional and remitted groups.

Chapter Three

Attributions and paranoid delusions.

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Written in accordance with British Journal of Psychiatry Instructions to Authors.

Attributions and paranoid delusions.

Summary

Background Research has shown that individuals with persecutory delusions excessively externally attribute negative events. This bias is thought to protect these individuals from becoming aware of their own negative self-referent attitudes. The present study asks whether this self-serving external attributional bias is a state feature of persecutory delusions or a trait feature of individuals who experience persecutory delusions. **Method** There were two groups: individuals with persecutory delusions, and individuals with remitted illness, but who typically experienced persecutory delusions during relapse. Subjects were required to complete implicit and explicit measures of attributional inference. Severity of depression and self-esteem were also rated. **Results** Individuals with persecutory delusions presented with an excessive external attributional bias for negative events, when compared with remitted controls. Delusional subjects were also significantly more depressed than remitted controls. **Conclusions** The results replicate findings of previous studies and also suggest that the attributional bias is a state feature associated with persecutory delusions rather than a trait feature of individuals who experience persecutory delusions. Treatment implications for delusional and relapse-prone individuals are discussed. Directions for future research are suggested.

Introduction

Studies of cognitive processing in people with delusions have facilitated considerable developments in the understanding of delusional beliefs. Research has demonstrated that, in comparison to depressed and normal controls, individuals with persecutory delusions excessively externally attribute negative events to others (Kaney & Bentall, 1989; Bentall, Kaney & Dewey, 1991). It is proposed that this attributional bias serves the function of preventing individuals becoming aware of their own negative self-referent attitudes (Kinderman & Bentall, 1996). Experimental support for this theory has been demonstrated by Bentall, Kinderman and Kaney (1994) who found that this bias was absent when attributions were assessed using a masked or implicit measure of attributional style. It is yet unknown, however, whether this self-serving bias is present when delusions are remitted. The present study asks whether the self-serving external attributional bias is a state feature of persecutory delusions or a trait feature of individuals who experience persecutory delusions. The hypotheses are that: (1) on an explicit measure of attributional style individuals with persecutory delusions will demonstrate external attributions for negative events in comparison to remitted controls and (2) on an implicit measure of attributional style no differences will be observed between the delusional and remitted groups. These findings would provide further experimental support for Kinderman and Bentall's (1996) theory of persecutory delusions.

Method

Subjects

Subjects were included in the study if they met DSM IV diagnostic criteria for schizophrenia, schizoaffective disorder, schizophreniform disorder or delusional disorder, if they were aged between 18 and 65 years, if they had persecutory paranoia either currently or in remission and if informed consent was given by the

patient and their Responsible Medical Officer. Subjects were excluded from the study if they had a learning disability, if they were known to be currently misusing alcohol or drugs, or if their symptoms had a known or suspected organic aetiology. There were two subject groups: the experimental group consisting of individuals with persecutory delusions and the control group whose illness was in remission and who were no longer presenting with persecutory delusions.

Measures

(1) Screening assessments

The Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders 4th edition – Clinical Version (SCID; First, Spitzer, Gibbon & Williams, 1997; American Psychiatric Association, 1994) is a semi-structured diagnostic interview for DSM IV Axis I diagnoses. The SCID is completed using one or more of the following sources of information: by interviewing the patient, his friends or family members, by interviewing health professionals or by examination of medical case records. It was used as a diagnostic screening tool to ensure inclusion and exclusion criteria were adhered to. The National Adult Reading Test (NART; Nelson, 1982; Nelson & Willison, 1991) is a standardised assessment of word-reading ability designed to provide an estimate of the pre-morbid intelligence of adults suspected of having intellectual deterioration. The NART was administered to ensure that any differences in the experimental variables could not be accounted for by group differences in verbal intellectual level.

(2) Research assessments

(i) The Pragmatic Inference Test (PIT; Winters & Neale, 1985) is an implicit measure of attributional style which is presented as a memory test to avoid conscious response biasing. Subjects are required to listen to an audio-taped recording of twelve self-referent vignettes which have been derived from the

Attributional Style Questionnaire (described below). Six of the vignettes describe positive events and six describe negative events and implied within each story are both an internal and an external causality. Subjects then answer four multiple-choice questions, two of which require recall of factual information, and two requiring inferential answers. The key question is that measuring the subject's attributional inference of causality within the vignette. Key questions are then rated for frequency on four accounts: internal attributions for positive events, internal attributions for negative events, external attributions for positive events and external attributions for negative events.

(ii) The Attributional Style Questionnaire (ASQ; Peterson, Semmel, von Bayer, Abramson, Metalsky & Seligman, 1982) was administered as an explicit measure of the three dimensions of attributional theory. Subjects are required to generate casual explanations for six negative and six positive hypothetical situations and rate the causes on bipolar rating scales. The scales measure the degree to which the subject believes the cause of the event is: (1) due to themselves (internality), (2) likely to be present in the future (stability) and (3) likely to affect all areas of their lives (globality).

(iii) The Rosenberg Self Esteem Questionnaire (RSEQ; Rosenberg, 1965) is a standardised 10 item measure of global self-esteem. Subjects are required to rate the self-statements on a four-point scale.

(iv) The Hamilton Depression Scale (HDS; Hamilton, 1960 & 1967) is a 21-item measure of the severity of depressive symptoms. Given that three of the four research measures are self-report, this scale was chosen as an observer-rated assessment to reduce the potential for self-report bias.

The PIT, ASQ and RSEQ have been administered in previous studies with similar subject groups (e.g.: Lyon, Kaney & Bentall, 1994), hence, were chosen as the key research measures to ensure some comparability.

Procedure

Referrals were sought via psychiatrists, psychologists and nurses working in either hospital or community settings. In-patient participants were seen either on the psychiatry wards of the district general hospital or the admission and rehabilitation wards of the psychiatric hospital. Outpatient participants, all of whom were in receipt of continuing support or treatment from the Community Mental Health Team, were visited in their homes. When necessary, for the purpose of clarifying information or reducing anxiety, the researcher met with individuals prior to the inclusion in the study. When informed written consent had been obtained from both the patient and the Responsible Medical Officer, the investigation began with the diagnostic interview (SCID). The research measures were then administered in the following order. The National Adult Reading Test, the Pragmatic Inference Test, the Attributional Style Questionnaire, the Rosenberg Self Esteem Questionnaire and the Hamilton Depression Scale. This was done over 2-4 sessions, which varied in duration from 20-75 minutes, depending on the requirements of the participants. Fatigue and preoccupation with psychotic symptoms at times gave rise to concentration difficulties, particularly for in-patient participants. Procedure was adapted to accommodate these factors by shorter, more frequent sessions. The measures used in the study are also clinical assessment tools yielding useful clinical material, such as severity of depressive symptoms or indicators of poor self-esteem. Based on this, participants were offered feedback providing the availability of a psychological assessment in addition to existing treatment or care.

Referrals

A total of fifty patients were referred to the study. Of these, twenty met inclusion criteria consented and gave completed data. Of the remaining thirty, 17 failed to satisfy inclusion criteria, 7 failed to consent, 4 were unable to be followed up and 2 defaulted from the study.

Results

The research questions were as follows: (i) Do individuals with persecutory delusions have a particular attributional bias externalising blame for negative events and internalising credit for positive events? (ii) Is there an association between attributional style and the deluded state indicated by less of an attributional bias in remitted patients when compared with deluded patients? The results were analysed using the Mann-Whitney test for comparison of the means of two independent samples.

Subjects

The persecutory group consisted of nine subjects, eight males and one female. All nine subjects had a symptom presentation fulfilling DSM IV diagnostic criteria for schizophrenia and were currently suffering from persecutory delusions (Table 3.1). Seven of the nine subjects were in-patients and two were outpatients. All subjects in this group were unemployed at the time of data collection. A summary of the subjects' demographic variables is given in table 3.2. The remission group consisted of eleven subjects, eight males and three females. Six subjects had a diagnosis of schizophrenia and five of schizoaffective disorder. All subjects were in remission at the time of data collection, but had suffered persecutory delusions in previous psychotic episodes (Table 3.1). Three of the eleven subjects were in-patients and eight were outpatients. With the exception of one subject who was in

a supported work placement, subjects in this group were unemployed. A summary of the subjects' demographic variables is given in table 3.3.

Table 3.1 Persecutory beliefs of the subjects in each research group

	Persecutory Group
1	"everyone's out to get me because of how I look"
2	"people are out to get me and harm me"
3	"others single me out to demean and persecute me"
4	"the nurses are poisoning me with medicine"
5	"the great spirit will harm me"
6	"the nurses are cannibals and will kill me"
7	"people are planning my execution"
8	"government agencies are conspiring against me"
9	"neighbours sprinkle chemicals in my water tank"
	Remission Group
1	"everyone take advantage of me because they think I'm weak "
2	"my family are poisoning me"
3	"everyone is against me because of my past "
4	"my colleagues are trying to get me into trouble with the boss"
5	"people conspire against me because I'm related to JFK"
6	"other patients will suffocate me"
7	"people are trying to kill me"
8	"my tutors conspire together to fail my work "
9	"my mother is trying to poison me"
10	"people interfere with my thoughts to torment me"
11	"the controller with god-like powers inflicts pain on me"

Table 3.2 Demographic variables of persecutory group

Subject	*Gender*	*Age*	*Diagnosis*	*Years of illness*	*Hospital admissions*
1	Male	28:9	Schizophrenia	10	1
2	Female	29:3	Schizophrenia	16	10
3	Male	62:8	Schizophrenia	40	5
4	Male	47:10	Schizophrenia	30	3
5	Male	33:0	Schizophrenia	4	3
6	Male	30:5	Schizophrenia	14	20
7	Male	45:11	Schizophrenia	24	10
8	Male	33:11	Schizophrenia	7	2
9	Male	61:8	Schizophrenia	31	4

Table 3.3 Demographic variables of the remission group

Subject	*Gender*	*Age*	*Diagnosis*	*Years of illness*	*Hospital admissions*
1	Male	48:7	Schizoaffective	29	10
2	Male	25:0	Schizophrenia	6	1
3	Male	54:2	Schizophrenia	5	2
4	Male	32:0	Schizophrenia	2	3
5	Male	26:11	Schizophrenia	2	2
6	Female	32:0	Schizoaffective	2	4
7	Male	24:10	Schizophrenia	4	1
8	Male	30:11	Schizoaffective	9	0
9	Male	19:10	Schizoaffective	2	4
10	Male	44:5	Schizophrenia	11	2
11	Female	31:0	Schizophrenia	7	5

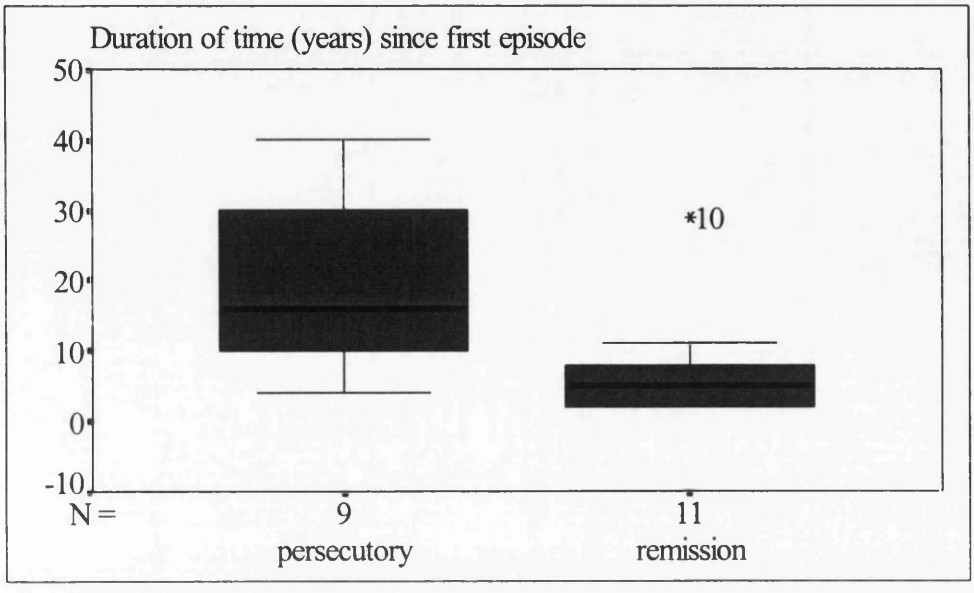
Age group

In the persecutory group there was an age range of 28 years, 9 months to 62 years, 8 months. The mean age was 41.29 years (s.d. 13.60). In the remission group, there was an age range of 19 years, 10 months to 54 years, 2 months. The mean age was 33.34 (s.d. 11.06). There was no difference in age between the two groups ($U = 30.00$, $p = 0.15$, n.s.).

Duration of illness

The duration of illness is defined as the time passed since subjects' first psychotic episode, including periods of remission. In the persecutory group, this ranged from seven to forty years, the mean time being 19.5 years (s.d. 12.31). In the remission group, this ranged from two to twenty-nine years, the mean time being 7.2 years (s.d. 7.85). There was a significant difference between the groups ($U = 15.00$, $p = 0.007$). This indicates that subjects in the persecutory group had a significantly longer duration of illness compared with those in the remission group. These results are shown in figure 3.1.

Figure 3.1



Frequency of hospital admissions

In the persecutory group, one subject had been hospitalised on one occasion, five subjects had been hospitalised between two and five occasions, and three subjects had a history of more than five admissions to hospital. The mean number of admissions was 6.44 (s.d. 6.02). In the remission group, one subject had never been hospitalised, two subjects had been admitted once, six subjects had been admitted between two and five occasions and one subject had been in hospital on more than five occasions. The mean number of admissions was 3.09 (s.d. 2.73). There was no difference in the number of hospital admissions between the two groups ($U = 30.0$, $p = 0.15$, n.s.).

NART

There were no differences in NART scores between the two groups ($U = 35.0$, $p = 0.29$, n.s.).

Internality for negative events

On the explicit measure (ASQ) of internal attribution for negative events, the persecutory group scored a mean of 3.56 (s.d. 1.43) and the remission group scored a mean of 5.06 (s.d. 0.93). This is statistically significant ($U = 21.00$, $p = 0.03$), indicating that individuals with persecutory delusions excessively externally attribute negative events. These results are shown in figure 3.2. On the implicit measure (PIT) of internal attribution for negative events, the persecutory group scored a mean of 3.22 (s.d. 1.09) and the remission group scored a mean of 3.09 (s.d. 1.37). This indicates that there was no difference internality when it is rated on the implicit measure of attribution ($U = 49.00$, $p > 1.00$, n.s.). These results are shown in figure 3.3.

Figure 3.2

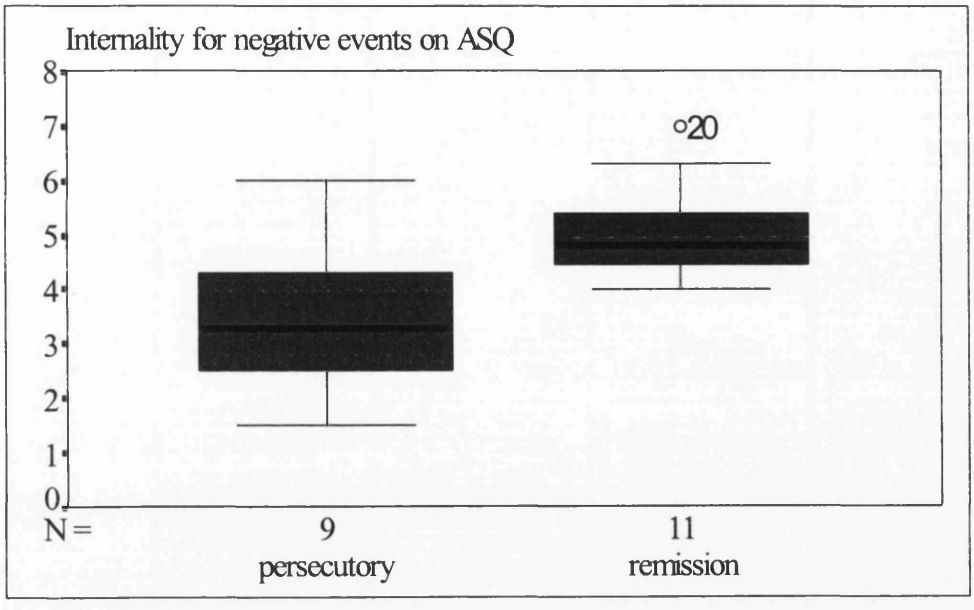
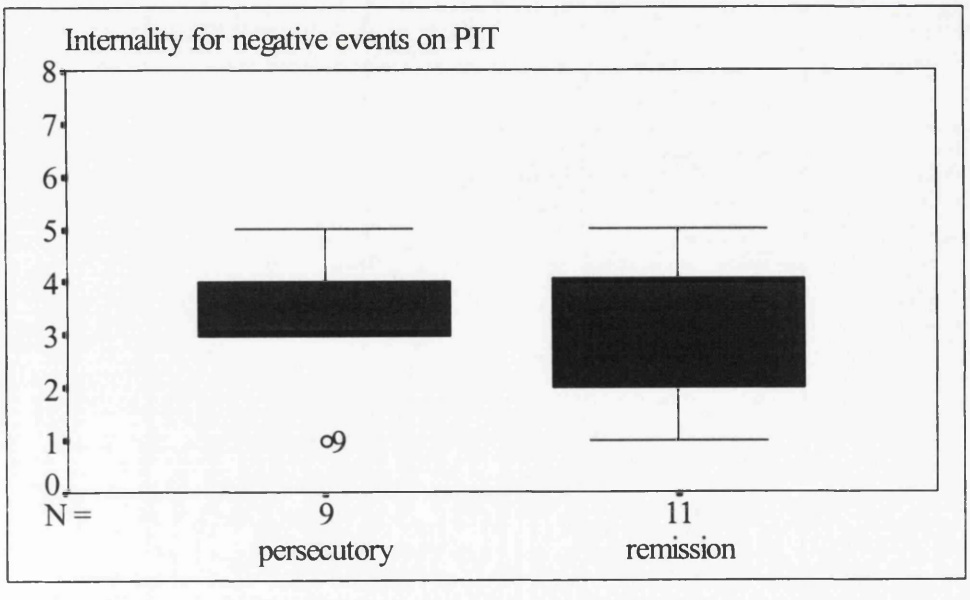


Figure 3.3



Internality for positive events

On the explicit measure (ASQ) of internal attribution for positive events, the persecutory group scored a mean of 5.02 (s.d. 1.62) and the remission group scored a mean of 4.99 (s.d. 0.89). There was no difference in internality of attribution for positive events (U = 42.50, p = 0.60, n.s.). These results are shown in figure 3.4. On the implicit measure (PIT) of internal attribution for positive events, the persecutory group scored a mean of 3.22 (s.d. 1.20) and the remission group scored a mean of 2.45 (s.d. 1.03). There was no difference on internality of attribution for positive events (U = 30.00, p = 0.15, n.s.). These results are shown in figure 3.5.

Figure 3.4

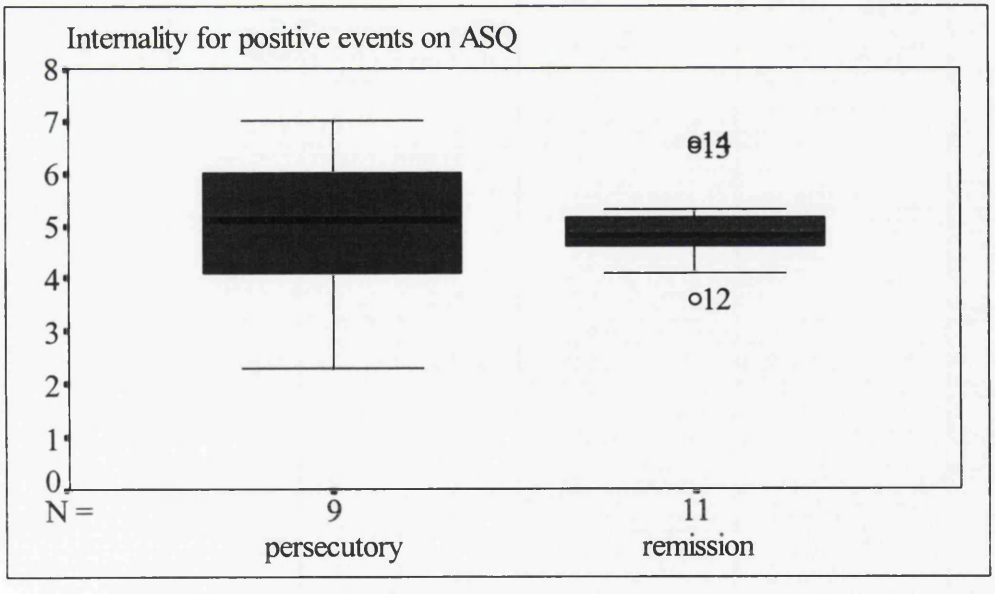
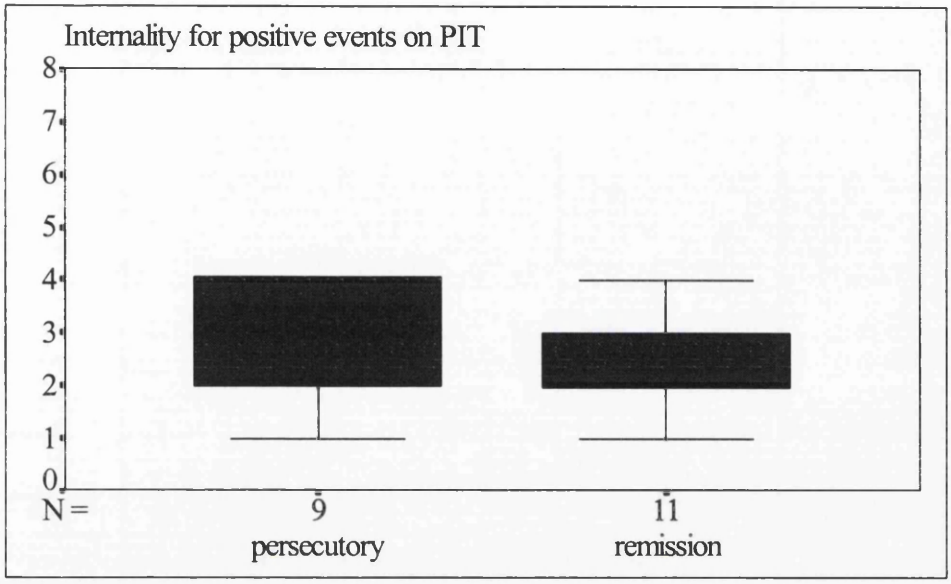


Figure 3.5



Stability for negative and positive events

On the ASQ stability rating for negative events, the persecutory group scored a mean of 4.35 (s.d. 1.11) and the remission group scored a mean of 5.19 (s.d. 0.96). There was no difference on stability of attributions for negative events ($U = 27.00$, $p = 0.09$, n.s.). On the ASQ stability rating for positive events, the persecutory group scored a mean of 4.78 (s.d. 1.62) and the remission group scored a mean of 4.63 (s.d. 1.14). There was no difference on stability of attributions for positive events ($U = 42.50$, $p = 0.60$, n.s.).

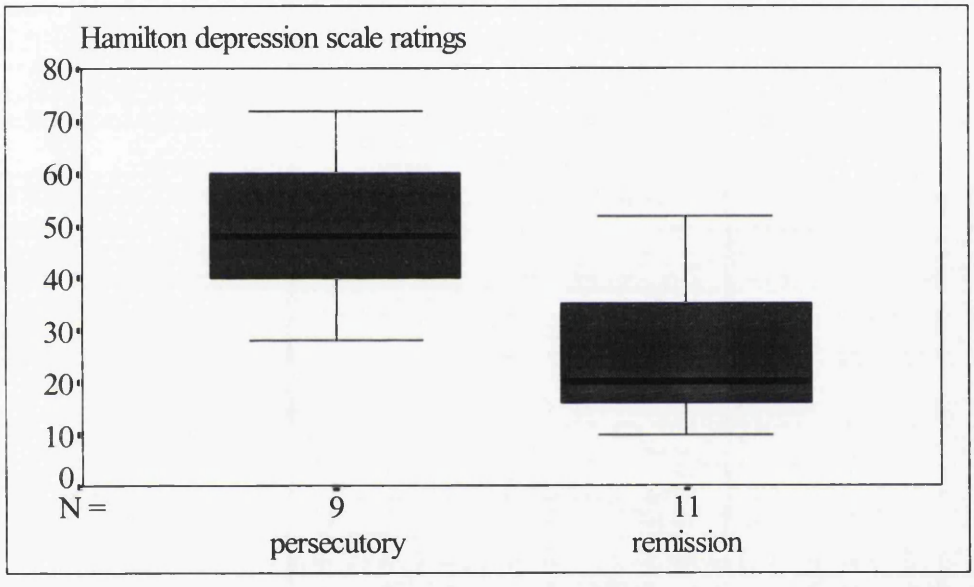
Globality for negative and positive events

On the ASQ globality rating for negative events, the persecutory group scored a mean of 4.05 (s.d. 1.56) and the remission group scored a mean of 4.57 (s.d. 0.87). There was no difference in the globality of attributions for negative events ($U = 33.00$, $p > 0.22$, n.s.). On the ASQ globality rating for positive events, the persecutory group scored a mean of 4.70 (s.d. 1.36) and the remission group scored a mean of 4.61 (s.d. 1.42). There was no difference in the globality of attributions for positive events ($U = 47.00$, $p = 0.88$, n.s.).

Depression

On the HDS the persecutory group scored a mean of 49.55 (s.d. 15.32) and the remission group scored a mean of 26.12 (s.d. 14.37). This indicated a significant difference in depression ratings (U = 13.50, p = 0.004). This indicates that the persecutory group were significantly more depressed than the remission group. These results are shown in figure 3.6.

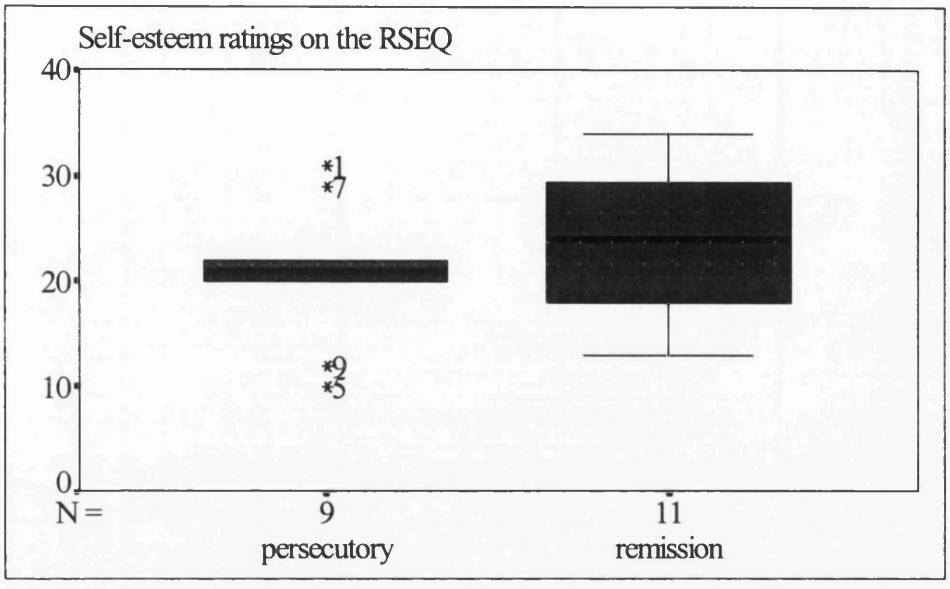
Figure 3.6



Self-esteem

On the RSEQ the persecutory group scored a mean of 20.66 (s.d. 6.78) and the remission group scored a mean of 23.72 (s.d. 7.51). There was no difference in self-esteem ratings (U = 35.50, p = 0.29, n.s.). These results are shown in figure 3.7.

Figure 3.7



Discussion

The results indicate that on an explicit measure of attribution, individuals with persecutory paranoia excessively externally attribute negative events. However, using an implicit measure of attribution, this bias appears to be absent. There was no difference on internality ratings for positive events on either the implicit or the explicit measure and no differences were found in the stability or globality of attributions for either negative or positive events. Further, individuals with persecutory paranoia were significantly more depressed than individuals whose illness was in remission. However, self-esteem ratings did not differ between the groups. Finally, the mean duration of illness since first psychotic episode was significantly longer for the persecutory group.

These results provide evidence to support the two hypotheses. Firstly, on an explicit measure of attributional style individuals with persecutory delusions demonstrated excessive external attributions for negative events in comparison to

remitted controls. Secondly, on an implicit measure of attributional style no differences were observed between the delusional and remitted groups.
The findings also replicate those of Kinderman et al (1992) and provide further experimental support evidence for Kinderman and Bentall's (1996) theory of excessive external attributional bias in persecutory delusions. The external self-serving bias is thought to represent a form of self-deception with the function of preventing the individual becoming aware of their negative self-referent attitudes. Individuals with persecutory paranoia attribute blame for negative events to others in order to protect against negative self-referent appraisals. The absence of a difference on internality ratings for positive events indicates that in comparison with a remission group, individuals with persecutory paranoia are not more likely to excessively attribute positive events and experiences to themselves. This may be explained by the high level of depression in the persecutory group, since it known that a depressed state is characterised by a tendency to externally attribute positive events. Further the finding that those with persecutory delusions were significantly more depressed than remitted controls, indicates that the attributional bias does not protect against depression.

From the findings of the present study, there are implications for the assessment and treatment of individuals with persecutory delusions. When assessing these individuals, clinicians should be aware that the explicit externalising bias is serving a protective function. Assessment should also differentiate between depressive and negative self-referent appraisals. It may be that accessing negative self-referent appraisals during intervention leads to an initial increase in depression. Thus it would be important that intervention incorporates strategies for building self-esteem. Further, the finding that the attributional bias appears to be a feature of persecutory delusions rather than trait feature of the individual has treatment implications for individuals who are currently delusional, but also for those who

are prone to relapse and a return of delusional beliefs. For those who are currently delusional, encouraging re-attribution of causal inference, in combination with strategies to enhance self-esteem, may offer an effective form of intervention. In a single case study of an individual with paranoid delusions, Kinderman and Bentall (1997) demonstrated improved outcome using attribution therapy to shift attribution to situational rather than person sources. Further, if the attributional bias is a state feature of persecutory delusions it is potentially useful to monitor change in attributional style as a sign of relapse. Birchwood (1995) suggests that an individual's attributions to explain emerging symptoms will potentially accelerate or delay relapse. For example, if the cognitive processing style associated or exaggerated with the delusional state is observed to be re-emerging, timely and effective intervention may halt the process of relapse. Thus, incorporating attributional style as a feature of the individual's relapse signature would allow the opportunity for early intervention. Early psychological intervention might target individual's attributions in order to prevent relapse.

Clearly, there are several limitations of the present study. Firstly, the findings do not account for all types of paranoia. For instance, the attributional style of individuals with punishment paranoia remains untested. The distinguishing feature of punishment paranoia is self-blame for negative events, which leads the individual to feel that they deserve punishment. Therefore, it would be predicted that individuals with punishment paranoia would demonstrate an excessive internal attributional bias for negative events, in comparison to individuals with persecutory paranoia. It would be predicted, also, that the internal bias would be present on both explicit and implicit measures of attribution, as these individuals retain negative self-referent attitudes. A second limitation of the present study is that of small subject numbers, which may not be representative of the clinical population. Thirdly, the study is limited by the absence of matched variables between the

groups, such as age, gender, diagnosis, length and course of illness. Further, the absence of a non-psychiatric control group does not allow the findings to be compared with normative data. The inclusion of a non-psychiatric sample would allow comparison of attributional inference with the remission group, to ensure that there is no bias within the remission group. Finally, there were difficulties with the face validity of the two attributional questionnaires. The content of both the PIT and the ASQ is heavily orientated to work and performance situations, which lacks validity with a group of individuals experiencing long-term unemployment.

On the basis of the findings, there are implications for further research. There is a need to replicate these findings with larger sample numbers and using a matched-subject design or preferably, a within-subject methodology measuring the same individuals during relapse and remission. Further, measurement of attributional style in individuals with punishment paranoia would clarify potential differences and highlight the specific intervention needs of this group of individuals. Finally, the efficacy of re-attribution therapy for individuals with paranoid delusions remains to be tested.

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Chapter Four

A comparison of Primary Care and Community Mental Health Team referrals to Clinical Psychology in a major Scottish city.

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Written in accordance with Clinical Psychology Forum Notes for Contributors.

Introduction

Within the United Kingdom over the last ten to fifteen years, there has been a movement towards the provision of community-based care for individuals with serious and long-term mental health problems. This movement was given considerable impetus by the NHS and Community Care Act (1990). Adult mental health services are increasingly being established as Community Mental Health Teams (CMHTs). As the move away from in-patient psychiatric care occurs, and services for the mentally ill are provided from within the community, these multi-disciplinary and multi-skilled teams aim to focus their resources on individuals with 'severe' or 'serious' mental health problems.

Support for the CMHT model is variable, and there is mixed evidence of the success of CMHTs. Paxton (1995) lists several problems for CMHTs ranging from lack of focus to de-skilled and demoralised staff; and argues for local professional services with service specifications as an alternative model. However, Onyett and Ford (1996) suggest that teams can be economically viable when focused on offering proactive support to those individuals with severe and long-term mental health difficulties.

Strathdee and Thornicroft (1992) note that defining priority patient groups to be served by local mental health services invariably remains unspecified. However, they review several potential definitions (e.g.: Goldman et al, 1981 & Tyrer et al, 1989) whose criteria are based on diagnosis, duration of illness, disability and vulnerability factors (Strathdee & Thornicroft, 1992, p147).

In Glasgow, clinical psychology services are provided to both primary care and CMHTs. Primary care services provide a direct route of access to psychology for the General Practitioner. Clinical psychologists offer a generic service to patients presenting with a

range of difficulties, in terms of both the nature and severity of psychological needs. In comparison, the service which clinical psychology provides to CMHTs will differ from primary care by reflecting the increasing emphasis on the provision of services for individuals with severe and long-term mental health problems within CMHTs. One implication is that individuals presenting to the CMHT will have more complex psychological difficulties than those individuals treated within the primary care setting. If this is correct, it might be expected that CMHT patients differ from primary care patients on a number of variables relating to psychopathology and treatment. Firstly, more of the patients referred to the CMHTs will present with psychotic disorders and will have more than one diagnosis. Secondly, CMHT patients will have lower Global Assessment of Functioning scores. Thirdly, CMHT patients will require more treatment sessions over a longer period. To test these predictions, the following variables were measured. Diagnostic profile, pre- and post-treatment Global Assessment of Functioning (GAF) score; number of treatment sessions offered and attended; duration of treatment; and change in functioning following treatment.

Method

Six clinical psychologists who work in both primary care and CMHT in the north of Glasgow were selected. Data was obtained from their ten most recently discharged cases, where treatment was not terminated through default. The ten cases consisted of five primary care and five CMHT cases. This yielded data for 60 cases: 30 primary care and 30 CMHT.

Twenty-seven of the thirty primary care cases were referred by General Practitioners. The remainder were referred by general medicine, other psychology services and occupational health. This is consistent with the primary care model of service provision. The primary

referral source of CMHT cases was psychiatry - twenty-four out of thirty. A further five were referred by their GP and one by social work. The primary care sample consisted of 14 males and 16 females and the mean age in this group was 37.8 years (SD 10.3). In the CMHT sample there were 18 males and 12 females and the mean age was 37.3 years (SD 11.3).

Diagnosis was made by the clinical psychologist providing treatment, according to ICD-10 criteria (World Health Organisation, 1992). Global assessment of functioning (American Psychiatric Association, 1994) was rated pre- and post-treatment by the treating clinician. Number of sessions offered and attended was noted and number of weeks of treatment. Outcome of treatment was assessed by clinician's rating of progress on a four-point scale where zero indicated 'no change' and three indicated that the condition was 'completely resolved'.

Results

Data were analysed using Chi Square and t-tests for independent samples.

ICD-10 category: primary diagnosis

There was no difference in primary diagnosis of patients between primary care cases and CMHT cases ($\chi^2 = 4.28$, df = 2, n.s.). (Table 4.1)

Table 4.1 Frequency of ICD 10 categories in each sample.

Sample	Group one	Group two	Group three
Primary Care (n=30)	6	19	5
CMHT (n=30)	10	11	9

Group one: Mood disorders (e.g.: mania, depression, dysthymia)

Group two: Neurotic, stress related and somatoform disorders (e.g. phobias, OCD, PTSD, adjustment disorder)

Group three: Other disorders, including psychotic disorders

Pre-treatment Global Assessment of Functioning (GAF) Scores

The Global Assessment of Functioning (GAF) Scale is a clinician rated measure of "psychological, occupational and social functioning on a hypothetical continuum of mental health-illness" (American Psychiatric Association, 1994, p32). The mean pre-treatment GAF score for the primary care group was 53.36 (SD 12.82) indicating moderate symptoms; and for CMHT group was 44.77 (SD 16.60) indicating serious symptoms. The CMHT patients' lower score indicated that they had significantly greater mental health related symptomatology as measured by the GAF ($t = 2.25$, $df = 58$, $p < 0.05$).

Post-treatment Global Assessment of Functioning (GAF) Scores

The mean post-treatment GAF score for the primary care group was 74.13 (SD 8.36) indicating symptoms, if present, are transient and expected reactions to psychosocial stressors. For the CMHT group the mean post-treatment GAF score was 66.4 (SD 14.10), indicating the presence of some mild symptoms or some difficulty in functioning. The

CMHT patients' lower score indicated that they had significantly lower level of psychological, social and occupational functioning at the end of a treatment episode, as measured by the GAF ($t = 2.58$, $df = 58$, $p < 0.05$).

Change in GAF score with treatment

The mean change in GAF score from baseline assessment to discharge from treatment for the primary care group was 20.77 (SD 11.98) and for the CMHT group was 20.40 (SD 12.26). There was no difference between the groups in the amount of change in functioning as measured by GAF score ($t = 0.12$, $df = 58$, n.s.).

Number of Sessions Offered and Number of Sessions Attended

There was no difference in the number of treatment sessions offered to primary care and CMHT patients. The mean number sessions offered in primary care was 9.87 (SD 4.21) and in CMHT was 11.50 (SD 5.10); ($t = -1.35$, $df = 58$, n.s.). There was no difference in the number of sessions attended between the two groups. The mean number of sessions attended in primary care was 7.93 (SD 3.74) and in CMHT was 9.80 (SD 4.61); ($t = -1.72$, $df = 58$, n.s.).

Duration of Treatment (weeks)

There was no difference in the duration of treatment between the two groups. The mean number of weeks of treatment for primary care cases was 22.40 (SD 12.92, range 1-53; and for CMHT cases was 27.43 (SD 17.75, range 1-66 ($t = -1.26$, $df = 58$, n.s.).

Outcome of Treatment

Clinicians rated overall outcome of treatment on a four point global scale. The categories used to describe treatment outcome were as follows: 'no change'; 'slightly resolved';

'moderately resolved'; 'markedly or completely resolved'. There was no difference in treatment outcome between the primary care and CMHT groups ($\chi^2 = 1.82$, df = 2, n.s.). Table 4.2 shows the frequency of individuals in each outcome category.

Table 4.2 Global assessment of outcome of treatment.

Group	'no change'	'slightly resolved'	'moderately resolved'	'completely resolved'
Primary Care (n=30)	0	6	4	20
CMHT (n=30)	0	10	5	15

Discussion

The results of the study show a significant difference between CMHT and primary care patients on two of the seven variables measured. Pre- and post-treatment GAF scores indicate that individuals treated by clinical psychologists within CMHTs, have a significantly lower level of psychological, social and occupational functioning, both when they initially present to the psychologist and following completed treatment. Nonetheless, CMHT and primary care patients benefit equally from psychological treatment as indicated by the degree of change in functioning measured by the GAF ratings. This supports the prediction that CMHT patients will have lower Global Assessment of Functioning scores. Duration and frequency of treatment sessions did not differ between the two groups. Thus, the prediction that CMHT patients will require more treatment sessions over a longer period was not supported. There were no significant differences in the diagnoses of patients in the two settings suggesting that clinical psychologists assess and treat similar types of patients

regardless of the setting in which they work. Thus, there was no evidence that more of the patients referred to the CMHTs will present with psychotic disorders and will have more than one diagnosis.

The lower level of psychological, social and occupational functioning of CMHT patients may be the consequence of severe and long-term mental illness. Equally however, it may simply be reflecting greater socio-economic deprivation in those individuals referred to CMHTs. Further investigation might consider whether level of functioning is associated with illness status or socio-economic status. This might be achieved by measuring variables such as length of illness, frequency of hospital admissions and Jarman combined index of social deprivation (Jarman, 1983). Further, as suggested by Strathdee and Thornicroft (1992), there perhaps remains a need to clarify the term "seriously mentally ill" as these are implicated as the priority group served by CMHTs.

Conclusion

There is no difference in diagnosis of cases, indicating that clinical psychologists are essentially treating the same population and in this respect their role is similar in both settings. The amount of change in functioning following treatment indicates that CMHT and primary care patients benefit equally from psychology treatment, albeit CMHT individuals do not reach the same level of functioning. It appears that severity of illness rather than diagnostic category determines where individuals are referred. The present study found limited evidence to indicate that clinical psychologists within the CMHT are serving the function of the CMHT by treating individuals with serious and long-term mental health difficulties. Only one of three predictions was met and this may be explained by alternative factors.

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Single Case Research Studies Abstracts

Chapter Five

Cognitive behavioural interventions for chronic fatigue syndrome: a case study.

Summary

Definitions of chronic fatigue and outcome studies of cognitive behavioural interventions are briefly reviewed. To date there is promising evidence of the effectiveness of cognitive behavioural approaches with this syndrome. The case study exemplifies key issues of a cognitive behavioural approach with chronic fatigue. Intervention included pleasure-scheduling, monitoring activity level, challenging negative cognitions and re-appraisal of illness beliefs. Formulation-based intervention resulted in improved mood, reduced fatigue and stabilised activity level, but no change in health-related anxiety. Results were maintained at two-year follow up. Limitations of the interventions are discussed in the light of existing knowledge that initial attributions of symptoms to a physical cause are associated with poor outcome and greater disability. Re-formulation using Sharpe's (1997) complex specific model of Chronic Fatigue Syndrome highlights the individual's appraisal of initial symptoms as a key feature to be addressed.

Key words

Chronic fatigue, Cognitive behavioural intervention, Formulation, Illness beliefs.

Written in accordance with Behaviour Research and Therapy Information for Contributors.

Chapter Six

Cognitive intervention for acute psychosis: a case study.

Abstract

Cognitive theory has highlighted beliefs about illness and related self-appraisal as key elements in the course of psychotic illness. Based on this model, a 19-year old female with a diagnosis of schizoaffective disorder was treated in the acute phase of her illness. Daily intervention during a ten-day hospital admission, entailed modification of beliefs about voices, re-appraisal of negative self-evaluations and enhancement of natural coping skills. The results indicate a reduction in the anger, loudness and threat of voices and reduced associated distress. Results on the PANSS showed a 50% reduction in positive and negative symptoms. Compared with a previous hospital admission, incorporating standard medical care only, the duration of hospital stay was reduced by over six weeks (56 days to 10 days). However, results were not maintained and within two months a relapse of symptoms necessitated re-admission to hospital. Potential explanations are discussed including traumatic incident shortly after discharge and underlying depressive symptomatology. Results are interpreted with reference to two psychological models of auditory hallucinations. Important clinical and research implications are described.

Key words

Voices, beliefs, self-appraisal, formulation, cognitive intervention.

Written in accordance with Behavioural and Cognitive Psychotherapy Instructions to Authors.

Chapter Seven

Testing possible causal explanations for severe memory impairment: a neuropsychological assessment case study.

Abstract

Purpose The purpose of the present study is to differentiate possible causal explanations for severe memory impairment. It is predicted that the main explanation arises from either thiamine deficiency resulting from prolonged alcohol misuse or hypoxic brain damage following status epilepticus. **Method** A range of neuropsychological tests were administered to a 28-year-old female with severe global memory impairment. In addition, clinical interviews with both the patient and her carers, and review of medical casenotes were conducted. **Results** The results indicate a clear organic presentation of memory impairment. However, there is limited observable evidence to state a clear distinctive cause of this organic damage. Factors potentially confounding deficit presentation include poorly controlled childhood epilepsy, anti-epileptic medication, ongoing seizure activity and the effects of depression. Results are discussed in the context of current knowledge regarding organic brain damage and its impact on functioning. **Conclusion** It is concluded that, in the case of the present study, a single causal entity was not identifiable due to the range and severity of impairment. Recommendations for intervention and further clinical investigation are outlined.

Written in accordance with Brain Injury Instructions for Authors.

Appendices

Appendix One British Journal of Psychiatry Instructions to Authors.

Appendix Two Ayrshire and Arran Research and Ethics Committees Submission Guidelines.

Appendix Three Clinical Psychology Forum Notes for Contributors.

Appendix Four Behaviour Research and Therapy Information for Contributors.

Appendix Five Behavioural and Cognitive Psychotherapy Instructions to Authors.

Appendix Six Brain Injury Instructions for Authors.

Appendix One

British Journal of Psychiatry Instructions to Authors

Instructions to Authors

The *British Journal of Psychiatry* is published monthly by the Royal College of Psychiatrists. The *BJP* publishes original work in all fields of psychiatry. Manuscripts for publication should be sent to The Editor, The British Journal of Psychiatry, 17 Belgrave Square, London SW1X 8PG.

All published articles are peer reviewed. A decision will be made on a paper within three months of its receipt.

Contributions are accepted for publication on the condition that their substance has not been published or submitted for publication elsewhere. Authors submitting papers to the *BJP* (serially or otherwise) with a common theme or using data derived from the same sample (or a subset thereof) must send details of all relevant previous publications, simultaneous submissions and papers in preparation.

The *BJP* does not hold itself responsible for statements made by contributors. Unless so stated, material in the *BJP* does not necessarily reflect the views of the Editor or the Royal College of Psychiatrists.

Published articles become the property of the *BJP* and can be published elsewhere in full or in part, only with the Editor's written permission.

Manuscripts accepted for publication are co-edited to improve readability and to ensure conformity with house-style.

We regret that manuscripts and figures unsuitable for publication will not normally be returned.

MANUSCRIPTS

Three high quality copies should be submitted and authors should keep one copy for reference. Articles should be 3000-5000 words long, must be typed on one side of the paper only, double-spaced throughout (including tables and references) and with wide margins (at least 4cm); all the pages including the title page must be numbered.

TITLE AND AUTHORS

The title should be brief and relevant. If necessary a subtitle may be used to amplify the main titles.

All authors must sign the covering letter; one of the authors should be designated to receive correspondence and proofs, and the appropriate address indicated. This author must take responsibility for keeping all other authors informed of the paper's progress.

All authors should clearly state their involvement in the work presented, and any conflict of interest arising, in the accompanying letter.

If authors wish to have their work peer reviewed anonymously, hey must submit their work without personal identification; names and addresses of all authors should be given in the covering letter. Otherwise the names of the authors should appear on the title page in the format that is wished for publication, and the names, degrees, affiliations and full addresses at the time the work described in the paper was carried out given at the end of the paper.

STRUCTURE OF MANUSCRIPTS

A structured summary should be given at the beginning of the article, incorporating the following headings: Background; Method; Results; Conclusions. This should be up to 150 words long. Editorials do not requires summaries.

Introductions should be no more than one paragraph (up to 150 words). Use of subheadings is encouraged, particularly in Discussion sections. Three clinical implications and three limitations of the study should be provided. A separate Conclusions section is not required.

REFERENCES

References should be listed alphabetically at the end of the paper, the titles of journals being given in full. Reference lists not in the *BJP* style will be returned to the author for correction.

Authors should check that the text references and list are in agreement as regards dates and spelling of names. The text reference should be in the form '(Smith, 1971)' or 'Smith (1971) showed that...'. The reference list should follow the style example below (note that *et al* is used after three authors have been listed for a work by four or more).

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Personal communications need written authorisation; they should not be included in the reference list. No other citation of unpublished work, including unpublished conference presentations, is permissible.

TABLES

Each table should be submitted on a separate sheet. They should be numbered and have an appropriate heading. The tables should be mentioned in the text but must not duplicate information in the text. The heading of the table together with any footnotes or comments should be self-explanatory. The desired position of the table in the manuscript should be indicated. Do not tabulate lists, which should be incorporated into the text where if necessary, they may be displayed. Authors must obtain permission if they intend to use tables from other sources and due acknowledgement should be made in a footnote to the table.

FIGURES

Figures should be individual glossy photographs or other camera-ready prints or good-quality output from a computer, not photocopies, clearly numbered and captioned below. Avoid cluttering figures with explanatory text, which is better incorporated succinctly in the legend. Lettering should be parallel to the axes. Units must be clearly indicated and should be presented in the form quantity: unit (note: 'litre' should be spelled out in full unless modified to ml, dl, etc.). Authors must obtain permission if they intend to use figures from other sources and due acknowledgement should be made in the legend. Colour figures may be reproduced if authors are able to cover the costs.

STATISTICS

Not all papers require statistical analysis. Case histories and studies with very small numbers are examples. In larger studies where statistical analyses are included it is necessary to describe these in language that is comprehensible to the numerate psychiatrist as well as he medical statistician. Particular attention should be paid to clear description of study designs and objectives, and evidence that the statistical procedures used were both appropriate for the hypotheses tested and correctly interpreted. The statistical analyses should be planned before data are collected, and full explanations for any *post hoc* analyses carried out. The value of test statistics used (e.g.: $\%^2$, t, f-ratio) should be given as well as their significance levels so that their derivation can be understood. Standard deviations and errors should not be reported as $\pm$, but should be specified and referred to in parentheses.

Trends should not be reported unless they have been supported by appropriate statistical analyses for trends. The use of percentages to report results from small sample is discouraged, other than where this facilitates comparisons. The number of decimal places to which numbers are given should reflect the accuracy of the determination and the estimates of error should be given for statistics. A brief and useful introduction to the place of confidence intervals is given by Gardner & Altman (1990, *British Journal of Psychiatry* **156,** 472-474). Use of these is encouraged but not mandatory. Authors are encouraged to include estimates of statistical power where appropriate. To report a difference as being statistically significant is generally insufficient and comment should be made about the magnitude and direction of change.

GENERAL

All abbreviations must be spelled out on the first usage. The generic names of drugs should be used and the source of any compounds not yet available on general prescription should be indicated. Generally, SI units should be used; where they are not, the SI equivalent should be included in parentheses. Units should not use indices, i.e.: report g/ml, not g ml^{-1}. The use of notes separate to the text should generally be avoided, whether they are footnotes or a separate section at the end of a paper. A footnote to the first page may however, be included to give some general information concerning the paper. If an individual patient is described, his or her consent should be obtained and submitted with the manuscript. The patient should read the report before submission. Where the patient is not able to give informed consent, it should be obtained from an authorised person. Where the patient refuses to give consent, the case study can only be written up if personal details and dates and other information which identifies the patient is omitted to ensure there is no breach of confidentiality. Contributors should be aware of the risk of complaint by patients in respect of defamation and breach of confidentiality and where concerned should seek advice.

PROOFS

A proof will be sent to the corresponding author of an article. Offprints which are prepared at the same time as the *BJP* should be ordered when the proof is returned to the Editor. Offprints are despatched up to six weeks after publication. The form assigning copyright to the College must be returned with the proof.

LETTERS TO THE EDITOR

Letters should not exceed 350 words. They will be edited for clarity and conformity with *BJP* style and may be shortened. There should be no more than five references. Proofs will not be sent to authors.

Appendix Two

Ayrshire and Arran Research and Ethics Committees Submission Guidelines

Ayrshire and Arran
Guidelines for Application and Proposals to Research and Ethics Committees

Based on Standard Operating Procedures for Local Research Ethics Committees prepared by Christine Bendall for the Scottish Office (1994)

Introduction
Ayrshire & Arran Community Health Care NHS Trust Research and Ethics Committees have together devised a standard application protocol. This protocol is based on the form used by Ayrshire & Arran Health Board Local Research Ethics Committee. The use of a standard protocol eases the submission process for researchers who have to submit their research application for ethical approval, to first the Community Trust's Ethics Committee and then the Board's Ethics Committee.

Application Form
Requiring all applicants to complete a standard application protocol enables Committees to consider applications more efficiently. Time can be saved in terms of administration and consideration of documentation, and Committees are ensured of receiving in a summarised form, all the essential basic information they require in order to perform their function. The standard documentation used by the Ayrshire & Arran Community Health Care NHS Trust research and Ethics Committees will be reviewed and updated as required.

FORMAT
1. THE TRUST ETHICS COMMITTEE specifies that applications for ethical approval of proposed research must be made in the format set out. An application form, in both printed format and on Microsoft WORD on PC disc, can be provided to all applicants.

GUIDANCE
2. THE TRUST ETHICS COMMITTEE will also provide all applicants with a copy of the guidance document in order to assist the proper completion of the proposed application.

CONTENT
3.1 THE TRUST ETHICS COMMITTEE will require all sections of the application form to be completed. Where a section is not applicable, this must be specifically indicated by the insertion of 'N/A'.

3.2 Incomplete application forms will generally be returned to the applicant for completion. However, (minor) omissions may at the discretion of the acting Chairman, be remedied by correspondence. In such cases, a letter signed by the acting Chairman should be sent to the applicant identifying the omission and requesting supply of all relevant information within a specified time fame. A copy of the applicant's subsequent response must be attached to the original application. The application may then be put to THE TRUST ETHICS COMMITTEE for consideration.

3.3 In the event that the applicant fails to reply within the time specified, the full application form should be returned for completion and resubmission. In the event that an application form is not resubmitted within two months, the full documentation originally supplied by the applicant should be returned to the applicant.

4. THE TRUST ETHICS COMMITTEE will require applications to be accompanied by the additional documentation set out in the Appendix.

5. Applicants will be requested to supply two sets of application papers, to include the documents in 1 and 4 above for the convenience of THE TRUST ETHICS COMMITTEE.

6. Following approval from THE TRUST ETHICS COMMITTEE the applicant is required to ensure that the application is submitted to the Ayrshire & Arran Health Board Ethics Committee for final approval.

Guidance Notes

- *Please read this form and accompanying notes before attempting to complete it in order to avoid unnecessary duplication of answers.*
- *Please complete all sections of this form. Where a section is not relevant tot he proposed research project please write 'N/A' in the space provided.*
- *Cross-referencing of answers is not acceptable. E.G.: responses such as "refer to protocol" or "see above" must be avoided.*
- *Sections must be completed in ink and preferably typewritten. It is acceptable if desired for applicants to prepare word-processed applications providing that this text and format are used and strictly adhered to.*
- *Please avoid the use of jargon wherever possible. If technical terms are to be used, please explain them.*
- *Forms which have not been completed will not be passed to the Committee for appraisal.*
- *On completion this form should be submitted to either of the following:*

  Sylvia Morrison, Director of Quality Services
  Ian Smith, Head of Contracts and Business Planning

INVESTIGATORS

(1) Please provide the following details of the Principal Investigator who will take overall responsibility for the conduct of the research.

(a) Name and title
(b) Appointments held/ Status
(c) Department/ Institute
(d) Address
(e) Telephone number

(2) Please provide the following details for any and all other investigators who will work on the research project.

(a) Name
(b) Appointments held
(c) Department
(d) Address
(e) Telephone number

(f) The site/s at which the research will be conducted and the facilities available.

(g) Whether research is multi-centre and to how many and which other LREC's an application in relation to the research is to be or has been made. Please specify which is to be 'lead' site for the research.
(h) The expected duration of the research.
(i) How the data generated by the research will be analysed.

PROCEDURES

(3) Please state whether the project includes procedures which

(a) are physically invasive
(b) involve the taking of bodily samples
(c) involve the administration of doses of radiation

(4) Please outline the procedures involved. This outline must include details as applicable, of:

(a) the dosage and route of administration of the drugs used in and under research
(b) other substances and/ or appliances to be administered/ used and the method of administration
(c) measurements and sample to be taken
(d) tests to be performed
(e) the use of questionnaires, visual aids or the administration of psychological tests.

(5) Please specify:

(a) which procedure/s may cause pain, discomfort, distress or inconvenience to a subject and the likely extent of such pain, discomfort, distress or inconvenience
(b) any particular requirements or abstentions that will be imposed upon the participating subject (e.g.: multiple visits, abstention from alcohol, tobacco etc).

(6) Where sample will be taken from the subject, please state which samples, the amount and frequency of them, and whether the sample would be taken as part of the normal patients care or specifically for the purposes of the research. If a sample would normally be taken as part of the usual patient care – will the amount taken be any greater due to the participation of the subject in the research?

(7) Where the research involves the use of radioactive isotopes, please confirm that the dosage proposed to be used in the research has been approved by the ARSAC, and that the person/s who will administer the dose/s is/ are properly qualified and hold/s the necessary certificates.

(8) Where the research involves the testing of a medicinal product (or medical device), please state the regulatory status of the drug/ device in question. Is the research being conducted under the terms of a product licence, CTC, CTX or DDX?

RISKS AND HAZARDS

(9) Please:

(a) describe the potential hazards or risks if any, for the subject associated with participation in the research and the precautions being taken to minimise and deal with them

(b) specify the probability and seriousness of the hazard/ risk in each case.

(10) In cases of therapeutic research involving patients, describe the alternative/ standard treatments (if any) normally given or available to the type/s of patient/s intended to be recruited to the research. Where a subject has been receiving such alternative or standard treatment prior to enrolment in the research or would normally be prescribed such a treatment, state whether that treatment will be temporarily suspended or withheld during the conduct of the research. Please state what the implications if any, of such withholding or temporary suspension may be for the subject.

GOOD CLINICAL RESEARCH PRACTICE

(11) Please confirm that the research will be carried out in accordance with recognised standards of good clinical research practice – in particular, the Declaration of Helsinki and the Committee for Proprietary Medicinal Products Note for guidance on Good Clinical Practice for Trials of Medicinal Products 1990. Please state which UK Guidelines/ Standards the investigators will adhere to.

SUBJECTS

General

(1) Please state the numbers of subjects to be recruited to the research, stating where more than one research centre will be involved, the total for the research as a whole as well as per investigation site.

(2) Please describe the type/ class of subject (e.g.: under 60's, patients with specified disease, male/ female) to be recruited to the research, setting out the inclusion criteria and stating whether they are patients or healthy volunteers, the age group or range which will be recruited and from where/ what source they will be recruited.

(3) Please describe the type of subject and conditions which are to be contraindicated and excluded from the research. What measures will be taken to identify and exclude subjects who have recently or who are concurrently taking part in other resea5rch projects?

(4) Please state whether any individual benefit to a subject's health (physical or mental) may be gained by participation in the research.

(5) Please describe the means and methods of recruitment (e.g.: advertising for subjects).

(6) Please indicate whether any payment is intended to be made to research subjects and if so, the amounts in question.

(7) Please state the relationship if any, which may/ will exist between the investigator/s and potential subjects. E.g.: will any of the subjects be students, subordinates or colleagues of the investigator or members of the Authority's staff or Investigator's staff?

(8) Please describe how information on the proposed research is to be provided to the subject? If it is not proposed to provide written information, please justify the provision of verbal information alone.

(9) Please confirm the method and manner in which the subject's consent to participation will be obtained, and where potential subjects will/ may suffer from any difficulties of

communication, the special methods to be employed both as to information and consent procedures, to overcome those difficulties.

(10) Please state:

(a) whether the subject's GP will be informed of the subject's agreement to participate in the research prior to its commencement and
(b) whether the subject's consent to contact being made and to information being supplied and obtained will be a condition of participation. If not, why not?

(11) Please state what measures will be taken to protect the confidentiality of subject's data (i.e.: arising out of the research and obtained in personal records). Who will have control of data generated by the research?

Special Groups

(12) Please state whether subjects belong to any of the following groups: children, pregnant/ nursing mothers, women of child-bearing age, the elderly, mentally incompetent, or emergencies/ unconscious patients.

(13) Please state what special or additional arrangements if any, will be applied particularly in information and consent procedures to safeguard the interests of such subjects.

(14) Please explain why it is necessary to conduct the research in such subjects and whether the required data could be obtained by any other means.

Children (i.e.: under 18 years)

(15) Please state whether and if so how, participation in the proposed research may/ will be of benefit to individual child subjects (e.g.: will the proposed subjects suffer from any condition which it is anticipated that the drug or techniques under research has the potential to alleviate, treat or diagnose?)

(16) If the proposed research is not intended to produce any direct benefit to the individual child subject, please describe and quantify the risks anticipated in relation to participation. Please state whether it would be correct to describe such risks of harm as 'negligible' (i.e.: not greater than those ordinarily encountered in daily life or during the performance of routine physical or psychological examination or tests).

(17) Where the child subject is over16, please confirm that consent to therapeutic research will be obtained form the child him/ herself.

(18) Where the child is under 16 in the case of therapeutic research or under 18 in the case of non-therapeutic research, but is judged to have the maturity and capacity to understand the nature of the research, please confirm that his/ her consent will be sought.

[In Scotland: the text should be redrafted to take Scottish law and principles into account. It is believed that for those purposes, girls of 12 and over and boys of 14 and over, who have sufficient understanding and maturity]

(19) Where the child is judged not able adequately to appreciate the nature and implications of the research in order to consent in their own right, please confirm that the child's assent and co-operation (as opposed to consent) will nonetheless be sought.

(20) Please state whether and how parental consent or the consent of the legal guardian or the order/ declaration of the Court, will be sought in relation to the participation of child subjects in the research.

(21) Please state the manner in which any apparent objection to participation by a child subject will be handled.

Mentally Incompetent Adults (i.e.: those not able to consent in their own right)
(22) Please state whether the research proposed will relate to the/ a condition suffered by the proposed subjects.

(23) Please state whether it is proposed to seek the prior approval of an informed independent adult or any other person or body to the inclusion of the subject in the research and what precise arrangements will be put in place.

(24) Please state whether:

> (a) the participation of the subject in the research could be of potential benefit to the subject in the management of his condition or in any way in relation to the maintenance or improvement of his/ her health and wellbeing
> (b) the research is non-therapeutic but may contribute to the general knowledge and understanding of the subject's condition or related conditions.

(25) Please state the degree of risk involved to the subject and its nature. Please state whether it would be correct to describe such risks of harm as 'negligible'. (i.e.: not greater than those ordinarily encountered in daily life or during the performance of routine physical or psychological examination or tests.

(26) Please state the manner in which any apparent objection to participation by the subject will be handled.

COMPENSATION FOR DEATH OR PERSONAL INJURY

(1) If the research is sponsored by a pharmaceutical company, has that company agreed to abide by: (a) the ABPI Clinical Trials Compensation Guidelines 1991 (patient studies) or (b) the ABPI Guidelines for Medical experiments in non-patient human volunteers 1988 (healthy volunteer studies)?

(2) If the research is not sponsored by a pharmaceutical company, please state what arrangements or insurance are/ is in place (if any) to compensate a subject in the event of personal injury or death arising out of participation in the research. If none, please say so.

FINANCIAL AND OTHER ARRANGEMENTS

(1) Please state any financial or other interests the applicant, his department or employer has in relation to the conduct of this research. In the case of a hospital/ university, please state what additional costs will be incurred through the conduct of the research to such institutions and how these are t be met.

(2) Please confirm that the necessary arrangements have been or will be made, to comply with the requirements of the Data Protection Act 1984 with regard to computer storage and processing of subjects' personal information and generally in the course of the research.

Signed (Investigator).....

Signed (Supervising Head of Dept/ Consultant).....

A full statement should be included here of all payments funding and grants which may be made to or have been agreed with the applicant, his department or employer in connection with the performance of the research. "Payment" includes donations of equipment or other appliances. (Such financial support should be related to expense, costs incurred and resources expended in the conduct of the research.

Client Consent

(1) It is important that the Committee is made aware of the status and type of subject to be recruited and the criteria for inclusion and exclusion of individuals. The relative level of acceptable risk in a trial may be greater in therapeutic research in patient volunteers (where there is a balancing factor of potential benefit) than in non-therapeutic research using 'healthy volunteers'.

(2) You must state whether subjects will be selected with specific reference to sex, age group and status. You should make clear what proportion of subjects recruited (if any) will act as controls.

(3) The Committee needs also to be satisfied as to the effectiveness and propriety of recruitment and selection procedures given the type and class of subject involved. E.g.: that the subject will not feel in any way obliged to participate, that advertisements do not appear to offer inducement.

(4) The Committee will be particularly interested in cases where a subject's relationship with the investigator could raise issues as to the voluntaries or motive of the subject in consenting to participation (e.g.: medical students).

(5) The need to conduct research in 'special' or vulnerable' groups as listed on the application form, should be justified and it needs generally to be shown that the data required could not be obtained from any other class of subject. The needs of special groups may indicate extra safeguards/ procedures in relation to the provision of information and consent procedures. Moreover, it should be borne in mind that research in certain groups (e.g.: children and mentally incompetent adults in a non-therapeutic context) raises difficult ethical and legal issues. It is for the applicant to make a string ethical argument for the conduct of such research in those groups taking into account that there is no clearly established legal principle which legitimises third party giving consent to non-therapeutic procedures on behalf of such a child or adult.

(6) The Committee will generally require written consent of subjects. If however, the applicant proposes for any reason (e.g.: illiteracy) not to obtain consent in writing and explanation must be given fully justifying the approach which is proposed to be adopted. It may be acceptable only to obtain and record consent orally in certain cases of research where the involvement of the subject and the requirements placed upon him/ her are strictly limited to very minor matters/ procedures. Where problems may be encountered as a result of language or hearing difficulties, the applicant must explain how these difficulties are to be handled, e.g.: interpreter, translation of documents.

(7) In any circumstances where the investigator does not anticipate being in a position to obtain a subject's consent (e.g.: studies involving emergency patients, the unconscious, children under 16 who are not judged competent in their own right) the applicant must provide full details of the course proposed to be taken with regard to consent and the justification for it. The answer must address the patient's best interests, i.e.: will or could enrolment into the research be of therapeutic value to the individual, or would the research provide information only of general scientific value. If the latter, does the research carry any risks which may result in physical or mental harm?

(8) You are advised to take into account the issues and requirements set out.

(9) The Committee prefers information sheets and consent forms to be prepared and presented as separate documents. The information sheet should be given to the subject some time in advance of the consent form and the subject must have time for consideration, asking questions etc. This does not prevent a copy of the information sheet being appended to the consent document.

(10) In the majority of cases (all in healthy volunteer studies) the Committee would expect notification to be given to the subject's GP of the intention of the subject to participate in the research, i.e.: before the research commences, rather than after. If this is not the intention, the LREC will wish to know at what stage in the research the GP will be contacted. Subject consent o such notification (and to further related communication with the GP if necessary) should therefore generally be incorporated into the consent form (and notice of this requirement added to the information sheet). If you do not intend to contact subjects' GPs please give reasons.

Ayrshire and Arran Research and Ethics Committees Submission Guidelines

APPENDIX

Documents which must accompany the application for ethical approval of proposed research.

(i) Recruitment advertisements if applicable and any other material proposed to be used for recruitment.

(ii) GP letter if applicable.

(iii) Information sheet and if any, letter of invitation.

(iv) Other relevant study documentation (e.g.: investigator brochure, CRFs, subject questionnaires, diaries). This must include all documentation of any sort which will be shown or used by subjects and is not covered by other entry on this list.

(v) Consent form.

(vi) Where applicable, form of undertaking in favour of or contract with a 'healthy volunteer'.

(vii) Protocol and the investigator's brochure or a summary of it.

(viii) Where applicable, regulatory approval in the form of a copy of any product licence CTC, CTX, DDX or other authority in writing, i.e.: proof of regulatory compliance. (Not applicable in 'healthy volunteer studies.)

(ix) Data sheet if licensed products are being used in research.

(x) Administration of Radioactive Substances Advisory Committee (ARSAC) approval, where appropriate.

(xi) Risk assessment in compliance with Health and Safety executive requirements.

(xii) Where applicable company confirmation of adherence to relevant ABPI Guidelines.

Ayrshire and Arran Research and Ethics Committees Submission Guidelines

REFERENCES

1. Good Clinical Research Practices SOPs and audit checklists for sponsors. Bohaychuck W & Ball G (1991).

2. Good Clinical Practice in Europe, Rostrum Publications (1991).

3. Spreading the word on research or patient information: how we can get it better (draft), Anderson P, Consumers for Ethics in Research (CERES) (1993).

4. Manual for Research Ethics committees compiled by Foster C, Centre for Medical Law and Ethics, Kings College, London.

5. Local Research Ethics Committees: Guidelines from DoH and the EC, Diamond & Lawrence.

6. Ethics and Healthcare: The role of research ethics committees in the UK, Neuberger J, Kings Fund Institute report 13 (1992).

7. Report to the Department of Health on Training of Local research Ethics Committees, The Director, Centre for Philosophy and Healthcare, University College Swansea and trainers Manual, Evan, Evans, Greaves and Morgan.

8. Standard Application form of the Harrow Health Authority.

9. Paragraphs and key items to assist participants in providing information to

Appendix Three

Clinical Psychology Forum Notes for Contributors

Clinical Psychology Forum

Clinical Psychology Forum is produced by the Division of Clinical Psychology of the British Psychological Society. It is edited by Steve Baldwin, Lorraine Bell, Jonathon Calder, Lesley Cohen, Simon Gelsthorpe, Laura Golding, Helen Jones, Craig Newnes, Mark Rapley and Arlene Vetere and circulated to all members of the Division monthly. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial collective welcomes brief articles, reports of events, correspondence, book reviews and announcements.

Notes for contributors

Articles of 1000-2000 words are welcomed. Shorter articles can be published sooner. Please check any references. Send two copies of your contribution, typed and double-spaced. Contributors are asked to keep tables to a minimum; use text where possible.

News of Branches and Special Groups is especially welcome.

Language: contributors are asked to use language which is psychologically descriptive rather than medical and to avoid using devaluing terminology; i.e.: avoid clustering terminology like "the elderly" or medical jargon like "schizophrenic". Articles submitted to **Forum** will be sent to members of the Editorial Collective for refereeing. They will then communicate directly with authors.

Copy

Please send all copy and correspondence to the Co-ordinating Editor:
Craig Newnes
Field House
1 Myddlewood
Myddle
Shrewsbury SY4 3RY
Tel and Fax: 01939 291209
106071.666@compuserve.com

Division News

Please send all copy to:
Helen Jones
Psychology Consultancy Service
Chaddeslode House
130 Abbey Foregate
Shrewsbury SY2 6AX
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Hjones9@compuserve.com

Book Reviews

Please send all book and review requests to the Book Reviews Editor:
Arlene Vetere
Department of Psychology
University of Reading
White Knights
Reading RG6 2AL
Fax: 01734 316604

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The British Psychological Society
St Andrews House
48 Princes Road East
Leicester LE1 7DR
Tel: 0116 252 9501 (direct line)
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Clinical Psychology Forum is published monthly and is dispatched from the printers on the penultimate Thursday of the month prior to the month of publication.

Appendix Four

Behaviour Research and Therapy Information for Contributors

BEHAVIOUR RESEARCH AND THERAPY

Incorporating ADVANCES IN BEHAVIOUR RESEARCH AND THERAPY

Information for Contributors

Behaviour Research and Therapy incorporating *Advances in Behaviour Research and Therapy* will be published monthly.

Neither the Editors nor the publisher accept responsibility for the views or statements expressed by authors.

This journal should be cited in lists of references as *Behaviour Research and Therapy*.

Manuscripts

All manuscripts submitted for publication for the regular section of the journal and all scientific correspondence should be sent to the Editor: Dr S. RACHMAN, Department of Psychology, University of British Columbia, Vancouver, British Columbia, Canada V6T 1Z4. Manuscripts for the Behavioural Assessment Section should be sent to Dr S. TAYLOR, Department of Psychiatry, 2255 Wesbrook Mall, Vancouver, British Columbia, Canada V6T 2A1.

Manuscripts should be typewritten on *one side* of the paper, *double-spaced* and in triplicate (one original and two carbon copies). The original manuscript and diagrams will be discarded one month after publication unless the publisher is requested to return original material to the author.

Manuscripts must be carefully checked and proof alterations – except printer's errors – should be minimal.

Disks

Authors are encouraged to submit a computer disk (5.25" or 3.5" HD/DD disk) containing the **final** version of the paper along with the **final** manuscript to the editorial office. Please observe the following criteria:

1. Send only hard copy when first submitting your paper.
2. When your paper has been refereed, revised if necessary and accepted, send a disk containing the final version with the final hard copy. **Make sure that the disk and hard copy match exactly.**
3. Specify what software was used, including which release, e.g.: WordPerfect 5.1.
4. Specify what computer was used (either IBM compatible, PC or Apple Macintosh).
5. Include the text file and separate table and illustration files if available.
6. The file should follow the general instructions on style/arrangement and in particular the reference style of this journal as given below.
7. The file should be single-spaced and should use the wrap-around and-of-line feature, i.e.: no returns at the end of each line. All textual elements should begin flush left; no paragraph indents. Place two returns after every element such as title, headings, paragraphs, figure and table call-outs.
8. Keep a back up disk for reference and safety.

The articles submitted must contain original material which has not been published and which is not being considered for publication elsewhere. Papers accepted by *Behaviour Research and Therapy* may not be published elsewhere in any language without the consent of the Editor.

The title of the paper, the author's name and surname and the name and address of the institute, hospital etc. where the work was carried out, should be indicated at the top of the paper. Where possible, the fax number of the **corresponding author** should be supplied with the manuscript for use by the publisher.

Summaries A summary not exceeding 200 words, should be submitted on a separate sheet in duplicate. The summary will appear at the beginning of the article.

Key words Authors should include up to six key words with their article. The controlled list of key words is based on the APA list of index descriptors; however, authors may include one or two additional 'free' words if they wish to do so.

References should be prepared carefully using the *Publication Manual of the American Psychological Association* for style. They should be placed on a separate sheet at the end of the paper, double-spaced and in alphabetical order. References should be quoted in the text by giving the author's name, followed by the year, e.g.: (Hersen and Barlow, 1976) or Hersen and Barlow (1976). For *more than two* authors the name of the first author is given followed by the words "et al" as for example: Nau et al. (1974).

[Continued opposite

BEHAVIOUR RESEARCH AND THERAPY

Incorporating BEHAVIORAL ASSESSMENT

Information for Contributors – continued]

References to journals should include the author's name followed by initials, year, paper title, journal title, volume number and page numbers, e.g.:

Singh, N. N. (1980). The effects of facial screening on infant self-injury. *Journal of Experimental Therapy and Experimental Psychiatry, 11,* 131-134.

Or

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J. & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4,* 561-565.

References to books should include the authors' name followed by initials, year, paper title, editors, book title, volume and page numbers, place of publication, publisher, etc, e.g.:

Brownell, K. D. (1984). Behavioural medicine. In C. M. Franks, G. T. Wilson, P. C. Kendall & K. D. Brownell (Eds.), *Annual review of behaviour therapy* (Vol. 10, pp 11-20). New York: Guilford Press.

Footnotes, as distinct from literature references, should be indicated by the following symbols: *, †, ‡, §, ||, ¶, commencing anew on each page.

Illustrations and diagrams should be kept to a minimum: they should be numbered and marked on the back with the author's name. Caption's accompanying illustrations should be typewritten on separate sheets. Diagrams and graphs must be drawn with Indian ink on stout paper or tracing linen.

Photographs and photomicrographs should be submitted unmounted on glossy paper.

The following standard symbols should be used in line drawings since they are easily available to the printers:

Tables and figures should be constructed so as to be intelligible without reference to the text, each table and column being provided with a heading.

Tables Captions should be typewritten together on a separate sheet. The same information should not be reproduced in both tables and figures.

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Reprints Reprints and copies of the issue (at a specially reduced rate) may be obtained at a reasonable cost provided that they are ordered when the proofs are returned and using the reprint order form which will accompany author's proofs.

Appendix Five

Behavioural and Cognitive Psychotherapy Instructions to Authors

Submission

Articles written in English and not submitted for publication elsewhere should be sent to:

Paul Salkovskis
Editor
Behavioural and Cognitive Psychotherapy
Department of Psychiatry
University of Oxford
Warneford Hospital
Oxford OX3 7JX
UK

Manuscript preparation

Four complete copies of the manuscript must be submitted. Original figures should be supplied at the time of submission. Articles must be typed double-spaced throughout on standard sized paper (preferably A4) allowing wide margins all round. Where unpublished material e.g.: behaviour rating scales, therapy manuals, is referred to in an article, copies should be submitted to facilitate review. Manuscripts will be sent out for review exactly as submitted. Authors who want a blind review should mark three copies of their article 'review copy', omitting from these copies details of authorship and other identifying information. Submission for blind review is encouraged. *Abbreviations* where used must be standard. The Systeme International (SI) should be used for all units; where metric units are used the SI equivalent must also be given. Probability values and power statistics should be given with the statistical values and the degrees of freedom (e.g.: $F(1, 34) - 123.07$, $p < .001$), but such information may be included in tables rather than the main text. *Spelling* must be consistent within an article, either using British usage *(The Shorter Oxford English Dictionary),* or the American usage *(Webster's new collegiate dictionary).* However, spelling in the list of references must be literal to each original publication. Details of style not specified here may be determined by reference to the *Publication Manual of the American Psychological Association* or the style manual of the British Psychological Society.

Articles should conform to the following scheme:

(a) *Title page.* The title should phrase concisely the major issues. Author(s) to be given with departmental affiliations and addresses grouped appropriately. A running head of no more than 40 characters should be indicated.

(b) *Abstract.* The abstract should include up to six key words that could be used to describe the article. This should summarise the article in no more than 200 words.

(c) *Text.* This should begin with an introduction, succinctly introducing the point of the paper to those interested in the general area of the journal. *Attention should be paid to the Editorial Statement which appears in the January and July issues at the back of the Journal.* References within the text should be given in the form Jones and Smith (1973) or (Jones & Smith, 1973). When there are three or up to and including five authors the first citation should include all authors; subsequent citations should be given as Williams *et al* (1973). Authors with the same surname should be distinguished by their initials. The approximate positions of tables and figures should be indicated in the text. Footnotes should be avoided where possible.

(d) *Reference note(s).* A list of all cited unpublished or limited circulation material, numbered in order of appearance in the text, giving as much information as possible about extant manuscripts.

(e) *References.* All citations in the text should be listed in strict alphabetical order according to surnames. Multiple references to the same author(s) should be listed chronologically, using a, b, etc, for entries within the same year. Formats for journal articles, books and chapters should follow these examples:

BECKER, M. R. & GREEN, L W. (1975). A family approach to compliance with medical treatment: A selective review of the literature. *International Journal of Health Education, 18,* 173-182.

THARP, R. G. & WETZEL, R. J. (1969). *Behaviour modification in the natural environment.* New York: Academic Press.

ROSKIFS, E. & JAZARUS, R. S. (1980). Coping theory and the teaching of coping skills. In P. O. Davidson & S. M. Davidson (Eds), *Behavioural Medicine: Changing Health Lifestyles.* New York: Brunner/ Matzel.

(f) *Footnotes.* The first and preferably only footnote will appear at the foot of the first page of each article and subsequently may acknowledge previous unpublished presentation (e.g.: dissertation, meeting paper), financial support, scholarly or technical assistance or a change in affiliation. A concluding (or only) paragraph must be the name and full mailing address of the author to whom reprint requests or other enquiries should be sent.

(g) *Tables.* Tables should be numbered and given explanatory titles.

(h) *Figure captions.* Numbered captions should be typed on a separate page.

(i) *Figures.* Original drawings or prints must be submitted for each line or half-tone illustration. Figures should be clearly labelled and be camera-ready wherever possible.

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Appendix Six

Brain Injury Instructions for Authors

BRAIN INJURY: Instructions for authors

Submission

Contributions, which may be in the form of reviews, original papers, case studies, programme developments or letters to the Editors, should be sent to Henry H Stonnington (Medical Director, Rehabilitation Center of Memorial Medical Center, Provident Office Building, 4750 Waters Avenue, Suite 307, Savannah, GA 31404, USA), Nathan Cope (Paradigm Health Corporation, 1001 Galaxy Way, Suite 400, Concord, California 94520, USA), William McKinlay (Case Management Services Ltd, 17a Main Street, Balerno, Edinburgh EH14 7EQ, UK) or to one of the regional editors listed on the inside front cover. Two complete copies should be submitted, typed double-spaced, on standard 8.5 x 11 in paper with ample margins. Manuscripts are accepted on the understanding that they are not already under consideration for publication by another journal.

Style and presentation

Manuscripts should be in English, typed or printed out, double-spaced on A4 or 8.5 x 11 in paper and the pages numbered. Pages should include a separate title page with a clear, specific, but brief title and a suggestion for a shorter title (40 characters or less) for running heads should be included. The names and present affiliations of each author should be given. One author should be designated as the corresponding author to whom proofs and offprint requests should be addressed and a full correspondence address, including telephone and fax numbers given as a footnote. All papers must have an abstract not exceeding 200 words and including a statement of purpose, methods used, results obtained and conclusions reached. No keywords are necessary. The text should be divided into sections; original papers should use headings in the order: Introductory paragraphs, Methods, Results, Discussion. All terms to be abbreviated should be spelled out at first mention with the abbreviation following in parentheses. Avoid obscure abbreviation, slang, jargon and other usage that decreases clarity. CITE REFERENCES CONSECUTIVELY BY NUMBER. ALL references must be cited in the text. Personal communications and unpublished data should be placed in parentheses in the text, not in the list of references. Also cite each figure and table in the text and indicate clearly where these are to be positioned. Use Arabic numbers for both figures and tables.

Tables

Tables should be cited in the text. Each table should be given a number and a brief informative title and should appear on a separate page. Omit vertical rules and use extra space to delineate sections of a table. Explain in footnotes all abbreviations used in the table. For footnotes, use the following symbols in this sequence, †, ‡, §, ||, ¶, and then double symbols as necessary.

Illustrations

Use only those illustrations that clarify and augment the text. Authors are asked to provide glossy prints or good photocopies; computer printouts should be re-drawn wherever possible. Each figure should have a label pasted on its back indicating the figure number and the top of the figure. Legends should be on a separate sheet. Specific permission for facial photographs of patients is required. A letter of consent must accompany the photographs of patients in which a possibility of identification exists. It is not sufficient to cover the eyes to mask identity.

References

References must be cited in the text CONSECUTIVELY BY NUMBER, and listed at the end of the paper in the following styles (provide all authors' names for three or fewer; where there are three or more than three, add 'et al'):

1. BROOKS, N., MCKINLAY, W., SYMINGTON, K *et al:* Return to work within the first seven years of severe head injury. *Brain Injury,* **1:** 5-19, 1987.

For a book:

2. RIMEL, R. W. and JANE, J. A.: Characteristics of the head-injured patients. In M. Rosenthal, E. R. Griffith, M. R. Bond and J. D. Miller (editors) *Rehabilitation of the Head Injured Adult.* (Philadelphia: F. A. Davies Company), pp. 9-21, 1983.

Guidelines for animal and human research

When experimental animals are used, state the species, strain, number used and other pertinent descriptive characteristics. For human subjects or patients, describe their characteristics. When describing surgical procedures on animals, identify the pre-anaesthetic and anaesthetic agents used and state the amount of concentration and the route and frequency of administration for each. The use of paralytic agents such as curare or succinylcholine, is not an acceptable substitute for anaesthetics. For other invasive procedures on animals, report the analgesic or tranquillising drugs used; if none were used, provide justification for such exclusion. When reporting studies on unanaesthetised animals or on humans, indicate that the procedures followed were in accordance with institutional guidelines.

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Offprints

Fifty (50) offprints will be sent to the principal author of each paper. An order form for additional offprints will accompany the proofs. There are no page charges in *Brain Injury*.

Acknowledgements

Thank you to all the patients who participated in the study, without whom there would be no research! Your willingness to trust me and share personal and distressing information with me is appreciated. Thanks also to the three individuals who agreed for their efforts in assessment and treatment to be documented as case studies. You have both collectively and individually, taught me the importance of curious listening and sympathetic questioning and have helped reduce my discomfort with knowing I don't have the answers.

Thanks to all the staff in Ayrshire - Nurses, Psychiatrists and Psychologists - who trusted me enough to refer their patients to the study. Thanks to Margaret (research team secretary) for your admin support and to all the CMHT staff for your hospitality in allowing me to share your already cramped and cosy team base. Thanks also to Alison (psychology assistant) for your help with social (and alcohol!) therapy, which helped keep me sane.

For practical and sensible guidance (especially regarding method and statistics!) thanks to Paul Fleming. Thank you to Andrew Gumley for being a source of constant support and inspiration. I may never reach your highest of standards, although I will continue with my feeble attempts. To Kate Davidson, I appreciate your timely encouragement as well as your excellent teaching. Thanks also for your help (and endless patience!) with statistics for the service evaluation project. Thanks to the psychologists who gave of their time to enable me to collect data on their referrals. Your prompt responses were appreciated. Special thanks to Sheila Neilson for, amongst uncountable practical help, your stability and humour. No matter the problem, it's reassuring to know that when you answer the phone, all is well with the world!

I also thank Mike Henderson, although not a formal part of my training in clinical psychology, who has nevertheless kept my feet on the ground with his words of earthly wisdom. What I learned from you as an assistant psychologist has been a foundation for my learning in formal clinical and research training. I intend to continue being 'curious, interested, sympathetic, reflective and a wee bit distanced' in all areas of my work as a psychologist.

Most importantly, thanks to my peers for all the arguments and laughs. Especially to Ewan for trusting my brain enough to share in exam study. Enormous thanks to Kirsten for your patience and support. You were there to listen to the tears and moans - you truly are a pal.