Cognitive distortions and emotional states of sex offenders

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Abstract

Study aim: To investigate whether cognitive emotions and emotional states are different in three groups, namely: Sex offenders against adults, child sex offenders and non-sexual offenders. Cognitive distortions and emotional states prove to be valid predictors of treatment potential, predicted relapse in crime behaviour and are considered effective treatment procedures. By gaining insight into these distorted thinking patterns and emotional states, crimes can possibly be prevented in the future.

Material and methods: Patients staying in TBS clinic De Rooyse Wissel were included in the current study. To investigate cognitive distortions and emotional states, the schema modes inventory (SMI): and young schema questionnaire (YSQ) were used. The PCL total score, the Psychopathy Checklist from Hare (1980), comes from file study. Differences in psychopathy and crime type has been tested. To test whether the averages are the same between groups, one way ANOVA were performed. To examine the correlation of the YSQ-S3 and SMI-R subscales, multivariate ANOVA (MANCOVA) is used to determine group differences (sex offenders against adults, child sex offenders, non-sexual offenders) while controlling for PCL-R scores.

Results: A total of 77 patients participated in the current study: 23 sex offenders against adults, 23 child sex offenders and 31 non-sexual offenders. Based on the MANCOVA, no significant differences were found between the early maladaptive schemata (EMSs) and modes of the different groups.

Conclusion: Our findings suggest that early maladaptive schemata (EMSs) and modes do not differ between patients with different types of offenses (sex offenders against adults, child sex offenders and non-sexual offenders). In conclusion, schemata and schemamodes do not differ from patients with different types of offenses (sex offenders against adults, child sex offenders and non-sexual offenders). Therefore, this method cannot currently be implemented into this type field.

Introduction

Sexual violence occurs whenever a person is forced, coerced, and/or manipulated into any unwanted sexual activity, including when he/she is unable to consent due to age, illness, disability, or the influence of alcohol or drugs. Examples of sexual violence are rape, incest, child sexual assault, sexual exploitation, and voyeurism. In recent years, the number of victims of sex offenses in the Netherlands has increased from 18% of girls and 4% of boys (<25 years) in 2005 to 41% of girls and 21% of boys (<25 years) in 2011 (De Graaf, Kruijer, van Acker & Meijer, 2012; De Graaf, Meijer, Poelman & Vanwezenbeeck, 2005). The psychological and emotional impact on the victims of sex offenders, the high recidivism risk of sex offenders and the financial costs for society, call for more research on assessment and treatment of sex offenders (Hanson, Steffy, & Gauthier, 1999; Kokish, Levenson & Blasingame, 2005).

Multiple previous studies have shown that there are four constructs of symptoms and problems that are typically found in sex offenders, namely emotional regulation problems, cognitive distortions, social problems and abnormal sexual arousal (e.g. Hanson & Harris, 2000; Marshall, 1989; Thornton, 2002; Ward & Beech, 2004). The first construct, problems with emotional regulation, refers to the problems with controlling emotions or mental states (McGrath, Cann & Knonopasky, 1998, Marshall, 1999; Ward & Beech, 2006). Negative feelings, depression and negative situational factors often appear to be precursors of sexual aggression (Pithers, 1994). In addition, many studies have shown that emotional loneliness and intimacy deficits are present in the sexual aggressor (Garlick, Marshall, & Thornton, 1996; Seidman, Marshall, Hudson, & Robertson, 1994; Ward, McCormack, & Hudson, 1997). An inability to effectively regulate emotional states can lead to loss of control and feelings of stress and impotence. This level of stress can lead to disinhibited use of sex as a relaxing strategy (Ward, Hudson & Keenan, 1998; Ward & Siegert, 2002). Cortoni and Marshall (2001) found that child abusers used significantly more emotion focused strategies than sex offenders against adults and non-sexual offenders. Empathic deficits and selective empathy inhibition are ultimately automatic cognitive responses to avoid shame and guilt after the offending experience (Bumby, 2000). Also the study from Carvalho and Nobre (2014) shows that sex offenders score significantly higher than non-sexual offenders on problems with impaired autonomy and performance, which suggest that sex offenders are more dependent individuals.

The second construct, abnormal sexual arousal, refers to deviant arousal of sexual desire, such as hyper sexuality (Thornton, 2002). Typically, cognitive distortions and emotional regulation problems are important targets for psychological treatment of sex offenders (McGrath, Cann & Knonopasky, 1998, Marshall, 1999; Ward & Beech, 2006). After periods of rejection by adults, extreme loneliness or disappointment, one often sees a deviant sexual interest towards young children. For example, adults with mental disorders may feel a better connection with children than with adults because they interact at the same level of development (Ward & Beech, 2004).

The third construct, social problems, refers to difficulties in self-management and adaptability that are precursors to offenses. Bickley and Beech (2002) found that sex offenders who used passive strategies, restraint and suddenly, during their offense were more impulsive, subconscious and externally controlled than sex offenders who used active, considered and prepared, strategies during their offense. Lifestyle impulsivity has proven to be a good predictor of recurrence among rapists (Ward & Beech, 2004). Likewise, poor self-control can have an indirect influence on recidivism in a sex offender. Consider, for example, a disruption with a vulnerable victim (sad victim or during a burglary or similar). In these cases, well-considered thinking is missing. Self-management skills are needed to support life changes in long term and are therefore important for the treatment of sex offenders. Research by Chakhssi, de Ruiter and Bernstein (2013) shows that there is a difference in early maladaptive schemes between child abusers and sex offenders against adults on schemes related to abandonment, social isolation, suppression of failure/shame, social isolation and self-sacrifice. These concepts triggers the avoidant coping modes and the overcompensatory modes that indicate withdrawal or overcompensation as self-protection.

Finally, cognitive distortions, refer to distorted thinking patterns and attitudes that serve to justify, minimize and rationalize the actions of the offender (Abel, Becker, & Cunningham-Rathner, 1984; Murphy, 1990; Stermac & Segal, 1989). An example of cognitive distortions among sex offenders is that sexual behaviour is rarely harmful, even if the recipient is a child. Child sex offenders often believe that children are also sexually active or benefit from sexual intercourse (Ward, 2000; Marshall, Marshall, Serran, & Fernandez, 2006). Sex offenders against adults often have a disturbed perception that women try to mislead men concerning their

continuous sexual needs (Polaschek, & Ward, 2002). Sex offenders often blame their crime on the victim and trivialize their crimes with a distorted perception of their behaviour (Barbaree, 1991; Ward, Hudson, Johnston, & Marshall, 1997; Gannon, Wright, Beech, & Williams, 2006). Because of this distorted perception, the offender is able to accept the deviant sexual behaviour and continue with other crimes, often without experiencing any feelings such as guilt, shame or fear (Abel, Becker, & Cunningham-Rathner, 1984; Murphy, 1990).

Each construct shows a specific deviation with different psychological and behavioral profiles, underlying deficits and etiologies. The four constructs can activate each other but can also cause sexual deviations in themselves. With focus on these deviant constructs during treatment, sexual offenses can possibly be prevented (Ward & Beech, 2004).

Successful treatment of sex offenders demands detailed information of the cognitive factors such as cognitive distortions, which largely determine the initiation, maintenance and justification of sexual crimes (Beck, 1996). Cognitive distortions are often valid predictors of treatment potential and success, and are also an important part of cognitive behavioural treatment of sex offenders (Bumby, 1996; Yates, 2013). Cognitive behavioural interventions and cognitive restructuring are considered to be effective treatment procedures for sex offenders (Mann & Fernandez, 2006; Marshall, Marshall, Serran, & Fernandez, 2006; Drake & Ward, 2002). Yochelson and Samenow (1977) argue that the only effective method to prevent a chronic sex offender from relapsing is to identify and change possible existing distorted thought patterns. Possibly distorted thought patterns have given the offender a trigger or the decisive factor to an offense. By making the offender aware of these distorted thinking patterns and possibly changing them, such an offense can maybe be prevented.

In recent years, Schema Therapy (ST; Young, Klosko & Weishaar, 2003) has been increasingly used for conceptualization and treatment for long-lasting emotional problems and personality pathology in offenders, including sex offenders. Schema Therapy combines insights from psychodynamic, cognitive behavioural therapy, and experimental approaches. Schema therapy distinguishes between 3 central concepts, namely; early maladaptive schemata (EMS), dysfunctional coping styles, and fluctuating emotional states (also referred to as “schema modes”). In sex offenders, ST conceptualizes cognitive distortions as stable and permanent offense supportive dysfunctional beliefs and attitudes about themselves, others and the

environment. These arise from patterns of early family interaction and serve as a guide for later information processing and behavioural patterns (Baker & Beech, 2004; Young et al., 2003). A recent study explored whether different types of sex offenders (i.e., child sexual abusers and sex offenders against adults) have different cognitive distortions or early maladaptive schemata (Chakhssi, de Ruiter, & Bernstein, 2013). Results showed that early maladaptive schemata related to abandonment, social isolation, defectiveness/shame subjugation and self-sacrifice were more prevalent in child sexual offenders compared with non-sexual offenders. Furthermore, with sexual offenders against adults, child sexual offenders showed a trend to have higher scores on EMSs related to social isolation (Chakhssi et al., 2013).

According to ST, offenders with severe psychopathology or longstanding emotional problems can exhibit frequent and rapid fluctuations in emotional states, or remain rigidly stuck in a particular emotional state, lacking the flexibility to respond adaptively to situations and regulate emotions. These states are also referred to as schema modes (Young, Klosko, & Weishaar, 2003). A recent study shows that schema modes play an important role in explaining violent behaviour in 90 offenders of which 27 were charged for a sexual offence (Keulen-de Vos et al., 2016). For example, criminal behaviour is often preceded by schema modes that refer to feelings of vulnerability and abandonment, loneliness, and states of intoxication. Criminal behaviour itself is characterized by schema modes that refer to states of impulsivity, anger, and the use of overcompensatory strategies involving threats, intimidation, and aggression (Keulen-de Vos et al., 2016). Schema Therapy distinguishes four types of maladaptive schema modes: child modes, avoidant coping modes, parent modes, and overcompensatory modes. Child modes refer to feeling, thinking and acting in a child-like manner. The name of the domain refers to childhood basic emotional needs that have been neglected, overindulged or frustrated (Young et al., 2003). Dysfunctional parent modes refer to internal critic, messages that reflect negative internalized parent behaviour and emotional stance. Avoidant coping modes involve attempts to protect oneself from pain by means of avoiding whereas overcompensatory modes refer to extreme attempts to overcompensate painful feelings (Young et al., 2003). See Appendix B for an overview of each domain and schema mode.

The relationship between cognitive distortions and emotional states among sex offenders has rarely been investigated. But it is assumed that there is a possible causal and/or reinforcing

relationship between them (Ward, Hudson, Johnston, & Marshall, 1997). Mann and Beech (2003) presented a case example of a sex offender who was stuck in a cognitive pattern that gave him control over others, with the cognitive distortions that others will otherwise hurt him. As his threatening thoughts become stronger, this could activate the emotional state of fear and anger, activating the motivational state of humiliation or domination. For the sex offender, sexual assault becomes an appropriate, necessary of attractive behavioural response. These findings raise the question of the extent to which the cognitive distortions and emotional states of sex offenders differ from non-sex offenders, and the distinction between sex offenders against adults and child abusers. Mentioned earlier, cognitive distortions are often valid predictors of treatment potential, predict relapse in delict behaviour and are considered effective treatment procedures (Bumby, 1996; Mann & Fernandez, 2006; Marshall, Marshall, Serran, & Fernandez, 2006; Drake & Ward, 2002 Yates, 2013; Yochelson & Samenow, 1977). By mapping these possible distorted thinking patterns, new offenses can be prevented. Little research has been done into the connection between cognitive distortions and emotional states. This current study will provide insight into this possible connection.

Current study and hypotheses

The main purpose of this study is to explore EMSs and schema modes in child sex offenders and sex offenders against adults, compared to non-sexual offenders. Based on the results and assumptions of the earlier mentioned studies, with regard to cognitive distortions, this study hypothesize that sex offenders against adults are more likely to endorse early maladaptive schemata related to over-vigilance and inhibition and impaired autonomy and performance compared to child sex offenders and non-sexual offenders (hypothesis 1). Carvalho and Nobre (2014) endorse this hypothesis. Their study shows that sex offenders score significantly higher than non-sexual offenders on problems with impaired autonomy and performance, which suggest that sex offenders are more dependent individuals.

Mann and Beech (2003) presented that when threatening thoughts of sex offenders become stronger, this could activate the emotional state of fear and anger, activating the motivational state of humiliation or domination. With regard to schema modes, we expect child sex offenders to endorse schema modes primarily related to avoidant schema modes (e.g.,

detached from emotions, compliance) and overcompensatory modes that refer to manipulation (grooming behaviour) and controlling their environment, compared to sex offenders against adults and non-sexual offenders (hypothesis 2).

Next, in line with research findings that child sex offenders are often victims of abuse (i.e., sexual, physical) and neglect (Jespersen, Lalumière, & Seto, 2009; Whitaker et al., 2008), we hypothesize that child sex offenders are more likely to endorse EMSs related to disconnection and rejection and schema modes related to child modes compared to non-sexual offenders (hypothesis 3).

Finally, in line with research findings that rapists' level of aggression are often significantly higher than that of child abusers (Shechory & Ben-David, 2005), we expect sex offenders against adults to endorse schema modes that primarily refer to aggression, impulsivity and overcompensatory emotional states, compared to child sex offenders and non-violent sex offenders (hypothesis 4).

Material and methods

Participants

A total of 77 patients participated in the current study: 23 sex offenders against adults, 23 child sex offenders and 31 non-sexual offenders. They all have a treatment on behalf of the state (TBS) measure. Taking the conservative .80 as the lower bound estimate and with power set at .95 and alpha = 0.05, two-tailed, G*Power analysis indicated that the required sizes to demonstrate an effect would be 30 patients for each sub-sample. Exclusion criteria for participating in this study were the presence of acute psychotic symptoms and an acute relapse in drug or alcohol use. These factors influence patients focus, which is needed for the tests used.

Setting

De Rooyse Wissel is a forensic centre where patients with psychiatric problems are treated. Patients of De Rooyse Wissel generally have a treatment on behalf of the state (TBS) measure, sometimes another criminal or civil measure. This measure can be imposed when a person has committed a crime with a minimum penalty of 4 years and who is declared totally or

partially unaccountable for their actions because they have (a) mental disorder(s) (van Marle, 2002). The goal of TBS is to protect society in the short term and to reduce the recidivism risk in the long term, by treating the mental disorder(s). Every 1 to 2 years, an interdisciplinary evaluation is made to verify whether the measure should be extended or terminated.

Design

The research had a cross-sectional design; each patient is measured once. Diagnostic details will be retrieved from the dossiers of the patients. This study has been approved by the institution. Because this study is part of an ongoing study, no additional ethical approval was obtained (part of University of Maastricht METC 06-3-066). The original study is a randomized clinical trial (RCT) on the effectiveness of schema therapy in offenders with personality disorders.

Materials

Schema Mode Inventory (SMI-R)

The SMI-R is a self-report questionnaire to measure the frequency of schema modes, which refers to how often the participant was in a certain emotional state in the past six months (Lobbestael et al., 2010). The questionnaire contains 80 items and rates 16 schema modes which are merged into 5 domains (Appendix A). Administration time is approximately 20 minutes. The 80 items of the SMI-R are scored on a 6-point Likert frequency scale (1= never, 6= always). Each schema mode is calculated based on the average of the items from that mode. Examples of Items are: ‘I feel sad’ (Child modes), ‘I feel detached’ (Avoidant coping modes), ‘I have to be the best in what I do’ (Parent mode), ‘My needs and feelings are wrong’ (Overcompensatory mode), ‘I’m worth it’ (Healthy mode) . Appendix C shows all items of the SMI-R, in Dutch. The SMI-R is a reliable instrument for assessing schema modes in offender samples with Cronbach’s alpha ranging from .69 to .90 (Keulen-de Vos, et al., 2017). Studies in non-forensic samples also show good to excellent internal consistency (Cronbach’s alpha ranging from .76 to .96).

Young Schema Questionnaire (YSQ-S3)

The YSQ-S3 is a self-report questionnaire to measure the presence of early maladaptive schemata in the past six months. The questionnaire contains 90 items and 18 schema modes

which are merged into 5 domains (Appendix 2). Administration time is approximately 20 minutes. The 90 items of the YSQ-S3 are scored on a 6-point Likert frequency scale (1=absolutely not applicable to me, 6= entirely applicable to me). Each schema mode is calculated based on the average of the items from that mode. Examples of Items are: 'I need people so badly that I'm afraid of losing them' (Disconnection and rejection), 'I feel unable to manage alone in daily life' (Impaired autonomy and performance), 'I have a hard time accepting refusal if I want something from other people' (Impaired limits), 'If I do what I want, I will only get into trouble' (Other directedness), 'Even when things seem to go well, I feel that this is only temporary' (Over-vigilance and inhibition). Appendix D shows all items of the YSQ-S3, in Dutch. The YSQ-S3 has proven to be an adequate and stable measuring instrument in clinical practice, with Cronbach's alpha ranging from .54 to .83 (Rijkeboer, van den Bergh & van den Bout, 2005; Calvete, Orue, & González-Diez, 2013).

Psychopathy Checklist-Revised (PCL-R)

The PCL total score comes from file study. The Psychopathy Checklist-Revised (PCL-R; Hare, 2003) assesses a patient's level of psychopathy based on 20 items that are rated on a 3-point Likert-type scale (0 = item does not apply, 1 = item applies to a certain degree, 2 = item definitively applies). Total scores can range from 0 to 40. The PCL-R is the most widely used instrument for assessing psychopathy and has been extensively studied (e.g., Leistico, Salekin, DeCoster, & Rogers, 2008). Appendix E shows the twenty traits of the Hare Psychopathy checklist. Examples of traits are: 'Pathological lying', 'Glib and superficial charm' and 'Grandiose sense of self'.

Procedure

Tests are performed by one researcher, a student from Tilburg University, Master clinic forensic psychology, a trainee since September 2018 at FPC De Rooyse Wissel. The researcher gave the patient information about the study, what the patient can expect and what the researchers are expecting from the patient during the research. Before approaching the patients, permission is asked from the treatment coordinator. After permission from the treatment coordinator, the patient is asked to cooperate with the study. The patient received an information letter and was given two weeks to think about participating. All participants gave their written

informed consent to participate in the study and to collect file information (e.g., index crime, age, diagnoses).

After permission for participation given during an intake between researcher and participant, an appointment was scheduled for administering the two questionnaires. In this appointment, the patient filled out the SMI-R, followed by the YSQ-S3. The questionnaires are administered on paper and the patient was allowed to ask questions during the entire appointment.

The intake took place at the unit where the patient was staying, but the questionnaires were administered in an office in the diagnostics and research department.

Statistics

First of all, the average and standard deviations have been calculated for all schemes, modes and domains of the YSQ and the SMI (Table 3). Normality of distribution and homogeneity of variance between groups are tested for all data. In cases of non-normal distribution, according to Kurtosis and Skewness, data have been log-transformed for creating new normalized variables. Next differences regarding psychopathy and crime type were analysed. To verify whether the averages between groups were similar, one way ANOVA was performed. To examine the correlation of the YSQ-S3 and SMI-R subscales, multivariate ANCOVA (MANCOVA) is used to determine group differences (child sex offenders, sex offenders against adults, non-sex violent offenders) while controlling for PCL-R scores.

Results

The sample of this study consisted of 77 male TBS patients from De Rooyse Wissel. A distinction has been made between patients based on crime. The type of crimes were child sex offenders (29.9%, *n*=23), sex offenders against adults (29.9%, *n*=23) and non-sexual offenders (40.3%, *n*=31). The mean age of the patients at start therapy was 39.33 years (*SD*=9.3) and the mean age at the first conviction was 23.23 years (*SD*= 9.6). The Borderline Personality disorder (PD) (17,6%) and the Histrionic PD (17,5%) are most common in the sample. All diagnoses are included in table 1a. Most patients have disorders related to drugs use (42,5%) and Paraphilia disorders (16,8%). All disorders are included in table 1b. The PCL FINAL score runs from 2 to 37 with a mean of 24.2 (*SD*=7.8).

Current study showed a Cronbach's alpha ranging from .78 to .91 for the individual scales. For the domains of the YSQ, the Cronbach's alpha was ranging from .84 to .95 (Table 2a). For the domains of the SMI the Cronbach's alpha was ranging from .78 to .93 (Table 2b). Table 3 shows the mean and standard deviation of the domains for all type of crimes. Kurtosis and Skewness showed that a number of domains (Child modes and Parent modes) were not-normally distributed, these data have been log-transformed for creating new normalized variables.

Analysis of covariance

ANCOVA demonstrated that on average, sex offenders against adults score higher on the psychopathy scale (*M*=26.22, *SE*=1.49) than non-sexual offenders (*M*=25.21, *SE*=1.31) and likewise higher than child abusers (*M*=20.85, *SE*=1.76). There was a significant effect of psychopathy on type of crime at the $p<.05$ level for the three conditions F=(2,73)=3.293, $p=0.043$).

The difference of finale score of psychopathy was not significantly related to the dependent variables 'Over-vigilance and inhibition' and 'Impaired autonomy and performance' of the YSQ (Pallai's Trace, V=0.02, $F(1,67)=0.67$, $p>.05$). There was also no significant effect of type of crime on the dependent variables after controlling for the effect of psychopathy, V=0.14, $F(1,67)=2.400$, $p>.05$ (hypothesis 1). Type of crime was at a trend level of significance with a *p*-value of 0.053 (Table 4).

The difference of finale score of psychopathy was not significantly related to the dependent variables 'Overcompensatory modes' and 'Avoidant coping modes' of the SMI (Wilks's Lambda, $\Lambda=0.98$, $F(1,70)=0.84$, $p>.05$) (hypothesis 2). There was also no significant effect of type of crime on the dependent variables after controlling for the effect of psychopathy, $\Lambda=0.99$, $F(1,70)=0.12$, $p>.05$.

The difference of finale score of psychopathy was not significantly related to the dependent variables 'Child modes' and 'Disconnection and rejection'(Wilks's Lambda, $\Lambda=0.99$, $F(1,69)=0.24$, $p>.05$) (hypothesis 3).There was also no significant effect of type of crime on the dependent variables after controlling for the effect of psychopathy, $\Lambda=0.89$, $F(1,69)=1.99$, $p>.05$.

The difference of finale score of psychopathy was not significantly related to the dependent variables 'Avoidant coping modes', 'Child modes' and 'Overcompensatory

modes'tion' (Wilks's Lambda, Λ=.973, $F(1,69)=0.63$, $p>.05$). There was also no significant effect of type of crime on the dependent variables after controlling for the effect of psychopathy, Λ=0.92, $F(1,69)=1.007$, $p>.05$ (hypothesis 4).

Discussion

This study examined the correlation between cognitive distortions and emotional states in child sex offenders and sex offenders against adults, compared to non-sexual offenders. Cognitive distortions are operationalized to early maladaptive schemata and emotional states to schema modes. Previous research showed that psychopathy is one of the most important clinical constructs in criminal justice and mental health, consequently analyses were controlled for psychopathy by adding the PCL-score as covariate (Hare, Clark,Grann, & Thomton, 2000). According to our results, the group non-sexual offenders score noticeably lower on all the domains of the YSQ and SMI variables. Regarding the healthy modes of the SMI, child abusers score significantly lower than the sex offenders against adults and the non-sexual offenders. However, these findings are not reflected in the multivariate analyses of covariance. MANCOVA analyses gave no significant differences between the different schemata and modi for the different groups (sex offenders against adults, child sex offenders and non-sexual offenders) (Table 4).

Emotional regulation- and confidence problems (hypotheses 1,2)

Based on Cortoni and Marshall (2001), who demonstrated that child abusers used significantly more emotion focused strategies (M=31.50) (e.g., blaming oneself) than sex offenders against adults (M=28.55) and non-sexual offenders (M=22.27), we did suggest that there would be significant differences between sex offenders against adults, child sex offenders and non-sexual offenders on schemata related to over-vigilance and inhibition and impaired autonomy and performance compared. However, the multivariate analyses of covariance showed non-significance differences (Table 4). Also no significant difference was found between the schema modes primarily related to avoidant schema modes and overcompensatory modes that refer to manipulation and controlling their environment.

These finding do not correspond with recent research by Chakhssi, de Ruiter, & Bernstein (2013). They investigated the difference in early maladaptive schemes between child

abusers and sex offenders against adults. These results showed that child abusers scored significantly higher on schemata with regard to abandonment, social isolation, suppression of failure/shame, social isolation and self-sacrifice. These different findings may be due to the sample size of the study. The current study generally had an equal distribution of disorders where the unspecified personality disorder represents the majority of the sample (56,5%) in the study of Chakhssi, de Ruiter and Bernstein (2013). In addition, the researchers in the study of Chakhssi, de Ruiter, & Bernstein (2013) were experienced researchers, in contrast to the psychology student in the current study.

Problems and abuse in youth (hypothesis 3)

In line with research findings that child sex offenders are often victims of abuse (25,4%, *n*=757) (i.e., sexual, physical) and neglect (41.3%, *N*=225) (Jespersen, Lalumière, & Seto, 2009; Whitaker et al., 2008), we assumed that child sex offenders are more likely to endorse EMSs related to disconnection and rejection and schema modes related to child modes compared to non-sexual violent offenders. Yet, multivariate analyses of covariance did not give a significant difference here either (Table 4). In contrast to our study, a previous study of Whitaker et al (2008) based on 89 studies, which makes the sample considerably larger and considering the six comparisons they made, all were small in magnitude and only one was statistically significant. Possibly there would be found an effect in the current study by using a larger sample size. Also showed this study that sex offenders against children are often victims of sexual abuse, but despite these findings, most sex offenders against children have not been abused as a child. Besides most individuals who are sexually abused as a child do not become perpetrators of child sexual abuse. Research by Jespersen, Lalumière & Seto (2009) used an overview of multiple studies. This study had the important limitation that certain victims of sexual abuse participated in several. This increases the chance of finding an effect because the sexual abuse is reported more often.

Influence of the level of aggression (hypothesis 4)

Shechory & Ben-David (2005) concluded that rapists' level of aggression (*M*=54.45) are often significantly higher than that of child abusers (*M*=40.87). We expected sex offenders against adults to endorse schema modes that primarily refer to aggression, impulsivity and overcompensatory emotional states, compared to child sex offenders and non-sexual offenders.

Multivariate analyses neither showed a significance difference between different type of offenders (Table 4). However, type of crime was at a trend level of significance as a result. Explanations for the absence of a significant difference in the current study shows agreement with the research from Whitaker et al. (2008) and Hanson & Harris (2000). This study concludes that child offenders not differ from sex offenders against adults in risk factors which could indicate that both groups would use the same patterns to commit a crime.

Limitations and future research

A strength of this study is that the sample had sufficiently different diagnoses. For example, if patients with an antisocial personality disorder participated to a greater extent in the study, social desirability could be present to a large extent. Due to the variance in disorders this kind of confounding has not influenced the results. In addition, all test were conducted in the presence of the researcher. Patients could immediately ask questions if necessary. The researcher was at a suitable distance and engaged in his own non-distracting tasks, such as reading a book. This reduces the chance of a bias.

Surprisingly, none of the hypotheses were confirmed by current research. The high number of limitations of the study may possibly contribute to these findings. The main limitation in current study is the small sample size. There are relatively few child abusers, making a realistic comparison difficult. For subsequent research we strongly recommend expanding the sample size.

In addition to the sample size, it is also important to observe the setting in which the patients reside in the next study. Current research has only approached patients staying in TBS clinic De Rooyse Wissel (the Netherlands). De Rooyse Wissel is a treatment clinic where most patients have a full program of therapies, examinations and daily activities. Current research may have been taken less seriously or faded due to lack of time and interest. This is also related to the next limitation. Current research used self-reporting questionnaires, which entails biases. Although it has been indicated for patients that participation in the study does not affect their treatment, it is still possible that patients respond socially desirable because they think that the results of the questionnaire will improve their treatment progress.

Future research could focus on a longitudinal study. It would be interesting to investigate whether the schema modes do change over time during treatment. It is also interesting to experience whether early maladaptive schemata disappear more into the background or can be compensated by strong coping skills, during the time of treatment. Besides, this research investigated, in connection with the small sample size, only the domains of the SMI and YSQ. It would be interesting to also focus on the different schemes and modes. For example, for the domain 'Impaired autonomy and performance' of the YSQ you can distinguish the schemata: 'Dependence/incompetence', 'Vulnerability to harm or illness', 'Enmeshment/ undeveloped self' and 'Failure' (Young et al., 2003). And for the schemamodi of the SMI you can distinquish for the domain 'Avoidant coping modes' in 'Detached protector', 'Detached self-soother/self-stimulator', 'Compliant surrender' and 'Angry protector'(Keulen-de Vos et al., 2014).

In conclusion, schemata and schemamodes do not differ with patients with different types of offenses (sex offenders against adults, child sex offenders and non-sexual offenders). Therefore, this method cannot currently be implemented into this type field.

Literature

Abel, G., Becker, J., & Cunningham-Rathner, J. (1984). Complications, consent, and cognitions in sex between children and adults. *International Journal of Law and Psychiatry, 7*, 89-103.

Baker, E., & Beech, A. R. (2004). Dissociation and variability of adult attachment dimensions and early maladaptive schemas in sexual and violent offenders. *Journal of interpersonal violence*, *19*(10), 1119-1136.

Barbaree, H. E. (1991). Denial and minimization among sex offenders: Assessment and treatment outcome. *Forum on Corrections Research, 3*, 300–333.

Beck, A. T. (1996). Beyond belief: A theory of modes, personality, and psychopathology. In: P. Salkovskis (Ed.), *Frontiers of cognitive therapy*, (pp. 1–25). New York, US: Guildford Press.

Bickley, J. A., & Beech, A. R. (2002). An investigation of the Ward and Hudson pathways model of the sexual offense process with child abusers. *Journal of Interpersonal Violence*, *17*(4), 371-393.

Bumby, K. M. (1996). Assessing the cognitive distortions of child molesters and rapists: Development and validation of the MOLEST and RAPE scales. *Sexual Abuse: A Journal of Research and Treatment*, *8*(1), 37-54.

Bumby, K. M. (2000). Empathy inhibition, intimacy deficits, and attachment difficulties in sex offenders. *Remaking relapse prevention with sex offenders: A sourcebook*, 143-166.

Calvete, E., Orue, I., & González-Diez, Z. (2013). An examination of the structure and stability of early maladaptive schemas by means of the Young Schema Questionnaire-3. *European Journal of Psychological Assessment, 29*, 283-290.

Carvalho, J., & Nobre, P. J. (2014). Early maladaptive schemas in convicted sexual offenders: Preliminary findings. *International journal of law and psychiatry*, *37*(2), 210-216.

Chakhssi, F., Bernstein, D. P., & Ruiter, C. (2014). Early maladaptive schemas in relation to facets of psychopathy and institutional violence in offenders with personality disorders. *Legal and Criminological Psychology*, *19*(2), 356-372.

Cortoni, F., & Marshall, W. L. (2001). Sex as a coping strategy and its relationship to juvenile sexual history and intimacy in sexual offenders. Sexual Abuse: A Journal of Research & Treatment, 13, 27-43.

Drake, C. & Ward, T. (2002). Treatment models for sex offenders: A move towards a formulation based approach. In: T. Ward, D. R. Laws & S. M. Hudson (Eds.), *Sexual Deviance: Issues and Controversies,* (pp. 227/243). Thousand Oaks, CA, US: Sage.

De Graaf, H., Meijer, S., Poelman, J., & Vanwesenbeeck, I. (2005). *Seks onder je 25ste. Seksuele gezondheid van jongeren in Nederland anno 2005*. Delft, NL: Eburon.

De Graaf, H., Kruijer, H., van Acker, J., & Meijer, S. (2012). *Seks onder je 25ste . Seksuele gezondheid van jongeren in Nederland anno 2012*. Utrecht/Amsterdam, NL: RutgersWPF/SOAIDS.

Farrell, J.M., Reiss, N., & Shaw, I. A. (2014). *The schema therapy clinician's guide*: A complete resource for building and delivering individual, group and integrated schema mode treatment programs. UK: John Wiley & Sons, Ltd.

Gannon, T. A., Wright, D. B., Beech, A. R., & Williams, S. (2006). Do child molesters hold distorted beliefs? What does their memory recall tell us? *Journal of Sexual Aggression*, *12*(1), 5-18.

Garlick, Y., Marshall, W. L., & Thornton, D. (1996). Intimacy deficits and attribution of blame among sexual offenders. *Legal and Criminological Psychology, 1*, 251-258.

Hanson, R. K., & Harris, A. J. R. (2000). Where should we intervene? Dynamic predictors of sexualoffence recidivism. *Criminal Justice and Behavior, 27,* 6–35.

Hanson, R. K., Steffy, R. A., & Gauthier, R. (1993). Long-term recidivism of child molesters. *Journal of Consulting and Clinical Psychology 61,* 646-652.

Hare, R. D., Clark, D., Grann, M & Thornton, D. (2000). Psychopathy and the predictive validity of the PCL-R: An international perspective. *Behavioral sciences & the law, 18*(5), 623-645.

Jespersen, A.F., Lalumière, M.L., & Seto, M.C. (2009). Sexual abuse history among adult sex offenders and non-sex offenders: A meta-analysis. *Child Abuse and Neglect, 33*,179–192.

Keulen-de Vos, M.E., Bernstein, D.P., & Arntz, A. (2014). Schema Therapy for offenders with aggressive personality disorders. In: R.C. Tafrate & D. Mitchell (Ed.), *Forensic CBT: A Practioner's Guide*, (66-83). Chichester, UK: Wiley Blackwell.

Keulen-de Vos, M.E., Bernstein, D.P., Vanstipelen, S., de Vogel, V., Lucker, T.P., Slaats, M., Hartkoorn, M., & Arntz, A. (2016). Emotional states in the criminal and violent behavior of forensic cluster B PD patients: a retrospective and prospective study. *Legal and Criminological Psychology, 21,* 56-76.

Keulen-de Vos, M., van den Broek, E. P., Bernstein, D. P., Vallentin, R., & Arntz, A. (2017). Evoking emotional states in personality disordered offenders: An experimental pilot study of experiential drama therapy techniques. *The Arts in Psychotherapy*, *53,* 80-88.

Kokish, R., Levenson, J. S., & Blasingame, G. D. (2005). Post-conviction sex offender polygraph examination: Client-reported perceptions of utility and accuracy. *Sexual Abuse: A Journal of Research and Treatment*, *17*(2), 211-221.

Leistico, A. M. R., Salekin, R. T., DeCoster, J., & Rogers, R. (2008). A large-scale meta-analysis relating the Hare measures of psychopathy to antisocial conduct. *Law and human behavior*, *32*(1), 28-45.

Lobbestael, J., van Vreeswijk, M., Spinhoven, P., Schouten, E., & Arntz, A. (2010). Reliability and validity of the short Schema Mode Inventory (SMI). *Behavioural and Cognitive Psychotherapy*, *38*(4), 437-458.

Mann, R. E., & Beech, A. R. (2003). Cognitive distortions, schemas, and implicit theories. In: T. Ward, D. R. Laws, & S. M. Hudson (Eds.), *Sexual deviance: Issues and controversies*, (pp. 135−153). Thousand Oaks, CA, US: Sage

Mann, R. E., & Fernandez, Y. M. (2006). Sex offender programmes: Concept, theory, and practice. In: C. R. Hollin, & E. J. Palmer (Eds.), *Offending behavior programmes: Applications and controversies*, (pp. 155–177). Chichester, England: Wiley, Publications.

van Marle, H. J. (2002). The Dutch Entrustment Act (TBS): its principles and innovations. *International journal of forensic mental health*, *1*(1), 83-92.

Marshall, W. L. (1989). Invited essay: Intimacy, loneliness and sexual offenders. *Behavior Research and Therapy, 27,* 491–503.

Marshall, W. L. (1999). Current status of North American assessment and treatment programs for sexual offenders. *Journal of Interpersonal Violence, 14,* 221–239.

Marshall, W. L., Marshall, L. E., Serran, G. A., & Fernandez, Y. M. (2006). *Treating sexual offenders: An integrated approach.* New York, US: Routledge.

McGrath, M., Cann, S., & Konopasky, R. (1998). New measures of defensiveness, empathy, and cognitive distortions for sexual offenders against children. *Sexual Abuse: A Journal of Research and Treatment*, *10*(1), 25-36.

Murphy, W D. (1990). Assessment and modification of cognitive distortions in sex offenders. In: W L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender,* (pp. 331-342). New York, US: Plenum Press.

Muste, E., Weertman, A., & Claassen, A. M. (2010). *Handboek klinische schematherapie*. Bohn Stafleu van Loghum.

Pithers, W D. (1994). Process evaluation of a group therapy component designed to enhance sex offenders' empathy for sexual abuse survivors. *Behaviour Research and Therapy, 32,* 565-570.

Polaschek, D. L. L., & Ward, T. (2002). The implicit theories of potential rapists: What our questionnaires tell us. *Aggression and Violent Behavior, 7,* 385–406.

Rijkeboer, M.M., Bergh, H. van den, & Bout, J. van den (2005). Stability and discriminative power of the young schema-questionnaire in a Dutch clinical versus non-clinical population. *Journal of Behavior Therapy and Experimental Psychiatry, 36*, 129-144.

Seidman, B. T., Marshall, W. L., Hudson, S. M., & Robertson, P. J. (1994). An examination of intimacy and loneliness in sexual offenders. *Journal of Interpersonal Violence, 9,* 518-534.

Shechory, M., & Ben-David, S. (2005). Aggression and anxiety in rapists and child molesters. *International Journal of Offender Therapy and Comparative Criminology, 49*(6), 652 661.

Stermac, L. E., & Segal, Z. V (1989). Adult sexual contact with children: An examination of cognitive factors. *Behavior Therapy, 20*, 573-584.

Thornton, D. (2002). Constructing and testing a framework for dynamic risk assessment. *Sexual Abuse: A Journal of Research and Treatment, 14,* 139–154.

Vreeswijk, M. V., Broersen, J., & Nadort, M. (Eds.). (2009). *Handboek schematherapie: theorie, praktijk en onderzoek*. Bohn Stafleu van Loghum.

Ward, T. (2000). Sexual offenders' cognitive distortions as implicit theories. *Aggression and Violent Behavior, 5*, 491–507

Ward, T., & Beech, A. R. (2004). The etiology of risk: A preliminary model. *Sexual Abuse: A Journal of Research and Treatment, 16*, 271–284.

Ward, T., & Beech, A. (2006). An integrated theory of sexual offending. *Aggression and violent behavior*, *11*(1), 44-63

Ward, T., Hudson, S. M., Johnston, L., & Marshall, W. L. (1997). Cognitive distortions in sex offenders: An integrative review. *Clinical Psychology Review, 17,* 479–507.

Ward, T., Hudson, S. M., & Keenan, T. (1998). A self-regulation model of the sexual offense process. *Sexual Abuse: A Journal of Research and Treatment, 10,* 141–157.

Ward, T., McCormack, J., & Hudson, S. M. (1997). Sexual offenders' perceptions of their intimate relationships. *Sexual Abuse: A Journal of Research and Treatment, 9*, 57-73.

Ward, T., & Siegert, R. J. (2002). Toward a comprehensive theory of child sexual abuse: A theory knitting perspective. *Psychology, Crime, and Law, 8,* 319–351.

Whitaker, D.J., Hanson, R.K., Baker, C.K., McMahon, P., Ryan, G., Klein, A., & Rice, D.D. (2008). Risk factors for the perpetration of child sexual abuse: A review and meta analysis. *Child Abuse Neglect, 32*, 529-548.

Yates, P. M. (2013). Treatment of sexual offenders: Research, best practices, and emerging models. *International Journal of Behavioral Consultation and Therapy, 8*, 89–95.

Yochelson, S., & Samenow, S. (1977). *The Criminal Personality. Vol. 2. A profile for change.* New York, US: Jason Aron

Young, J., Klosko, J., & Weishaar, M. (2003). *Schema therapy: A practitioners's guide.* New York, US: The Guilford Press.

Table 1a.

Graph with percentages of the diagnoses of all patients

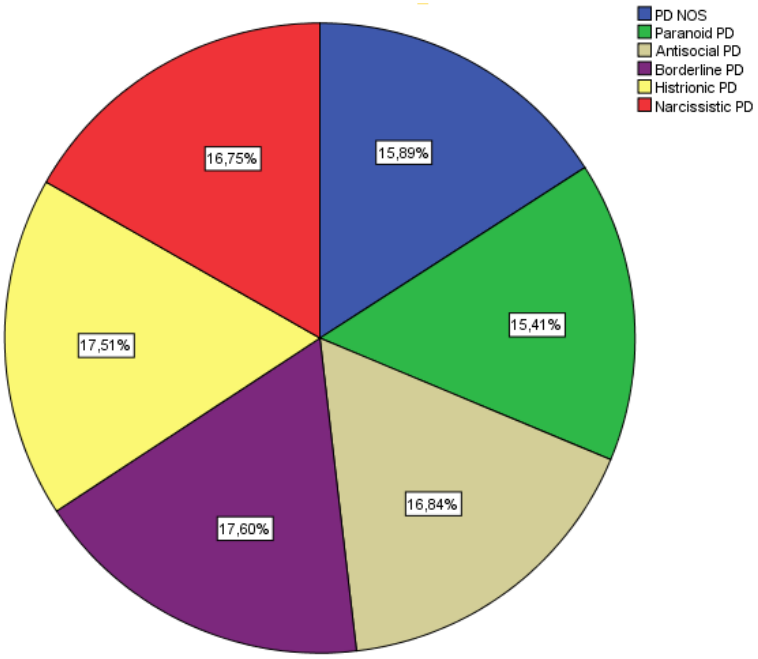

Table 1b.

Graph with percentages of the disorders of all patients

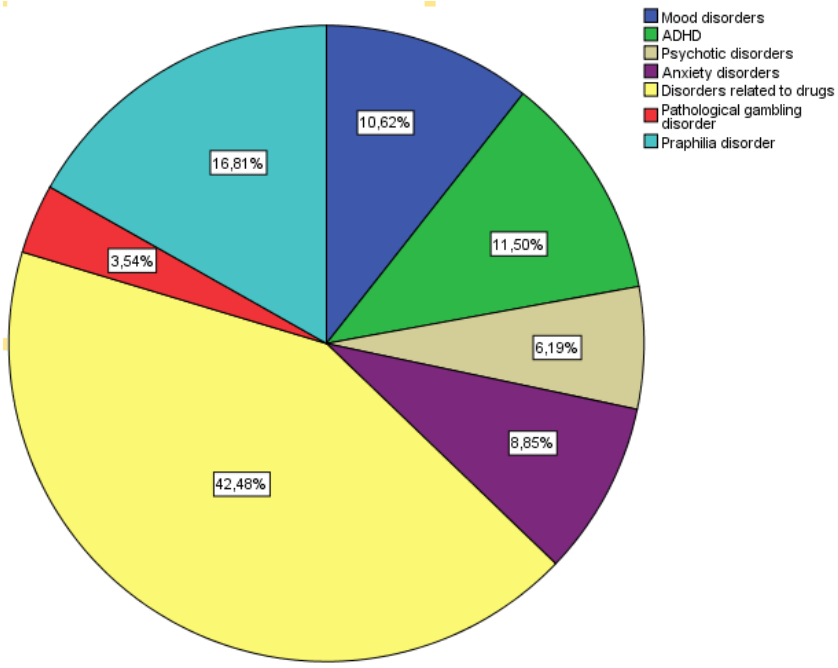

Table 2a.

Cronbach's alpha of the domains of the YSQ

Domain	Cronbach's Alpha
Child modes	.95
Avoidant coping modes	.90
Parent modes	.84
Over compensatory modes	.90
Healthy mode	.86

Table 2b.

Cronbach's alpha of the domains of the SMI

Domain	Cronbach's Alpha
Disconnection and rejection	.93
Impaired autonomy and performance	.87
Impaired limits	.86
Other-directedness	.78
Over-vigilance and inhibition	.86

Table 3.

Mean and Standard deviations for the schemata, modes and domains of the YSQ and SMI.

Schemata/Modes/Domain	**Child sex offenders (SD) (N=23)**	**Sex offenders against adults (SD) (N=23)**	**Non-sexual offenders (SD) (N=31)**
YSQ			
Disconnection and rejection	56.50 (25.15)	49.55 (21.76)	44.73 (14.24)
Impaired Autonomy and performance	18.38 (6.89)	19.25 (6.80)	14.39 (3.13)
Impaired limits	12.54 (6.98)	11.53 (3.82)	10.62 (3.87)
Other- directedness	36.44 (7.62)	35.83 (11.16)	31.54 (3.87)
Over-Vigilance and inhibition	26.85 (6.29)	27.87 (9.34)	26.70 (9.93)
SMI			
Child Modes	33.01 (13.32)	32.16 (10.79)	34.96 (11.69)
Avoidant Coping Modes	31.30 (11.4)	32.57 (12.72)	31.48 (11.62)
Parent Modes	12.12 (4.04)	11.94 (4.69)	11.07 (4.11)
Over compensatory Modes	11.36 (5.34)	11.39 (4.41)	10.90 (4.95)
Healthy modes	40.35 (8.26)	43.87 (8.08)	43.03 (8.03)

Note. SD= standard deviation, YSQ= Young Schema Questionnaire, SMI= Schema Mode Inventory

Table 4.

Multivariate analyses of covariance.

Dependent variable	Effect		Value	F	Sig.
Over-vigilance and inhibition Impaired autonomy and performance	PCL	Pillai's Trace	.020	.673	.513
	Delict	Pillai's Trace	.134	2.400	.053
Overcompensatory modes Avoidant coping modes	PCL	Wilks'Lambda	.976	.844	.434
	Delict	Wilks'Lambda	.993	.116	.976
Child modes Disconnection and rejection	PCL	Wilks'Lambda	.993	.243	.785
	Delict	Wilks'Lambda	.893	1.998	.100
Avoidant coping modes Child modes Overcompensatory modes	PCL	Wilks'Lambda	.973	.627	.600
	Delict	Wilks'Lambda	.916	1.007	.423

Note. PCL= psychopathy score (covariate), Significance level $p<0.05$.

Appendix A

Early Maladaptive Schemata and its corresponding domains

Domain	Definition	Early Maladaptive Schemata
Disconnection and rejection	Abuse, traumatic youth; unstable family life; feeling different, lacking something in a certain way; long periods of insecurity and inconsistent parenthood; parents are constantly arguing and threatening to leave each other regularly	Emotional deprivation Abandonment/instability Mistrust/abuse Defectiveness/shame Social isolation/alienation
Impaired autonomy and performance	As a child overprotected or overcontrolled, or misunderstood, or neglected, or left alone without attention to their lives; or constantly undermined and tackled to make them feel incompetent, or encouraged to be dependent on other	Dependence/incompetence Vulnerability to harm or illness Enmeshment/undeveloped self Failure
Impaired limits	The internal sense of control is not developed; have difficulty respecting the rights of others; family very limitless; children received no rules	Entitlement/grandiosity Insufficient self-control/self-discipline
Other Directedness	Have experienced conditional love; family overly focused on how they come across; parents focused on their own needs	Subjugation Self-sacrifice Approval seeking/recognition seeking
Over-vigilance and inhibition	Strict parental control to get permission; always vigilant – waiting for bad things that can happen; afraid of severe punishment for expressing feelings	Negativity/pessimism Emotional inhibition Unrelenting standards/hyper criticalness Punitiveness

Note. Discriptions are adapted from Vreeswijk, Broersen, & Nadort, (2009) and Muste, Weertman, & Claassen, (2010).

Appendix B

List of schema mode and their definitions

Domain	Definition	Schemamodi
Child modes	Intense feelings such as fear, helplessness, or rage, and involve the innate reaction a child has.	Vulnerable child Angry child Impulsive child Lonely child
Avoidant coping modes	Involves physical, psychological, and social withdrawal and avoidance.	Detached protector Detached self-soother/self-stimulator Compliant surrender Angry protector
Parent mode	Reflect the selective internalization of negative aspects of attachment figures (e.g., parents, teachers, peers, etc.) during childhood and adolescence.	Punitive parent Demanding parent
Overcompensatory modes	Person acts in opposition to the schema of schemata that are triggered.	Self-aggrandizer Bully and attack Conning and manipulator Predator Over-controller
Healthy modes	Functional thoughts and behaviours, and the skills needed to function in adult life. Resource for playful and enjoyable activities, especially in social networks.	Happy child Healthy adult

Note. Discriptions are adapted from Farrell, Reiss, & Shaw, (2014) and Keulen-de Vos et al., (2014).

Appendix C

Items of the SMI-R.

Naam / ppnr: .....
Geboortedatum:.....
Datum:.....
Geslacht:.....
Opleiding:.....

SMI-R
1-A

INSTRUCTIE: In deze vragenlijst staan uitspraken die mensen kunnen gebruiken om zichzelf te beschrijven. We willen u vragen van deze uitspraken de FREQUENTIE te beoordelen; dus **hoe vaak** je **over het algemeen** van de uitspraak overtuigd bent of hoe vaak het zo voelde.

FREQUENTIE: Over het algemeen

1= Nooit of bijna nooit
2= Zelden
3= Af en toe
4= Regelmatig
5= Meestal
6= Altijd

Frequentie	**Over het algemeen...**
	1. Ik voel me inadequaat, gebrekkig of waardeloos.
	2. Ik voel me verloren.
	3. Ik ben streng voor mezelf.
	4. Mijn behoeften of gevoelens zijn verkeerd.
	5. Meestal vind ik mezelf aardig en accepteer ik mezelf zoals ik ben.
	6. Ik voel me hopeloos.
	7. Ik raak geïrriteerd als mensen niet doen wat ik van hen vraag.
	8. Ik kan mijn impulsen slecht controleren.
	9. Als ik een doel niet kan bereiken, raak ik snel gefrustreerd en geef ik het op.
	10. Ik ben de moeite waard.
	11. Ik heb woedeaanvallen en driftbuien.
	12. Ik handel impulsief of ik uit emoties die me in de problemen brengen of die andere mensen kwetsen.
	13. Ik voel me tevreden.
	14. Ik voel me verdrietig.
	15. Ik kruip vaak in bed om aan alle ellende te ontsnappen.
	16. Ik voel me tevreden en kalm.
	17. Als ik me eenmaal boos begin te voelen, houd ik het vaak niet onder controle en verlies ik mijn beheersing.
	18. Het is voor mij belangrijk nummer één te zijn (bijvoorbeeld de meest populaire, meest succesvolle, meest rijke, meest machtige).
	19. Ik vind het moeilijk om voor mezelf te zorgen en mezelf een plezier te doen.
	20. Ik voel me tekortschieten.
	21. Ik voel me onthecht (geen contact met mezelf, mijn emoties en anderen).
	22. Ik voel me wanhopig.
	23. Ik voel me gefrustreerd door andere mensen.

FREQUENTIE: Over het algemeen

1= Nooit of bijna nooit
2= Zelden
3= Af en toe
4= Regelmatig
5= Meestal
6= Altijd

Frequentie	Over het algemeen...
	24. Ik denk niet na over wat ik zeg en breng daarmee mezelf in de problemen of kwets anderen.
	25. Ik zoek naar manieren om mensen te slim af te zijn, zodat ze geen misbruik van me kunnen maken of me kunnen kwetsen.
	26. Ik voel me waardeloos.
	27. Ik voel me schuldig.
	28. Ik ben boos op mezelf omdat ik zwak ben.
	29. Ik gooi en smijt met dingen als ik boos ben.
	30. Ik ben woedend op iemand.
	31. Ik heb veel opgekropte boosheid die eruit moet.
	32. Ik voel me eenzaam.
	33. Ik doe graag iets opwindends of troostends om mijn gevoelens te vermijden (bijvoorbeeld eten, seksuele activiteiten, uitgaan, gokken of shoppen).
	34. Gelijkwaardigheid bestaat niet, dus kan je maar het beste boven de ander staan.
	35. In mijn boosheid verlies ik de controle over mezelf en bedreig ik andere mensen.
	36. Ik voel me minder waard dan andere mensen.
	37. Ik voel dat ik genoeg stabiliteit en zekerheid in mijn leven heb.
	38. Ik ben erg bezitterig ten opzichte van of vastklampend aan mensen die belangrijk voor me zijn
	39. Ik heb moeite mezelf onder controle te houden.
	40. Ik kan me er niet toe zetten dingen te doen die ik vervelend vind, ook al weet ik dat het voor mijn eigen bestwil is.
	41. Ik raak makkelijk verveelt en verlies snel interesse in dingen.
	42. Ook als ik mensen om me heen heb, voel ik me eenzaam.
	43. Ik blijf te lang in situaties die niet gezond voor me zijn of waarin niet aan mijn behoeften wordt voldaan.
	44. Als je anderen niet overheerst, word je overheerst.
	45. Om vervelende gevoelens te vermijden kijk ik veel televisie, of zit ik veel achter de computer (bijvoorbeeld internetten, chatten of computerspelletjes spelen).
	46. Ik zeg wat ik voel of doe dingen impulsief, zonder over de gevolgen na te denken.
	47. Ik voel me goed.
	48. Ik voel me afhankelijk van andere mensen.
	49. Ik sta onder een constante druk om te presteren en dingen te bereiken.
	50. Ik probeer geen fouten te maken, anders ga ik mezelf naar beneden halen.
	51. Ik verneder anderen.
	52. Ik wil mezelf afleiden van gedachten en gevoelens die mij van streek maken.
	53. Ik voel me verdoofd.
	54. Ik ben boos op mezelf.
	55. Ik raak meer in de problemen dan andere mensen.
	56. Ik voel me vlak.

FREQUENTIE: Over het algemeen	
1= Nooit of bijna nooit 2= Zelden 3= Af en toe	4= Regelmatig 5= Meestal 6= Altijd

Frequentie	Over het algemeen...
	57. Ik moet de beste zijn in wat ik doe.
	58. Ik offer plezier, gezondheid of geluk op om aan mijn eigen eisen te voldoen.
	59. Ik manipuleer om mijn doelen te bereiken.
	60. Ik voel me leeg.
	61. Ik ben veeleisend tegenover andere mensen.
	62. Ik zou iets opwindends of troostends willen doen om mijn gevoelens te vermijden (bijvoorbeeld werken, gokken, eten, winkelen, seksuele activiteiten, tv-kijken).
	63. Ik voel me veilig.
	64. Ik voel me gehoord, begrepen en gesteund.
	65. Het is voor mij onmogelijk mijn impulsen te controleren.
	66. Ik ben boos omdat iemand me niet de liefde, aandacht en zorg geeft die ik nodig heb.
	67. Als ik voel dat ik ergens geen controle over heb, raak ik in paniek.
	68. Ik maak dingen kapot als ik boos ben.
	69. Ik haat of verafschuw mezelf.
	70. Mijn relaties lijden eronder dat ik zoveel van mezelf vraag.
	71. Ik voel me vaak alleen op de wereld.
	72. Ik voel me zwak en hulpeloos.
	73. Ik ben bedrogen of oneerlijk behandeld.
	74. Ik kan mezelf moeilijk laten gaan.
	75. Ik kleineer anderen.
	76. Ik voel me optimistisch.
	77. Ik wil niets voelen.
	78. Ik ben 'een rebel' op vele manieren en ga in tegen de gevestigde orde.
	79. Als mensen te dicht bij me komen of mijn leven binnendringen, houd ik ze op afstand.
	80. Ik heb een goed beeld van wie ik ben en wat ik nodig heb om mezelf gelukkig te maken.

Note. Items are adapted from Lobbestael, van Vreeswijk, Spinhoven, Schouten & Arntz., (2014).

Appendix D

Items of the YSQ-S3

Naam / ppnr: .....
Datum:.....

YSQ-S3
Jeffrey Young, Ph.D.

Instructies: deze vragenlijst bestaat uit een aantal uitspraken die mensen kunnen gebruikten om zichzelf te beschrijven. Wilt u iedere uitspraak lezen en aangeven in welke mate deze uitspraak op u van toepassing is voor het afgelopen jaar. Wanneer u twijfelt, baseer uw antwoord dan op hetgeen u *voelt* en niet wat u *denkt* dat van toepassing is.

Een aantal items vragen naar uw relatie met uw ouders of levenspartners. Mocht een van deze personen overleden zijn, beantwoord deze vragen gebaseerd op de relatie die u met deze personen had toen zij nog leefden. Als u op dit moment geen partner heeft, maar in het verleden wel hebt gehad, beantwoord de uitspraken dan met uw laatste partner in het achterhoofd.

Kies de hoogste score tussen 1 en 6 en noteer deze achter het nummer van de uitspraak.

Score Range

1= helemaal niet waar	4= tamelijk waar
2= vrijwel geheel niet waar	5= vrijwel geheel waar
3= enigszins waar	6= helemaal waar

Score	
	1. Meestal was er niemand die voor mij zorgde, dingen met me deelde of die het echt kon schelen wat er met me gebeurde.
	2. Ik merk dat ik mij vastklamp aan mensen om wie ik veel geef, omdat ik bang ben dat ze me zullen verlaten.
	3. Ik denk dat mensen misbruik van me zullen maken.
	4. Ik pas er niet bij.
	5. Geen enkele man of vrouw tot wie ik mij aangetrokken voel, zou nog van me kunnen houden, zodra hij of zij mijn tekortkomingen leert kennen.
	6. Bijna niets wat ik in mijn werk (of studie) doe, haalt het bij wat andere mensen kunnen.
	7. Ik voel mij niet in staat me alleen te redden in het dagelijks leven.
	8. Ik kan maar niet aan het gevoel ontkomen dat er iets ergs staat te gebeuren.
	9. Ik ben niet in staat geweest me los te maken van mijn ouder(s) zoals anderen van mijn leeftijd dat wel gedaan lijken te hebben.
	10. Als ik doe wat ik wil, raak ik alleen maar in de problemen.
	11. Uiteindelijk ben ik meestal diegene die de zorg op zich neemt van mensen met wie ik mij verbonden voel
	12. Ik ben te verlegen om positieve gevoelens aan anderen te tonen (bv. genegenheid tonen, laten merken dat ik om iemand geef).
	13. Ik moet de beste zijn in alles wat ik doe; ik accepteer geen tweede plaats.
	14. Ik heb grote moeite met weigering te accepteren als ik iets van andere mensen wil.
	15. Ik kan er maar niet toe komen om routinewerk te doen of vervelende taken af te maken.

Score Range	
1= helemaal niet waar	4= tamelijk waar
2= vrijwel geheel niet waar	5= vrijwel geheel waar
3= enigszins waar	6= helemaal waar

Score	
	16. Het hebben van geld en belangrijke mensen kennen geven mij het gevoel dat ik de moeite waard ben.
	17. Zelfs als dingen goed lijken te gaan, heb ik het gevoel dat dit maar tijdelijk is.
	18. Als ik een fout maak, verdien ik het om gestraft te worden.
	19. Over het algemeen was er niemand die mij warmte, geborgenheid en genegenheid gaf.
	20. Ik heb andere mensen zó hard nodig dat ik bang ben ze te verliezen.
	21. Ik moet bij andere mensen op mijn hoede blijven, anders zullen ze me opzettelijk kwetsen
	22. Ik ben wezenlijk anders dan anderen.
	23. Niemand van de mensen tot wie ik me aangetrokken voel zou nog bevriend met me willen zijn, als hij/zij me echt zou kennen.
	24. Zodra het op presteren aankomt, ben ik tot weinig in staat.
	25. Ik vind mijzelf in het dagelijks functioneren een afhankelijk persoon.
	26. Ik denk dat er op ieder moment een ramp (in de natuur of van criminele, financiële of medische aard) kan gebeuren.
	27. Mijn ouder(s) en ik hebben de neiging om teveel betrokken te zijn bij elkaars leven en problemen.
	28. Als ik niet toegeef aan de wensen van anderen, pakken ze me op een of andere manier terug of wijzen ze me af.
	29. Ik ben een goed mens, omdat ik meer rekening houd met anderen dan met mezelf.
	30. Ik schaam me ervoor om mijn gevoelens naar anderen te uiten.
	31. Ik probeer mijn uiterste best te doen; ik neem geen genoegen met 'goed genoeg'
	32. Ik ben bijzonder en zou veel van de beperkingen, die wel voor andere mensen gelden, niet hoeven te accepteren.
	33. Als het me niet lukt een gesteld doel te halen, raak ik gemakkelijk gefrustreerd en geef ik het op.
	34. Succes is het meest waardevol voor mij als andere mensen dit merken.
	35. Als iets goeds gebeurt, maak ik mij zorgen dat dit door iets slechts gevolgd wordt.
	36. Als ik mijn uiterste best doe, moet ik verwachten dat ik faal
	37. Ik heb nooit het gevoel dat ik bijzonder was voor iemand.
	38. Ik maak me zorgen dat mensen die me dierbaar zijn, me in de steek zullen laten
	39. Het is slechts een kwestie van tijd voordat iemand me bedriegt.
	40. Ik hoor nergens bij; ik ben een eenling.
	41. Ik ben de liefde, aandacht en het respect van anderen niet waard.
	42. De meeste mensen kunnen meer dan ik op het gebied van werk en prestaties.
	43. Het ontbreekt mij aan gezond verstand.
	44. Ik ben bang aangevallen te worden
	45. Het is voor mijn ouder(s) en ik erg moeilijk om zeer persoonlijke zaken voor onszelf te houden, zonder ons daarover schuldig of verraden te voelen.
	46. In relaties laat ik de ander de baas zijn.

Score Range	
1= helemaal niet waar	4= tamelijk waar
2= vrijwel geheel niet waar	5= vrijwel geheel waar
3= enigszins waar	6= helemaal waar

Score	
	47. Ik ben zo druk met de anderen om wie ik geef, dat ik weinig tijd voor mijzelf overhoud.
	48. Ik vind het moeilijk om los en spontaan te zijn bij andere mensen.
	49. Ik moet aan al mijn verantwoordelijkheden voldoen.
	50. Ik vind het heel vervelend als ik beperkt of verhinderd word om te doen wat ik wil.
	51. Ik vind het erg moeilijk om iets aangenaams, wat ik meteen kan krijgen, op te offeren voor een doel dat nog ver weg is.
	52. Tenzij ik veel aandacht van anderen krijg, voel ik mij minder belangrijk.
	53. Je kunt niet te voorzichtig zijn; vrijwel altijd gaat er iets mis.
	54. Als ik een taak niet goed doe, moet ik de consequenties verdragen.
	55. Er zijn in mijn leven maar weinig mensen geweest die echt naar mij luisterden, me begrepen of die oog hadden voor mijn ware behoeften en gevoelens.
	56. Wanneer ik merk dat iemand om wie ik geef afstand van me neemt, word ik wanhopig.
	57. Ik ben vrij wantrouwend over andermans motieven.
	58. Ik voel me vervreemd of afgesloten van andere mensen.
	59. Ik voel dat ik iemand ben waar niemand van kan houden.
	60. Ik heb niet zoveel talent als de meeste mensen in hun werk.
	61. Mijn oordeel in alledaagse situaties is niet betrouwbaar.
	62. Ik ben bang dat ik al mijn geld kwijtraak en arm word.
	63. Mijn ouder(s) zijn vaak zo overbetrokken en opdringerig dat ik niet mijn eigen leven kan leiden.
	64. Ik heb altijd anderen keuzes voor me laten maken, dus ik weet werkelijk niet wat ik zelf wil.
	65. Ik ben altijd degene die luistert naar de problemen van anderen.
	66. Ik houd me zo in de hand, dat andere mensen denken dat ik geen gevoelens heb.
	67. Ik voel me constant onder druk staan om te presteren en dingen gedaan te krijgen.
	68. Ik vind dat ik niet hoef te voldoen aan de normale regels en afspraken.
	69. Ik kan mezelf er niet toe zetten dingen te doen die ik vervelend vind, ook al weet ik dat het voor mijn eigen bestwil is.
	70. Als ik opmerkingen maak op een vergadering of geïntroduceerd word in een sociale situatie is het belangrijk voor mij om erkenning en waardering te krijgen.
	71. Hoe hard ik ook werk, ik maak mij zorgen dat ik financieel gezien word weggevaagd en alles kwijtraak.
	72. Het maakt niet uit waarom ik een fout maak. Als ik iets fout doe, moet ik met de gevolgen leven.
	73. Op momenten dat ik niet wist wat ik moest doen, was er zelden een sterk persoon die me wijze raad kon geven of me op weg kon helpen.
	74. Soms ben ik zo bang dat mensen me verlaten, dat ik ze juist wegjaag.
	75. Meestal ben ik op mijn hoede voor de verborgen beweegredenen van mensen.
	76 Ik voel me in groepen altijd een buitenstaander.
	77. In mijn diepste wezen ben ik te verwerpelijk om mezelf aan anderen bloot te geven.
	78. In mijn werk of studie ben ik niet zo intelligent als de meeste mensen.

Score Range	
1= helemaal niet waar	4= tamelijk waar
2= vrijwel geheel niet waar	5= vrijwel geheel waar
3= enigszins waar	6= helemaal waar

Score	
	79. Ik heb geen vertrouwen in mijn vermogen om alledaagse problemen op te lossen.
	80. Ik ben bang dat ik een ernstige ziekte onder de leden heb, ook al is er door de dokter niets ernstigs geconstateerd.
	81. Ik heb vaak het gevoel dat ik geen identiteit heb ten opzichte van mijn ouder(s) of partner.
	82. Ik vind het erg moeilijk te eisen dat mijn eisen worden gerespecteerd en dat er rekening wordt gehouden met mijn gevoelens.
	83. Andere mensen vinden dat ik te veel doe voor anderen en te weinig voor mezelf.
	84. Mensen vinden mij emotioneel geremd.
	85. Ik ben erg streng voor mezelf en vind het moeilijk om mijn fouten toe te geven.
	86. Wat ik heb te bieden is van meer waarde, dan wat andere mensen bieden.
	87. Ik heb me bijna nooit aan mijn voornemens kunnen houden.
	88. Veel lofuitingen en complimenten doen mij de moeite waard voelen.
	89. Ik ben bang dat een foute beslissing tot een ramp kan leiden.
	90. Ik ben een slecht persoon die gestraft moet worden.

Note. Items are adapted from Di Francisco, E., (2017).

Appendix E

Traits on the Hare Psychopathy checklist.

1. Pathological lying
2. Glib and superficial charm
3. Grandiose sense of self
4. Need for stimulation
5. Cunning and manipulative
6. Lack of remorse or guilt
7. Shallow emotional response
8. Allousness and lack of empathy
9. Parasitic lifestyle
10. Poor behavioral controls
11. Sexual promiscuity
12. Early behavior problems
13. Lack of realistic long-term goals
14. Impulsivity
15. Irresponsibility
16. Failure to accept responsibility
17. Many short-term marital relationships
18. Juvenile delinquency
19. Revocation of conditional release
20. Criminal versatility

Note. Items are adapted from Hare, Clark, Grann & Thomton, (2000).