BSc in Psychology

Hostile Thoughts in People with Schizophrenia: Comparing Data from the Ambiguous Intentions Hostility Questionnaire (AIHQ) List between a Clinical Sample and a Control Group

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Abstract

The study aimed to improve the use of the AIHQ-list in measuring symptoms of psychotic disorders in Icelandic patients by creating a control group to use as a baseline reference against clinical groups. A control group of 161 volunteers and a patient group of 72 individuals was used. The controls accessed the list on the internet while the patients answered on paper in the presence of trained professionals. Three dimensions of the attributional style were studied, i.e. blame, hostility and aggression, using an independent sample t-test to compare results from the groups. A significant difference was demonstrated between the groups for both blame, and the hostility dimensions while an insignificant difference was exhibited between groups for the aggression dimension. However, while internal consistency as measured by the Cronbach's Alpha was acceptable for the blame dimension, it was low for the hostility dimension and unacceptable for the aggression dimension. Results for the latter two dimensions, therefore, need to be interpreted cautiously. The study suggested that while the AIHQ-list is acceptable to measure the blame dimension, it requires amendments to be of good use for the hostility dimension and needs radical restructuring to be applied to measure the aggression dimension.

Keywords: AIHQ-list, social cognition, attributional style, hostility, blame, aggression

Útdráttur

Tilgangur rannsóknarinnar var að finna íslenskan samanburðarhóp til að bæta notkun AIHQ kvarðans við mælingu á einkennum geðraskana hérlendis. Myndaður var samanburðarhópur 161 sjálfboðaliða sem borinn var saman við hóp 72 einstaklinga frá meðferðargeðdeild Landspítala fyrir ungt fólk með geðrofssjúkdóm á byrjunarstigi. Samanburðarhópurinn svaraði spurningum á netinu en sjúklingarnir svöruðu skriflega í viðurvist þjálfaðra leiðbeinanda. Þrjár víddir eignunarstíls voru skoðaðar, þ.e. ásökun, fjandsemi og árásargirni. Óháð t-próf var notað til að bera saman niðurstöður fyrir hópana. Marktækur munur kom fram á niðurstöðum milli hópa fyrir bæði ásökunar- og fjandsemisvíddina en fyrir árásargirni reyndist munurinn ómarktækur. Réttmæti, mælt með Cronbach´s Alpa, reyndist ásættanlegt fyrir ásökunarvíddina, en hins vegar lágt fyrir fjandsemi og ófullnægjandi fyrir árásargirni. Af þeim sökum ber að túlka niðurstöður fyrir tvær síðari víddirnar með varúð. Kvarðann þarf þessvegna að bæta til að nýta megi með góðu móti við mælingu á fjandsemi, og hann þarfnast róttækra endurbóta eigi að nýta hann til að mæla árásargirni.

Hostile thoughts in people with schizophrenia

Psychotic diseases can seriously affect the ability of an individual to cope with life´s challenges, and to create and preserve healthy relationships to family, friends and themselves (Blair, Hume & Creek, 2008). Perälä et al. (2007) reported that prevalence of psychotic symptoms is suggested to be 3%-3.5% of the population. A systematic review of epidemiological studies had suggested that 0.3%-0.7% of the population suffer from schizophrenia (Van Os & Kapur, 2009). However, most studies on the prevalence of psychotic diseases have only been carried out in small groups and thus may not be entirely representative of how common psychotic disorders may be.

According to DSM-5 (American Psychiatric Association, 2013), schizophrenia symptoms cover eight dimensions. The first four are termed positive symptoms (delusions, hallucinations, disorganized speech, abnormal psychomotor behaviour). The fifth is termed as negative symptoms, where sufferers experience difficulties in expressing emotions, with ensuing inhibitory effects on daily functioning that may result in withdrawal from social activities. The last three dimensions are cognitive impairment, mania, and depression. Social cognition is one part of cognition which is in general impaired in those who suffer from psychotic disorders (Flavell & Miller, 1998). It had been suggested that social cognition is a fundamental element of how individuals diagnosed with schizophrenia function in daily life (Pinkham, 2014). Impaired cognition can lead to weakened quality of social outcomes in multiple situations (Harvey & Penn, 2010). Complications in that domain affect any relationship to other people as well as the respective individual´s school or work environment (Couture, Penn & Roberts, 2006).

Everyday social interactions are obscure and demand high levels of cognitive capability. Cultural rules and norms manage what emotions an individual expresses or does not express,

depending on circumstances (Harvey & Penn, 2010). Therefore, the ability to process social information is imperative for social interactions (Couture et al., 2006).

The social cognition is a broad construct but generally is divided into four dimensions: affect recognition, social perception, the theory of mind and attributional style (Fizdon et al., 2017). In the literature, the emphasis had been on research on attribution style. Thus this particular dimension merits particular discussion here.

The attributional style theory states that individuals tend to attribute events in three main dimensions, internal (attributing the cause of events to themselves), external (attributing the causes of events to actions of others) and situational dimensions (attributing the cause of events to circumstances or incident) (Abramson, Seligman & Teasdale, 1978). That is consistent with the most recent definition from Fizdon et al. (2017) who defined attributional style as the types of attributions individuals make about the causes of events, with individuals who have psychosis being more likely to blame others for negative events. The authors of the attributional style theory stated that attribution could predict when individuals would foresee helplessness and in fact, the attributional style theory is a reformulation of the learned helplessness model of depression (Liu et al., 2017). The internal attributional style is sometimes labeled as depressive attributional style (Liu et al., 2017) and is thought to define symptoms of people that are prone to depression (Diener & Seligman, 2002). A depressive attributional style is designated as the tendency to view unpleasant events as if they are caused by permanent internal factors that influence multiple realms in one´s life rather than by the behaviour or mindset of others (Cutrona, Russell & Jones., 1985). It had been suggested that this can lead to depression because individuals tend to blame themselves for problems and have negative thoughts about the future which is a symptom of depression (Sweeney, Anderson & Bailey, 1986). However, Cutrona et

al. (1985) only found a weak link between attributional bias and depression in an experiment on 1133 psychology university students. Zuroff (1981) also challenged the attributional style theory when he reported that depressed individuals were prone to stable attributions for both negative and positive outcomes of social situations. He nevertheless concluded that depressed individuals were more likely to exhibit an internal attributional bias for negative outcomes than people that had never been diagnosed with depression. Furthermore, he concluded that participants were prone to use external rather than internal attributional style for negative outcomes and internal over external for positive outcomes. The impact of cultural factors on attributional style still needs to be further clarified (Liu et al., 2017).

The attributional style is generally measured by using questionnaires. The Ambiguous Intentions Hostility Scale (AIHQ) is the most widely used measurement for schizophrenia patients (Buck et al., 2017). Research is lacking on whether deficits in attributional style are specific to delusions that have persecutory content. Previous studies report evidence of different patterns of attribution deficits depending on whether the patients have paranoid ideation or not. According to Zaytseva et al. (2013) patients diagnosed with paranoid ideation were more likely to show aggressive behaviour and blame others in accidental and intentional situations whereas non-paranoid patients only showed aggression and blame attributional bias in an accidental situation. This led Zayetseva et al. (2013) to hypothesize that patients that are non-paranoid struggle with self-referential biases and might feel defenseless or vulnerable in social circumstances and experience themselves as treated unfriendly. These findings also supported the hypothesis that patients that have experienced psychosis only once show deficits in attribution biases and the hypothesis appears to be valid for the positive (Janessen et al., 2006), negative and general symptoms (Zayetseva et al., 2013). Furthermore, this supports findings that

patients with non-paranoid ideation have aggressive tendencies in common with patients that are paranoid (Zayetseva et al., 2013).

The attributional style dimension had received little attention regarding social functioning. Lysaker, Lancaster, Nees & Davis (2004) studied 40 patients diagnosed with schizophrenia or schizoaffective disorder. They reported that individuals that are prone to unstable attributional style are associated with social dysfunction independent of symptom level. Waldheter, Jones, Johnson & Penn (2005) concluded that hostile attributional bias leads to a small but significant increase in social aggression.

Thus people diagnosed with psychotic disorders are more likely to evaluate enigmatic situations as hostile. However, Combs, Adams, Penn, Roberts, Tiegreen & Stem (2007) did a similar study where they found no significant difference between the patient group and the control group in any of the AIHQ dimensions. That is in contrast to Combs et al. (2009) who compared three groups; a patient group who suffered from persecutory delusions (PD group), a patient group who did not suffer from persecutory delusions (non-PD group) and a control group. They found a significant difference between the PD group and both of the other groups (the non-PD group and the control group) on all dimensions. Waldheter, Jones, Johnson & Penn (2005) report that patients with a tendency for hostility bias show a significant increase in social aggression.

The clinical research appears to have proved the validity of the leading theories discussed. Nevertheless, better psychometric methodology to measure and quantify the effects of psychotic disorders is still needed. Early intervention treatment for psychosis has proved to be of great help. Improving methods to recognize individuals at risk is therefore of uttermost importance. This study applied the AIHQ-list on a control group with the intention to use the

results as a baseline reference against clinical groups. This was the first time that the AIHQ-list was used for this purpose in Iceland. The overall aim was to improve the AIHQ as a psychometric measure to enhance the ability of clinical psychology to help and support sufferers. It was hypothesized that the patient group will score significantly higher on the blame and hostility dimensions compared to the control group, but on the aggression dimension, no significant difference between the groups was expected.

Method

Participants

The participants were unpaid volunteers that did not benefit from the experiment. They were divided into two groups, a control group, and a patient group. The total control group consisted of 275 individuals chosen by convenient sample, thereof 96 (34.9%) were males and 176 (64.0%) females. Only 3 (1.1%) individuals defined themselves as neither male nor female.

The patient group was recruited from attendees at an early intervention center for psychosis at Landspitali – The National University Hospital of Iceland, in the years between 2015- 2017. The group consisted of 72 individuals, 18-30 years old, who had their first psychotic episode within the last five years. Thereof were 62 males (86.1%) and 10 females (13.9%). On average the sample was 24.0 years old (SD = 3.1). As the patient group consisted of individuals in the age interval 18-30 years, the same age group from the control group was used for comparison.

This age group of controls consisted of 186 participants. Some participants were eliminated from the study based on the following three reasons. Firstly, if a respondent confirmed having previously been diagnosed with the psychotic disorder (17 participants).

Secondly, if the answering ratio of a participant was low enough to skew the result (5 participants). Thirdly, three participants identified themselves as neither male nor female, and as that group was too small for statistical investigation these were eliminated (3 participants). Consequently, valid controls consisted of 161 participants. Of these, 61 were males (37.9%), and 100 were female (62.1%). Average female age was 24.7 years (*SD* = 2.8), and average male age was 24.3 years (*SD* = 3.0).

Instrument and Measurement

Background information for the control group was assessed with four question on basic demographics (gender, age), level of education and if a participant had been diagnosed with a psychotic disorder.

The Ambiguous Intervention Hostility Scale (AIHQ) was applied to both the patient group and the control group. The list is a widely used scale, translated to Icelandic by Ólína Guðbjörg Viðarsdóttir (Appendix A). The AIHQ attributional scale consists of 5 vignettes that give examples of negative situations with unknown reasons (f.ex. "You are supposed to meet a new friend for lunch at a restaurant, but she/he never shows up"). The 5 vignette list has 5-item dimensions for *hostility* and *aggression* and 15-item dimension for *blame*. Participants rated the vignettes on a 5 or 6 point Likert scale and also gave two open-ended answers to each vignette. They had to write down an answer to what they thought the reason was for this situation and how they would react to it. Participants also had to evaluate on a six-point Likert scale if they thought that this act was intentional (1 = *Definitely not*; 6 = *Definitely*), how angry they would feel (1 = *Not angry at all*, 6 = *Very angry*), and to what degree they would accuse the respective person (1 = *Not at all*, 6 = *A lot*). Furthermore, they had to evaluate if the situations in the vignettes were evasive, accidental or intentional (Combs et al., 2007). The list used the following parameters to

measure attributional bias; hostility bias, the attribution of blame or blame score, and the tendency to respond aggressively to the situations (Combs et al., 2007).

The internal consistency was measured by the Cronbach´s Alpha. For the controls, the blame dimension was found to have acceptable reliability (15 items, α = .84), the aggression dimension was found to be unacceptable (5 items, α = .15) and the hostility dimension was found to be poor (5 items, α = .48). Regarding the patients, the blame dimension was found to have acceptable reliability (15 items α = .87) whereas the hostility dimension was found to have poor reliability (5 items α = .56). The aggression was found to have unacceptable reliability (5 items α = .34).

Procedure

The AIHQ-list was originally developed using 15 vignettes. Here it was decided only to submit 5 vignettes to both groups as it has proved to be a reliable measurement for the attributional style (Buck et al., 2017). The 5-vignette list was submitted to the patient group on paper by a professional psychologist.

The AIHQ-list was converted into an internet survey using Google forms to collect answers from participants in the control group. The internet participants could respond to the survey between December 2017 and February 2018. The list was shared on social media and also answered by some psychology students in a classroom at Reykjavik University. Before participating in the study, each participant was presented with an informed consent paper (Appendix B) advising they were volunteers in a control group in a study on cognitive behaviour. They were also informed that the study had received the required permission from the Health Research Ethics Committee of Landspitali and the Data Protection Authority (Appendix C). They were similarly advised that the information collected in the study was to improve clinical

treatment for young people with first episode psychosis. The consent paper also promised confidentiality to participants and informed of potential risks and benefits. The right to withdraw consent at any time was emphasized to the participants, and they were reminded of the option to skip questions they did not feel like answering.

Research Design

This was a case-control study where the AIHQ scale was used to measure three dimensions of attributional style, i.e. blame, aggression, and hostility. The independent variable was the group, with two levels, i.e. patients and controls. The three dependent variables were how the participants answered (scored) on the AIHQ-list. An independent t-test was used to measure if there was a significant difference between the scores of the patient and the control group and the Levene's test examined the assumption of homogeneity of variance. A criterion of $\alpha = .05$ was used in significance test, and reliability was measured using the Cronbach´s Alpha.

Results

Descriptive statistics

In this study, the AIHQ scale was used to measure three dimensions of attributional style, i.e. blame, aggression, and hostility. Data were analyzed from 161 controls and 72 patients. The AIHQ scores on the hostility, aggression and blame dimensions ranged from 1-5 and were calculated by using the mean score of the participants. In the control group, mean blame score was 2.0 ($SD = 0.6$), aggression mean was 1.7 ($SD = 0.3$) and hostility mean was 1.8 ($SD = 0.7$).

Comparison of groups and gender

Group distribution was unequal according to the Levene's test for all scales (blame $p < 0.05$; aggression $p < 0.05$ and hostility $p < 0.05$). This suggests that the assumption of homogeneity of variances was violated and therefore the Welch t-test was used.

As demonstrated in Figure 1, there was a significant difference between the groups regarding the blame dimension, where the mean score of the patient group was 2.2 (*SD* = 0.8) compared to the control group scoring 2.0 (*SD* = 0.6), conditions t(2) = 97.43, *p* = 0.052. These results indicate that patients are more likely to blame individuals for situations rather than controls. There was an insignificant difference in the scores for the aggression dimension, where the patient group scored 1.6 (*SD* = 0.4) and the control group 1.7 (*SD* = 0.3), conditions t (-0,978) = 185.936, *p* = 0.331, indicating that both groups show the same aggression toward similar circumstances. For the hostility dimension the difference was significant with the score for the patient group 2.1 (*SD* = 0.7) and the control group 1.8 (*SD* = 0.5), conditions t(3) = 218, *p* = 0.001. These results indicate that patients show more hostility than the controls towards similar situations.

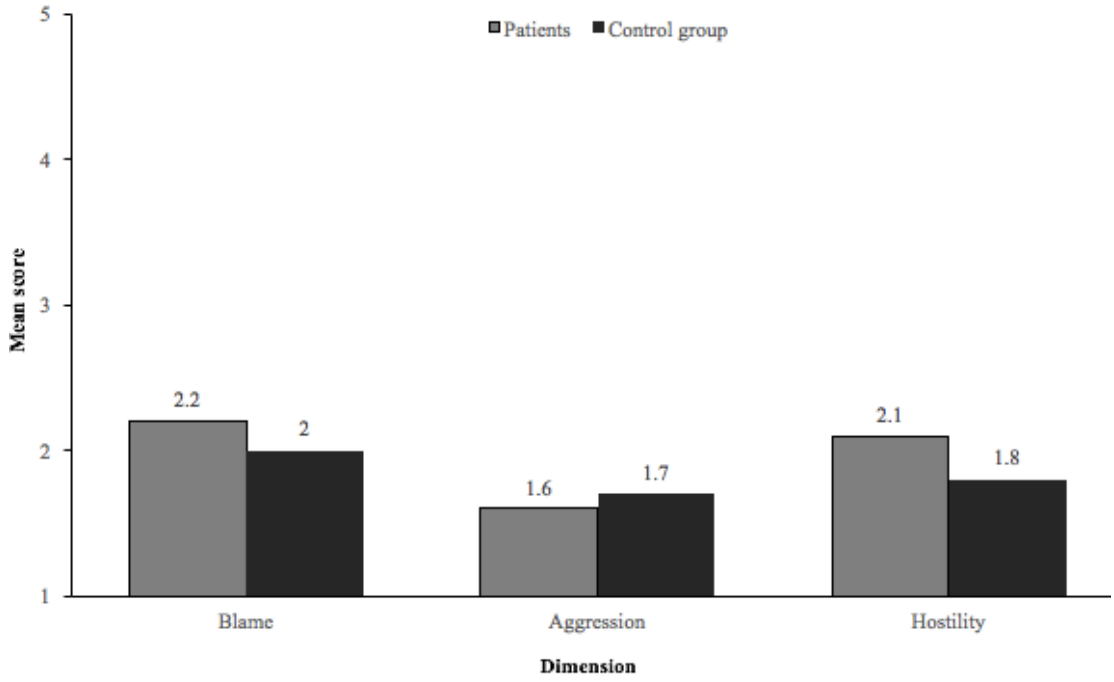

Figure 1. The figure compares scores on three dimensions of the AIHQ scale between patient and control groups.

As demonstrated in Figure 2, a t-test was conducted to analyze score between the genders in the patient group. On average males scored 2.2 (*SD* = 0.8), on the blame dimension compared to females scoring 2.2 (*SD* = 0.8), conditions t(0.59) = 62, (*p* = 0.953). The results suggested that gender does not affect whether participants blamed individuals for situations. On the aggression dimension males scored 1.5 (*SD* = 0.4) compared to females scoring 1.7 (*SD* = 0.3), conditions t(62) = -0.393, *p* = 0.696. The results indicated that gender did not affect if participants reacted aggressively in situations. Furthermore, in the hostility dimension males scored 2.1 (*SD* =0.7), compared to females scoring 2.1 (*SD* = 0.5), conditions t(61) = 0.092, *p* = 0.927 demonstrated that gender did not influence if people acted hostile or not. Overall these results showed that gender did not have a significant effect on how people scored in the patient group.

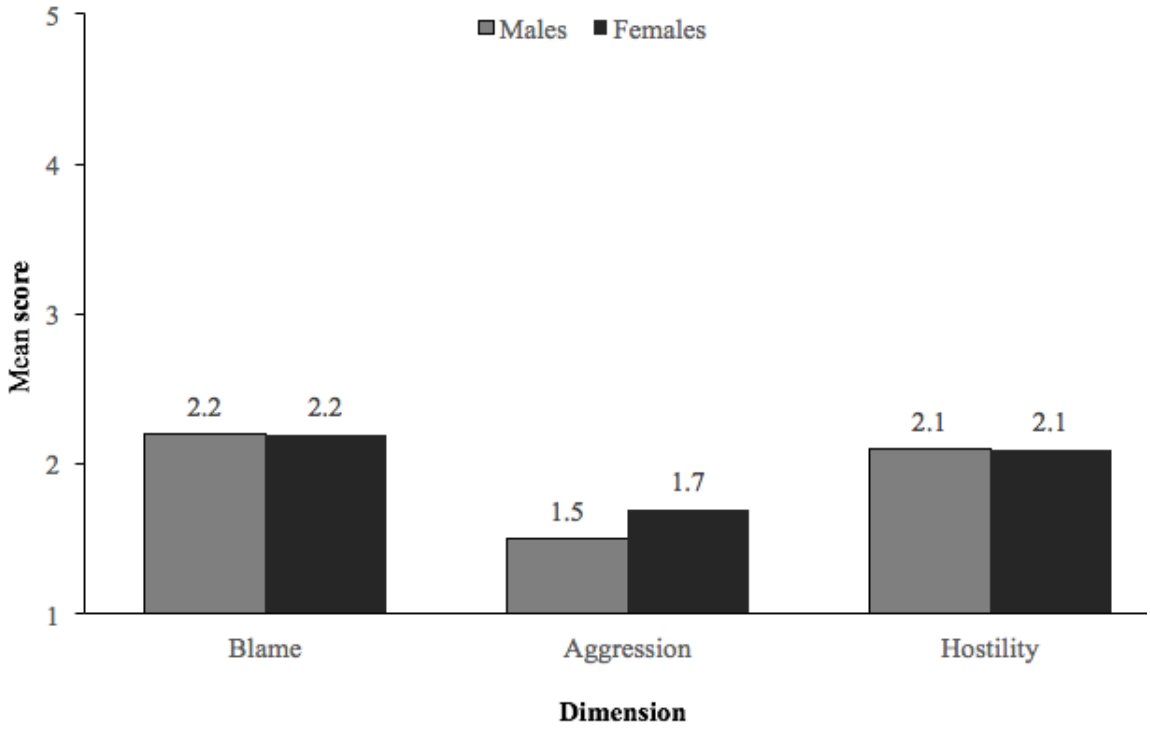

Figure 2. In the figure scores on three dimensions of the AIHQ scale are compared between males and females within the patient group.

A t-test was conducted to analyze scores between the genders in the control group, Figure 3. Males scored on average 1.8 (*SD* = 0.5) on the blame dimension, compared to females scoring 1.8 (*SD* = 0.7), conditions t(159) = -0.031, *p* = 0.976. The results indicated that gender did not affect whether participants blamed individuals for situations. In the aggression dimension the mean scores of males was 1.7 (*SD* = 0.3), compared to females scoring 1.7 (*SD* = 0.2), conditions t(159)= -0.124, *p* = 0.901. The results suggested that gender did not affect if participants reacted aggressively in situations. In the hostility dimension males scored 1.1 (*SD* = 0.5) compared to females scoring 1.8 (*SD* = 0.4), conditions t(152) = -0.655, *p* = 0.513, indicating that gender did not affect if people act hostile or not. Overall the results showed that gender did not have a significant effect on how people scored within the control group.

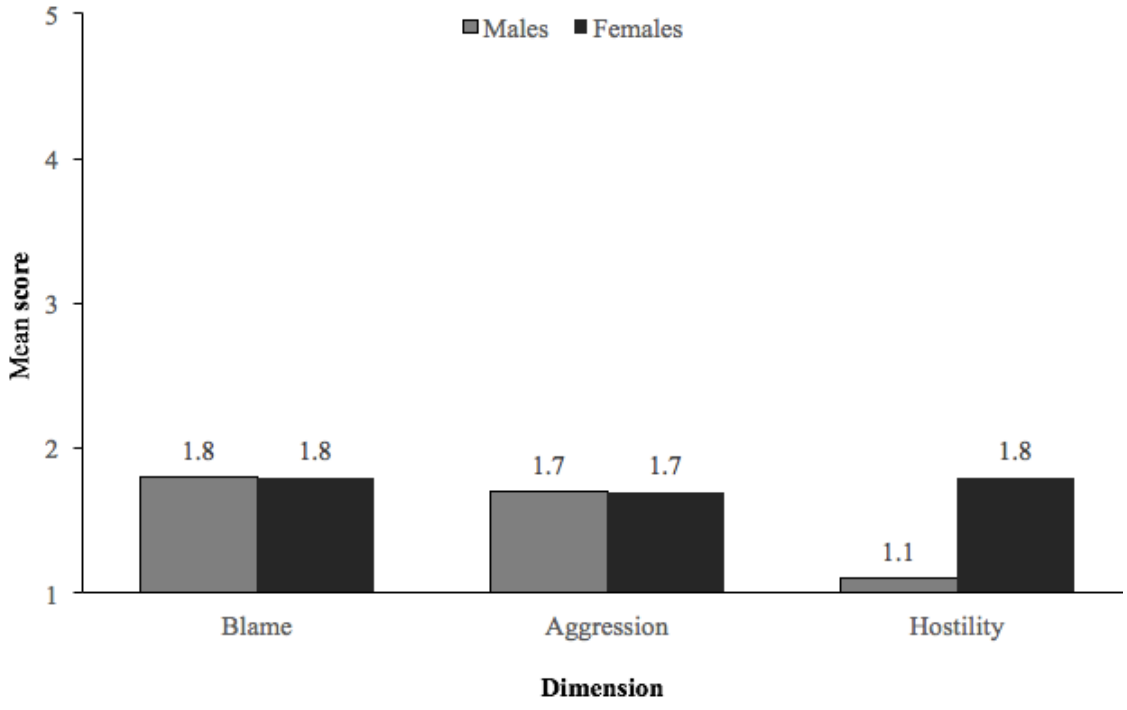

Figure 3. The figure shows scores in the control group based on gender.

Discussion

The present study offered insight into how suffering from psychotic disorders can bias attributional style, a core domain of social cognition. The results supported the importance of cognitive therapy for people with psychotic disorders. This is valuable as while medicine can considerably contribute to better life quality medication can not correct cognitive biases in social circumstances.

The main aim was to examine if there was a significant difference in how people evaluate social situations based on whether they belong to patients or controls. This was explored by comparing the scores of a patient group to a control group on three dimensions of the AIHQ-list (aggression, hostility, and blame), using independent t-test in the SPSS program, with particular emphasis on the hostility dimension.

Results of the t-test supported the working hypothesis that the patient group scores higher than the control group on the hostility dimension. The difference was significant ($p = 0.001$). As hypothesized, there was also a significant difference between the two groups on the blame dimension ($p = 0.052$). The significant tendency of the patient group to evaluate situations as hostile or blameful, as compared to the control group, is in accordance with the cognitive symptoms of the psychotic disorders and disturbed social cognition (Fiszdon et al., 2017; Harvey & Penn, 2010). The results were consistent with earlier findings that have demonstrated that one of the main symptoms of cognitive deficits is a decline in reading social situations (Harvey & Penn, 2010; Couture et al., 2006; Sergei et al., 2006). The present results on the blame and hostility dimensions did also agree with a study by Combs et al. (2009) but were in contrast with Combs et al. (2007), where no significant difference was oberved between the groups. In accord with Waldheter et al. (2005), the results of the present study show that patients with a tendency

to hostility bias score higher on the aggression dimension even if the difference here was not significant. Also in agreement with the working hypothesis, the results showed no significant difference between the two groups on the aggression dimension ($p = 0.331$). This is in agreement with Zayetseva et al., (2013) that found that patients with non-paranoid ideation have aggressive tendencies in common with patients that are paranoid. This is also supported by the description of symptoms in the DSM-5 and the ICD-10 where an excessive tendency to aggression is not a symptom of the psychotic disorders (American Psychiatric Association, 2013). However, lack of internal consistency for the hostility and aggression dimensions makes it important to interpret the results for these dimensions very carefully as discussed below.

The study had some important strengths. The sample had satisfactory numbers of participants in both the control (161) and the patient group (72). As this type of patients is often difficult to reach for similar research studies, have often used smaller numbers for the patient groups. This increases the reliability of the results as compared to studies based on smaller patients groups. It also benefits the study that the number of males in both groups was similar, i.e. 62 to 61, respectively, in the patient and control groups. The participants also were requested to contribute supportive background information, i.e. on age, educational level and history of psychotic disorders. Such information enables researchers to gain better insight into the population and may facilitate further analysis of the dataset in future.

Certain limitations were, however, entailed in the execution of the study. Firstly, the list of questions was put to the control and patient groups in a different manner. The control group accessed the list on the internet whereas it was put on paper to the patient group. This was done in an attempt to get higher number of participants for the control group. It can not be excluded that this possibly influenced the fact that fewer answers were obtained for the hostility dimension

in the patient group, where respondents had to write open-ended answers instead of only ticking in a box, as was required of the control group. Ideally, both groups should answer the same questions in an identical form, either on paper in front of a trained psychologist/supervisor or on the computer. It should also be noted that even though education was not considered when comparing the groups, it is possible that the control group, drawn partly from university students, had a higher level of education than the patient group. It would be of advantage to future application of the AIHQ-list if the influence of education on the results would be explored. Secondly, there was a risk of sampling bias as some of the questions may induce stress. It, therefore, cannot be excluded that some paranoid individuals, especially with a heavy affliction of the disorder, may have ceased participating in the study due to distress. The frequency of such events is likely to have been higher in the patient group than among the controls. It should also be pointed out that the number of participants in each of the two groups was quite uneven although as already stated the number of participants in the patient group is larger than in several similar studies. Gender distribution within the group was also uneven but, interestingly, no significant difference was discovered in scores between gender. The scores were quite similar within both groups and exhibited very high *p*-values. This suggests that the uneven gender ratio of the groups did not impair the validity of the results.

While the internal consistency, a measure of reliability, as measured by the Cronbach's Alpha was acceptable for the blame dimension for both the patient and control groups ($\alpha = .88$ and .84, respectively) it was relatively low in both groups for the hostility dimension with $\alpha = .56$ and 0.48, respectively. Concerning the aggression dimension the internal consistency was unacceptable, i.e. $\alpha = .34$ for the patient group and lower still, or $\alpha = .15$, for the control group. In

view of this statistically significant results from the present study that relate to the hostility and not least the aggression, dimensions should be interpreted with great caution.

The results confirm the practicality of using the AIHQ-list to measure the blame dimension, as previously stated. To the contrary, they also demonstrate that if the AIHQ-list is in future to be used with regard to the hostility dimension the relevant parts of the list have to be critically reviewed, e.g. by removing or adding questions, with the intent to improve internal consistency. As the aggression dimension regards more drastic measures are needed, and a complete re-design of the pertinent parts of the AIHQ-list is needed should it be used in future to measure the dimension. In relation to the different internal consistency with respect to the three dimensions, it is relevant to note, that 15 items formed the blame dimension, where internal consistency proved acceptable, while only 5 items formed the other two dimensions. This may indicate that a more detailed questionnaire is needed to ensure better internal consistency.

For design of future studies the shortcomings discussed above should be considered. Of special importance is to ensure that both the patient and control groups contribute answers to the AIHQ-list in an identical manner, i.e. either on paper or on a computer. It also would be of scientific and practical interest to examine if the emotional response to questions in terms of stress or anxiety differed between the groups to the extent of influencing the results. It would also aid future clinical application of the AOHQ-list if emotions that have been highly correlated with the dimensions under study would be further explored. Similarly, the present study would have gained if other important variables, such as cognitive function, had been measured as well. This should be included in future research. As the present study indicated some shortcomings of the AIHQ-list it is recommended that future researchers approach attributional style with more extensive measures than simply the AIHQ-list. In view of the fact that the results of the study

may have practical implications for clinical use of the list it is recommended that their reproducibility be tested by repeating the experiment.

In conclusion, the present study supported the importance of cognitive therapy for people with psychotic disorders. The results demonstrated significant difference on the blame and hostility dimensions ($p = 0.052$ and $p = 0.001$), between the patient and the control groups whereas the difference on the aggression dimension is insignificant ($p = 0.331$). The results for the hostility and aggression dimensions should, however, be interpreted carefully in light of low or unacceptable internal reliability. The study confirms the AIHQ-list as a useful and practical diagnostic tool for the blame dimension, but also indicates that unless amended the list may not correctly reflect the hostility dimension and without radical restructuring the AIHQ-list will not be a practical tool to analyze and diagnose symptoms of the aggression dimension.

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Appendix A

Spurningalisti um óljósar og fjandsamlegar fyrirætlanir

Ambiguous Intentions Hostility Questionnaire (AIHQ)

Vinsamlega lestu dæmin hér að neðan og ímyndaðu þér að þú værir í þessum aðstæðum. Ég mun einnig lesa þessi dæmi upphátt. Skrifaðu niður ástæðu, í stuttu máli, á hverjum aðstæðum fyrir sig. Næst skaltu meta hvort þér finnist manneskjan hafi gert þér þetta viljandi. Þú munt síðan vera beðin/n um að meta hversu reið/ur þú í verður þessum sömu aðstæðum og að hve miklu leyti þú myndir kenna hinni manneskjunni um. Að lokum skaltu skrifa niður hvað þú myndir sjálf/ur gera í þessum aðstæðum.
Ekki er nóg að skrifa "ég veit það ekki" heldur skaltu lýsa einhverjum viðbrögðum.

1. Þú hefur verið í nýju starfi í þrjár vikur. Dag einn sérðu einn af nýju samstarfsmönnunum úti á götu. Þú gengur í áttina að honum og ætlar að heilsa en hann gengur framhjá þér án þess að heilsa.

A. Hver heldur þú að hafi verið raunveruleg ástæða þess að samstarfsmaður þinn gekk framhjá þér?

Svar:_____

B. Heldurðu að samstarfsmaðurinn hafi gert þetta viljandi?

1	2	3	4	5	6
Örugglega ekki	Líklega ekki	Kannski ekki	Kannski	Líklega	Örugglega

C. Hversu reið/ur myndir þú verða?

1	2	3	4	5
Alls ekkert reið/ur				Mjög reið/ur

D. Hversu mikið myndir þú ásaka samstarfsmann fyrir að hafa gengið framhjá þér?

1	2	3	4	5
Alls ekkert				Mjög mikið

E. Hvernig myndir þú bregðast við?

Svar:_____

2. Þú átt bókaðan tíma hjá mikilvægri manneskju. Þegar þú mætir í tímann segir ritarinn að hún sé ekki við; hún hafi tekið sér frí.

A. Hver heldur þú að hafi verið raunveruleg ástæða fyrir því að hún mætti ekki í tímann?

Svar:_____

B. Heldur þú að hún hafi gert þér þetta viljandi?

1	2	3	4	5	6
Örugglega ekki	Líklega ekki	Kannski ekki	Kannski	Líklega	Örugglega

C. Hversu reið/ur myndir þú verða?

1	2	3	4	5
Ekkert reið/ur				Mjög reið/ur

D. Hversu mikið myndir þú ásaka hana fyrir að mæta ekki í tímann?

1	2	3	4	5
Alls ekkert				Mjög mikið

E. Hvað myndir þú gera í þessum aðstæðum?

Svar:_____

3. Þú gengur framhjá hópi unglinga í verslunarmiðstöð og heyrir að þeir fara að hlæja.

A. Hver heldur þú að hafi verið raunveruleg ástæða þess að unglingarnir fóru að hlæja eftir að þú gekkst framhjá þeim?

Svar:_____

B. Heldur þú að unglingarnir hafi gert þér þetta viljandi?

1	2	3	4	5	6
Örugglega ekki	Líklega ekki	Kannski ekki	Kannski	Líklega	Örugglega

C. Hversu reið/ur myndir þú verða?

1	2	3	4	5
Ekkert reið/ur				Mjög reið/ur

D. Hversu mikið myndir þú ásaka unglingana fyrir að hlæja um leið og þú gekkst framhjá þeim?

1	2	3	4	5
Alls ekkert				Mjög mikið

E. Hvað myndir þú gera í þessum aðstæðum?

Svar:_____

4. Þú ætlar að hitta nýjan vin í hádegismat á veitingastað en hann mætir ekki.

A. Hver heldur þú að hafi verið raunveruleg ástæða þess þessi nýji vinur þinn hafi ekki komið á veitingastaðinn?

Svar:_____

B. Heldur þú að hann/hún hafi gert þér þetta viljandi?

1	2	3	4	5	6
Örugglega ekki	Líklega ekki	Kannski ekki	Kannski	Líklega	Örugglega

C. Hversu reið/ur myndir þú verða?

1	2	3	4	5
Ekkert reið/ur				Mjög reið/ur

D. Hversu mikið myndir þú ásaka vin þinn fyrir að mæta ekki?

1	2	3	4	5
Alls ekkert				Mjög mikið

E. Hvað myndir þú gera í þessum aðstæðum?

Svar:_____

5. Þú hringir í vin þinn sem svarar ekki, þannig að þú sendir honum SMS og biður hann um að hringja í þig. Viku seinna hefur vinur þinn ekki enn hringt í þig.

A. Hver heldur þú að hafi verið raunveruleg ástæða þess að vinur þinn hringdi ekki aftur í þig?

Svar:_____

B. Hringdi vinur þinn viljandi ekki aftur í þig?

1	2	3	4	5	6
Örugglega ekki	Líklega ekki	Kannski ekki	Kannski	Líklega	Örugglega

C. Hversu reið/ur yrðir þú í þessum aðstæðum?

1	2	3	4	5
Alls ekkert reið/ur				Mjög reið/ur

D. Hversu mikið myndir þú ásaka vin þinn fyrir að hringja ekki aftur í þig?

1	2	3	4	5
Alls ekkert				Mjög mikið

E. Hvað myndir þú gera í þessum aðstæðum?

Svar:_____

Appendix B

Kynningarbréf til þátttakenda í samanburðarhópi

Vitrænt mat og endurhæfing ungs fólks eftir fyrsta geðrof
- Félagsskilningur –

Kæri lesandi,
Geðsvið Landpítala í samstarfi við Háskóla Íslands og Háskólann í Reykjavík leitar eftir þátttakendum í samanburðarhóp í rannsókn á vitrænni getu og endurhæfingu ungs fólks eftir fyrsta geðrof þar sem lagt er mat á félagsskilning. Rannsóknin hefur fengið leyfi siðanefndar Landspítala og hefur verið tilkynnt til Persónuverndar.

Markmið rannsóknar
Heildar markmið rannsóknarinnar er að framkvæma mat á vitrænni getu og síðar, byggt á því mati, gera árangursmat á vitrænni endurhæfingu á Laugarásnum, deild á geðsviði Landspítala sem sérhæfir sig í meðferð fyrir ungt fólk með byrjandi geðrofssjúkdóma. Rannsóknin er sú fyrsta sem kannar árangur af slíkri endurhæfingu hérlendis en erlendar rannsóknir benda til góðs árangurs. Upplýsingunum sem verður safnað í rannsókninni er ætlað að nýtast til að bæta meðferð fólks með byrjandi geðrofssjúkdóma og auka lífsgæði þeirra.

Þátttakendur
Óskað er eftir þátttöku þinni í hluta rannsóknarinnar sem felur í sér mat á félagsskilningi og er öllum einstaklingum eldri en 18 ára er boðið að taka þátt.

Hvað felst í þátttöku?
Þátttakendur eru beðnir að fylla út spurningalista sem ætlað er að meta félagsskilning. Einnig er óskað eftir bakgrunnsupplýsingum; aldri, kyni og menntun og hvort fólk glími við geðrofssjúkdóma. Ekki er óskað eftir neinum persónugreinanlegum upplýsingum um þátttakendur. Áætlað er að það taki um 5 mínútur að svara spurningalistanum.

Trúnaður við þátttakendur
Upplýsingar sem safnast í rannsókninni verða varðveittar í læstum gagnagrunni sem einungis rannsakendur hafa aðgang að. Engar persónugreinanlegar upplýsingar verða skráðar og því verður ekki hægt að rekja upplýsingarnar til einstakra þátttakenda.

Áhætta og ávinningur
Engin líkamleg áhætta fylgir þátttöku í rannsókninni. Áhætta af þátttöku felst helst í því að spurningarnar gætu valdið þér vanlíðan, en minnt er á að þú getur sleppt að svara einstaka spurningum.

Svörun spurningalistans jafngildir samþykki fyrir þátttöku í rannsókninni.

Nánari upplýsingar um rannsóknina veitir:
Brynja Björk Magnúsdóttir lektor við Háskólann í Reykjavík og sálfræðingur á geðsviði Landspítala – Háskólasjúkrahúsi, v/Hringbraut, 101 Reykjavík, sími: 543 4062, 543 1000, netfang: brynjabm@lsh.is

Appendix C

Reykjavík, 30.10.2017

Berist til Siðanefndar Landspítala Háskólasjúkrahúss

Óskað er eftir leyfi til að leggja AIHQ matslista fyrir hóp heilbrigðra einstaklinga sem hluta af rannsókn umsækjanda: **Vitrænt mat og endurhæfing ungs fólks eftir geðrof**.

Leyfi frá Siðanefnd Landspítala nr: 20/2015.
Leyfi Framkvæmdastjóra lækninga á Landspítala nr: Tilv. 16, LSH 42-15

Markmið rannsóknarinnar er að leggja mat á árangur af vitrænni endurhæfingu fyrir fólk með geðrofssjúkdóma sem sækir þjónustu á endurhæfingargeðdeild Landspítala á Laugarási. Ólína G. Viðarsdóttir, doktorsnemi við HÍ og sálfræðingur á deildinni, leggur mat á vitræna getu áður en meðferð hefst og að henni lokinni. Hluti af matinu felst í fyrirlögn AIHQ sjálfsmatskvarða sem ætlað er að meta óljósar og fjandsamlegar fyrirætlanir og hefur fyrirlögn á þeim lista meðal fólks með geðrofssjúkdóma þegar fengið samþykki Siðanefndar LSH. Listinn hefur verið þýddur og notaður í klínísku starfi hér á landi en það skortir þó íslensk viðmið. Óskað er eftir leyfi til að leggja listann fyrir um 150 þátttakendur í heilbrigðum samanburðarhópi. Gert er ráð fyrir að setja listann upp sem netkönnun, sett verður upp vefsíða til kynningar á rannsókninni og má á meðfylgjandi skjali sjá kynningartexta. Allir þátttakendur munu lesa upplýsingar um rannsóknina og veita upplýst samþykki áður en þeir svara listanum (sjá meðfylgjandi skjal). Svör þátttakenda verða nafnlaus og órekjanleg. Einungis verður óskað eftir upplýsingum um aldur, kyn og menntun þátttakenda auk spurningar um hvort viðkomandi glími við geðrofssjúkdóm, sem eru nauðsynlegar upplýsingar við úrvinnslu gagna.

Nemi í sálfræði við Háskólann í Reykjavík mun sinna gagnasöfnun og úrvinnslu undir handleiðslu Brynju B. Magnúsdóttur lektors við Háskólann í Reykjavík í samvinnu við Ólínu G. Viðarsdóttur doktorsnema.

Engilbert Sigurðsson
Prófessor í geðlæknisfræði og yfirlæknir
Ábyrgðarmaður rannsóknar