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Managing Sex Offenders by Assessing Dynamic Risk Factors

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Mental health experts have made enormous progress during recent years in assessing the risk of recidivism of sex offenders. Little more than a decade ago, no empirically validated risk assessment instruments were available for this population. If one were to read the report of any sex offender evaluation from the early 1990s (or before), one would see a relatively unstructured clinical narrative concerning risk, each narrative idiosyncratic to that evaluator (and perhaps to that evaluatee as well). Needless to say, such lack of standardization or empirical grounding did little to convince the public of mental health experts' accuracy in assessing risk.

The above method of risk assessment is termed clinical risk assessment. It has the advantage of convenience. But it has the many disadvantages of lack of agreement between independent raters, lack of clarity on what factors are considered or what weight individual factors are given, and perhaps most importantly, lack of empirical support. (See Philip H. Witt and Natalie Barone, "Assessing Sex Offender Risk: New Jersey's Methods," 16 Fed. Sentencing Rep. 170 (2004).) Nonetheless, for many years, such testimony by mental health experts regarding risk has been admissible in court.

Empirically Grounded Risk Assessment Instruments

The first wave of empirically grounded risk assessment instruments focused heavily on static, historical risk factors—characteristics of the offense (such as use of force), history of antisocial behavior (sexual and otherwise), age at first offense, or gender of victims. Such instruments included, for example, the:

- Violence Risk Appraisal Guide (VRAG) (M.E. Rice and G.T. Harris, "Cross Validation and Extension of the Violence Risk Appraisal Guide for Child Molesters and Rapists," 21 L. and Human Behav. 231 (1997));
- Rapid Risk Assessment for Sex Offense Recidivism (RRASOR) (R. Karl Hanson, "What do We Know About Sex Offender Risk Assessment?," 4 Psych., Public Policy, and L. 50 (1998)); and
- Static-99 (R.K. Hanson and D. Thornton, "Improving Risk Assessments for Sex Offenders: A Comparison of Three Actuarial Scales," 24 L. and Human Behav. 119 (2000)).

Static risk variables are relatively easy to study. Typically, these variables can be gathered from archival data, such as criminal history records. Coding of such variables is straightforward and results in high levels of agreement between independent observers.

However, the heavy reliance of risk assessment scales on static, historical risk factors has been criticized for neglecting dynamic, changeable risk factors. After all, if an individual's risk is completely determined by historical, unchangeable factors, then why bother providing psychotherapy? Psychotherapy cannot change a person's history; it can only affect variables that are amenable to change, termed dynamic risk variables. Moreover, total reliance on static, historical risk factors and exclusion of dynamic risk factors, such as the situational context in which sex offenses are triggered for an individual, leaves one with an actuarial scale that may statistically predict recidivism in the long-term, but says nothing

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Sex Offender Treatment Rating Scale.

The SOTRS was designed as both a process and outcome measure, using therapist ratings, for a cognitive-behavioral sex offender treatment program in Connecticut. (R.D. Anderson, D. Gibeau, and B.A. D'Amora, "The Sex Offender Treatment Rating Scale: Initial Reliability Data," 7 (3) *Sexual Abuse: A J. of Res. and Treatment* 221 (Jul. 1995).) Scoring categories include the following:

1. Insight;
2. Deviant thoughts;
3. Awareness of situational risks;
4. Motivation;
5. Victim empathy; and
6. Offense disclosure.

A reliability study based upon a sample of 122 sex offenders referred to outpatient treatment through probation or parole suggested the scale had high internal consistency. However, no predictive validity study has yet been conducted.

Goal Attainment Scaling. Stripe, Wilson, and Long developed Goal Attainment Scaling (GAS) to objectively assess the impact of clinical and motivational elements of treatment for sex offenders on conditional release. (T.S. Stripe, R.J. Wilson, and C. Long, "Goal Attainment Scaling With Sexual Offenders: A Measure of Clinical Impact at Post-Treatment and at Community Follow-up," 13 *Sexual Abuse: A J. of Res. and Treatment* 65 (2000).) The three areas assessed include nonrelapse prevention clinical dimensions, relapse prevention clinical dimensions, and motivational dimensions.

Nonrelapse clinical dimensions include:

1. Acceptance of guilt for the offense;
2. Showing insight into victim issues;
3. Showing empathy for their victims;
4. Acceptance of personal responsibility;
5. Recognizing cognitive distortions; and
6. Minimization of consequences.

Relapse prevention clinical dimensions include:

1. Understanding of lifestyle dynamics;
2. Understanding the offense cycle; and
3. Identification of relapse prevention concepts.

Motivational dimensions include:

1. Disclosure of personal information;
2. Participation in treatment; and
3. Motivation to change.

In a concurrent validity study, individuals with positive attitudes were more likely to complete the treatment program, whereas offenders with negative attitudes were less likely to complete the program.

In a concurrent validity study, individuals with positive attitudes were more likely to complete the treatment program, whereas offenders with negative attitudes were less likely to complete the program. Comparisons between offenders in different stages of treatment showed that although both groups made gains between pretreatment and follow-up in the community, the low-risk group consistently outperformed the high-risk group in terms of total score.

Community Adjustment Measures

Three scales focus to varying degrees on both progress in therapy and broader risk factors related to community adjustment. These hybrid scales have use not only for monitoring progress in treatment, but also for managing sex offender risk in the community.

Treatment Progress Scale (TPS). The Treatment Needs and Progress Scale is composed of dynamic risk factors linked to sexual offending to evaluate initial treatment need as well as progress in treatment when administered regularly at six-month intervals. (Robert J. McGrath, J. Livingston, and G.F. Cumming, *Development of a Treatment Needs and Progress Scale for Adult Sex Offenders* (U.S. Dept. of Just., Office of Just. Prog., 2002).) Risk factors included in the TPS are:

1. Admission of offense behavior;
2. Acceptance of responsibility;
3. Sexual interests;
4. Sexual attitudes;
5. Sexual behavior;
6. Sexual risk management;
7. Criminal attitudes;

8. Criminal behavior;
9. Substance abuse;
10. Emotion management;
11. Mental health stability;
12. Problem solving;
13. Impulsivity;
14. Stage of change;
15. Cooperation with treatment;
16. Cooperation with supervision;
17. Employment;
18. Residence;
19. Finances;
20. Adult love relationship;
21. Social influences; and
22. Social involvement.

The TPS was developed based upon a sample of 329 adult male sex offenders enrolled in outpatient treatment programs under community correctional supervision in Vermont. TPS scores demonstrated a moderate correlation with existing static risk scales known to have predictive validity, including the RRASOR, Static-99, and VASOR. Moreover, differences were found among total mean scores of participants at various stages of treatment; that is, clients at the beginning of treatment with the highest risk and needs had higher total scores than clients in the later stages of treatment, providing evidence of the concurrent validity. (McGrath and his associates have later made minor modifications to the TPS and retitled it the Sex Offender Treatment Needs and Progress Scale.)

Sex Offender Need Assessment Rating (SONAR). Hanson and Harris summarize the motivation behind the SONAR as follows:

The Hanson and Bussière meta-analysis summarized our knowledge of those risk factors most closely related to sexual recidivism. From this starting point, we began a retrospective file-review and interview study, the Dynamic Predictor Project, in 1997. (citation omitted). (Andrew Harris and R. Karl Hanson, "The Dynamic Supervision Project: Improving the Community Supervision of Sex Offenders," 65 *Corrections Today* 60 (Aug. 2003).)

Thus, the SONAR, probably the dynamic risk assessment scale most widely used in North America, was developed by interviewing probation and parole officers about

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factors, in combination with static factors, are indeed related to recidivism. Fourth, stable dynamic risk factors are positively correlated with static risk factors (Hanson, supra), supporting the notions that such stable factors constitute markers for personality traits. Finally, acute dynamic risk factors—such as dysphoric mood, substance abuse, or victim access—act as precipitants for new sex offenses.

Presently, a number of empirically guided structured instruments exist that can guide the evaluator's thinking in this area. These instruments focus on three broad areas:

1. Assessment of stable dynamic risk factors (or traits);
2. Assessment of acute dynamic risk factors (or immediate precipitants) relat-

ed to community adjustment; and

3. Assessment of acute dynamic risk factors related to therapy progress.

One can hope that we are approaching the time when risk assessment will shift from mechanistic assessment of historical factors to ongoing monitoring of dynamic factors. As Hanson aptly states the case:

With increased scientific understanding, static factors will become less and less important. When evaluators are able to accurately identify the causes of recidivism (i.e., criminogenic needs, triggers), the practice of purely mechanical prediction using static factors will become a historical footnote. (Hanson, supra.)

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