REVIEW ARTICLE

Psychological and Legal Aspects of Dangerous Sex Offenders: A Review of the Literature

M. T. Rowlands, G. Palk and R. McD. Young

Institute of Health & Biomedical Innovation, Queensland University of Technology, Brisbane, Australia

The purpose of this article is to review legislation on ‘dangerous sex offenders’ critically. Most modern legislation determines an individual to be ‘dangerous’ if he or she is at unacceptably high risk of committing further sexual violence. While the decision is judicial in practice, clinical testimony is utilised to inform courts’ decision-making. Dangerousness may be a normative (legal) construct, but it is reliant on clinical assessment. Offenders are not at risk only due to historical factors; the possibility of committing sexual violence in the future is likely affected by temporal factors such as response to therapy, substance misuse, and proximity to victims. It is not clear that mental illness would place an offender at risk, although certain personality disorders are considered to be risk factors. In reporting actual risk, clinicians need to consider a range of variables, and not exclusively use actuarial measures or unstructured clinical interviews.

Keywords: clinical risk assessment; dangerousness; dangerous sex offenders; sex offender legislation; sex offending.

Introduction

This article is a critical review of the construct of ‘dangerousness’ as noted in sex offender legislation. Understanding dangerousness is important given the physical and emotional impact of sexual violence (Bonta, Zinger, Harris, & Carrière, 1998). The term implies that there is a risk to the community that any one individual or group will commit an act that results in some form of harm. This may vary from committing fraud through to murder or rape, with a range of potential violent and/or sexual offences in between. When the designation of ‘dangerousness’ is applied to an individual it may become a signifier that he or she is at serious risk of causing harm to others. While this can be physical, financial, or mental harm, this review focuses

on those considered to be ‘dangerous sex offenders’, given the significant impact of sexual violence (Robertiello & Terry, 2007).

In criminal justice, dangerousness might convey that, through the *principle of proportionality*, individuals are sentenced accordingly for the severity of their crime and the degree of responsibility (McSherry & Keyzer, 2009). However, once the sentence is over, are they no longer dangerous? From a scientific point of view, the signifier is not sufficient as it is not *explanatory*: what are the factors associated with someone being dangerous, and does the construct have predictive validity? This review therefore explores the nature of dangerousness as defined in legal systems as a psychological and legal construct. The literature on both scientific

Correspondence: M.T. Rowlands, Faculty of Health, Institute of Health & Biomedical Innovation, Queensland University of Technology, GPO Box 2434 Brisbane, Australia 4001. Phone: +07 3138 4911. Email: mt.rowlands@hdr.qut.edu.au

and legal views on dangerousness, and its assessment, is examined.

Dangerous Sex Offenders in Legislation

A review of modern legislation for sentencing and managing dangerous sex offenders revealed the legal procedures in most countries. Due to the limitations of this article, only three countries are considered: the United States, the United Kingdom, and Australia.

United States

The United States was the first country to develop a legal framework for dealing with sex offenders who are considered to be dangerous (Pratt, 1993). In the early part of the twentieth century, 'Sexual Psychopath Laws' were created in response to public fear that sexual violence was 'engulfing' the United States (Lave, 2009). The 'sexual psychopath' (or 'sexually dangerous person' in some statutes) was considered to be someone who was unable to control his or her impulses, and who must be detained until the psychological illness causing this problem was treated successfully. Following concerns about treatment (and about the diagnostic term 'sexual psychopath'), by the end of the twentieth century there were very few states using the law (Lave, 2009; McSherry, 2014). In 1990, the Washington State Sexually Violent Predator (SVP) Law was passed, allowing for indefinite custodial episodes for sex offenders who were still considered to be dangerous after they had completed a sentence (Lave, 2009; Washington Laws, 1990). Like the Sexual Psychopath Laws, the Washington Laws were not criminal law and instead dealt with civil commitment, as they had a therapeutic focus (Prentky, Janus, Barbaree, Schwartz, & Kafka, 2006). If the court could establish on reasonable grounds that an offender was at risk of committing violence *due* to a mental disorder or abnormality, he or she was held in a forensic facility until rehabilitated

(Washington Laws, 1990). Otherwise, the individual would be managed in criminal court. Similar to the Sexual Psychopath Laws, the court is reliant on expert testimony from mental health professionals to determine whether sexual offences are being committed due to mental abnormality (Prentky et al., 2006; Washington Laws, 1990).

A total of 19 states adopted the SVP Law, although with some variations (Sreenivasan, Frances, & Weinberger, 2010). For instance, the Texas SVP Law was similar in that it had a non-punitive (civil) aim, but it differed from other states' laws as offenders classed as sexually violent were placed in community (outpatient) centres as opposed to forensic facilities. The rationale was that offenders tend to have poorer rehabilitation outcomes when treated in prisons (McSherry, Keyzer, & Freiberg, 2006).

United Kingdom

The United Kingdom's Criminal Justice Act 2003 identifies dangerous offenders as those who are at risk of committing *further* serious offending. This is different to the United States legislation; whereas the United States model identifies a dangerous individual as someone with a diagnosed condition that places him or her at *risk* of committing sexually violent acts, the 2003 act equates dangerousness to risk without requiring a diagnosis of a mental abnormality (or the likelihood of sexual violence). Once the court has determined that 'there is a significant risk to members of the public of serious harm' upon release from custody, then the individual receives an extended sentence (Criminal Justice Act 2003, p. 135). Unlike the United States model, the Criminal Justice Act does not provide a clinical framework for managing dangerous sex offenders, as it is punitive in nature; individuals are kept in custody (not a forensic psychiatric facility) in order to protect the community. The act does not state that clinical expertise is required for the court to determine dangerousness – only that it has

to take into account information regarding the offences and the behaviour of the offender. Hence, it is up to the court to determine the suitability of the information, although legal counsel can call upon psychiatric evidence (Bickle, 2008).

By contrast to the Criminal Justice and Mental Health Acts, Scotland's Order for Lifelong Restriction (OLR; Criminal Justice Act 2003) is more explicit in the process of risk assessment. The orders are placed on offenders during sentencing. Again, dangerousness is synonymous with the likelihood of serious injury being caused by violent sexual behaviour. The court relies upon a risk-management authority, which assesses risk using established guidelines (McSherry et al., 2006). Qualified experts are required to assess and advise, allowing for more effective judicial decision-making. In this regard, accredited methods of determining risk are necessary for the court to make an informed decision.

Australia

In Australia, there are five bodies of legislation specifically dealing with dangerous sex offenders: the Serious Sex Offenders Monitoring Act 2009 (Vic), the Crimes (Serious Sex Offenders) Act 2006 (NSW), and parts of the Criminal Law (Sentencing) Act 1988 (SA), the Dangerous Sexual Offenders Act 2006 (WA), and the Dangerous Prisoners (Sexual Offending) Act 2003 (Qld). Post-sentence detention (or supervision) options are risk-focused, given the concerns of sexually violent reoffending. This can be seen in the guidelines of each act. In the Serious Sex Offenders Monitoring Act 2009 (Victoria), the court can utilise medical (psychiatric and psychological) advice in determining whether someone will commit further sexual offending upon release into the community. The Dangerous Prisoners (Sexual Offending) Act 2003 (Queensland) categorises dangerousness as an offender being a serious danger to the community 'if the person is released from

custody' or 'released from custody without a supervision order being made (p. 9)'. Hence, once the Supreme Court is satisfied that there is a high degree of probability that this is likely, the person is considered to be an 'unacceptable risk (p. 9)'. The court, in its decision-making, has access to psychiatric and psychological reports and assessments, criminal and behavioural histories, and efforts (or lack thereof) by the individual to address his or her offending behaviour, such as attending intervention programmes aimed at reducing criminal behaviour.

Psychiatric risk assessment is explicitly noted in the Dangerous Sexual Offenders Act 2006 (Western Australia). Two psychiatrists are required to examine the offender in order to determine the level of risk of reoffending (if the individual was to be released without supervision); however, the court is to utilise this information – in addition to other assessments and the offender's response to intervention programmes – in concluding whether or not the individual is at an 'unacceptable risk ... [of committing] a serious sexual offence (p. 12)'. The Crimes (Serious Sex Offenders) Act 2006 (New South Wales) is similar to Western Australian's legislation in the use of clinical evidence, although it also makes reference to the use of psychometric measures to determine the likelihood of risk.

While the Criminal Law (Sentencing) Act 1988 (South Australia) pertains to the offender's sentence and does not allow for detention after the sentence or (extended supervision), it is identical to those of the other states of Australia in that the individual is considered dangerous if 'on the balance of probabilities' he or she will be a 'serious danger to the community' if released (p. 8). It also differs as it does not stipulate that expert testimony (i.e. from psychiatrists and psychologists) is required for the court's consideration of risk. The act makes reference to reports, likelihood of sexual recidivism, and mental condition as being factors, which suggests that some clinical expertise may be required even if it is not specified.

Dangerousness and Risk

According to the majority of legislative provisions on the issue, a person is considered dangerous by virtue of being (likely) at risk of committing further sexually violent offences. While the United States model states that an offender is dangerous by virtue of mental abnormality, it can be said that he or she would technically remain a risk if the condition remains untreated. Risk is not explicitly noted, but a court is legally bound to consider releasing an offender if therapy is deemed to have been successful. One of the criticisms of the Washington SVP Laws is that the process in defining risk in court is entirely discretionary, and many states have not developed assessment standards (Prentky et al., 2006). Only a few laws determine dangerousness based on the offence, such as the Serious Sex Offenders Monitoring Act 2009 (Victoria), wherein sexual offences alone make the perpetrator a serious sexual offender. But it is difficult to argue that an individual can be considered a dangerous offender simply on the basis of his or her offending; for what period of time is someone a serious sexual offender due to historical offences? The community would be more concerned about the likelihood of further sexual offending in the future (Robertiello & Terry, 2007). Risk appears to be a valid definition for a dangerous sex offender. Yet, without clear means and standards of assessing the likelihood of sex offending, the threshold for a person being considered dangerous varies from court to court, increasing the risk of false positives (and negatives); these are clear violations of legal principles (i.e. the principle of proportionality; McSherry, 2014; McSherry & Keyzer, 2009; Prentky et al., 2006).

A high quality of practice is therefore necessary for determining risk. Only two forms of legislation (above) state specific risk assessment processes: the Order for Lifelong Restriction (Criminal Justice Act (Scotland) 2003) and the Crimes (Serious Sex Offenders) Act 2006 (NSW, Australia). The

process by which dangerousness is determined (by the court) relies on expert evidence; as noted in most legislation, decisions on risk are *informed* by clinical opinion: how is an offender considered to be at risk of reoffending? Courts are otherwise reliant (among other sources of information) on the informed opinion, or report, of a clinical expert (a psychiatrist, psychologist or medical person). There is no set method for how clinicians advise on risk; studies have found that clinical experts likely use a combined approach – clinical interview and actuarial measure (Hanson, 1998). However, most legislation is not explicit on how each is to be used and reported, or on how to combine these forms of information into a statement on overall risk.

What are the factors associated with risk? If risk was determined by *only* current (and past) offences, then legislation would recommend an individual being classed as dangerous during sentencing (such as the Serious Sex Offenders Monitoring Act 2009 (Victoria)). Evidently, then, a court requires statements on what determines that an individual is at risk of reoffending. According to legislation, dangerousness in the legislative sense is a complex construct: judicial consideration may incorporate current (and historical) offences, psychiatric issues, historical and risk factors, and clinical needs, most of which are informed through clinical reporting and testimony. Thus, clinical expertise plays a very important part in the determination of dangerousness and it is essential to identify what constitutes best practice in this regard. An understanding of the clinical process is therefore required.

The risk model has been criticised on ethical grounds. McSherry (2014) argues that detaining someone on the basis of future violence may infringe on human rights. This also places added weight to the concern that an individual's rights may be compromised by a false positive (Norko & Baranoski, 2008). Further, the principle of proportionality notes that the sentence should match the

‘seriousness of the harm and the degree of responsibility of the offender’ (McSherry et al., 2006, p. 15). If someone is detained for a lengthier period than recommended by the court, due to risk, then the principle has been violated. The predicted reality has now not eventuated, thus the extra time that the individual has served is not equivalent to his or her actual violent behaviour; or, in other words, no criminal behaviour has occurred to warrant a proportional increase to the custodial sentence.

Second, judicial outcomes are normative in nature, reflecting values established by society, whereas clinical testimony reflects a descriptive, non-normative understanding of predicted reality (Prentky et al., 2006). There is therefore a discontinuity between scientific and legal frameworks. However, clinicians are not obligated to make normative statements; otherwise, they are making value judgements and should therefore only work within a scientific context. Last, the law also demands that clinicians adopt a ‘dual role’, such as when providing clinical testimony as well as acting as ‘agents of the state’, in which their informed opinion has the potential to enforce preventative detention or strict supervision measures for those who the government consider ‘socially undesirable’ (McSherry, 2014). Clinicians are therefore placed in a difficult ethical position. These criticisms can be directed towards most dangerous offender legislation.

Clinical Assessment of Risk

Actuarial Assessment

As seen in the majority of legislation above, modern laws consider dangerous those individuals who are likely to commit serious offences; this stands in contrast with an earlier conceptualisation, where the traits of the individual – as identified by diagnosis (i.e. ‘sexual psychopath’) – were what classed him or her as dangerous. Modern developments in psychological science have allowed for the measurement and probability of risk

of violence. These measures are based upon the empirical relationships between measurable variables and how they relate to an outcome (violence, for example; Andrews & Bonta, 2010; Hanson, 1998; Litwack, 2001; Seto, 2005). The measure of these factors conceptualises an individual’s risk within a period of time. In contrast, clinical judgement relies on taking into account the factors that the clinician considers to be important for assessing risk, although this creates the possibility that different experts will arrive at different conclusions simply due to considering different factors (Litwack, 2001; Quinsey & Ambtman, 1979). The actuarial approach to dangerousness involves identifying risk factors that are empirically associated with criminal behaviour.

Actuarial measures may be a necessary part of identifying risk. A variety of studies have found that they accurately predict violent behaviour. Hare’s (1979) Psychopathy Checklist – Revised (PCL-R) is considered a valid measure of psychopathy, and studies have found that those scoring high on this test are also more at risk of engaging severe violence (Leistico, Salekin, DeCoster, & Rogers, 2008; Porter et al., 2000; Serin & Amos, 1995). However, this test has been found to be a weak predictor of sexual recidivism (Langevin & Curnoe, 2014). This may be due to the variance in types of sexual offending, as rapists tend to score higher on the test than other types of sex offenders (i.e. intrafamilial; Porter et al., 2000). This suggests that the PCL-R can evaluate the risk of more violent types of sexual offending, but overall has low predictive validity in sex offending in general. Similarly, the Violence Risk Appraisal Guide (VRAG) is accurate in determining the risk of violence (M. Doyle, Carter, Shaw, & Dolan, 2012), but it has not been effective in predicting sexual violence (Hanson, 1998) and there has been difficulty applying it to non-psychiatric/non-prisoner populations (Borum, 1996).

As sex offenders are considered a heterogeneous group and reoffend at different rates

(Craig, Browne, & Stringer, 2004; Hall & Hirschman, 1991; Prentky & Knight, 1991; Wortley & Smallbone, 2013), generic actuarial measures of risk may be less accurate than scales designed for particular types of violence. Hence, tests designed specifically for the latter are more accurate (Craig et al., 2004; Langevin & Curnoe, 2014; Rice & Harris, 1997). Actuarial scales can therefore provide meaningful information in assessing dangerousness in court. In a meta-analysis of 118 studies, Hanson and Morton-Bourgon (2009) found that actuarial measures for assessing general recidivism were the most accurate, although the most accurate means of determining risk of sexual recidivism were measures designed for predicting sexual reoffending and any recidivism (i.e. STATIC-99).

While no measure is completely accurate – possibly owing to errors in test development or administration (Allard & Faust, 2000) – they are generally accurate enough to be effective in estimating risk of violence. Given this, it is therefore surprising that legislation does not demand that they are exclusively used in determining ‘unacceptable risk’. Does their use therefore constitute best practice?

Recommendations of risk based on the pure use of actuarial measures is problematic. Judges have been found to be more cautious in determining dangerousness in sex offenders, given the saliency of sexual violence (McSherry et al., 2006; Prentky et al., 2006). They tend to be more concerned about making errors in *not* determining an individual as dangerous who then goes on to commit another violent offence than errors which result in an individual who is not in reality dangerous being further detained. If tests were entirely without error then one would expect no false negative or positive error rates – but this is not the case (Allard & Faust, 2000). Incorrectly scoring or interpreting tests, ignoring test limitations, and placing too much emphasis on risk scores may all result in an increase in false positives (Allard & Faust, 2000; Prentky et al., 2006). While

this is more of an ethical issue for the courts, it still places clinicians in a difficult decision in regard to how they communicate test results. Further, given this and the tendency of judges to be less concerned with false positives, conceptualising risk as case formulation may assist in ensuring a medical framework (within a greater legal structure). The burden then is purely to work within a scientific mechanism, as opposed to making normative judgements.

Second, many actuarial measures have been criticised for incorporating unchanging (static) factors and not measuring dynamic factors that may relate to reoffending (Walters, Knight, & Thornton, 2009). Agnew (2011) argues that accounting for temporal changes to variables may also explain criminal behaviour. Situational deviations such as periods of alcohol abuse, deviancy, relationship difficulties, and associating with pro-criminal peers may result in a sudden readiness to engage in crime. Researchers have found that accounting for these factors increases predictive accuracy (Andrews & Bonta, 2010; Dempster & Hart, 2002; Eher, Matthes, Schilling, Haubner-MacLean, & Rettenberger, 2012; Thornton, 2002). In reality, the likelihood of committing sexual violence will vary from moment to moment due to factors such as the proximity of the offender to potential victims, the influence of alcohol or drugs, and mood changes (Andrews & Bonta, 2010; Eher et al., 2012). Not considering dynamic factors may therefore limit the predictive accuracy of risk assessments (Craig et al., 2004; Sjöstedt & Långström, 2001). Given that dynamic variables change over time, it could also be argued that there are problems reporting measures in court in relation to long-term considerations. However, for clinicians, they could be used instead to identify treatment needs or inform the nature of the case management (i.e. regular substance testing; Andrews & Bonta, 2010).

Combining static and dynamic tests may be problematic; tests were never designed to be used with other measures, and there may

be an epistemological issue if the results from different tests do not agree (Vrieze & Grove, 2010). It is therefore difficult to take the outcome of one test as truly representing risk when others challenge that result (or even if the results differ by a small margin). Sampling error in each test's construction, test administration error and miscalculations in the mechanical 'process' of the test all result in uncertainty in outcome probabilities, therefore raising the question of whether or not *any* result in a battery of tests represents true knowledge of an offender's recidivism. Any attempt to predict risk cannot therefore be made with certainty (Litwack, 2001; McSherry & Keyzer, 2009). Similarly, individuals are scored by being placed into groups of risk probability ('low', 'medium' or 'high', for example) but is not possible to identify where within that category they fall – only how similar they are to the sample from which the scale was developed, which makes it difficult to know their *exact* level risk (McSherry, 2014). Reliance on actuarial measures alone is therefore problematic.

Clinical Case Formulation

In considering dangerousness, a broader understanding of risk is necessary. As actuarial measures limit what is investigated, given that they delineate avenues of exploration (i.e. only items correlated with a particular outcome) in establishing risk, assessments of actual risk should be free to explore all avenues of information (Litwack, 2001). For instance, if two offenders score highly on the same actuarial measure but differ on other factors (i.e. treatment needs), these need to be considered when advising a court about the level of risk (Lennings, 2013). Falzer (2013) has suggested that the actuarial and clinical interview approaches are incompatible, although it is asserted in this article that in addition to actuarial measures, a collateral approach may obtain information on an individual's coping level, emotional lability, and

therapeutic needs (Papapietro, 2012). The clinical interview may also provide a qualitative understanding of offending behaviour; for instance, a narrative of the offending process – how distal and proximal factors led to the offending itself. A recurrence of these factors could result in similar offending; if the offender finds him or herself in similar circumstances then there may be increased risk of reoffending. A range of actuarial measures may provide a statistical basis for the recommendation, but a mapping of the offending process (and risk factors) may suggest possible avenues of clinical intervention and the unfolding of offending over time (Andrews & Bonta, 2010). Clinical advice in court can therefore be regarded as case formulation (Papapietro, 2012; Prentky et al., 2006).

Despite the criticisms of actuarial measures, not incorporating such guidance into risk assessment is fraught with problems. Unstructured clinical interviewing has, as a basis, a scientific approach in exploring a causal link between underlying issues and syndromes. However, there may be an issue with the diagnostic process itself. In the absence of using actuarial tests, unstructured clinical judgement is considered a difficult and imprecise task due to crime being complex and multi-factorial in nature (Craig et al., 2004; Falzer, 2013; McSherry & Keyzer, 2009). Low average correlation coefficients for predicting risk have been reported (Craig et al., 2004). Faust and Ziskin (1988) found that 'clinicians cannot agree on psychiatric diagnoses' and that the clinical determination of risk is no more accurate than that made by a layperson (p. 34). Elbogen (2002) reported that clinicians tend to see some cues as more relevant in determining risk than others, and focus more on violent history than social history factors. The clinical process is not without its strengths, however.

When clinicians consider risk factors (such as those targeted by treatment) associated with violence, they have been found to be accurate in predicting the seriousness and

location of violence (Mulvey & Lidz, 1998). They have also been found to be accurate when predicting short-term violence (Vaaler et al., 2011). Further, as protective factors are considered important in the deterrence of criminal behaviour and unlikely to be measured in a pure actuarial approach, not factoring them into risk assessments may result in a less comprehensive understanding of an offender's actual likelihood of reoffending (de Vries Robbé, Vogel, & Stam, 2012; Walters, 2015). The clinical interview may therefore recommend interventions to develop them.

The structured professional judgement (SPJ) is one such approach which involves the use of (clinically-guided) tests that incorporate static and dynamic risk factors that can be targeted by intervention, such as the Historical Clinical Risk 20 (HCR-20; de Vries Robbé et al. 2012; Falzer, 2013; Webster, Douglas, Eaves, & Hart, 1997) and the Sexual Violence Risk 20 (SVR-20; Boer, Hart, Kropp, & Webster, 1997). While these tests are measures of risk, they are also risk-management focused in that they identify factors which decrease violence (Guy, Packer, & Warnken, 2012). In a study of patients discharged from psychiatric care, the HCR-20 was found to be accurate at predicting violence (M. Doyle et al., 2014). Although the sample was not comprised of sex offenders (and sexual violence was not the predicted outcome), the study suggests that a clinical understanding of the protective and dynamic factors targeted by treatment is an effective means of understanding risk.

Dangerous Offenders – Mad or Bad?

The relationship between mental illness and violence is salient given people's fears of irrational thinking and erratic, risky behaviour (Andrews & Bonta, 2010). Are dangerous sex offenders 'mad' or just 'bad' in nature? It is important to examine whether a mental disorder places an individual at greater risk of sex offending. The Washington

SVP Law (Washington Laws, 1990) is predicated on the attitude that sex offenders with a mental abnormality or personality disorder may commit further sexual violence if left untreated. However, as seen in other legislation, individuals can be considered dangerous without a psychopathology (although its presence would *without doubt* be considered by the court), as risk is determined by a range of factors. Therefore, does having a mental disorder make someone at risk of non-sexual or sexual violence?

Research findings have been contradictory regarding mentally disordered individuals being more at risk of committing acts of violence. Swanson, Holzer, Ganju, and Jono (1990) report that more assaults were committed by individuals with psychiatric disorders than non-psychiatric individuals in their sample. High rates were observed for those with multiple diagnoses in addition to abusing drugs and alcohol. This group was also more likely to have assaulted more than one victim and to have used a weapon. The assault rates also varied by gender, age, and socio-economic status, however. The violence rates varied depending upon the criminal history of the offenders (among other factors), in which case aggregating types of patients in the data may inflate rates of violence. However, as the mentally ill are more likely to be caught – or to plead guilty due to not being able to afford legal representation – then the crime rates may be overestimated (Davis, 1991). Kramp and Gabrielsen (2009) found that discharged patients have low rates of *immediate* violent behaviour, but, over a longer period, de-institutionalisation results in increasing numbers of criminals with mental illness, as they found themselves being managed within the legal system due to lacking institutional support. Lamberti (2007) report that schizophrenics are more likely to engage in minor crimes (i.e. public nuisance) than violence. Scott and Resnick (2006) argue that those with delusional beliefs with an associated negative emotion are more likely to use violence against their perceived

persecutors. This violence tends to involve weapons and to be well planned. Low rates of psychotic disorders have been observed in sex offenders, although they are at risk of violence when negative symptoms are low (Lamberti, 2007).

In a study of sex offenders classed as dangerous by the Australian courts, D. J. Doyle, Ogloff, and Thomas (2011) found that 70% of offenders had an Axis 1 disorder. Of these, 64% were diagnosed with paraphilia, 50% with a personality disorder, 8% with a psychopathic personality, and 42% with subclinical depression and anxiety. However, half of the sample was also found to have vulnerability factors such as a history involving poor education, sexual and physical abuse, and abuse of alcohol and drugs. Similar results were found in a larger study of Canadian dangerous offenders and general offenders (Langevin & Curnoe, 2014). While both groups were similar in regard to rates of psychoses, paraphilia and deviancy, the dangerous offenders had a significantly higher proportion of antisocial personality disorders. This group also had a history of substance abuse, poor education, and crime.

Rapists tend to score higher on measures of psychopathy than child molesters, with the latter having prevalent paraphilia (Barbaree et al., 2009) and mood problems (Robertiello & Terry, 2007). As they often have higher reoffending rates than the general offender population, and will likely reoffend with violent crimes, some psychopaths could be considered at risk of further violence (Porter et al., 2000). Given the lack of victim empathy, the identification of psychopathy among sex offenders may be necessary in considering whether an individual is a dangerous sex offender. Psychopaths may form a more serious group of offenders, as there is evidence to suggest that they are likely to engage in violent offences (Cornell et al., 1996; Harris, Skilling, & Rice, 2001) and have an affective deficit and disregard for social rules and regulations (Hare, 1979). However, clinicians need to be cautious in interpreting any

measures of psychopathy, as the test may be tautological – i.e. it is merely measuring how well an offender scores on items designed to tap into a *construct* of psychopathy.

Individuals with antisocial personality disorder (ASPD) generally have a history of disobeying the law, problematic behaviour, hostility, and impulsiveness (Andrews & Bonta, 2010). There is a significant association between the disorder and violence (Yu, Geddes, & Fazel, 2012), and a meta-analysis (involving 10,000 case studies) found that social deviance (a core component of the disorder) is also a significant predictor of violence. The proportion of sex offenders with paraphilia has been found to be significant (D. J. Doyle et al., 2011; Langevin & Curnoe, 2014), which suggests that consideration of the persistency of deviant beliefs is important in determining the risk of sexual offending. For instance, Chan, Beauregard, and Myers (2015) found a high proportion of deviant sexual fantasies among serial sexual homicide offenders. Woodworth et al. (2013) report that a significant proportion of high-risk sex offenders have deviant sexual fantasies, and that the types of fantasy vary by the nature of the offender (i.e. the fantasies of rapists are generally more sadistic than those of child molesters).

While it is difficult to argue that any of these disorders makes a person a dangerous offender by default, in determining dangerousness they would likely be considered distal (psychopathy, ASPD) or proximal (paraphilia, fantasies) risk factors. That the rate of violence is affected by other factors such as age, poor educational history, and substance misuse suggests that irrational thinking and erratic behaviour do not lead, or contribute significantly, to sex offending. Hence, dangerous offenders are not necessarily more likely to be at risk of reoffending if they have a mental abnormality, but the more antisocial disorders (ASPD and psychopathy) are important factors in considering risk. It is therefore the case that they are unlikely to be ‘mad’, but may have ‘bad’ personality traits.

Conclusion – Dangerous Sexual Offenders and Case Formulation

Dangerousness is a complex construct. The current legal definition is that if there is a likelihood that an offender will commit further serious harm, through violence (and in particular, sexual violence) then he or she is classed as a dangerous offender. The majority of legislation on dangerous offenders requires a judge to consider clinical expertise – and even where this is not recommended, courts will usually call upon it to enhance their understanding of risk (Bickle, 2008). Clinicians report to the court their understanding of the likelihood of offending and the suitability to treatment. An offender's level of risk, regardless, would not only be determined by historical factors, situational factors, or psychopathologies (Ducrol & Pham, 2006). An integrated model of offending needs to account for biological, sociological, psychological, and ecological factors to explain the complexity of crime. Understanding the offending process would link these elements together so that someone is only dangerous *circumstantially*. A complete understanding of risk therefore requires a comprehensive approach, not just involving the exclusive use of actuarial assessments or clinical interviews.

While dangerousness is outlined specifically in legislation, it can also be considered a clinical construct within a legal (normative) framework. The efficacy of clinical decision-making in clinical or forensic treatment settings has been repeatedly studied, less so the legal field. Understanding how clinicians conceptualise risk – whether they default to actuarial scores but consider protective and therapeutic factors as having a mitigating effect on violence, or consider the balance of risk and protective factors alongside case formulation for further intervention – is important when exploring the notion of dangerousness. Future research in this area would be productive and has the potential to be of benefit to the community.

The process for how clinicians conceptualise overall risk needs to be explored – how

clinicians and judges arrive at a determination of the level of risk of reoffending by utilising a range of information. There is sparse research in this area (for instance, how are different psychometric scores reconciled, what are the salient factors in risk assessment, and how does the presence of protective factors affect overall risk?) and few studies have been conducted on the effectiveness of sex offender risk assessment. There are many studies looking at the strengths (and weaknesses) of the separate actuarial and clinical processes, but relatively few on how both are used in clinical testimony. The process by which clinicians explore risk, and the degree of dangerousness of offenders who are managed under DPSOA legislation, is a topic of research that is currently being pursued and will be explored in a future publication.

Disclosure Statement

No potential conflict of interest was reported by the authors.

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