

CASE FORMULATION WITH SEX OFFENDERS: AN ILLUSTRATION OF INDIVIDUALIZED RISK ASSESSMENT

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There has been a rapid expansion of the professional literature in risk assessment with sexual offenders over the past 20 years. However, recent professional experience suggests that risk assessment reports often fail to be as relevant or useful as they might be for judicial decision-makers. Research with large samples of offenders has refined our understanding of identifiable subgroups with different rates of sexual reoffending, but the management of risk requires that we deal effectively with individual offenders. One area that can be improved is the development of case formulations of risk. Clinicians must move beyond the mechanical use of actuarial static and dynamic risk factors to a broader integration of relevant information about the individual if they are to assist in managing risk in a way that serves the needs of the offender while protecting public safety.

The advent of a controversial new generation of legislative initiatives aimed at increasing public protection from high risk sexual offenders has helped to stimulate a rapidly expanding research literature in the area of risk assessment. Despite significant advances in the field's understanding of various factors associated with higher risk for sexual reoffending, clinical experience to date suggests that significant improvements can be made in the formulation and reporting of risk by mental health professionals. A separate article addressed the broader issue of case formulation as part of the comprehensive assessment of sexual offenders, primarily for the purpose of treatment planning (Collie, Ward & Vess, in press). In brief, a case formulation is a conceptual model representing an offender's various problems, the hypothesized underlying mechanisms, and their interrelationships that is clearly linked to contemporary theory and research. A case formulation specifies how the symptoms or problems are generated by psychological mechanisms, for example, dysfunctional core beliefs or behavioral deficits. Furthermore, a case conceptualization provides a rational basis for determining treatment needs that can be used to tailor interventions with offenders in the aim of achieving optimal outcomes.

In this article the focus is more specifically on case formulation in risk assessment. The goal is to illustrate a process that moves from the mechanical assessment aspects of using actuarial measures, combined with consideration of empirically grounded dynamic risk factors, to the development of a thorough and integrated case formulation that provides an etiological explanatory framework for understanding risk in an individual sexual offender.

First a brief review of the measures and risk factors currently considered to represent best practice standards in sex offender risk assessment is provided. Drawing on this foundation, the nature of etiological

case formulation is presented. This is followed by a few considerations in reporting risk. The challenge here is to communicate the findings of the formulated risk assessment in an effective manner so as to be of assistance to those making use of the assessment results, such as the courts, parole boards, or other judicial decision-makers. Finally, two case examples derived from clinical forensic experience are used to illustrate the utility of case formulation in sex offender risk assessment.

Elements of current best practice

Static factors. There is a current consensus in the assessment field that actuarial measures have demonstrated a statistically significant level of predictive accuracy regarding the risk of sexual reoffending, and consistently outperform clinical judgement in this respect (Abracen et al., 2004; Borum, 1996; Miller, Amenta, & Conroy, 2005; Barbaree, Seto, Langton, & Peacock, 2001; Hanson, 1998; Hanson & Thornton, 1999, 2000). Actuarial measures function by placing individual offenders into groups with known reconviction rates, so that individual risk estimates are based on observed group outcomes. Examples of such measures with research evidence of predictive validity include the Violence Risk Appraisal Guide (VRAG) (Harris, Rice & Quinsey, 1993), the Sex Offender Risk Appraisal Guide (SORAG) (Quinsey, Harris, Rice, & Cormier, 1998), the Rapid Risk Assessment of Sexual Offense Recidivism (RRASOR) (Hanson, 1997), and the Static-99 (Hanson & Thornton, 1999). Actuarial measures such as these form the foundation of the best-validated risk assessment procedures currently available.

One of the actuarial measures with the most empirical support is the Static-99 (Hanson & Thornton 2000). Doren (2004) notes that there have been at least 22 studies of the Static-99's predictive validity beyond the Hanson and Thornton (2000) developmental study. In a recent development,

Thornton et al. (2003, as cited in Craig, Beech & Browne, 2006) developed a risk assessment system referred to as the Risk Matrix 2000/Sexual. This new measure looks promising, but has not yet been as widely validated as the Static-99.

Dynamic factors. Standard practice in sexual offender recidivism risk assessment also includes consideration of dynamic factors that can change over time and influence the degree of risk for reoffending. Douglas and Skeem (2005) make a conceptually important distinction between risk status, which they define as inter-individual risk level based on static risk factors, and risk state, defined as intra-individual risk level determined primarily by the current status of dynamic risk factors. The role of intra-individual variables has particular relevance for case formulation. Variations in risk over time will be primarily influenced by these dynamic factors, and a clear understanding of their function will be crucial for effective risk management. The refinement of empirically validated models of dynamic risk should assist not only in the prevention of sexual reoffending, but in the reduction of other forms of violence as well.

The Sex Offender Need Assessment Rating (SONAR) is an actuarially based measure of dynamic risk factors empirically related to rates of sexual recidivism (Hanson & Harris, 2000, 2001). The SONAR allows clinicians to evaluate changes in dynamic risk factors over time across the two domains; five stable dynamic variables (intimacy deficits, negative social influences, attitudes tolerant of sex offending, sexual self-regulation, general self-regulation) and four acute dynamic variables (substance abuse, negative mood, anger, victim access). A recent development based on the SONAR is the STABLE 2000 (Harris & Hanson, 2003, as cited in Harris, 2006), which adds the variable of cooperation with supervision.

Combining measures. Recent research on sex offenders has shown that risk predictions made by static actuarial measures can be improved by incorporating dynamic variables to give a fuller picture of individualized assessment of risk (Craig, Browne, & Stringer, 2004; Craissati & Beech, 2005). A recent review of the effectiveness of sexual recidivism risk assessments found that structured clinical judgement, where a clinician makes a prediction of risk guided by an appropriate actuarial measure, combined with dynamic variables individual to an offender, showed good predictive accuracy (Hanson & Morton-Bourgon, 2005). Furthermore, Webster, Hucker and Bloom (2002) contend that combining validated actuarial measures

with empirically based dynamic variables allows for greater clarity not only for the clinician but also for decision makers. When important decisions about the release of offenders (or any special conditions imposed upon release) are made, it is no longer considered sufficient to reference a large heterogeneous population to which an offender belongs, or even a specific subset of similar offenders with a known rate of sexual recidivism. A more complete picture of the offender is being requested by criminal justice professionals and decision makers (Dvoskin & Heilbrun, 2001; Monahan, 2004).

Limitations of actuarial measures. We agree that the use of purely static actuarial measures is insufficient for a comprehensive risk assessment because it fails to address the multiple goals such an assessment is designed to achieve (i.e., treatment planning, treatment evaluation, parole evaluations, and so on). While such measures are effective in placing an individual offender within a specified group with similar characteristics for which there is a known rate of sexual recidivism, they do not permit an individualized formulation of the specific contingencies and risk factors operating in a given case. Hanson and Thornton (1999) note that without the inclusion of dynamic variables, the Static-99 alone cannot determine when sexual re-offending may occur, or what conditions may precipitate such an offence. Static actuarial risk measures therefore do not facilitate an approach to the active management of risk for individual offenders. Moreover, because they are by definition static and unchanging, they do not allow for the assessment of changes in risk over time, and thereby do not assist in the judicial decisions about release or supervision that must be routinely made by judges and parole boards.

What is needed is an individualized risk assessment which provides an aetiological (i.e., causal) understanding of the factors contributing to sexual offending in a given case, but that is primarily grounded in the relative risk of reoffending based on a recognized actuarial measure. Such an approach will also incorporate other factors known to be associated with risk of sexual reoffending.

Deviant arousal and psychopathy. Beyond the static risk factors covered by measures like the Static-99, and the dynamic factors covered by the SONAR, two other factors are conclusively associated with higher risk of sexual reoffending. Research has consistently shown that psychopathy and deviant sexual arousal are predictive of increased risk for sexual reoffending, especially in combination (Hanson & Morton-Bourgon, 2005; Olver & Wong,

2006). In a recent study Hildebrand, de Ruiter and de Vodel (2004) examined the sexual recidivism rates among a sample of treated rapists. They reported a sexual reconviction rate of 82% over an average follow-up of 11.8 years for offenders who were both psychopathic and sexually deviant, compared to 18% for offenders who were both non-psychopathic and non-deviant. Similar outcomes have been observed with other samples including child molesters (Rice & Harris, 1997).

Factors not empirically associated with sexual reoffending. In Hanson and Morton-Bourgon's (2005) large review of the research evidence related to sexual reoffending found that several factors often assumed to influence risk were in fact not related to sexual recidivism. These factors included lack of empathy for victims, denial of sexual offending, minimization of sexual offending, and lack of motivation for treatment. Such factors may be considered important in an individual case, but they must be convincingly incorporated into the formulation of risk as explanatory mechanisms for sexual offending. It is not sufficient, in light of current research, to simply list the presence of these factors as indicators of increased risk.

Identification of risk factors within an etiological framework.

Optimal risk assessment and management requires the extension of case formulation skills, whereby risk factors are identified within an etiological framework (Ward & Beech, 2006). While it is important to be aware of the static and dynamic factors associated with a given type of risk, these factors are most useful for risk management purposes when they are formulated into a coherent set of inter-related causal mechanisms. This requires examination of several categories of contributing factors, including historical (e.g. offence history, past episodes of violence, previous treatment compliance and response, performance under supervision or parole), developmental (e.g. adverse developmental events, nature of family relationships, attachment style), cognitive (e.g. level of intelligence, cognitive distortions, attitudes supportive of criminality or violence), personality (e.g. psychopathy, or traits such as impulsivity and hostility) and clinical (e.g. psychiatric diagnosis, level of functioning, substance abuse).

An especially important element in an etiological formulation is an individual's personality features. It has been suggested that focusing on traits may be a more effective approach than personality disorder diagnosis, given the overlap in diagnostic criteria and the commonality of such relevant features

as antagonism, hostility, and impulsivity (Beech & Ward, 2004). Personality disorders in general and psychopathic features in particular have been included in several well established risk assessment schemes (e.g. HCR-20, LSI-R, SONAR, SORAG). Such personality features represent not only a marker of risk level in some contexts, but also bear on issues of treatment responsiveness and the selection of treatment and case management approaches. Clinical and case management issues as the client's ability to establish rapport, maintain a therapeutic alliance, and develop trust or empathy as mechanisms of change, will all hinge largely on the personality features of the individual client.

In light of these individual factors, it is important to recognize that risk is contingent upon current situational or contextual variables (Doren, 2002). Even high risk cases will not be at extreme risk at all times, but will vary in their likelihood of reoffending depending on such factors as access to victims, current degree of alcohol or drug use, access to and compliance with treatment and supervision services, the nature of interpersonal relationships and support systems, and current mood states. Thus different individuals who have similar profiles in terms of their scores on various risk assessment measures will not necessarily respond in a similar way to the same interventions or risk management plan. The recidivism risk at any given time will emerge from an aetiological process determined by the interaction of individual characteristics and contextual factors.

One advantage of communicating risk estimates as probabilities based on groups of similar offenders is that it provides an explicit characterization of the risk of reoffending. To say that an offender belongs to a group in which 15% have sexually reoffended at 10 years following release from prison gives a relatively clear understanding of the level of reoffending that has occurred among similar offenders. This level of explicitness or clarity is potentially diminished through the use of categorical labels such as high, medium or low risk. The use of such labels is comparative; a group or individual presents as high, medium or low risk compared to some other group or individual. The information that is often not made explicit is, "compared to whom?" When compared to non-offenders, most sexual offenders will present a significantly higher risk of reoffending. In judicial decision-making, the concern is more likely to be how an individual offender compares to other offenders. So the question arises of how to best apply labels to well-defined groups of offenders in

order to convey to the court the relative level of risk for specific types of reoffending.

An important practical issue concerns what level of risk represents the threshold for actions such as applying a special sentence or denying release. While these are clearly judicial decisions, it may be more useful to the court to have explicit information on the relative risk presented by an individual offender rather than merely a categorical label or information concerning a specific re-offense rate in a group of similar offenders. This can be facilitated only through the development of an individualized, etiological formulation of risk that is based on the relevant research but also incorporates multiple factors into a contingency-based, causal explanation of sexual offending. Risk assessments should state as clearly as possible the recognizable contingencies that will influence the degree of risk present. The report should specify primary causal conditions, the most likely victims, and the likelihood and severity of harm of subsequent offences.

Case Examples

Case 1. Mr. Smith is a 33 year old male of European-American descent who is currently serving a prison sentence for the sexual assault of an adult female. His first conviction was at age 23 for damaging property. He now has a total of eight convictions, including shoplifting, theft, assaulting a fellow inmate, the current rape and wounding with intent to commit Great Bodily Harm, and setting fire to a holding cell while awaiting trial for the current rape. He was also acquitted on a prior charge of raping his girlfriend, then seven months pregnant.

Mr. Smith experienced an unstable early environment and developed behavioral difficulties from an early age. He was raised by his maternal grandparents after his parents separated due to violence in their relationship. Mr. Smith had little contact with his father, who was diagnosed with schizophrenia and apparently required a supervised living arrangement of some sort. Mr. Smith did poorly in school, was disruptive and distractible, and left without graduating. He began to use cannabis during childhood, and moved on to the abuse of inhalants, alcohol and possibly other drugs during his teens. He may therefore have a genetic vulnerability to serious mental illness, exacerbated by heavy substance abuse beginning at a time when his central nervous system was still developing and particularly susceptible to the damaging effects of these substances.

These factors contributed to the development of a psychotic disorder in his late teens.

His condition has been variously diagnosed as different forms of schizophrenia, bipolar disorder with mania, drug induced psychosis, and more recently as schizoaffective disorder. He has also been described as having an impulse disorder, personality disorder characterized by antisocial features, and a persistent substance abuse problem.

His mental state at the time of his index offences was clearly impaired. It appears that he was acutely intoxicated from drug use. The degree to which his pre-existing psychiatric disorder also contributed directly to his offence related cognitions and behaviors is less clear, although his subsequent accounts of these offences have remained inconsistent and bizarre, suggesting that his psychosis prevents him from having a coherent and accurate understanding of his actions at the time of the offences. He has been consistently described as having little or no insight into the nature and consequences of his offences.

Mr. Smith was assessed using the PCL-R, scoring in the high range. This assessment found psychopathic traits such as a callous, self-serving lack of remorse, a lack of empathy, marked impulsivity and poor behavioral controls that may contribute to a higher risk for reoffending. Such features are evident in Mr. Smith's vicious assault and opportunistic rape of his victim, a stranger he accosted in a public park. Furthermore, Mr. Smith does not accept responsibility for his behavior, lacks realistic long term goals, has a grandiose sense of self, and does not modify his behavior as a result of experience, all of which contribute to a lower likelihood of positive treatment outcomes.

Mr Smith continues to have treatment needs in the areas of alcohol and drug abuse, violence propensity, offence-supporting cognitions, impulsivity (including sexual and general self-regulation), and possible sexual preoccupation, especially when disinhibited by drugs or alcohol. He also needs to develop sufficient understanding and acceptance of his mental illness to gain the skills necessary to assist in the management of his psychiatric symptoms, which appear to contribute to his risk for violent or sexual reoffending. These skills would include recognizing the need for and complying with long-term use of psychotropic medications, recognition of the precursors to psychiatric decompensation (e.g. grandiose or paranoid ideation, feedback from others regarding unusual thoughts or behaviors), and the exacerbating effect that drugs and alcohol have on his mental state.

Unfortunately Mr. Smith's current mental status and level of insight is impaired to the degree

that interventions to address these needs remain impractical. Although he has recently been more compliant with prescribed medication, has apparently refrained recently from substance use while incarcerated, and is less of a management problem than earlier in his sentence, he still does not recognize the delusional nature of his belief system about his index offending, and he is at best ambivalent about the need for ongoing medication or treatment following his release. Until such time as Mr Smith's overt psychiatric symptoms are sufficiently suppressed and he accepts the need to engage in treatment to address his relevant needs, it is unlikely that such interventions will be effective at reducing his risk of reoffending.

The Static-99 placed Mr. Smith in the moderate-high range, whereby 33% of the original research sample in this range were reconvicted for a sexual offence within five years of release. This rating may in fact provide an underestimation of Mr. Smith' actual risk, based on several prior allegations of sexual offending that were apparently not prosecuted because of Mr. Smith' extensive involvement in the mental health system. Had the sexual offences attributed to him in his psychiatric records resulted in criminal charges, his Static-99 score would be in the high range, with associated sexual reoffending rates of 39% at five years, 45% at 10 years, and 52% at 15 years post-release for offenders in this category.

Additional risk factors contribute to Mr. Smith' level of risk for violent or sexual reoffending. These include self-regulation problems, employment instability, substance use, conflicts with intimate partners, and attitudes tolerant of offending. When pressed on the matter of treatment, if it were to be stipulated as a condition of release, Mr Smith agreed reluctantly that he would undertake the required treatment, as long as it did not place him under too much pressure. He asserted that he would much rather "get a good job" and make "some decent money". Mr Smith's employment history and psychiatric condition suggests that this is not currently realistic.

Prior reports also suggest a consistent pattern of sexual preoccupation and poor judgment about interpersonal boundaries and relationships. These concerns are further compounded by periods of apparent delusional grandiosity, when he has been reported to believe that women love him, desire him sexually, and want to have babies with him. The influence of these factors do not appear to have changed substantially over several years, and continue to contribute to an elevated level of risk.

The level of risk for Mr. Smith is also influenced by his psychiatric condition. Although the presence of schizophrenia or psychotic disorder does not appear to contribute significantly to the risk of violence in studies conducted with large numbers of offenders, the specific form that the mental illness takes can contribute to risk in individual cases. In light of his subsequent accounting of events, it appears that Mr. Smith was acutely delusional, severely impaired by drugs, or some combination of both at the time of his index offending. Regardless of the specific etiology of his impaired psychiatric state, it was directly related to the perceptions, emotional states, and cognitions that led to the assault and rape of the victim. He continues to maintain that the offence was part of a pre-planned and mutually agreed upon scheme between himself and the victim. To the degree that he remains vulnerable to such psychiatrically impaired perceptions and beliefs, the risk for similar unfortunate outcomes is higher.

It is likely that Mr. Smith's condition is chronic, and that the personality, cognitive, and psychiatric traits that he has long manifested will continue to prevent his effective participation in interventions that allow him to more effectively manage his own level of risk. In light of the probable course of Mr. Smith' condition and the associated risk that he presents, a comprehensive case management plan based primarily on external monitoring and supervision will be required if he is to be released from prison without posing a significant threat to public safety. In preparation for that outcome, focused and sustained efforts should be made to facilitate compliance with prescribed medications to control the psychiatric symptoms that contribute to his risk.

The nature of Mr. Smith's living and supervision arrangements following release will therefore be crucial to his chances of a successful transition to the community and maintaining an offence-free lifestyle. It will be essential that he is provided ongoing psychiatric management, including the availability and monitored administration of prescribed medication. It must be emphasized that there continue to be serious doubts about Mr Smith' ongoing voluntary compliance with treatment requirements, and without such compliance he has previously demonstrated rapid and significant deterioration in his mental status with a corresponding increase in his risk for violent or sexual offending. He will have to avoid the use of recreational drugs and carefully control any use of alcohol (abstaining would be optimal). He should have the opportunity to develop a pro-social support network and appropriate interpersonal and sexual

relationships. For this to occur, he will need intensive and ongoing guidance, support, and supervision.

Finally, it is suggested that Mr. Smith's level of risk is primarily due to factors that may not change substantially between now and the end of his sentence in three years. If a process for accomplishing the transition of his supervision and management, including his psychiatric case management, into the community is not already underway at that time, it is anticipated that he will present essentially the same level of risk that he does currently. While retaining him in prison will continue to protect the public, it will not in itself ultimately contribute to the reduction of his risk at whatever time he is released. At that point, the adequacy of the supervision, psychiatric management, and support in the activities of daily living will be central to his chances of reoffending.

Discussion of Mr. Smith. Although many sex offenders identified by recent community protection initiatives such as the Sexually Violent Predator laws do not suffer from conditions of major mental illness, this case represents a common scenario in forensic psychiatric settings, whereby risk for sexual reoffending is compounded by a persistent Axis I disorder and attendant concerns about treatment compliance. The long-term goal is typically to adequately control psychotic symptoms to allow the development of internalized risk management skills. It is hoped that this will allow eventual reintegration into the community under the least restrictive conditions, whereby the individual can achieve the basic human needs for a fulfilling life while not putting the public at undue risk. The reality is often that limited treatment responsiveness and inadequate community support resources will mean that risk management will rely primarily on external supervision and monitoring. The goal then becomes one of developing a continuing care plan that allows for a highly structured and adequately monitored transition from incarceration or involuntary inpatient treatment into the community. Knowing the broader needs of the individual in an etiologically informative framework can best serve in the development of such a plan.

Case 2. Mr. Jones is a 41 year old male of European-New Zealand descent is currently serving a sentence of Preventive Detention following his conviction for kidnapping, sexual violation, and indecent assault upon a 15 year old male. In this incident, Mr Jones approached the victim and induced him to get into his car. He then drove to a secluded area and became physically assaultive,

striking the victim repeatedly across the face. He then fondled the victim's penis, despite his resistance, and digitally penetrated the victim's anus. Mr. Jones finally drove to the victim's home address and released him, threatening to have him killed if he reported the incident.

This offence represents a significant increase in the level of violence compared with previous sexual offences. Mr. Jones has a pattern of offending sexually against pre-adolescent and adolescent males, with six convictions for indecent assault from the age of 18 until his current offence at age 29. He has also acknowledged an earlier onset of offending and a more extensive number and type of offences than those reflected in his criminal convictions. In addition to his sexual offences, he has previous convictions for a variety of property and fraud offences.

Mr. Jones reports being doted on and materialistically overindulged as a child by his mother and grandmother. His father became ill with a progressive dementia when Mr. Jones was eight years of age, with a corresponding reduction in parental discipline. Mr. Jones resented the family's focus on his father's illness, and began to behave disrespectfully and abusively toward his father. He became exceptionally self-focused and developed a sense of entitlement in relation to his overindulgent mother and ineffectual father. He developed the capacity to lie and manipulate his mother in order to get what he wanted. He is described as having poor impulse control, poor ability to delay gratification, and deficits in social skills appropriate for his age, including a lack of empathy for others. His father died when Mr. Jones was 18 years old, and he continues to experience feelings of guilt, shame and anger in relation to his behavior with his father.

Mr. Jones has described himself as a slow learner who preferred to stay home rather than attend school. He was severely teased by his peers regarding his small stature, eczema and chronic asthma. He was also ashamed of his father's condition. He was not accepted by his peers, leading to a self-perception of social inadequacy and corresponding feelings of anxiety and rejection. He developed maladaptive strategies to attempt to align himself socially, such as telling exaggerated stories and engaging in farcical behavior, but such attempts ultimately served only to compound his rejection and isolation. Mr. Jones began to withdraw socially and ruminate over others' responses, leading to anger and resentment. These ruminations would escalate his anger to the point that he would sometimes act out on more physically and emotionally vulnerable peers.

During this period of adolescence he also appears to have developed a pattern of alleviating his emotional distress through compulsive sexual self-stimulation and fantasy relating to themes of aggression and dominance. Such sexual stimulation would strongly reinforce fantasies of dominance over others as a way of defending against his feelings of rejection and inadequacy, while simultaneously sexualizing his violent impulses. This repeated early pairing of sexual and aggressive, retributinal drives represents one of the primary risk factors in Mr. Jones' sexual offending.

Mr. Jones left school at age 16 to join the workforce, but he demonstrated an unstable work history. He has reported difficulty interacting effectively with adults, but another factor in his employment problems was his sense of entitlement, such that he did not like to be told what to do. Such an attitude, if not substantially modified, will also serve as a significant barrier to treatment aimed at reducing his risk of reoffending.

Mr. Jones continued to experience difficulties developing and maintaining satisfactory adult relationships, resulting in subjective distress and feelings of isolation. He utilized his previous pattern of sexual preoccupation to mediate stress and regulate his affect. Fantasies of control and dominance served to soothe his sense of inadequacy while expressing his anger and resentment over the perceived rejections of others. These behaviors manifest Mr. Jones' sexualized fantasies of dominance, control and aggression, which serve to facilitate temporarily reinforcing feelings of power and efficacy that he otherwise lacks. In the absence of more appropriate relationships with others through which to gain these positive subjective feelings about himself, he is likely to continue to fall back on these behaviors, which will in turn reinforce and escalate his risk. This suggests that a potentially effective treatment variable will be to provide Mr. Jones with more appropriate experiences in his relationships with others.

In summary, his early life experiences included rejection and ridicule by his peers, combined with an overindulgence by his mother and ineffectual discipline related to his progressively disabled father. These conditions lead to the development of a profound sense of inadequacy and anxiety, social incompetence and isolation, along with a sense of entitlement and the use of manipulation and lying to get his way within the family. Although he had a strong desire to connect interpersonally with others, he did not develop the social skills or interpersonal sensitivity to achieve

lasting relationships. When his dependency needs were not met and he experienced instead the teasing and ridicule of his peers, he began to comfort himself through sexual stimulation, with fantasies of control, aggression and retribution. His offending resulted from a highly sexualized ideation of others, particularly physically and emotionally less mature males with whom he could act out the deviant sexual fantasies that boosted his sense of efficacy and power.

On the STATIC-99, Mr. Jones scored in the high range of risk for sexual reoffending, based on his prior sexual offences, his choice of unrelated, male strangers as victims, and his lack of long-term intimate adult relationships. Large samples of other sexual offenders scoring in this range on the STATIC-99 have shown sexual recidivism rates of 39% at five years, 45% at ten years, and 52% at fifteen years following release to the community.

Results on the PCL-R indicate that although Mr. Jones demonstrates moderately high levels of psychopathic traits, he does not meet the criteria to be classified as a severe psychopath, and therefore is not a member of the subgroup of offenders with the highest rates of sexual reoffending. However, his characteristics of pathological lying, manipulation, lack of remorse and empathy, impulsivity and irresponsibility, make it more difficult for him to conform to the expectations of a treatment program, and to internalize and consistently utilize the gains he has made in treatment.

Considering personality features more broadly, results of a Million Clinical Multiaxial Inventory (MCMI-III) provide a profile of emotional and interpersonal functioning. On this measure he displays prominent avoidant and self-defeating personality features, marked by a significant level of anxiety. Despite remarks regarding a sense of entitlement presented in earlier reports, Mr. Jones had a particularly low score on the scale measuring narcissistic traits. It appears that Mr. Jones displays entitlement stemming from his overindulgence as a child and his limited capacity to recognize the impact of his behavior on others or the consequences to himself. Unlike the grandiose sense of self-worth associated with narcissism, Mr. Jones in fact struggles with a profound sense of overt inadequacy and social incompetence, contributing to his anxiety and occasional depression.

As a result of extensive inpatient treatment, he appears to have a solid cognitive understanding of his offence cycle, including the precursors and high risk situations associated with his sexual offences. The areas where he needs to demonstrate continuing

progress involve applying the skills and insights that he has learned in his current everyday interpersonal relationships. He accurately identifies that he needs to work on being consistently open and honest in his dealing with others and eliminate his use of deceit, manipulation, and secrecy, as these behaviors have contributed to the development of situations in which he has offended and interfered with his capacity to benefit from interventions. However, his inability to be consistent in his application of therapy and an intermittent return to manipulative and dishonest behavior have restricted the progress he has made in treatment.

In light of his extensive treatment history, it is anticipated that little more is to be gained from additional intensive residential treatment for his sexual offending. He appears to have acquired, at a cognitive level, an understanding of the precursors to his offending and the factors associated with increased risk of reoffending. He has been taught a variety of cognitive and behavioral techniques for managing this risk. These will not be enough. A key factor in minimizing his risk will be the adequacy of his close relationships with appropriate adult partners. The distress, isolation and frustration that have resulted from previous situations in which he has failed to establish adequate relationships with other adults have directly contributed to his sexual offences. Therefore it is essential that he establish and maintain a strong social network of individuals familiar with his offence cycle who are actively involved in his transition to a fulfilling and offence-free life in the community.

Discussion of Mr. Jones. This case represents a situation common to many correctional settings. The offender does not manifest significant Axis I psychopathology, but demonstrates important Axis II characteristics, including features of psychopathy. Largely because of these personality features, extensive exposure to treatment focusing on sexual offending has resulted in limited gains. The challenge becomes one of balancing the long-term process of internalizing the goals of treatment with the necessary restrictions and external monitoring required to keep others safe. Having accurate understanding of the individual's personality features and a broad sense of his needs for establishing a satisfying life will most effectively guide the process of his eventual reintegration into the community.

One issue highlighted by this case is the potential benefit of a thorough case formulation for providing specific treatment recommendations prior to and following release. The limitations of standardized cognitive-behavioral relapse prevention

treatment modalities have become apparent with Mr. Jones, and further treatment must take into account his personality dynamics and his tendency to recreate the dysfunctional dynamics of his early developmental experiences. Without an awareness of and a sensitivity to these intra-individual factors (Douglas & Skeem, 2005), treatment staff are likely to contribute to a repetition of the previously ineffective process by responding in ways that elicit his avoidant and self-defeating behaviors. Treatment approaches that explicitly consider early developmental experiences and repetitive dysfunctional behavior patterns, such as Cognitive Analytic Therapy (Ryle & Kerr, 2002), Dialectic Behavior Therapy (Linehan, Cochran, & Kehrer, 2001), or schema-focused therapy (Young, 1999), may be more effective with Mr. Jones.

Ultimately the Court must determine the applicable threshold for risk that must be met in making a decision regarding Mr. Jones' release to the community. This may reflect the communities perceived tolerance of risk in such cases, but is usually only vaguely specified in the language of the relevant laws. The role of the assessment expert is to provide as precise and clear an understanding of the risk presented by the individual, based on current empirical research and an etiological explanatory formulation of the case. In the case of Mr. Jones, much will depend on a careful balance between a strong therapeutic alliance with treatment staff knowledgeable of his particular risk factors, and effective external monitoring upon his release.

Conclusions

The aim of presenting the two cases illustrating the role of case formulation in risk assessment was to provide examples similar to those commonly encountered in forensic clinical settings. Several points are demonstrated. One is that a thorough evaluation of risk must move beyond the consideration of actuarial measures and dynamic risk factors to incorporate an understanding of developmental and personality factors. The inclusion of such causal factors provides an enriched etiological explanation of sexual offending in an individual case. Furthermore, the development of case formulations for risk assessment cannot be completely separate from considerations of treatment. In fact, risk assessment is most useful when it is explicitly tied to risk management, including both treatment and supervision needs.

Finally, the goals of risk management and public protect are best served when rehabilitation efforts focus on assisting the offender to develop as free and fulfilling a life as he is able to achieve in

light of his personal goals, strengths and deficits and social ecology. This requires a careful balancing of externally imposed restrictions on an individual with opportunities to meet his basic human needs in an effective and pro-social manner. The process of arriving at an appropriate rehabilitation plan is best guided by knowledge of the latest empirical research on the association between risk factors and recidivism, integrated with a clear understanding of the needs and psychological functioning of the individual concerned. In summary, case formulation in the service of risk assessment combines specialized knowledge of recently developed measures for sexual offenders with traditional clinical skills for understanding the individual. Neither component can be neglected if we are to provide assessments that contribute to both the well-being of the individual as well as the protection of the public.

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