SVP OFFENDERS

Neuropsychological Assessment in Sexually Violent Predator Civil Commitment Proceedings

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The U.S. Supreme Court held in Kansas v. Crane, the person's mental abnormality or personality disorder must cause the individual to have “serious difficulty in controlling his sexual behavior,” rather than “total or complete lack of control.” While most state civil commitment statutes do not mandate this volitional impairment language relevant to loss of control, they instead incorporate the requirement of findings of “likely” or “likelihood” to reoffend. Yet in some of these state SVP hearings, the forensic mental health expert witnesses testify as to the offender’s ability to control his sex offending behaviors. Occasionally, some of these experts are neuropsychologists and neurologists who testify about a sex offender's neurological and cognitive impairment resulting in sexually deviant behavior, volitional impairment, and likelihood of reoffending. This article's focus is to assess deviant sexual offending behaviors and volitional impairment through a neuropsychological and neurological lens. The author will provide an analysis of the literature as to the structural and functional neurocognitive processes of sex offending pertaining to neuropathology, neuropsychology, and neuroimaging data. The author will attempt to apply these findings to the legal requirements outlined in Crane necessitating commitment of sex offenders who experience some volitional impairment in their behaviors that lead them to be likely to sexually reoffend. The author will review state case law addressing neuroscience in SVP proceedings.

Years of Predicting Dangerously

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In 2001, Petrila and Otto wrote: "Perhaps most important, there [are] no data on the validity of adjusted actuarial assessment of risk for sexual reoffending, the technique used by almost all professionals who employ actuarial tests in their assessments" (p. 3-8) relevant to the civil commitment of sexually violent predators (SVPs). A decade later, there are data, and the data thus far show that clinical adjustments or overrides reduce the accuracy of actuarial-based risk prediction. What then must we do?

In their 2009 meta-analysis, Hanson and Morton-Bourgon found three studies that directly compared the accuracy of pure-actuarial risk assessment to adjusted-actuarial risk assessment, for
sexual recidivism. They wrote (p. 7), “Three studies examined the difference between actuarial scores and adjusted actuarial risk ratings (Gore, 2007; Hanson, 2007; Vrana, Sroga, & Guzzo, 2008). In these studies, evaluators were required to complete an actuarial risk tool and then were allowed to adjust the final risk rating on the basis of factors external to the actuarial tool. All three studies were prospective, and evaluators completed the ratings as part of their routine procedures. For all three measures, for all types of raters, and for all outcomes, the adjusted scores showed lower predictive accuracy than did the unadjusted actuarial scores.”

Since then, two more studies have addressed the accuracy of pure-actuarial risk assessment versus adjusted-actuarial risk assessment for sexual recidivism. Storey, Watt, Jackson, and Hart (2012) found that clinical adjustments or overrides of the Static-99 decreased the accuracy of risk prediction: “In 30 cases, clinicians used discretion to ‘override’ or adjust the Static-99 ratings when making final risk judgments, but the predictive validity of the clinical adjusted ratings was worse than that of the original Static-99 ratings made by clinicians” (p. 1). Wormith, Hogg, and Guzzo (2012) examined the predictive validity of the Level of Service/Case Management Inventory (LS/CMI) on a sample of sexual offenders extracted from a large cohort of offenders in Canada. “The study revealed that allowing assessors to override the numerically derived risk level with their professional judgment, a practice that increased risk level much more often than it decreased it, reduced the predictive validity of the scale and did so particularly for sex offenders by increasing risk excessively” (p. 1511).

SVP evaluators now have five research studies directly comparing pure-actuarial to adjusted-actuarial risk assessment for sexual recidivism. Available research does not support the use of professional judgment to adjust or override actuarial-based risk assessment of sexual recidivism. What then must we do?

Referencing the APA Ethical Principles of Psychologists and Code of Conduct¹ and quoting Paul Meehl, Grove (2005, p. 1236) concluded, “The principle of beneficence therefore generally requires psychologists to choose and use the prediction method that yields the most accurate predictions. . . . ‘It is therefore foolish, and I would say even immoral, for a trusted . . . expert . . . to employ a method which has a lower hit-frequency than another available method’ (Meehl, 1956, p. 163).”

Would it be practical for an SVP evaluator to rely solely on an actuarial instrument, no matter what? No. This paper adapts Meehl’s (1954, 1957) “broken-leg” examples to guide real-case decisions faced by current SVP evaluators.

References


