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Kyle Gamache
Community College of Rhode Island, kgamache1@ccri.edu

Judith Platania
Roger Williams University, jplatania@rwu.edu

Matt Zaitchik
Roger Williams University, mzaitchik@rwu.edu

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Evaluating Future Dangerousness and Need for Treatment: The Roles of Expert Testimony, Attributional Complexity, and Victim Type

Authors: Kyle Gamache, Judith Platania, and Matt Zaitchik

Kyle Gamache, M.A. CAGS, Department of Psychology, Community College of Rhode Island, Providence, RI ignatiusvienna@earthlink.net
Judith Platania, Ph.D., Department of Psychology, Roger Williams University, Bristol, RI
Matt Zaitchik, Ph.D., Department of Psychology, Roger Williams University, Bristol, RI

Abstract

In the current study, we explored the effect of risk-assessment testimony, attributional complexity, and victim type on participants' perceptions of the dangerousness of a sexually violent person and his need for treatment. Participants read details of a hypothetical sexual assault of a female minor and of an adult. Expert testimony of his risk assessment consisted of clinical opinion versus structured-clinical judgment (SCJ) versus actuarial assessment. Participants perceived clinical-opinion and SCJ testimony as equally influential when forming judgments of future dangerousness. In the context of treatment, however, participants relied on actuarial testimony when judging potential for risk. In addition, attributional complexity (AC) moderated perceptions of sexual risk. Overall, results point to the need for continued refinement of assessment techniques when determining dangerousness and need for treatment.

Key words: risk assessment, expert testimony, future dangerousness

Overview

In 1983, the United States Supreme Court ruled that mental-health experts could testify regarding the perceived dangerousness of a defendant (*Barefoot v. Estelle*, 1983). Since this ruling, testimony addressing violence-risk assessment has generally been presented in the form of clinical opinion, i.e., based on a clinician's experience as a practicing psychologist, without the use of standardized assessment instruments (Harris & Lurigio, 2007). Recently, however, concern has emerged over the ability of clinical opinion alone to accurately assess risk of violence (e.g., see Monahan, 2003). This concern has led to the development of various assessment tools and techniques in search of the best method for assessing risk. The methods currently utilized to assess risk include: clinical opinion; actuarial instruments, which attach a specific statistical weight to each factor assessing risk (Webster, Müller-Isberner, & Fransson 2002); and structured-clinical judgment (SCJ), which integrates clinical judgment with risk-assessment tools (Boer, Wilson, Gauthier & Hart, 1997; Melton, Petrila, Poythress, & Slobogin, 2007; Murray & Thomson, 2010). In the current study, we examined the differential impact of risk-assessment testimony consisting of clinical opinion, structured-clinical judgment, and the use of actuarial instruments on perceptions of a person's

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need for treatment and future dangerousness[1] in the context of a sexual assault of a female (adult versus minor) victim. In addition, we investigated the role of attributional complexity—the ability to utilize complex attributional schemata—when evaluating expert testimony and case facts (Fletcher, Danilovics, Peterson, & Reeder, 1986). Finally, we explored the role of gender in light of the recent emergence of participant gender as an important variable In "Sexually Violent Person" (SVP) trials (McCabe, Krauss, & Lieberman, 2010; Guy & Edens, 2006).

Background

Over the last fifty years, states have evolved laws specifically directed towards criminals who commit sexual crimes (Becker & Murphy, 1998). These SVP statutes have outlined the framework for a finding of "sexual dangerousness," which allows for the containment of sexual offenders in treatment facilities upon release from prison. These types of laws, as well as those that establish community-warning programs, have been enacted in 20 states (Boccaccini, Murrie, Hawes, Simpler, & Johnson, 2010; Fitch & Hammen, 2002; Gookin, 2007; *In re Young,* 1993). Although each jurisdiction defines "sexually violent" somewhat differently, all SVP laws require the individual to possess both a mental abnormality and the potential of future risk of re-offense (Schwartz, 1999). In many instances, definitions of mental abnormality require the individual to have a diagnosable mental disorder listed in Diagnostic and Statistical Manual of the APA, such as paraphilia, or other disorders that increase likelihood of sexual recidivism (Becker & Murphy, 1998).

Throughout the years, a growing number of cases involving the commitment of SVPs have been challenged, as in the case of Leroy Hendricks (*Kansas v. Hendricks,* 1997). Hendricks had been imprisoned for repeatedly molesting children. When he was scheduled for release, the state of Kansas sought to commit him under the Kansas SVP Act. The Kansas SVP Act allows for the civil commitment of an offender if the presence of a mental abnormality or personality disorder renders it likely the individual would re-offend. Hendricks appealed to the United States Supreme Court, which upheld his confinement. The Court ruled that a sexual offender committed to a treatment facility could be held beyond his sentence without violating his Fifth-Amendment rights. Most states following the Kansas law have identified the following criteria necessary for consideration prior to committing a sexual offender: a history of sexual offending, the presence of a mental abnormality, an inability to control his or her actions and a significant risk for sexual offending in the future (Boccaccini, Murrie, Caperton, & Hawes, 2009).

In 2002, however, the Supreme Court revisited the "mental abnormality" consideration required by the Kansas statute in *Kansas v. Crane*. Specifically, the state of Kansas sought to have Crane placed in a treatment facility even though he did not meet the criteria for mental illness as defined by the State. The Court ruled that the Kansas SVP law could be applied to defendants not experiencing significant impairment or total lack of control over their actions. This ruling allowed a broader application for SVP

[1]In the current study, the term *future dangerousness* is used synonymously with continued threat.

commitment than civil-commitment laws with respect to the mentally ill. Currently, 14 of 20 states allowing the involuntary commitment of sexually dangerous persons permit the right to a jury trial to assess the dangerousness of the defendant (Rush & Gransee, 2010). With over 4,500 individuals confined under current commitment laws, there is a high demand for accurate methods to assess dangerousness in sexually violent offenders (Sbraga, 2004).

Risk Assessment

Dynamic v. Static Factors. Expert testimony addressing violent and sexual recidivism typically relies on risk factors associated with the offender and the offense. These risk factors are commonly divided into two groups: static and dynamic (Conroy, 2003; Hanson & Bussiere 1998; Hanson & Harris, 2000). Static risk factors are defined as fixed or historical characteristics of an offender, such as offender age, offense history, age at first offense, and victim characteristics. Conversely, dynamic risk factors are identified as characteristics that can change over time, such as anger control methods, substance abuse, and social networks. Dynamic risk factors are divided into two subgroups: stable and acute. Stable factors should remain relatively unchanged, whereas acute dynamic factors can change rapidly. Sex-offender recidivism has been associated with stable dynamic factors such as positive social support, deviant sexual interests, use of alcohol and illegal substances, and victim access (Hanson & Bussiere, 1998; Hanson & Harris, 2000; 2001). Acute dynamic factors include intoxication and sexual arousal. Research addressing the predictive utility of dynamic and static risk factors reveals important yet disparate findings. For example, results of a meta-analysis conducted by Hanson and Bussiere (1998), found that *static* risk factors were the best predictors of long-term recidivism. On the other hand, research finds identifying *dynamic* risk factors most useful in predicting future violence (Conroy, 2003). Research concerning the ability of dynamic factors to predict sexual recidivism reveals inconsistent findings, with some studies demonstrating that dynamic factors are good predictors of sexual recidivism while others find that dynamic risk factors can predict general criminal recidivism but not sexual recidivism (Gendreau, Little, & Goggin, 1996; Hanson & Harris, 2000; Hanson, Scott, & Steffy, 1995; Lindsey, Elliot, & Astell, 2004). Hanson and Harris (2000) found that victim access, anger, and unwillingness to cooperate with individuals in authority/supervisory positions were the most reliable predictors of recidivism. This assessment was made among the acute factors studied by the researchers, explaining, “most of the factors that were stable risk factors were also acute *risk* predictors” (p. 23). Regardless of the label allocated to these factors, assessment of sex-offender recidivism should include both static and dynamic factors.

Expert Testimony. Although increasing numbers of clinicians are offering testimony regarding violence-risk assessment, there is considerable debate regarding the accuracy of the various methods used to determine potential for risk (see Murray & Thomson, 2010 for a review). That said, the methods currently utilized to assess risk include: clinical opinion; actuarial instruments, which attach a specific statistical weight to each factor assessing risk; and structured-clinical judgment, which combines the use of assessment tools with clinical judgment (Melton, et al., 2007; Murray & Thomson, 2010;

Webster, 2002). Each method's strengths and weaknesses have been thoroughly reviewed with respect their ability to assess potential for risk.

Clinical opinion. Clinical-opinion testimony, sometimes known as unstructured-clinical judgment/opinion, is the evaluation of an individual without the explicit use of risk factors or other tools. In clinical-opinion testimony, the determination of a defendant's dangerousness is made at the discretion of the expert (Dempster, 2003; Hanson, 1998). According to research (Elbogen & Huss, 2000), the context in which the evaluation is made may often affect the type of risk factors considered. In terms of the clinical interview, this suggests a reliance on salient cues (e.g., delusions) when assessing risk (Quinsey, 1995). Other researchers have found that clinicians base their recommendations on a history of violence, alcohol use, and level of anger more often than cues (Menzies & Webster, 1995). Supporters of this assessment method contend that its greatest strength is the freedom it allows evaluators, who can tailor each assessment to the individual (Dolan & Doyle, 2000). The clinical-opinion method has been heavily criticized, however, for such factors as ignoring base-rate data, assigning too much power to certain factors while ignoring others, the lack of rules or criteria governing the decision making, susceptibility to attributional errors, poor interrater reliability, and low accuracy and consistency (Dolan & Doyle, 2000; Grove & Meehl, 1996; Grove, Zald, Lebow, Snitz, & Nelson, 2000; Hanson, 2009; Hanson, 2002; Krauss, Lieberman, & Olson, 2004). Others have claimed that clinical opinion is no more accurate than the judgments of intelligent laypersons (Quinsey & Ambtman, 1979).

***Actuarial instruments*.** Actuarial assessment relies on the use of actuarial instruments in predicting future dangerousness (Hanson, 2002). These instruments evaluate an offender on a number of static factors, and are then combined into a total score. The score yields a determination of risk labeled as "low," "moderate," or "high" (Douglas & Skeem, 2005). The guidelines for determining risk are often very specific, offering little clinical interpretation (Yang, Wong, & Coid, 2010). Actuarial instruments have been slated as the most cost-effective manner of risk assessment (Beech, Fisher, & Thornton, 2003). Although actuarial assessments are viewed by some as superior to clinical opinion (Quinsey, Harris, Rice, & Cormier, 1998), there is still a great deal of debate over their use in cases involving SVPs. In fact, predominant criticisms include the inability of actuarial instruments to accurately illustrate a specific individual's amount of risk. Thus, overreliance on actuarial instruments may lead evaluators to ignore other factors of risk and the failure to provide recommendations for treatment objectives (Beech, et al., 2003).

Structured-clinical judgment. Structured-clinical-judgment testimony (SCJ), also referred to as guided-professional-judgment (GPJ) testimony, was developed to combine the expertise of clinical professionals with particular aspects of actuarial measures (Lieberman, Krauss, Kyger, & Lehoux, 2007). These judgments are based on empirically derived risk factors as well as clinical opinion regarding the defendant's presentation of these risk factors (Dempster, 2003; Dolan & Doyle, 2000). The Sexual Violence Risk-20-R (SVR-20-R) (Boer, Hart, Kropp, & Webster, 1997) is the most widely

used statistical tool utilized in this assessment method. The SVR-20-R measures future risk potential of sexual offenses and has been found to be one of the few predictive measures that not only predict future violence, but also sexual recidivism (Dempster & Hart, 2002). This method allows some freedom in judgment while still adhering to guidelines that aid in accuracy. Following this method, clinicians examine both static and dynamic factors, with emphasis on dynamic factors. Risk factors are evaluated with respect to the individual as opposed to the population of sex offenders (Dempster, 2003; Douglas & Skeem, 2005). Structured-clinical judgment has also been shown to be accurate and reliable (Dempster, 2003). Recent research finds increasing support for the structured-clinical-judgment model in assessing risk of violence (Maden, 2005; Singh, 2008). For example, field data examined on 107 Danish patients five years after discharge from forensic/psychiatric settings indicate that the structured-professional-judgment model of risk assessment utilizing the Historical-Clinical-Risk Management-20 scale (HCR-20) had the highest predictive accuracy of violent recidivism for future violence compared to utilizing the HCR-20 solely in an actuarial manner (Pedersen, Rasmussen, & Elsass, 2010).

Perceptions of Assessment Testimony

Results of empirical studies investigating the impact of different types of expert testimony assessing risk of violence have demonstrated less clear-cut findings than data obtained in the aforementioned field study. For example, in a recent study investigating the effect of the type of testimony on determinations of future dangerousness, researchers found higher levels of verdict confidence among venirepersons exposed to clinical opinion than among those exposed to actuarial testimony (Krauss, McCabe, & Lieberman, 2011). In addition, contrary to the researchers' predictions, *rational* information processors exposed to clinical testimony reported greater verdict confidence than those exposed to actuarial testimony. *Experiential* processors on the other hand, reported greater verdict confidence after hearing actuarial testimony than those who heard clinical testimony. In an earlier study on a sample of undergraduate students, researchers observed this effect in the predicted direction, however, only after individuals were encouraged to think rationally (Lieberman, et al., 2007). Namely, participant-jurors instructed to think about the case rationally were significantly more influenced by actuarial testimony than by clinical and guided-professional judgment (GPJ) testimony. Alternatively, experiential processors reported higher levels of perceived defendant dangerousness when exposed to clinical testimony. However, this effect was seen only for male participants. It was interesting that, regardless of processing mode, participants did not differentiate between GPJ and clinical testimony on ratings of dangerousness. This study appears to be the first to examine the differential effects of clinical-opinion, actuarial, and structured-clinical judgment testimony on evaluations of SVPs in the context of civil commitment.

Guy and Edens (2003) examined the effect of different types of expert-witness testimony (clinical-opinion testimony versus actuarial-assessment testimony) and the expert's assessment of the defendant (no 'psychopath' label versus the label of 'psychopath') on participants' perceptions of the defendant's dangerousness in a mock

SVP commitment hearing. In this study, participants were more likely to believe a defendant would commit future sexual violence if labeled a high-risk psychopath. This effect was more pronounced for females than for males. Namely, females were more likely to favor commitment than males were, particularly when the defendant was described as a psychopath. It is interesting that the researchers did not observe a difference between the clinical and actuarial conditions. This finding differed from a previous study examining differences between clinical and actuarial assessment testimony in the context of a capital trial (Krauss & Sales, 2001). In this study, clinical-opinion testimony was perceived as more accurate and more reliable than actuarial instruments in evaluating future dangerousness. Clinical-opinion testimony was also rated more favorably among participant-jurors than was actuarial-expert testimony. Krauss and colleagues (2010) found notable differences in perceptions of aspects of an SVP trial between a sample of undergraduate students and jury-eligible community members. Community members were more confident in their decision to commit. Commitment decisions for this group were also influenced by clinical-opinion testimony compared to actuarial testimony. Students, on other hand, were influenced more by actuarial testimony than by clinical testimony, which the researchers attributed to the *rational* cognitive processing style of students.

In 2006, Guy and Edens examined the role of victim type in the context of an SVP trial. In two separate sexual-assault scenarios, the researchers manipulated the age of the female victim as being 8 or 10 years old or 20 or 27 years old. In addition, they examined the effect that the type of testimony (clinical opinion versus actuarial testimony) and the presence of the "psychopath" label had on participants' assessment. Results indicated that, regardless of the type of testimony, participants overwhelmingly decided in favor of commitment in the child-victim condition. This finding was consistent for both male and female participants. In light of this finding, the researchers suggest future studies examine other aspects of a sexual-assault scenario (e.g., victim gender, level of seriousness of assault).

Attribution and Decision Making

Attribution theory. Attribution theory examines the relation between individuals' thoughts and behaviors and their interpretation of surrounding events (Heider, 1958). Accordingly, attribution theory has offered a new perspective in understanding research in the legal/forensic decision-making context. Specifically, results of studies investigating the role of attribution in this context have increased awareness of the importance of individual difference characteristics in the legal/forensic arena. Early research in this area uncovered a relationship between internal attributions and parole decisions (Carroll, 1978). In this study, the researcher found that parole-board decisions were significantly more influenced by attributions based on the parolee's internal characteristics than by case-specific factors. In a follow-up study, the researcher found that members of a parole board were less likely to grant parole to offenders whose crimes were attributed to internal factors than to external factors (Carroll, 1979). Supporting this finding, Cullen, Clark, Cullen, and Mathers (1985) demonstrated that individuals were more likely to favor rehabilitation over punishment if

an offender's crimes were linked to external factors rather than to internal attributions. In a later study, researchers found a strong relationship among causal attributions, juror attitudes, and sentencing decisions (Carroll, Perkowitz, Lurigio, & Weaver, 1987). Results indicated that participants assigning internal attributions to verdicts of guilt also assigned harsher sentences than did participants allocating external attributions to guilty verdicts. A recent study addressed attribution as a key moderator in understanding decision making in the context of a hate crime (Cramer, Chandler, & Wakeman, 2010). These researchers found a relation between blame attribution and punitiveness in a series of studies addressing perceptions of sexually oriented hate crimes with greater victim blame associated with less punitive punishment for the defendant. When examining mock-jury deliberations in a capital case involving child abuse, Stevenson, Bottoms, and Diamond (2010) found participant-jurors' use of stable attributions to conceptualize the defendant's behavior strongly indicative of pro-prosecution sentiment. Lupfer, Cohen, Bernard, Smalley, and Schipperman (1985) found similar results in the context of a civil trial. In this study, anti-plaintiff bias appeared to be guided by perceptions of negative stereotypes and hostile intentions rather than stable attributions.

Attributional complexity. In 1986, researchers conceptualized the construct of attributional complexity (Fletcher, et al., 1986). They reasoned that individuals differ both in their preference for how to explain behavior and in their motivation to do so. These differences are the result of how we respond to and evaluate information as a function of our attributional schemata, with some individuals organizing and interpreting stimuli at a higher, more detailed level than others. To measure this concept of "attributional complexity" Fletcher and colleagues (1986) created the Attributional Complexity Scale (ACS). The 28-item scale assesses attributional complexity across seven factors or constructs:

- level of interest/motivation
- preference for complex rather than simple explanations
- presence of metacognition concerning explanations
- behavior as a function of interaction with others
- tendency to infer abstract/complex internal attributions
- tendency to infer contemporary external attributions
- tendency to infer external causes from past experiences.

The idea is that individuals who are more (less) complex on one "attributional dimension" will be more (less) complex on the other dimensions (p. 876-877).

Research has demonstrated that individual differences in attributional complexity influence judgments and decision-making. For example, high levels of AC have been found to be associated with high levels of perspective taking and empathic concern (Joireman, 2004). Alternatively, low levels of AC have been related to endorsing punitive rather than rehabilitation models as well as perceptions of subtle racism (Reid & Foels, 2010; Tam, Au, & Leung, 2008). In addition, individuals with relatively complex attributional schemata have been found to spend a considerable amount of time reflecting on more cognitively challenging problems rather than on less challenging ones (Fletcher, Rosanowski, Rhodes, & Lange, 1992). High AC individuals also use this reflection time wisely—forming more accurate judgments not only in solving

complex discrimination tasks but also in accurately determining the personality characteristics of others (Fletcher, Reeder, & Bull, 1990). Finally, attributionally complex individuals are selective regarding the criteria they use to form attributions. They select not only more information but also more useful information in analyzing causal attributions than attributionally simple individuals do (Murphy, 1994).

Attributional complexity has also been shown to influence various aspects of legal decision-making. In the context of a simulated armed robbery, Pope and Meyer (1999) found that attributionally complex jurors were significantly more likely to consider external factors for the defendant's behavior than attributionally simple jurors were. In addition, Pope and Meyer found gender differences with respect to such measures as verdict, confidence, and witness credibility. Compared to females, male participants were significantly more likely to find the defendant guilty, report more confidence in their verdict preference, and view the eyewitness as more credible. It is interesting that these researchers included an attributionally average group in addition to high and low AC groups. While results indicated this group's tendency to interpret the evidence in much the same manner as the high AC group, they appeared to distinguish themselves as a separate group based on the seven subscales of the ACS. In a rather interesting experimental setting, Lassiter and colleagues (2005) examined the moderating effects of AC on susceptibility to camera perspective bias in the context of a videotaped "confession. Although they observed differences[2] in verdict as a function of attributional complexity, attributionally simple and attributionally complex participants did not differ with respect to their assessments of the voluntariness of a confession as measured by camera perspective. The authors account for this finding by suggesting a different type of information processing involved in assessing camera perspective bias compared to verdict determinations. Nonetheless, this study as well as others provides important insights into the moderating effects of attributional complexity in a broad range of legal and clinical circumstances.

The Present Study

Currently, only one study has empirically examined perceptions of the relative efficacy of clinical-opinion, actuarial, and guided-professional judgment (GPJ) expert testimony in the context of future dangerousness and civil commitment (Lieberman, et al., 2007). In that study, researchers found that perceptions of clinical opinion and GPJ testimony generally did not differ.[3] Considering the importance of determining the most efficient form of expert testimony in civil-commitment hearings of SVPs, more research needs to be conducted in this area. That said, the current study examines the influence of differing types of expert testimony[4] on perceptions of future dangerousness and need for confinement in a SVP civil-commitment hearing in which the defendant is considered a *moderate* risk for recidivism amidst charges of voyeurism, sexual assault, and breaking and entering. In addition, we were interested in the moderating effects of

[2] Differences reported by researchers as nearly significant: $p = .08$ (p. 31).
[3] Differences were observed as a function of cognitive processing mode (*rational v. experiential*).
[4] Modeled after Lieberman, et al., (2007)—clinical-opinion, actuarial assessment, and guided-professional judgment.

attributional complexity on perceptions of risk potential. An empirical examination of the combined effects of different types of expert testimony and attributional complexity in this context has the potential to offer more specific insights into how individual differences in attributional schemata contribute to our understanding of perceptions of SVPs. In view of the research demonstrating that individuals with complex attributional schemata are more efficient information processors than those with relatively simple schemata, we examined how individual differences in AC influenced participants' use of expert testimony when evaluating the defendant as well as case facts. Within this paradigm, we also varied victim type as female adult victim versus minor victim. Previous research examining the role of victim type in the context of a SVP trial found that, regardless of type of testimony, participants overwhelmingly decided in favor of commitment in the child-victim condition (Guy & Edens, 2006). In light of this finding, the researchers suggest that future studies examine other aspects of a sexual-assault scenario (e.g., victim gender, level of seriousness of assault). As a result, we decided to gauge level of seriousness of sexual assault by having the defendant hold the victim (adult and minor) at knifepoint. Finally, we explored the role of participant gender considering the recent emergence of this variable as an important factor in studies examining perceptions of dangerousness (Foels & Reid, 2010; Guy & Edens, 2006; 2003; Lieberman et al., 2007).

Accordingly, in a 2 (Victim Type: Adult v. Minor) x 3 (Expert Testimony: Structured-Clinical Judgment v. Clinical v. Actuarial) between-subjects design, the current study investigated (1) participant-jurors' preference for structured-clinical-judgment testimony over clinical opinion and actuarial testimony when determining need for treatment and future dangerousness in an SVP trial, (2) the moderating effects, if any, of attributional complexity on perceptions of the defendant, (3) the role of victim type in perceptions of the defendant, and (4) whether and to what extent gender differences exist in determinations of need for treatment and future dangerousness.

Method

Participants

Two hundred forty-five undergraduate students participated as part of a course requirement or for extra credit (88 men, 157 women). Participants were at least 18 years of age, registered voters, and predominantly Caucasian (91%).

Materials and Procedure

Pre-Trial Materials. Prior to administering the stimulus materials, participants responded to items assessing basic demographic information (age, gender, class year, ethnicity, and jury eligibility). In addition, they completed the 28-item Attributional Complexity Scale (Fletcher et al., 1986). After completing these items, and prior to reading the expert testimony in the case, participants read one of two 400-word summaries describing events leading to the defendant's arrest. See Appendix for summary of case facts. All participants then read a one-sentence explanation of state

law (Massachusetts) allowing for the confinement of sexually dangerous persons beyond their prison terms in a clinical institution.

Trial Materials. Participants then read one of three trial transcripts of the direct and cross-examination of expert testimony (clinical opinion v. structured-clinical judgment v. actuarial). The following aspects of the expert testimony remained constant across all experimental scenarios: (1) expert's background, experience, and education, (2) description of the offender as having a "moderate risk" of re-offending, and (3) discussion of the likelihood of the defendant re-offending and being a continuing danger to society.

Structured-Clinical Judgment (SCJ). In the structured-clinical-judgment condition, the expert utilized the SVR-20-R[5] in characterizing the offender's potential for future risk. The expert identified static factors including relationship problems, employment problems, and factors involving the defendant's crimes. Dynamic factors included interpersonal issues and sexual deviancy. Clinical-risk factors included minimizing the consequences of his actions to the victim, lack of long-term plans, and resistance to treatment, also emphasizing that the presence of these factors increases the likelihood of recidivism. In his testimony, the expert stated that he had reviewed the defendant's criminal and medical records. He also stated that he had held two two-hour interviews with the defendant at the prison

Actuarial. In the actuarial condition, the expert utilized the Static-2002[6] as the foundation for his opinion of the defendant. He described the instrument as a reliable and valid measure assessing recidivism based on risk factors. He indicated the defendant scored "4," earning one point each for the following: conviction for a prior sex offense, non-contact prior sexual offense, breaking and entering during the crime, and assault on an unrelated victim, stating the defendant "has a 26% chance of recidivating in the next five years, increasing to 31% after ten years and 36% after fifteen years."

Clinical Opinion. In the clinical-opinion condition, the expert relied on a series of interviews with the defendant. The interviews consisted of discussion of the defendant's social history, the events of the crimes, and his thoughts and feelings. He discussed the defendant's deviant sexual fantasies and attachments, stating that he specifically received and acted upon sexual thrills from stalking unsuspecting women. The expert

[5] The SVR-20-R consists of a checklist of twenty items categorized as: psychosocial adjustment, sexual offenses and future plans. Each item is assessed on a 3-point scale from 0 to 2 (Boer, et al, 1997).

[6] The Static-2002 actuarial instrument (Hanson & Thornton, 2003) has recently replaced the widely accepted Static-99 (Hanson & Thornton, 1999). The goal of the revised scale was to develop a reliable assessment of risk in predicting sexual recidivism. The variables chosen for the scale were a function of factors associated with sex-offense recidivism presented in research findings (e.g., Hanson & Bussière, 1998). The 13 items represent the following five categories: age at release, sex offense history, deviant sexual interests, availability of victims, general criminality with higher scores indicative of greater risk. Research with the Static-2002 has demonstrated moderate to high accuracy with respect to its predictive ability (Hanson & Morton-Bourgon, 2009). Research has also reported moderate-to-high interrater reliability (Langton, Barbaree, Hansen, Harkins, & Peacock, 2007).

also described the defendant as possessing poor skills in developing interpersonal relationships, showing little understanding for the assault on the victim, failing to appreciate the damage caused by such an attack, frequently finding excuses for his actions.

Cross-examination. The cross-examination by the defense attorney illustrated the common drawbacks of each type of testimony. Specifically, in the cross-examination of actuarial testimony, the expert was questioned on the predictive ability of the Static-2002 with respect to re-offending and the instrument's inability to consider specific dynamic factors related to recidivism. In the cross-examination of the structured-clinical-opinion testimony, the expert was questioned on several factors related to psychosocial behaviors and sexual offenses not present in the defendant (e.g., mental illness, suicidal and/or homicidal tendencies, anti-social behavior, substance abuse problems). Other factors included multiple victims, violence, and increase of frequency and severity of sex offenses. Finally, the cross-examination of the clinical-opinion expert questioned the prediction accuracy considering the relatively few interviews conducted with the defendant.

Transcripts ranged in length from 1,200 to 1,400 words, depending on testimony. After reading the requisite testimony, all participants read the following definition of Sexually Dangerous Persons taken from the Massachusetts statute:

> Sexually dangerous person—any person who has been (i) convicted of or adjudicated as a delinquent juvenile or youthful offender by reason of a sexual offense and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in sexual offenses if not confined to a secure facility; (ii) charged with a sexual offense and was determined to be incompetent to stand trial and who suffers from a mental abnormality or personality disorder which makes such person likely to engage in sexual offenses if not confined to a secure facility; or (iii) previously adjudicated as such by a court of the Commonwealth and whose misconduct in sexual matters indicates a general lack of power to control his sexual impulses, as evidenced by repetitive or compulsive sexual misconduct by either violence against any victim, or aggression against any victim under the age of 16 years, and who, as a result, is likely to attack or otherwise inflict injury on such victims because of his uncontrolled or uncontrollable desires (Mass. Gen Law., Title 17, Chap 123. Section 1).

Post-Trial Materials. At the completion of the trial stage, participants completed two primary items of interest: The first item measured participants' belief that the defendant should be placed in a clinical facility after serving his sentence. The second measured participants' belief that the defendant would be a continuing threat to society. In addition, participants responded to a series of items designed to assess the perceptions of expert testimony, case facts, the role of treatment in re-offending, and defendant characteristics.

Items. Unless otherwise indicated, all items were measured using a 6-point Likert-type scale ranging from 1 (not at all) to 6 (completely). Following are the two items measuring perceptions of need for confinement and future dangerousness: "Do you believe that the defendant should be placed in a clinical facility after his sentence is served?" "Do you believe that the defendant will be a continuing threat to society?" Additional items in our analyses included: "If the defendant *does/does* not participate in treatment, how likely is it that he will commit a sexual crime in the future?" "How much of your opinion on Mr. Cooke's sexual-risk potential was influenced by the expert?" "How credible was the expert?"

After signing the consent form, participants were randomly assigned to one of six experimental scenarios. They then completed the pre-trial instruments, read the state statute defining sexually dangerous persons and expert testimony, and completed all dependent measures. Participation required 20 minutes.

Results

Table 1 displays descriptive statistics for our sample on all dependent measures.

Table 1
Descriptive data on all dependent measures

Item	Mean	SD
The defendant should be placed in a clinical facility	4.96	.98
The defendant is a continuing threat to society.[a]	4.75	.92
Likelihood of committing a sexual crime without treatment	5.02	.93
Likelihood of committing a sexual crime with treatment	3.33	1.06
Rating of expert credibility	4.93	.93
Opinion of sexual risk potential influenced by expert testimony	4.22	1.06
Opinion of sexual risk potential influenced by case facts	4.88	.84

Note: *N = 245*
[a]This item's responses ranged from 2 to 6. Remaining items ranged from 1 to 6.

Preliminary Analyses

Two separate Chi-square analyses were conducted to examine the distribution of male and female participants among our treatment conditions. No significant associations were found between gender and expert testimony conditions: $\chi^2(2, N = 245) = .64$, $p = .73$, *Cramer's V* = .05; and gender and victim type: $\chi^2(1, N = 245) = .31$, $p = .57$, *phi* = -.04. According to these results, gender distribution among our experimental conditions appeared to be equivalent.

Attributional Complexity Scale Analysis

After recoding, internal consistency of the 28-item ACS revealed Cronbach's alpha = .90. Individual item responses ranged from 1 (strongly disagree) to 6 (strongly agree). Aggregate responses to the 28-item ACS ranged from 82 – 167, *M* = 126.63, *Md* = 126.00, *SD* = 16.14. Based on a median split, and in order to examine this factor as a moderator, we dichotomized responses into low AC (82 – 126) and high AC (127 – 167). Low AC participants composed 51% of our sample (*N* = 124); high AC participants composed 49% of our sample (*N* = 121). Consistent with research (Fletcher et al., 1986; Foels & Reid, 2010) females (*M* = 129.11, *SD* = 15.12) were significantly more attributionally complex than males (*M* = 121.92, *SD* = 17.09): *t*(243) = -3.46, *p* = .001. See Table 2 for the 28-item ACS.

Table 2
Mean Responses to ACS items

Item	Mean	SD
I don't usually bother to analyze and explain people's behavior.	4.79	1.02
Once I have figured out a single cause for a person's behavior I don't usually go any further.	4.29	1.22
I believe it is important to analyze and understand our own thinking process.	5.06	.927
I think a lot about the influence that I have on other people's behavior.	4.46	1.00
I have found that relationships between a person's attitudes, beliefs, and character traits are usually simple and straightforward.	4.46	1.00
I see people behaving in a really strange or unusual manner, I usually put it down to the fact that they are strange or unusual people and don't bother to explain it any further.	4.59	1.21
I have thought a lot about the family background and personal history of people who are close to me, in order to understand why they are the sort of people they are.	4.48	1.19
I don't enjoy getting into discussions where the causes for people's behavior are discussed.	4.45	1.28
I have found that the causes for people's behavior are usually complex rather than simple.	4.93	.991
I am very interested in understanding how my own thinking works when I make judgments about people or attach causes to their behavior.	4.79	1.09
I think very little about the different ways that people influence each other.	4.72	1.06
To understand a person's personality/behavior I have found it is important to know how that person's attitudes, beliefs, and character traits fit together.	4.70	.931
When I try to explain other people's behavior I concentrate on the other person and don't worry too much about all the existing external factors that might be affecting them.	4.52	1.08
I have often found that the basic cause for a person's behavior is located far back in time.	3.67	1.19
I really enjoy analyzing the reasons or causes for people's behavior.	4.22	1.28

I find that complicated explanations for people's behavior are confusing rather than helpful.	4.07	1.15
I give little thought to how my thinking works in the process of understanding or explaining people's behavior.	4.40	1.16
I think very little about the influence that other people have on my behavior.	4.64	1.14
I have thought a lot about the way that different parts of my personality influence other parts.	4.41	1.07
I think a lot about the influence that society has on other people.	4.85	1.00
When I analyze a person's behavior I often find the causes form a chain that goes back in time, sometimes for years.	4.18	1.15
I am not really curious about human behavior.	4.87	1.35
I prefer simple rather than complex explanations for people's behavior.	4.09	1.32
When the reasons I give for my own behavior are different from someone else's, this often makes me think about the thinking processes that lead to my explanations.	4.15	1.08
I believe that to understand a person you need to understand the people who that person has close contact with.	4.59	1.00
I tend to take people's behavior at face value and not worry about the inner causes for their behavior (e.g., attitudes, beliefs, etc.).	4.70	1.05
I think a lot about the influence that society has on my behavior and personality.	4.55	1.03
I have thought very little about my own family background and personal history in order to understand why I am the sort of person I am.	4.88	1.22

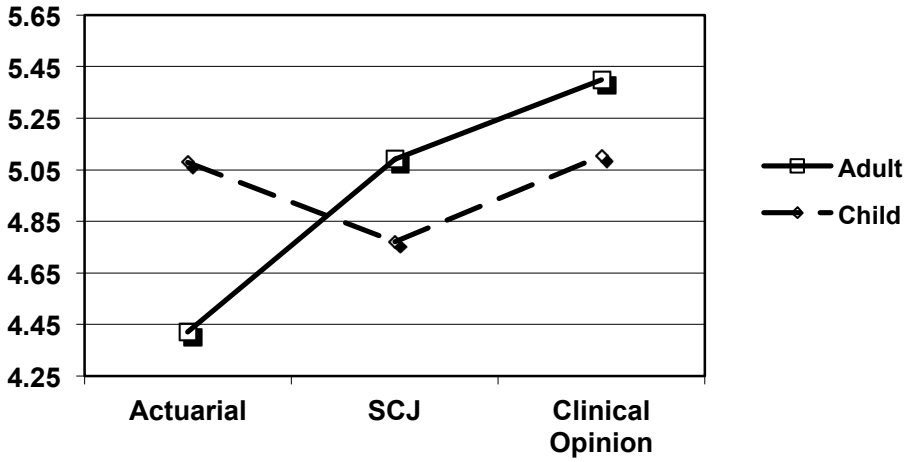
Note: N = 245. Responses scaled from 1 (strongly disagree) to 6 (strongly agree).

Two separate Chi-square analyses were conducted to examine the distribution of high and low AC participants among our treatment conditions. No significant associations were found between AC and expert-testimony conditions: $\chi^2(2, N = 245) = 2.54$, $p = .28$, *Cramer's V* = .10; and AC and victim type: $\chi^2(1, N = 245) = .19$, $p = .65$, *phi* = -.03. According to these results, the distribution of high and low AC participants among our experimental conditions appeared to be equivalent.

Need for commitment. We tested the influence of our manipulated factors as well as AC on evaluations of need for commitment and determination of future dangerousness through two separate three-way ANOVAs—expert Testimony (Clinical Opinion v. Actuarial v. Structured-Clinical Judgment - SCJ) x Victim Type (Adult v. Minor) x AC (Low v. High). On evaluations of need for commitment, a significant testimony x victim-type interaction was found: $F(2, 233) = 6.82$, $p = .001$, $h_p^2 = .05$. Participants were most likely to believe the defendant should be placed in a clinical facility in the clinical-opinion testimony/adult victim condition. Alternatively, they were least likely to believe the defendant should be placed in a facility in the actuarial testimony/adult victim condition. See Figure 1 for graphic explanation of this finding. In addition, a main effect for type of testimony was observed: $F(2, 233) = 5.47$, $p = .005$, $h_p^2 = .04$. Participants in the clinical-opinion-testimony condition were significantly more likely to believe the defendant should be placed in a clinical facility compared to the actuarial-testimony condition (Clinical: $M = 5.25$, $SD = .79$ v. Actuarial: $M = 4.75$, $SD = 1.15$). SCJ

testimony did not differ significantly from either of these conditions (*M* = 4.93, *SD* = .91). We did not observe a main effect for type of victim on perceptions of need for commitment nor did we find any significant effects of AC on this item.

Figure 1: Expert Testimony x Victim Type Interaction on Perceptions of Need for Commitment



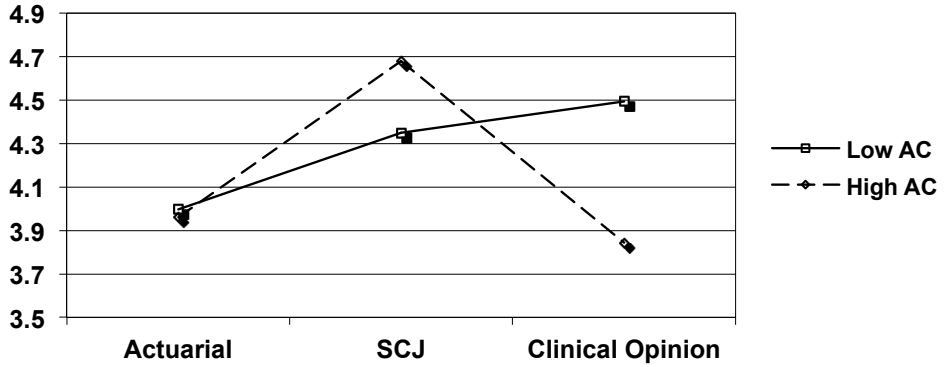
Future dangerousness. A second three-way ANOVA was conducted on participants' evaluations of the defendant as a continued threat to society: Expert Testimony (Clinical Opinion v. Actuarial v. SCJ) x Victim Type (Adult v. Minor) x AC (Low v. High). A main effect of type of testimony was found: $F(2, 233) = 10.41$, $p < .001$, $h^2 = .08$. Clinical-opinion and SCJ testimony differed significantly from actuarial instruments when assessing continued threat. Scheffé's test of multiple comparisons revealed the following: Clinical Opinion (*M* = 5.06, *SD* = .75) SCJ (*M* = 4.78, *SD* = .91) v. Actuarial (*M* = 4.42, *SD* = .97). Participants did not differentiate between clinical-opinion testimony and SCJ with respect to their effectiveness in assessing the defendant as a continued threat, thus perceiving them as equally influential in their evaluation. No other significant effects were observed.

Influence of Expert on Risk Potential for Sexually Violent Crime

Influence of expert testimony. In order to test the moderating effects of attributional complexity on our risk-potential items, we performed two separate three-way ANCOVAs: Expert Testimony (Clinical Opinion v. Actuarial v. SCJ) x Victim Type (Adult v. Minor) x AC (Low v. High). Our continuous measurement variables of future dangerousness and need for commitment were selected as covariates. Preliminary analysis revealed non-significant effects of our moderator variable AC on each of these items: *p* values = .29 and .45 (two-tailed independent samples *t*-tests), demonstrating the suitability of this analysis for our purposes. Results of the first ANCOVA indicated a significant expert testimony x AC interaction on the item: "How much of your opinion on Mr. Cooke's sexual-risk potential was influenced by the expert?" $F(2, 231) = 4.62$, $p = .011$, $h_p^2 = .04$. High AC participants in the clinical-opinion-testimony condition relied

the least on expert testimony when evaluating the defendant's sexual-risk potential and the most in the SCJ condition. Alternatively, when evaluating the defendant's sexual-risk potential, low AC participants relied most on clinical-opinion testimony and least on actuarial testimony. Figure 2 displays this interaction effect.

Figure 2: Expert Testimony x Attributional Complexity (AC) Interaction on Expert Influence



A main effect of testimony was also found on this item: F(2, 231) = 5.69, h_p^2 = .05. Post hoc comparisons revealed participant-jurors exposed to SCJ testimony indicated that their opinion regarding risk potential was greatly influenced by the expert (*M* = 4.52, *SD* = .97). This differed significantly from the actuarial condition (*M* = 3.98, *SD* = 1.19). Clinical-opinion testimony did not differ from either SCJ or actuarial (*M* = 4.17, *SD* = .89)

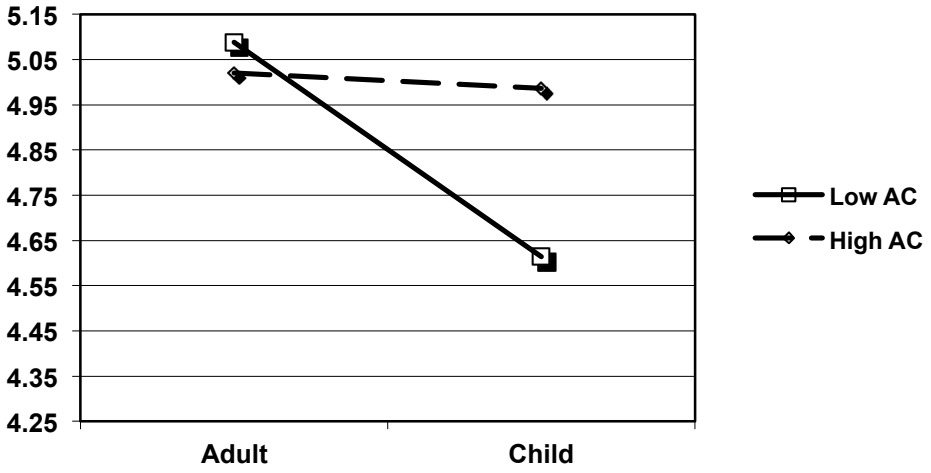
Recidivism Items

We assessed participants' perceptions of the likelihood of recidivism through two separate items: "If the defendant *does/does not* participate in treatment, how likely is it that he will commit a sexual crime in the future?" Based on the bivariate correlation *r* = .41, *p*< .001, (one-tailed) we performed a MANOVA. The resulting Expert Testimony (Clinical Opinion v. Actuarial v. SCJ) x Victim Type (Adult v. Minor) x AC (Low v. High) MANOVA found a significant effect of testimony on each item: Wilks' Lambda = .858: *F*(4, 464) = 9.26, *p* < .001. For the likelihood of recidivism *with* treatment, tests of between-subjects effects revealed participants were least likely to believe the defendant would commit a sexual crime in the future *with* treatment in Actuarial condition (*M* = 2.85, *SD* = 1.10). This differed significantly from both Clinical-Opinion (*M* = 3.59, *SD* = .91) and SCJ testimony (*M* = 3.617, *SD* = .93). For the likelihood of recidivism *without* treatment, participants were least likely to believe the defendant would a commit a sexual crime in the future *without* treatment in the Actuarial condition (*M* = 4.79, *SD* = 1.11). This differed significantly from Clinical Opinion (*M* = 5.32, *SD* = 1.21). SCJ did not differ from either condition.

Expert Credibility

An Expert Testimony (Clinical Opinion v. Actuarial v. SCJ) x Victim Type (Adult v. Minor) x AC (Low v. High) ANOVA was conducted on participants' ratings of expert credibility. We found a victim type x AC interaction approaching significance: $F(1, 233) = 3.43$, $p = .065$, $h_p^2 = .01$. Inspection of the means reveals high AC participants rated the expert as more credible in the child condition ($M = 4.98$, $SD = 1.01$) compared to low AC participants ($M = 4.61$, $SD = .91$). However, for both high and low AC participants these ratings were lower than the Adult condition: high AC (Adult: $M = 5.02$, $SD = .98$), low AC participants: (Adult: $M = 5.08$, $SD = .96$). Figure 3 displays this interaction finding.

Figure 3: Victim Type x Attributional Complexity (AC) Interaction on Expert Credibility



$p = .065$

The main effect of victim type reveals higher ratings of expert credibility in the adult condition than in the child condition: $F(1, 233) = 4.62$, $p = .033$, $h_p^2 = .02$: ($M = 5.05$, $SD = .91$ v. $M = 4.80$, $SD = .93$, respectively). The main effect of testimony was marginally significant: $F(2, 233) = 2.85$, $p = .059$, $h_p^2 = .01$. This result was not strong enough to distinguish any statistically significant between-group differences in post-hoc analysis, however SCJ expert ratings were the highest ($M = 5.13$), Clinical Opinion ($M = 4.84$) and Actuarial ($M = 4.81$).

Gender Effects

To test whether participant gender influenced responses to our dependent measures, two three-way ANOVAs were conducted: Expert Testimony (Clinical Opinion v. Actuarial v. SCJ) x Victim Type (Adult v. Minor) x Gender (Male v. Female). A main effect of gender was found on the belief that the defendant should be placed in a clinical facility: $F(1, 233) = 6.38$, $p = .012$, $h_p^2 = .03$. Females were significantly more likely to believe the defendant should be committed than males were: ($M = 5.06$, $SD = .94$ v. $M = 4.73$, $SD = 1.04$, respectively). Similarly, females were significantly more likely to view the

defendant as a continued threat to society than males were: $F(1, 233) = 9.13$, $p = .003$, $h_p^2 = .04$: ($M = 4.87$, $SD = .83$ v. $M = 4.50$, $SD = 1.03$, respectively). No gender effects were observed on our dependent measures of expert credibility, likelihood of re-offending with/without treatment, and opinion of sexual-risk potential influenced by expert testimony.

Discussion

The goal of the current study was to examine the effect of expert testimony, attributional complexity, and victim type on perceptions of dangerousness and need for commitment in the context of an SVP trial. Considering the importance of determining the most efficient form of expert testimony in this context, we felt it was essential to add to the literature comparing structured-clinical-judgment testimony (SCJ) to both actuarial and clinical-opinion testimony. In addition, in view of the research demonstrating that individuals with complex attributional schemata are more efficient information processors than are those with relatively simple schemata, we expected to observe differences in participants' use of expert testimony as a function of attributional complexity. If so, this result could add to the discussion of the importance of assessing information processing in SVP hearings (see Lieberman et al., 2007). Our decision to examine victim type was largely based on the relatively few studies investigating this factor in the context of an SVP trial (e.g., Guy & Edens, 2006). By gauging the level of seriousness of sexual assault on an adult versus a minor victim, we expected to observe differences in perceptions of dangerousness and need for commitment. Finally, we investigated the moderating effects of participant gender in considering the recent emergence of this factor as critical in understanding perceptions of dangerousness (Foels & Reid, 2010; Guy & Edens, 2006; 2003; Lieberman et al., 2007).

Overall, our participants did not indicate a strong preference for structured-clinical judgment (SCJ) testimony over clinical-opinion and actuarial testimony when evaluating need for commitment and future dangerousness. Specifically, participants perceived clinical-opinion testimony and SCJ testimony as equally influential when assessing future dangerousness. This finding supports Lieberman et al., (2007), who found no significant differences in dangerousness ratings between clinical testimony and guided-professional-judgment testimony regardless of individuals' processing mode. Similar to dangerousness findings, in the current study, SCJ testimony did not differ from either clinical or actuarial testimony on perceptions of need for commitment. However, victim type appeared to moderate the relation between expert testimony and perceptions of need for commitment. Participants were most likely to believe the defendant should be placed in a clinical facility in the clinical-opinion testimony and least likely to believe the defendant should be placed in a facility in the actuarial testimony but only when the victim was an adult. We also found that participants did not distinguish between clinical and SCJ testimony when evaluating the defendant's sexual-risk potential, rating each as equally influential. Finally, we did not observe the same type of overwhelming response to need for commitment when the victim was a child that was demonstrated by Guy and Edens (2006). In this study, participants were exposed to two sexual-assault scenarios

involving a child. This may have increased the likelihood that participants would respond in such an intense manner. In our study, participants were exposed to one of two sexual-assault scenarios in which the victim was either an adult or minor, thus providing one explanation for the differences in victim type.

The effects of SCJ testimony were less ambiguous however, when examining the moderating effects of attributional complexity. When evaluating the extent to which participants relied on expert testimony in determining a defendant's sexual-risk potential, high AC participants in the clinical-opinion testimony condition reported the least reliance on expert testimony and the greatest reliance in the SCJ condition. Alternatively, low AC participants relied the most on clinical-opinion testimony and least on actuarial testimony. It is interesting that we found that high AC participants' opinions of the defendant's sexual-risk potential were less influenced by the case facts when exposed to clinical-opinion testimony and most influenced when exposed to actuarial testimony. Low AC participants exposed to clinical testimony reported their opinion of risk potential was greatly influenced by the facts of the case and least influenced by SCJ testimony. It appears that, for high AC participants, the data-driven testimony was found to be more useful when determining sexual-risk potential. This result supports researchers who find that attributionally complex individuals not only seek out but also apply more useful information when determining causal attributions than attributionally simple individuals do (Murphy, 1994). Overall, these findings provide support for the moderating effects of AC in the context of an SVP hearing and offer insights into how individual differences in attributional schemata contribute to our understanding of perceptions of SVPs.

Participants relied on actuarial testimony when evaluating the likelihood of recidivism, regardless of opportunity for treatment, thus indicating the importance of utilizing static factors in favor of intervening treatments when determining risk. Considering that our sample consisted entirely of undergraduate students, this result mirrors Krauss and colleagues (2010) who found students were significantly more influenced by actuarial testimony than by clinical testimony. The researchers attributed this to the *rational* cognitive processing style of students. It is interesting that, in our study, actuarial testimony differed significantly from both clinical and SCJ testimony when evaluating the likelihood of committing a sexual crime in the future *with* treatment. In addition, higher ratings of expert credibility were found in the adult condition than in the child condition. At first glance, this finding may seem counterintuitive; however, it may appear that, when offending against adults, we need to rely on experts to determine what is deviant. Alternatively, we may rely significantly less on expert testimony when determining deviant behavior against a child. Finally, females were more likely to believe the defendant should be committed as well as a continued threat than were males, a modest result considering no gender effects were observed on our measures of expert credibility, likelihood of re-offending with/without treatment, and opinion of sexual-risk potential influenced by expert testimony. Although this result mirrors Guy and Edens (2003) who found females significantly more likely to commit a defendant described as a psychopath than males were, more research is needed to examine gender differences in expert testimony regarding risk potential.

Limitations and Future Research

In spite of our attempts to balance validity issues with implementing a tightly controlled research design, we recognize that the current study is limited with respect to specific validity issues. To start, ecological validity is hampered by the use of written trial transcripts as stimulus materials as opposed to videotaped or live testimony. In addition, although we attempted to provide consistency and strength among the expert-testimony conditions, the potential exists for different expert testimony to influence our measures. We also recognize the limitations to generalizability through the use of an undergraduate student sample. Although our sample consisted of jury-eligible individuals, the use of a more representative sample of jury-eligible community members is preferred. Finally, a more comprehensive examination of this topic would include a deliberation facet (Sommer, Horowitz, & Bourgeois, 2001; Stevenson, et al., 2010). In the present study, however, we attempted to minimize certain validity issues by including the definition of SVPs as listed in the Massachusetts statute. In addition, we formed our expert-testimony conditions to include both direct and cross-examination of the expert. Nevertheless, it is important to be cognizant of limitations when generalizing findings from simulated trial studies, such as the current study, to the more realistic aspects of jury trials.

To our knowledge, only one study has empirically examined perceptions of the relative efficacy of clinical-opinion, actuarial, and structured-clinical-judgment (SCJ) expert testimony in the context of future dangerousness and civil commitment (Lieberman, et al., 2007). In this vein, the current study offers important findings when evaluating the most influential form of expert testimony in civil-commitment hearings of SVPs. Future studies addressing expert testimony in the context of SVP should continue to assess individual difference characteristics in light of our findings as well as the findings of other researchers (Krauss et al., 2004). Considering the strong moderating effect of ACS, we suggest future research assess the seven specific constructs present in the 28-item measure of attributional complexity. Finally, in the current study we assessed the defendant as a moderate risk. We suggest that future studies vary risk for recidivism as well as the level of seriousness of sexual assault charges. Overall, this study provides important evidence into how contextual as well as individual difference factors contribute to our understanding of SVPs.

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Appendix

Mr. Joseph Cooke is currently thirty-eight years old. Joseph lived with his parents and brother in Arkham, Massachusetts and attended Arkham High School graduating in 1988. He moved out of his home at age 18. Joseph worked at a local machine shop immediately out of high school and began living with his girlfriend Jessica Rojas. He and Jessica continued living together for three years when, in 1991, they ended their relationship due to Joseph's infidelity. Joseph moved out of Jessica's apartment and began renting his own apartment in town.

In 1992, Joseph Cooke began working part time at the Gold's Gym in Arkham. Joseph was frequently disciplined at work for being lazy. Several customers complained that Mr. Cooke was sneaking into the women's locker room. Gold's Gym contacted the local Police Department, who investigated Mr. Cooke and arrested him on charges of voyeurism. Mr. Cooke pled guilty to the charge and was sentenced to two-year probation in 1993.

In the summer of 1995, Joseph Cooke started working for Allied Landscaping. In July, he started working on Lora Jacoby's lawn. Lora Jacoby, 30, lived with her *sister/daughter* Diane, *28/9*, in her home. During his time there, Mr. Cooke entered into the home several times for lunch breaks. Mr. Cooke worked at the Jacoby home until August of 1995. He later stated that he would return several times a week until the autumn of 1995 to watch Lora Jacoby and her sister.

On the evening of October 14, 1995, at approximately 11:45 pm, Joseph Cooke returned to the Jacoby home. Using a crowbar, Mr. Cooke entered through the kitchen door. He went up the stairs to the second floor, where he entered the room of Diane. Once inside the room, Mr. Cooke showed Diane a knife and told her that he would not harm her if she remained quiet. Mr. Cook then inserted his fingers into Diane's vagina. Lora Jacoby, sleeping in her first floor bedroom, was not awakened by the assault. Mr. Cooke fled from the house through the kitchen door.

The Arkham Police Department was able to obtain fingerprints from the kitchen door and the doorknob of Diane's bedroom doors. The fingerprints matched those taken of Joseph Cooke after his previous arrest. Joseph Cooke was apprehended three days later. He accepted a plea bargain and was convicted of two counts of sexual assault and breaking and entering. Joseph Cooke was sentenced to twelve years in prison in 1996.