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Research on Dangerousness and the Assessment and Prediction of Violent Behaviour:
Special Research Report

Centre of Criminology
University of Toronto
1987
Note on the Contents

Part I

Part I of this report consists of a covering letter (dated August 14, 1987) from the University of Toronto Centre of Criminology, and a report prepared by Christopher D. Webster for the Ministry of the Solicitor General in 1987: "Conducting a research program on dangerousness: indications for future study and indications for policy development."

Part II

Part II consisted of photocopies of "some thirty articles prepared by Dr. Webster and various colleagues over the last few years. The research reported in these articles was directly and indirectly facilitated by the Ministry's contribution to the Centre...". These articles are listed in the covering letter found at the front of the volume.

Since most of the articles are easily available in their published format, they have been removed to reduce the size of the volume. Part II now contains the following items, which were not available in published versions:


- Physical attractiveness, dangerousness and the Canadian Criminal Code. By Victoria M. Esses and Christopher D. Webster.
To: The Research Division
   Ministry of the Solicitor General,
   Canada

Re: FOCUSED RESEARCH
(Contributions Agreement)

As you will recall the topic for our special research report to be carried out as part of our recently completed agreement relating to your contribution to the Centre of Criminology for 1984-1987, related to research on dangerousness and the assessment and prediction of violent behaviour. The report that follows describes the work carried out in this area as a result of your contribution to the Centre.

The first part of the report is a detailed report prepared by Dr. Christopher Webster specifically for this purpose and is entitled "Conducting a Research Programme on Dangerousness: Indications for Future Study and Indications for Policy Development". The report outlines the general background to the project, describes studies that were carried out on the prediction of dangerous behaviour, studies on Part XXI of the Criminal Code, and several experimental studies. Following a brief summary of some of the editorial work and literature reviews by the project team, the report goes on to describe the work that is still in progress, indications for future research in the area, and concludes with a section on indications for policy development as seen by the principal investigator.

The second part of the report consists of some thirty articles which were prepared by Dr. Webster and various colleagues over the last few years. The research reported in these articles was directly and indirectly facilitated by the Ministry's contribution to the Centre, although some of the research also received support from other granting agencies as noted. The attached articles expand various aspects of the research topic and are referred to in the main body of the report. The articles, which are labelled Appendix A through to Appendix C1, are as follows:


Finally, we would like to take this opportunity to thank the Ministry once again for your support of criminological research at the Centre of Criminology, University of Toronto, through your Contribution to the Centre. The Contribution touches virtually all the research carried out at the Centre as we have noted in the following acknowledgement contained in our Handbook and Report for 1987-88:

"the Centre particularly wishes to thank the Solicitor General of Canada for its annual contribution to the Centre which has aided, among other things, the general planning, development and continuation of many of our research projects. Without this contribution, many of our research projects would have suffered considerably or, indeed, might not have been possible."
CONDUCTING A RESEARCH PROGRAMME ON DANGEROUSNESS:
INDICATIONS FOR FUTURE STUDY
AND INDICATIONS FOR POLICY DEVELOPMENT

Christopher D. Webster
Centre of Criminology
University of Toronto

A report to the Ministry of the Solicitor General, Canada.

While the research reported in these articles was supported by several different granting agencies, the research was directly and indirectly facilitated by the Solicitor General's contribution to the Centre of Criminology.

July 1987
GENERAL BACKGROUND

The main project summarized in this brief report began shortly after the inception of the Metropolitan Toronto Forensic Service (METFORS) in the fall of 1977 (see Turner, 1979). METFORS was established under the auspices of the Clarke Institute of Psychiatry as a brief assessment service for the Toronto courts. It was expected that the unit, in addition to providing routine evaluations, would become a centre for research and scholarly activity. The prediction of dangerous behaviour is one of the main issues in forensic psychiatry and clinical criminology and, once METFORS was operating, it was decided that a major venture was needed in this area. Accordingly, it was tackled in early exploratory work in which we attempted to learn more about the kinds of decisions made by forensic psychiatrists and other forensic clinicians.

Our early work was of two kinds. First, we examined "dangerousness" incidentally as we tried to find out how many fitness-to-stand trial assessments were conducted and with what effects in selected Canadian cities over a one-month period in the month of July 1978 (see Menzies, Webster, Butler and Turner, 1980, Appendix A; Webster, Menzies, Butler and Turner, 1982, Appendix B). Second, we studied in considerable detail the decisions made by clinicians at METFORS as they evaluated some 600 prisoner-patients during 1978 (Menzies, Jackson, and Glasberg, 1982, Appendix C). All of this work, coupled with some M.A. dissertations from the Centre (Henderson, 1980; Pivnick, 1981), eventuated
That book summarized much of the literature extant at that time on fitness-to-stand trial and the prediction of dangerous behaviour. Writing the volume helped us come to grips with the fundamental theoretical, methodological, and policy issues in the dangerousness debate. By "dangerousness debate" we refer to the fact that some researchers, clinicians, and academics hold that the task of prediction is inherently too complex to admit of scientific exploration at this time (Stone, 1985). Those on the other side of the fence, while admitting to the difficulties, argue that there is much to be gained through refinements in method (Dietz, 1985; Greenland, 1985; Monahan, 1981). The Webster et al (1982) book makes preliminary reference to the major study outlined in this report and considered in more detail below (see Appendix H of the book, included here as Appendix E).

Studies on the Prediction of Dangerous Behaviour

Our idea was to construct a scale for use by clinicians as they make routine assessments of "dangerousness" for the courts. No such instrument existed at the time. The closest we could come was an article by Megargee (1976). In this paper Megargee sketches some of the factors that perhaps ought to be included in such a scale. With a scale adapted from the Megargee paper we then trained METFORS' clinicians in its use.
But after two months or so it became evident that, despite our effort to obtain a reasonable degree of consistency in the use of the scale, individual clinicians varied considerably in the way they understood the items. Indeed, some used the items in ways quite different from those intended by the authors.

These revelations spurred us then to develop with our clinician colleagues a new rating scheme. We met with them regularly and together hammered out a set of variables which they thought to be important. After that we wrote specific definitions (see Slomen, Webster, Butler et al., 1979 unpublished, Appendix F). As the so-called Dangerous Behaviour Rating Scheme (DBRS) matured, so did our ambitions. We thought we could videotape the actual interaction between clinicians and prisoner-patients during brief assessment so that, later, we could search for subtle cues relating to "dangerousness". This plan was approved by the University of Toronto's Office of Research Administration. Yet we found, when we actually tried to put it into action, it was hard to obtain properly informed consents. So this snag and others forced us to revert to placing main reliance on the DBRS. Undaunted, we proceeded to use the DBRS on some 230 brief assessment patients during the early months of 1979. Clinicians completed the 22-item DBRS as did two specially-trained coders who observed assessment interviews from behind a one-way mirror.

As we evolved the "design" of the "1979 Study" it occurred to us that we could perhaps interview after two years as many of our former patients as possible. Yet as we thought it through,
we again began to see ourselves limited by ethical and practical considerations. We worried that, as researchers, we might find ourselves in an anomalous position if some of our subjects gave us the very information we sought. If they "confessed" in follow-up interviews to serious crimes we might well have been legally obliged to act against our former patients. There was, too, the problem of tracking these persons. In the end, we settled for a search of files, mainly hospital and correctional, at two years post assessment. This undertaking was financed partly by the Centre, partly by the Department of Justice, Canada, and partly by the Ministry of Health, Ontario. It was, as can be imagined, a major and time-consuming effort. The general conclusion from all this work is that the DBRS, though reasonably reliable and internally coherent, lacks much in the way of predictive validity (Menzies, Webster and Sepejak, 1985a, Appendix G; Webster, Sepejak, Menzies, Slomen, Butler and Jensen, 1984, Appendix H).

One difficulty with the "1979 Study" was that the sample size was relatively small. As the study progressed it did, however, occur to us that this problem could be overcome to a degree through the use of our data set from the 600 or so persons assessed at METFORS briefly throughout the full previous year. Although we did not have DBRS predictions on this sample we did have global opinions (on a four point scale). Accordingly we instituted a two year follow-up of these additional 600 persons. Again, the aim was to link prediction with outcome scores.
What we found was that overall prediction-outcome correlations were low (of the order of about +0.23 overall) but that there was considerable variability in predictive ability among clinicians (Sepejak, Menzies, Webster and Jensen, 1983, Appendix I; Sepejak, Webster and Menzies, 1984, Appendix J). We were also able to make some statements about the relationship between confidence in and accuracy of predictions (Menzies, Webster and Sepejak, 1985b, (Appendix K) and the connection between type of psychiatric disorder and eventual outcome at two years (Menzies, Webster and Sepejak, in press, see Appendix L for copy of proofs).

Around this time Robert Menzies, who had been involved in the project almost from its inception, decided to extend the "1978 Study" and turn it into a Ph.D. thesis (see Appendix M for a copy of the title page, abstract, acknowledgements, and table of contents). With the outcome data in hand and scaled he went back to the original assessment files and coded it afresh. This painstaking work told us much about how the police and clinicians ascribe "dangerousness". The thesis, completed through the Department of Sociology at the University of Toronto, was sponsored by the Centre (with Professor Richard Ericson as supervisor and Professors Doob and Webster on the committee). It yielded more precise information than was previously available about the prediction-outcome relations but, as well, it provided a great deal of new information about the "careers" of these "mentally disordered offenders" as they weave back and forth between the
mental health and criminal justice systems (Menzies, in press, Appendix N; Menzies and Webster, 1987, Appendix O). Robert Menzies is well advanced in the process of rewriting his substantial thesis into book form. It will be a major contribution to the field.

Studies on Part XXI of the Criminal Code – 'Dangerous Offender'

As our experience deepened with issues surrounding the clinical prediction of violent behaviour, we began gradually to become interested in wider issues. In the spring of 1983 we were asked, through the Centre, to conduct a study of the effect of Part XXI of the Criminal Code, the Dangerous Offender provision. This legislation, reworked in 1977, had attracted the interest of planners and administrators in the Department of Justice, Canada. By the summer of 1983 a contract had been signed between the Centre and the Department. With Christopher Webster and Bernard Dickens as co-principal investigators and a number of other Centre members and students in support, it became possible within the space of some four months, to produce a report dealing with the legal and scientific issues of main interest. It helped that an M.A. student, Douglas MacKay (1983), was at that time completing a descriptive study of persons declared 'Dangerous Offenders' in Ontario. This information, together with some results from an internal study by the Ministry of the Solicitor General and some of our own interview data, formed the base of information. The eventual report entitled Deciding
Dangerousness: Policy Alternatives for Dangerous Offenders (1983) came down against the idea of indeterminate sentencing. As well, it cast considerable doubt on clinical ability to predict dangerous behaviour. The report was accepted by the Department and translated into French. Subsequently the English form was reworked and put out as a Centre monograph under the title Constructing Dangerousness: Scientific, Legal and Policy Implications (Webster, Dickens and Addario, 1985, Appendix P).

By the time Constructing Dangerousness was published such few descriptive data as were available on the population of Dangerous Offenders were dated. Accordingly, Janine Jakimiec, a Centre M.A. student, undertook for her dissertation to write a descriptive account of the 60 persons then declared to be Dangerous Offenders. The idea was that the Ministry of the Solicitor General would arrange access to records and to provide a small grant. In the event, it proved cumbersome to negotiate funding and, instead, it was decided to absorb the travel and other costs through the sustaining grant. That study was completed during the summer of 1985. In due course a reworked version appeared as a Ministry Technical Paper (Programs Branch User Report No. 1986-44 by Jakimiec, Porporino, Addario, and Webster, 1986). Very recently, a further refined version has appeared in print (Jakimiec, Porporino, Addario and Webster, 1986, Appendix Q). The article by Jakimiec et al. provides basic demographic information about the population, shows which provinces are
are using the legislation and which are not, and gives limited data about conduct of the prisoners in confinement.

It has been a matter of considerable interest to us that, as a result of this work and the publications which have flowed from it, one of us (C.D. Webster) has been called to testify in court on some half dozen occasions in the past two or three years. In the course of Dangerous Offender hearings the courts have a tendency to interest themselves in the general issues of the predictability of violent behaviour. Although it would not be possible or even wise to make many such appearances, we have been struck with the use which the courts have made of our work. _Constructing Dangerousness_ has had an influence greater than we expected despite the fact that, the preparation of a draft bill notwithstanding, no change in the law has occurred or seems likely to be made in the near future. Some of the main points from _Constructing Dangerousness_ were eventually embodied in a short "off the cuff" piece written for defence lawyers (Webster, 1985, Appendix R). We would wish to stress the importance of this rather practical side of our work.

**Experimental Studies**

One of the difficulties with both the two-year, follow-along, prediction-outcome studies at METFORS and the descriptive study of Dangerous Offenders is that we as researchers have been unable to influence greatly the design of the projects. We have had to make what sense we could of the data which lay before us.
Yet from time to time we have been struck by certain ideas which seemed worthy of more detailed study under experimental conditions. For example, we wondered what clinicians and courts understand by certain probability statements like "moderately dangerous" and even particular phrases from Part XXI of the Criminal Code. This topic was explored in some detail in the course of an M.A. thesis in psychology (Rosen, 1983). The general conclusion was that much of the present confusion may arise from the lack of precision in terms used in everyday transactions within clinics and courts (see Webster, 1984, Appendix S, for a minor note on the topic).

We were also struck by the fact that there seemed to be some evidence from our Part XXI work that Dangerous Offenders may be a particularly physically unattractive-appearing group. This led us to conduct a small project, under the auspices of the sustaining grant, to examine the phenomenon. Victoria Esses, then a Ph.D. student in psychology with a minor study concentration in criminology, used clinical files to create scenarios. These were linked to photographs of persons supposedly "accused" of sexual and non-sexual crimes of varying seriousness. As anticipated, we found that attractiveness is a factor of some importance and that, likely, it plays a role in clinical and judicial determinations of dangerousness (Esses and Webster, 1985, unpublished, Appendix T).

The most ambitious piece of our work of this kind was completed by Margaret Jackson in the course of her Ph.D. research. This
dissertation was submitted through the Department of Psychology (with Professor Doob as chairman, and Christopher Webster on the committee) in the spring of 1985 (see Appendix U for a copy of the title page, acknowledgements, abstract and table of contents). The research itself arose from our earlier collaborative work (Menzies, Webster and Jackson, 1982). Jackson did two new studies, one with a large group of lay subjects and one with various professional groups. The idea was to find out how clinicians and others form judgements around various key issues in forensic psychiatry and clinical criminology. Dangerousness was one of these issues. The results of the work with lay subjects has just become available (Jackson, 1986, Appendix V). Results of the work with professional groups will appear in due course. Jackson's work is important because it takes clinical questions and places them within the wider context of a new and important literature on making judgements under condition of uncertainty. Elsewhere we have summarized her main findings in detail and explored the implications which arise from them (See Appendix W attached, pp 180-181).

**Scholarly Reviews/Editorial Work**

Of late we have written reviews of various aspects of the literature on the clinical prediction of dangerous behaviour (Webster and Menzies, in press, Appendix W; Menzies and Webster, in press, Appendix X for a marked copy of the final manuscript; Webster, in press, Appendix Y; Pollock and Webster, in press,
Appendix Z). Perhaps our most important contribution of this kind has been the edited book Dangerousness: Probability and Predictions, Psychiatry and Public Policy (1985, see Appendix A' for title page, table of contents, and foreword). This was designed to extend Monahan's (1981) earlier definitive text. Aside from a notable contribution by Bernard Dickens (1985) of the Centre (Appendix B'), the book contains a piece on the "1978 Study", already noted, by Menzies, Webster and Sepejak (1985b and attached as Appendix K). There is also a speculative piece by Webster and Ben-Aron (1985, see Appendix C'). The book has attracted favourable reviews by the British Journal of Psychiatry, the American Journal of Psychiatry, and the American Journal of Forensic Psychiatry. Dangerousness was also a sub-theme in our other 1985 edited book, Clinical Criminology: The Assessment and Treatment of Criminal Behaviour (Ben-Aron, Hucker and Webster, 1985). That book contains chapters on assessment and profiling by Menuk (1985) and Dietz (1985) respectively.

Work in Progress

The original METFORS work on the prediction of dangerousness was, as already noted, funded by the Ontario Ministry of Health, and the Department of Justice, Canada. Over recent years we have received additional help via the Clarke Institute Research Fund, the Canadian Psychiatric Research Foundation and the Ministry of the Solicitor General, Canada (through its special Fund for Independent Research). Our most recent award has been from
the Social Sciences and Humanities Research Council of Canada (C.D. Webster and R.J. Menzies). This $34,000 grant is administered through the Centre of Criminology. It is allowing us to do a six year follow-up of the entire 200 or so members of the "1979 Study" and approximately half of the about 600 persons in the "1978 Study". The eventual data will cast further light on the prediction of dangerousness and, as well, the psychiatric/criminal careers of patients assessed several years previously.

Three dissertations are in progress. One, by Meagan Daley, is virtually finished. It deals with prediction of harm to self. She has used our "1979 Study" data base to examine an important issue so far left unaddressed by our group. Two others are now beginning. One student, like Daley, will take advantage of our existing data base. Marion Malone is to sift the data emerging specifically from sex offenders over six years. The other student, Lorraine Yankee, is tentatively planning to do a retrospective file survey of the actual physical damage done to victims by child molesters.

**Indications for Future Study**

The main emphasis over the next two years or so will be on completing the six year follow-up study. This will entail our making further application to SSHRC in the early fall of 1987. Our funds are close to being exhausted and we would like not to have to draw from the sustaining grant any more than absolutely necessary. In the light of favourable reviews received
with the initial award, we are reasonably confident that we can achieve this aim.

As well as completing the 6-year follow-up study, which involves collecting data from previously untapped sources, we have a number of other options. First, we wish to examine METFORS repeat remands in more detail. As noted above, the "1979 Study" on the DBRS was based on assessments completed January - June 1979. But we have on file DBRS ratings made by psychiatrists (but not independent coders) until September 1980. Our interest would be to examine the particular sub-sample, one which includes those patients remanded again to METFORS over the ensuing fifteen months. Since predictions were made about these persons, and since the file data are readily available, it would be fairly easy to check whether or not the predictions held up. Second, our write up of the 1979 Study of the DBRS (Menzies et al, 1985a) is based solely on the coders' predictions. Although we have on file all of the DBRS forms completed by clinicians, these have never been analyzed. It is a task we badly need to complete. As well as checking the predictive validity, we need also to repeat our factor analyses since it could turn out that the scale is more internally robust when completed by coders than by uninvolved raters (and, it follows from the first point, that we would, in fact, be able to have a sample of some 900 rather than 200 cases). Third, as well as the formal DBRS sheets, not all of which have been properly analyzed, we have detailed
notes made by the research project coordinator at the time of the assessment by the clinical team. These, when coded, could prove to have predictive power. Fourth, when the "1979 Study" came to a conclusion we took the opportunity to interview the psychiatrist leaders of the BAU assessment teams. These interviews have never been analyzed. Fifth, during the course of the "1979 Study" we had one psychiatrist see some 30 patients without benefit of background material of any sort. He later saw other patients for brief assessments with the usual materials in hand. This needs to be examined as we have long been interested in the effects of background information upon psychiatric decision making (Menzies, 1985).

**Indications for Policy Development**

There are various recent official documents which could be used to set the stage for an extended discussion of policy issues relating to the assessment of dangerousness. The topic is touched on in the Law Reform Commission of Canada's 1976 publication entitled *Mental Disorder in the Criminal Trial Process* and is given considerable attention in the Department of Justice's 1984 report on *The Mental Disorder Project*. The most recent relevant work is the 1987 Report of the Canadian Sentencing Commission. A thorough study of this document is needed as it relates to dangerousness issues. This may be undertaken at some future time. For the moment it is necessary only to raise the central example.
Sentencing Reform takes a firm stand against the use of indeterminate sentencing. The authors argue that the Part XXI provisions constitute an exception to general criminal law principles (p.212). It is argued that it is improper to place "primary focus on the offender rather than the offence" (p.212) and that emphasis should instead be on "real-time sentencing". The Commission, citing the 1985 Webster, Dickens and Addario study in support of its' conclusions - see p.140 - (attached here as Appendix P), recommends the repeal of present dangerous offender provisions. In its' place the Commission would like to allow the court power to impose an "exceptional sentence" (see pp. 213-217). According to this scheme the court could exceed the maximum sentence by up to 50 percent for certain offences of a "serious personal injury nature". After conviction for an offence carrying a maximum sentence of 12 or 9 years it would be possible to apply to the provincial Attorney General for an exceptional sentence. The initial part of the sentence would be served as "straight time" (i.e. no parole possible) with a court review at the end of that period. The "enhanced portion" would similarly be served in "straight time" but with a review every two years.

What is now needed is a series of studies to examine experimentally the implication of the Commission's recommendations around exceptional sentencing. We need to construct careful case synopses from existing Dangerous Offender files (i.e. dealing with index offence and criminal background) and, using judges
as subjects, find out how they would apply the proposed new provisions. That is, it would be wise to test the proposed sentencing model. This could be done by having judges "sentence" under both the old (indeterminate) provisions and the new proposed (time-limited) sentencing option. In general, our work now needs to take an experimental turn to test these and other ideas put forward by the Sentencing Commission.
APPENDIX REFERENCES


ADDITIONAL REFERENCES


THE ASSESSMENT OF DANGEROUS BEHAVIOUR:
TWO NEW SCALES

D. Slomen, C.D. Webster, B.T. Butler, et al.

W.P. #14, 1979

This project was supported by Grant DM395, "The Assessment of Dangerousness", provided by the Ontario Ministry of Health.

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THE ASSESSMENT OF DANGEROUS BEHAVIOUR: TWO NEW SCALES

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J. Pepper, M. Penfold, D.S. Sepejak, L. Loftus, D. Byers, T. Chapeskie,
R.J. Mahabir, M. Schlager, K. Beckett, M. Ronald, A. Shinkoda,
A. McDonald, R. Glasberg, M. Jackson, R. Allgood, R. Harman, K.
Keeling, C. Taylor, M. Murray, D. Farquharson, I. Lawson,
L. Hermanstyne and L. Bendall.

'You can't possibly give yourself away more than you've done already, my dear fellow. Why, you're in a rage ...' (Porfiry to Raskolnikov, p.365).

'By this time he was almost running up and down the room, moving his fat little legs more and more rapidly, his eyes fixed on the ground, with his right hand behind his back and with his left hand performing all sorts of extraordinary gestures which were singularly out of keeping with his words'. (Description of Porfiry during an 'interview' with Raskolnikov, p.353).

'He sat pale and motionless, still peering into Porfiry's face with the same intense concentration' (Description of Raskolnikov during 'interview' with Porfiry, p.355).

'He'll turn pale, as though on purpose, as though in mere play; but unfortunately, he'll turn pale too naturally, too much like the real thing, and again he arouses suspicion'. (Porfiry discussing 'human nature' with Raskolnikov, p.357).

'Your lip's twitching again, just as it did before, Porfiry murmured almost with sympathy'. (p.468).

The quotations above from Dostoyevsky's *Crime and Punishment* first published in 1866(1) come from the scenes in which Raskolnikov the student is in discussion with Porfiry the Examining Magistrate. Although Raskolnikov has murdered an old lady, there is actually no strong evidence against him ('You have no facts', p.365) and Porfiry has in this case nothing but his method of observation ('this blasted psychology', p.464). For present purposes, these dramatic quotations

(1) Page references are to the Penguin Edition: Middlesex, 1951.
are of interest simply because they suggest how, during interview, the examiner comes to form conclusions at least partly on the basis of change in voice, quality, body posture, facial 'tics', and so on.

It might be argued that what is appropriate by way of method for an examining magistrate (concerned as he is with determining guilt) is not at all appropriate for an examining doctor (interested as he is in the individual's state of mind and mental health). By citing these lines we do not infer that mental health professionals perform a role similar to Court officials. Yet the fact is that such workers must become more than usually skilled in the art of observation. And we do not have to look beyond standard texts of psychiatry (cf., Freedman, Kaplan and Sadock, 1975) to find out that the skilled clinician is the one who has an "ability to recognize unconsciously determined nonverbal clues" (Hollander and Wells, 1975, p.778). These authors remind us that the psychiatrist has much to guide him or her during the first meeting. As the patient enters the room there is his gait to be studied (since unsteadyness may point to diffuse brain disease, chorea, spinocerebellar degeneration, etc.), once he is seated there is his grooming to be analysed (since lack of attention to dress and appearance may indicate emotional difficulties), and after he is settled there is posture to be dealt with (since, for example, a stooped, flexed posture with few automatic movements could suggest Parkinson's disease or diffuse hemispheric disease). Almost 'by second nature'

(1) A good case can, though, be made for Crime and Punishment being an important source for students of the mentally disordered offender. Whether or not Raskolnikov was mad before, during, and after the offence was of interest to Raskolnikov himself, his friend (Razumikhin), and his doctor (Zossimov).
the psychiatrist will look at the patient in order to obtain clues as to general health. It could be, for example, that looseness of clothing may indicate recent weight loss. Skin colour and hair condition are often important in these analyses.

The psychiatrist during the initial meeting has to listen carefully to his patient. If speech is slow it may be due to depression, to diffuse brain disease, or perhaps to other factors. If the voice is slow and low pitched there could be a possibility of hypothyroidism. Easy tiring of speech could suggest neurasthenia. And it may be that even a few mispronunciations may suggest aphasia and the possibility of a lesion in the dominant hemisphere. Vagueness of speech might bring to mind organic brain dysfunction or various kinds of psychological disorder.

There is no need here to extend this catalogue. The psychiatrist learns to observe his patient closely, to listen carefully, and indeed to pay attention to olfactory cues. In attempting to discern whether or not the patient is suffering from some kind of mental disorder, the psychiatrist has many sources of information to guide him. With experience he learns to narrow the possibilities, and, if appropriate, to formulate a diagnosis.

In regard to our particular problem of interest, the prediction of future dangerous behaviour in forensic psychiatric patients, the psychiatrist faces a task even more complex than that of forming a
diagnostic opinion. Here the clinician does not have an International Classification of Diseases (ICDA-8 or 9) or a Diagnostic and Statistical Manual (DSM-2 or 3) to guide him. Despite the fact that in the literature he is frequently criticised for his tendency to over-predict dangerous behaviour (e.g., Dershowitz, 1969; Kozol, Boucher and Garofalo, 1972), the local Court expects him to be able to offer informal opinion in these matters. This is of course particularly so in cases where the patient's mental stability is in doubt.

In the present project we follow Shah in his recent assertion that: "We don't know which clinicians are good predictors. And even worse, the good predictors don't know that they are good predictors ... Some clinicians seem to attend to very subtle cues" and with respect to the prediction of dangerous behaviour we too would like to think that: "Surely it can be done to some degree, though with serious limitations and with great difficulty" (see Webster, 1978, unpublished).

Our group of colleague clinicians has taken the view that a new scheme, based on inter-disciplinary study, needs to be devised in order to assess dangerous behaviour in the clinic. This paper aims to accomplish three tasks: (1), to make available a set of definitions forged from our various group meetings within the Brief Assessment Unit (BAU) at METFORS; (2), to describe in outline how those definitions were used by members of the B.A.U. staff in the course of a set number of routine group interviews; (3), to offer some comments about what the clinicians themselves thought of the scheme following a protracted period of use; and (4), to suggest how in the future we shall attempt to verify the rating scheme more fully and more formally.
I. A SCHEME FOR CLASSIFYING TYPES OF DANGEROUS BEHAVIOUR

As mentioned above, we have developed a rating scheme for the prediction of dangerous behaviour. The scheme was constructed by group effort and then used as the basis of a research project over a four month period within the daily routine of a forensic psychiatric assessment unit. In order to familiarize the reader with the clinical setting into which the rating scheme was introduced, a brief description of the assessment service will precede discussion of the scheme's development and present form.

A. Clinical Setting

The Brief Assessment Unit (BAU) of the Metropolitan Toronto Forensic Service (METFORS) functions primarily to assist the court decisions about an accused person's fitness to stand trial. As well, the B.A.U. offers opinion, when appropriate, about the individual's general state of mental health, his prospects for benefiting from treatment, his likelihood of being dangerous to himself or others in the future,(1) and other matters related. An interdisciplinary team of clinicians interviews up to four patients daily. Interviews are carried out in the morning and the patients usually undergo some psychological testing during the afternoon. Very often time limitations pressure the clinical team into working quickly(2). This pressure is felt most acutely by the main interviewer who must prepare a written report of

(1) It should be noted that the reports to the Court do not convey information about dangerousness as a matter of routine.

(2) The reader will of course recognize that the team can suggest to the Court that the individual be remanded for closer analysis as an inpatient over some 30 days.
the assessment for the Court. The report accompanies the patient back to the detention centre at the end of the day. Interview, discussion and testing must proceed as efficiently as possible in order to accommodate an often heavy case-load within the single-day time period.

B. Development of the present rating scheme

On the surface it is fairly easy to devise a rating scheme to cover dangerous behaviour. (1) There have in fact been a few previous attempts to develop such a system (see, for example, Marcus and Conway, 1969; Kozol, 1972). Yet it is in fact a very difficult task. It is hard for a group of clinicians and researchers to reach agreement about the dimensions of so-called dangerous behaviour (for example, it can be argued that the industrialist who knowingly pollutes water sources possesses a greater potential for dangerousness to others than the typical armed robber). It is also the case that what one clinician or researcher may mean by a given term in more-or-less everyday use may not at all correspond to his colleague's view (and even when they assume themselves to be in accord, protracted discussion frequently reveals striking differences in meaning). The problem of meaning is, of course, compounded when the clinician group is drawn from a variety of disciplines, each based on different theoretical assumptions about the nature of man. And there is too the problem of

(1) We too have found it simple enough when it is a matter of one clinician and one researcher working together on the basis of a closely shared interest and study of a particular part of the literature (See Dacre and Webster, 1978, unpublished).
finding sources of motivation sufficiently strong to keep a group of colleagues at work on the tedious task of discussing definitions (since some at least will quite naturally see the exercise as of marginal interest to them and be under pressure to spend their time in other ways).

In our work within the B.A.U. we had to find ways of dealing with these difficulties. Agreement was reached in August 1978 that we would meet weekly in order to establish a set of workable definitions (1) and that we would test our ideas as we went along. Over the next several weeks many such meetings were held. Some went very well. Agreement about terms was reached quickly. Some went poorly. The meetings ended with no conclusions and, worse, the distinct feeling that agreements reached on previous occasions were worthless. In general we were finally successful in producing a scheme which met most of the criteria outlined in a previous report (see Webster, Butler, Jensen and Turrall, 1978, unpublished) that is, we had a system which had a set of defined terms, which was neither too complex nor too simple, which allowed the rater to indicate the strength of his or her opinion, and which did not appreciably disrupt the ordinary daily routine of the clinic.

One of the strengths of the present system, or so we would like to argue, is that it permits the clinician to indicate the extent to which he is confident of his judgment. In our earlier notes (see Webster et al, 1978, unpublished) we make it clear that, just possibly

(1) It should be noted that during some of these meetings we considered the ideas of Megargee (1976) and Scott (1977).
clinicians may predict better when they are confident of their judgment. (1) Another strength of the present system, or so we think, is that it contains a fairly large number of terms. We suggest that, given the appropriate follow-up data, it may be possible to show that we can predict some kinds of dangerousness quite well and others more poorly. That is, we were in no way attempting to produce what Schiffer (1978) refers to as a "sanity meter"(2) when he rightly cites in a disparaging way the efforts of previous investigators (eg., Marcus and Conway, 1969) to arrive at a simple overall 'dangerousness score'.

C. The Rating System

In order to gain a full appreciation of the amount of information collected during a brief assessment, the reader would have to peruse a set of forms used by clinicians in all of the various disciplines.

(1) Of course, the opposite finding would be of great interest as well.

(2) Schiffer (1978) is here referring to a notion put forward by the science fiction writer, Sheckley and following Dershowitz (1973), cites the following passage from his book Pilgrimage to Earth (Bantam, 1957):

"The meter, installed in all public places, registered from zero to ten. A person scoring up to three was considered normal; one scoring between four and seven, while within the tolerance limit, was advised to undergo therapy; one scoring between eight and ten was required to register with the authorities as highly dangerous and to bring his rating below seven within a specified probation period; anyone failing this probationary requirement, or anyone passing the red line above ten, was required either to undergo immediate surgical alteration or to submit himself to the academy - a mysterious institution from which no one returned."
For the sake of simplicity, however, we show a copy of the form used by psychiatrists, attached as Appendix A. Though psychologists, nurses and social workers offer opinions within their particular areas of competence, the forms are the same with respect to (i), general recommendations, and (ii), the dangerousness scheme. An additional more highly specialized rating scheme used with some, but not all, of the clinicians is described in a third sub-section of this part of the report.

(i) General Recommendations

In related research we have found it very valuable to have clinicians record in standard form their impressions regarding the patient's fitness to stand trial, need for treatment and so on (see Menzies et al., 1978, unpublished, where we show how demographic variables interact with these opinion variables). Categories used in previous research, as well as in the present venture, are described below.

1. Fit to be granted bail at present - The specific criteria to be considered are dangerousness, risk of elopement and risk of committing further offences while in the community. The sorts of questions to be addressed are:

(A) Will the patient elope if released at present and fail to appear in Court?

(B) Will the patient re-offend if released at present?

(C) Will the patient pose an immediate danger to himself or others if released at present?
2. Fit to stand trial at present - The issues to be dealt with here are whether or not the patient is capable of appreciating the nature of his charges, of understanding basic courtroom proceedings and of advising counsel. This category is addressed when the assessment is during the pre-trial stage (i.e., in over 90 percent of cases).

3. Fit to receive sentence at present - For our purposes, this category addresses synonymous issues to that of "fit for trial" and is relevant only in the small number of pre-sentence assessments.

4. Patient mentally disordered at present - The patient is considered mentally disordered if a psychiatric classification can be assigned under ICDA - 9 with the important exceptions of personality disorders, drug and alcohol addiction and sexual deviation.

5. Certifiable at Present - This is to be seen as a gross index of the severity of the patient's mental condition. The question to be considered here is, "If this individual were in the community, would he fulfill the certification criteria of the Provincial Mental Health Act (assuming he was unwilling to enter the hospital voluntarily)?"

6. Inpatient hospital treatment needed now - Here the issue is one of determining whether or not the patient is mentally ill to the point of requiring inpatient hospital treatment. Is therapy and/or medication in such need that they must be administered in a psychiatric facility?

7. Further analysis of patient needed now - This category refers to the legal and medical questions that must be answered from the
assessment of the patient (i.e., fitness for trial, potential for re-offending, etc.). If these questions cannot be answered adequately through a brief assessment, then a recommendation for a thirty-day remand will probably be warranted and this is what the clinician will indicate.

8. Outpatient care required - Usually an affirmative response under this category would apply in the case of a patient who would benefit from psychiatric treatment on an outpatient basis.

9. Locked Hospital/Incarceration required - A locked hospital (i.e., a secure hospital specializing in the treatment of mentally disordered offenders) is differentiated from simple inpatient hospitalization in that some definite form of restraint and direct supervision is seen as necessary. Incarceration refers to detention in a prison, reformatory, or detention centre. In the present rating scheme the clinician was asked to indicate either locked hospital or incarceration by circling the appropriate term.

10. Cooperation in treatment likely in future - Under this category the clinician considers the patient's ability to recognize a problem and his motivation and ability to engage actively in a treatment programme.

(ii) The Scheme for Rating Dangerous Behaviour

The following categories deal with the issue of dangerous behaviour more directly and are based on the notion that personality, situational and additional factors interact to produce dangerous behaviour. Response alternatives span across a seven-point scale of
"Extremely Low", "Quite Low", "Fairly Low", "Medium", "Fairly High", "Quite High" and "Extremely High". The choices of "Not Applicable" and "Don't Know" are included for use where appropriate.

(a) PERSONALITY FACTORS:

1. Passive Aggressive - This refers to covert or latent hostility. The patient may be observed as sullen, petulant, resistant to questioning or negativistic.

2. Hostility - Unlike the previous category, this term refers to an overt and more direct form of resistance, antagonism and opposition. It also represents a pervasive and relatively enduring attitude or posture.

3. Anger - The behavioural component of hostility is reflected in this category and is transitory or situation-specific rather than enduring. This involves assessment of the patient's potential for translating hostility into aggressive acts.

4. Rage - This possesses the same characteristics as anger, but involves a major loss of control. A patient may be rated high on this factor where a pathological condition such as catatonic rage reaction is seen as a potential development.

5. Emotionality - This category is meant to indicate the patient's ability to control the expression of his current emotional state. The undercontrolled patient, therefore, may be tearful or hysterical while the overcontrolled patient may appear as very tense, rigid and guarded with respect to his true feelings.
6. Guilt - This refers simply to the presence of any regret or discomfort over past actions.

7. Capacity for Empathy - This category is designed to reflect the degree to which the patient is able to recognize the effect of his actions on others. It is a measure of his capacity for participating in the feelings of another individual.

8. Capacity for Change - The presence of situational factors which may facilitate or inhibit the patient's ability to modify certain behaviours is considered, along with the patient's degree of insight and motivation for change.

9. Self Perception as Dangerous - The patient's description of and comments on his own behaviour and personality are used in making this rating. The patient perceives himself as dangerous if he admits to an explosive temper, to losing control at times and acting "crazy". The patient may also see himself as needing external controls in order to prevent him from harming others or himself.

10. Control over Actions - Consideration is given as to whether the patient typically acts in an impulsive, as opposed to a premeditated fashion. Generally, control over one's actions is the ability to anticipate the results of one's behaviour and to act accordingly.

11. Tolerance - This is an estimate of the degree of frustration and stress the patient is capable of withstanding before he will act in an aggressive manner. "Tolerance" is a category distinct from "Control" in that a person may respond aggressively to relatively
small amounts of frustration (i.e., low tolerance) while choosing his specific response in a very controlled and decisive manner (i.e., high control over actions). The arsonist who carefully and methodically plans the demise of someone who is guilty of nothing more than verbal insults is an example of a person with low tolerance and high control over actions.

(b) SITUATIONAL FACTORS:

12. Environmental Stress - The death of a relative, or friend, a change or loss of employment, residential relocation, peer group pressure to engage in antisocial behaviour, an alcoholic parent or spouse, and separation from a spouse are examples of possible environmental factors which may exert psychological, social or economic pressure on the patient.

13. Environmental Support - This refers to the presence of beneficial supports in the patient's environment which may act to deter him from acting in a dangerous manner. Examples of supports include stable personal relationships, steady employment or schooling, and the presence of hobbies, sports or outside interests.

(c) ADDITIONAL FACTORS:

14. Dangerousness Increased under Alcohol - This rating is included to give some indication of the extent to which drinking contributes to the patient's potential for dangerousness. It should be noted that this category is not meant to reflect the level of alcohol
consumption per se, but rather the facilitative effect of alcohol in producing dangerous behaviour.

15. Dangerousness Increased under Drugs - Except that the focus is on drugs rather than alcohol, the same definition holds for this category as for that of the above.

The next three categories are designed to reflect the rater's confidence in the interview with regard to obtaining sufficient and accurate information. The ratings made under these categories aim to give an idea of the degree of certainty underlying all other ratings made on a particular patient.

16. Is the individual manipulative during the interview? - This is an estimate of the degree to which the patient is attempting to influence the clinicians' opinion of him. A middle rating on this scale would reflect an appropriate level of manipulation, since it is assumed to be only natural for patients to try and make "a good impression" during an assessment. Manipulation is thought to be excessive, however, when the patient is apparently insidiously projecting an overly positive image of himself in order to alter the clinicians' perceptions of him.

17. Did the individual provide accurate information? - While this category may indicate deception on the patient's part, memory impairment and physical or mental disorders would also play a role in the provision of accurate information.
18. Did you receive sufficient information to make an accurate assessment? It should be noted that "assessment" is defined here with respect to personality and social background information. As such, a rater may feel confident with respect to the accuracy of the assessment, even though he has indicated that further analysis is necessary in order to address specific legal issues.

GLOBAL RATINGS OF DANGEROUSNESS:

19. Self at Present:

20. Self in Future:

21. Others at Present:

22. Others in Future:

The above categories are meant to be used as general estimates of the patient's harmful behaviour with respect to target and time. In defining "present", consideration should be given to the patient's general social environment (i.e., support system, peer group pressures, etc.) and should not be limited to his present state of incarceration.

Explanatory Comments:

23. This section is designed to allow for the recording of specific and important details not already reflected by the preceding ratings. After choosing a summary statement with regard to dangerousness, raters are expected to give specific reasons for and qualifications
about their choice. The following considerations would be appropriate to this section of the scheme:

(a) any particular target for the patient's violence, e.g., father, authority figures, total strangers;
(b) probable changes in the patient's immediate environment, e.g., impending desertion by spouse;
(c) interaction between factors, e.g., the effect of drug use on the patient's control over his actions;
(d) the way in which a particular mental disorder contributes to the likelihood of dangerous behaviour, e.g., its effect on judgement or tolerance.

24. **Individual's Strengths** - This final category is included in order that positive aspects of the patient may be noted. It was an attempt to bring to light such assets as intelligence, a sense of humour or the ability to sustain beneficial relationships.

(iii) **The Detailed Interpersonal Analysis of Behaviour Rating Scheme**

It was decided that some type of scheme should be developed in order to isolate, examine and rate the various mainly nonverbal behaviours of patients, with the purpose in mind of analysing these data along with those from the dangerousness rating scheme. Since this scheme is of secondary importance its use in the present project was restricted to the social worker, the nurse, and two external raters. A copy of
the instrument is attached as Appendix B. Since the data were collected from the present project minor revisions have been subsequently made and are footnoted in the scheme's presentation where appropriate.

The essential idea here was to try to pin down some of the cues used by assessors as they begin and maintain their relationship with the patient during an interview. We have described elsewhere the kinds of cues apparently used by interviewers in forming judgments (see Webster et al., 1978, unpublished). But the quotations from Crime and Punishment given at the very outset of this paper should serve to indicate to the reader what we have in mind. Porfiry's extraordinary gestures which were singularly out of keeping with his words could be taken as a description of unusual "synchrony". Raskolnikov's "peering into Porfiry's face" might be seen as atypical eye contact.

The scheme was originally devised for the use of raters observing a patient being interviewed by a single clinician (and is now being tested in this way through use of videotaped interviews). In the present project ratings were global judgments reflecting the interaction of the patient with both the main interviewer and other team clinicians.

1. **Greeting Behaviour** - It is the initial greeting behaviour that is of concern here. Behaviours to keep in mind when making this rating are appropriate smiling, the offering or acceptance of a handshake and making eye contact.
2. **Grooming/Appearance** - Taking into consideration the conditions imposed by a custodial setting, this category is meant to indicate the patient's neatness of appearance with respect to fastening of clothes, combing of hair and general cleanliness.

3. **Eye Contact (Appropriateness)** - This simply refers to the patient making adequate and sufficient eye contact with the clinician with whom he is talking. If the main interview were to glance downward while making notes, it might not be considered inappropriate for the patient to make eye contact with another clinician.

4. **Eye Contact (Duration)** - This is self-explanatory. One patient may never make eye contact with the appropriate clinician while another patient at the opposite extreme may stare constantly.

5. **Affect 1** - Under this category of appropriateness of affect we are looking for the congruence between the content of verbalizations and the emotions expressed. Neutral events may produce a severe affective outburst in the patient, while situations which are usually viewed as emotionally charged do not intensify the patient's emotional expression. At times, a patient's affect in general appears somewhat bizarre and, therefore, inappropriate to the interview setting (e.g., the blunting of affect seen in some schizophrenics). Note that a certain degree of interpretation on the part of the raters may be necessary for this category. That is, wellfounded anxiety or embarrassment may be responsible for a seemingly inappropriate affect in some instances.

6(a) **Posturing** - This category does not refer to posturing in the traditional, clinical sense. The present definition is more

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1. This category has been subdivided into three separate categories: Range of Affect, Intensity of Affect and General Appropriateness of Affect.
encompassing and refers to any excessive or exaggerated body movements or postures. Examples of a great deal of posturing include: (i) rising from the chair and pacing; (ii) rigidity and inflexibility of the body or parts of the body; (iii) fixed and deliberate movement such as repetitive swinging of an arm or leg in a wide arc.

6(b) Activity Level - This is a self-explanatory category which may range from almost no perceptible movement to a great deal of physical agitation on the part of the patient.

7. Agreeability - Under this heading the rater offers a subjective indication of how likeable the patient is to him or her.

8. Verbal Responses 2 - Several factors should be considered when making this rating. It is meant to reflect coherence of ideas, relevance of responses to questions asked, any evidence of digressions, and finally the appropriateness of length and timing of verbal responses.

9. Extent to which the Patient Controlled the Interview - Control on the part of the patient may be external if any of the following behaviours are evident:
   (a) excessive verbalizations even though the interviewer is making an effort to interject;
   (b) refusal to talk;
   (c) choosing the order of topics to be discussed and the issues to be addressed;
   (d) selection of specific clinicians with whom the patient consents to interact;

2. This category has been subdivided into a number of separate categories: Response Delay, Response Length, Volume Rate, Presence of Speech Disruptions, Relevance; Coherence, Degree of Articulation, Concreteness.
(e) threatened or actual acting-out behavior which may result in a necessary modification of the usual interview procedure.

10. Pace of the Interview - This rating should represent the speed with which information and ideas are exchanged between the patient and the clinicians. Usually an observer may formulate a subjective impression with respect to pace, affected by his own interest in the interview, as well as the particular speech characteristics of a clinician or patient.

11. Tension - Often observers will note the presence of tension when there is an element of unpredictability about the patient. The patient may have a history of acting out or may have been disruptive in the Holding Area prior to the interview. Patients who are particularly hostile and verbally abusive may also contribute to a strained atmosphere in the interview room.

12. Rapport - Here the intent is simply to gauge how well the patient and clinicians are communicating with each other. A sense of mutual respect, cooperation and trust would indicate good rapport.

13. Interactional Synchrony - This is a measure of the way in which the body movements of one person coincide with, relate to, or are affected by those of another person (including that person's speech). It is an index of harmony of movement. Assessing interactional synchrony, however, may prove to be very difficult for several reasons since: (a) body movements between persons occur very rapidly and, without slow motion data, it is hard to determine relationships among sets of movements occurring simultaneously between persons; (b) during a face to face
interview, movements are constrained by physical circumstances (e.g., having to sit). Nevertheless, since it is very rare for there to be little interactional synchrony, results should be possible with careful observation.
II. IMPLEMENTATION OF THE PRESENT SCHEME
FOR RATING DANGEROUS BEHAVIOUR

By mid-January of 1979 we were, as a group, in sufficient agreement that we could distribute to the staff a typed set of definitions and put the scheme into effect. As mentioned previously, we were anxious to disrupt the clinical routine as little as possible.1 Filling in an assessment form for each patient was no novelty for the clinicians since each member of the team had been doing this since the inception of the brief assessment programme exactly one year previously. In each case these forms had asked for an opinion regarding potential for dangerous behaviour. What was new was the stipulation that the form be completed immediately after the patient left the room and before discussion was begun.2 This aspect of the procedure was monitored by one of us (D.S.). Also new was the introduction of two temporary staff members (external raters) who simply observed the group.

1. In actual fact the matter was more complex than this. It was not so much a matter of interfering with the routine of the clinic but with its development. Over time some of the psychiatric staff had handed over to other team members the responsibility for acting as primary interviewer. From a research point of view it was, however, necessary to try to keep the overall procedure reasonably simple. Analysis of data based on a dozen or so interviewers would have been quite difficult. As it is we had six (four psychiatrists and two resident psychiatrists). Non-psychiatric members of the team thus had to relinquish their role as interviewer just at a time when it had become accepted. We had not forseen this difficulty at the outset but it served to remind us that while research demands consistency of application, clinical practice demands innovation and change. However this may be, it must be said that the non-psychiatric members of the team accepted the dictates of the plan cheerfully and with good grace.

2. It was also agreed that the clinicians, though having access to the patient's file (which contained little actual information beyond police reports), would not discuss the case before the group interview.
interviews (but not the discussion which followed) from behind a one-way mirror. These persons completed the standard dangerousness assessment as well as the scale designed to measure the more subtle aspects of interaction between patient and interviewer(s).

It was further agreed that one day each week the usual clinical routine would be altered such that the patient would be interviewed by a psychiatrist alone (i.e., acting without the support of his colleagues in other disciplines). On these "individual" days the examining psychiatrist declined to avail himself of the police report and other background documents until the interview was over and he had completed his dangerousness assessment.1 This specific procedure allowed us a chance to obtain from the psychiatrist opinion data which would not have been influenced by colleagues.2,3

During the four and a half month study period an effort was made to standardize and extend psychological testing. This part of the

1. Of course, the psychiatrist was free to see the patient again later in the day after he had examined the pertinent documents.

2. Even though the team agreed to fill in their forms before discussion and even though we were at pains to 'police' ourselves in this regard, there exists the distinct possibility that an unintentional sigh or cough may exert considerable influence among a close-knit group of colleagues.

3. Of course, we recognize that this particular procedure, departing as it did in two ways from the routine, may eventually yield an outcome which could be hard to interpret (simply because absence of file data and absence of clinician colleagues were confounded).
project was coordinated by one of us (G.T.). Wherever at all possible patients completed the Minnesota Multiphasic Personality Inventory (MMPI). Moreover the psychologist in charge of testing offered his interpretations in the absence of the psychiatrist's formulation and opinion (i.e., he was blind to the usual sources of information). We chose this course because there is some recent evidence that the MMPI does have at least some predictive power with respect to dangerous behaviour (Megargee and Bohn, 1979). It will now be necessary to relate MMPI profiles to scores from our rating system (and, eventually, both to follow-up data).
III. USE OF THE SCHEME IN PRACTICE: COMMENTS FROM THE CLINICAL STAFF

The dangerousness rating scheme was used daily on the Brief Assessment Unit over a four and a half month period. As such, the scheme was superimposed on an already operating clinical process. In order to establish to what degree, if any, the research requisites of the scheme affected or disturbed this process, a questionnaire was administered to all those who took part in the dangerousness project, a copy of which is attached as Appendix C. As previously described, the scheme was originally constructed through joint clinical-research endeavour and was subjected to trial runs before formal commencement of the project. We hoped to isolate through the feedback questionnaire, however, any areas of difficulty with regard to category definitions which might only become apparent after the repeated use of the scheme within the clinical setting.

For the most part, the clinicians said that the imposition of the dangerousness rating scheme affected the clinical process somewhat adversely. Since it was important to the research project that no discussion occur just prior to the interview, strategies for questioning could not be decided upon among team members. As such, the type and direction of questions posed during the interview may have been guided more by the requirements of the rating scheme than by clinical judgment. In general, the clinicians seemed to be concerned that research-imposed restrictions reduced spontaneous discussion and

1. For the purposes of this paper, only the opinions of those raters who directly participated in the clinical assessments will be considered. The feedback from the external, nonclinical raters will not be alluded to at this time.
and that some of the clinical focus of attention was lost due to a preoccupation with the rating scheme forms.¹

Interestingly enough, the actual presence of external, nonclinical raters was not viewed as a problem by most of the clinicians. Two-thirds indicated that the presence of the external raters had either no impact or only a slight impact on the clinical process. Those clinicians who did voice some form of objection to the presence of external raters were concerned with possible added nervousness on the part of the patient and the associated difficulty in developing good patient-clinician rapport.

The clinical raters were asked whether or not the rating scheme proved inadequate for certain types of patients and almost three-quarters described patients for whom the scheme was less than satisfactory. On the whole, these patients fell into two categories; those who were completely nonverbal or at least resistant to verbal communication and those who were psychotic. Since the rating scheme necessitates extrapolation even in the case of the relatively communicative and reliable patient, the task would appear to be too demanding when the patient talks insufficiently, with dubious accuracy, or in a way which is difficult to comprehend.

With regard to problems associated with specific category definitions, almost one-half of the raters indicated that they were either unsure

¹ Of course, had the clinicians come to the view that the various procedures precluded the giving of a fair assessment, there would have had to be changes. In the main, our procedures meant that the professional staff had to 'grop' somewhat more than usual.
about some definitions or realized they had been incorrectly applying some of the categories. No common categories or category definitions surfaced as problems, however, and any inconsistencies or confusion with regard to definition application may have best been remedied through periodic reading of the coding manual of definitions.

In terms of gaining sufficient information to make valid ratings, over one-half of the clinicians felt there were one or two categories which were consistently not addressed during interviews, thereby resulting in an overall lack of information for those categories. There was no agreement, however, as to which categories consistently posed a problem in this regard. On the whole, a clear majority of clinicians indicated their satisfaction with the definition specifications of categories after having used the scheme for several months.
IV INTER-RATER RELIABILITY: PRELIMINARY ANALYSES

It should be clear from the above rather general description of the procedure employed in the study that we shall now have an opportunity to test the reliability of the scale through analysis of data from the two external coders. Since these two persons saw all 242 cases we have ample consistency in our measurement procedure. It is these data which, in the main, will be used to establish inter-rater reliability.

Some analyses of the all important reliability data between external coders, in fact, have already been completed. These will be reported in proper detail in due course. For the moment we can say that 17 of the 23 items described above yielded satisfactory intraclass correlations (ICCs) according to the method described by Winer (1962, pp.124-132). The following items proved "acceptable" in the sense that ICCs were sufficiently high - Passive Aggression (ICC = 0.64), Hostility (ICC = 0.56), Anger (ICC = 0.50), Emotionality (ICC = 0.73), Guilt (ICC = 0.75), Capacity for Empathy (ICC = 0.64), Capacity for Change (ICC = 0.63), Self Perception as Dangerous (ICC = 0.81), Environmental Stress (ICC = 0.54), Environmental Support (ICC = 0.73), Individual Manipulative (ICC = 0.40), Accurate Information (ICC = 0.67), Dangerous to Self at Present (ICC = 0.83), Dangerous to Self in Future (ICC = 0.75), Dangerous to Others in Present (ICC = 0.63), Dangerous to Others in Future (ICC = 0.68), and Is/ May Be/ Is Not Dangerous (ICC = 0.53). The remaining seven items were unacceptable.
V VALIDATION OF THE SCALE

In addition to the data from the two external coders we do have many more data on each patient in the form of reports from each of the several clinicians. Since not all clinicians saw all patients, analyses of these scores will not be straightforward. Yet since the overall number of patients was quite large, and since all the various clinicians did in fact assess several patients (though team composition varied day-by-day), we shall have good opportunity to establish in a second way the inter-rater reliability of the scale. While, without question, low levels of inter-rater reliability among external coders would jeopardize the entire scheme (since their academic backgrounds were similar and their responsibilities identical), low levels of reliability among clinician coders would not necessarily be taken as failure. After all, our project is based on the assumption that, conceivably, some clinicians are better able to predict future dangerous behaviour than others. While we did train the external coders we did not train the clinicians (though, naturally, they will have trained themselves to a degree, and did in fact do so in the course of constructing the scale). Perhaps the happiest outcome with respect to the clinician coders would be some reasonable degree of reliability (thus indicating that the definitions were shared to an appreciable extent) without that reliability being extremely high
(thus ruling out the kinds of individual differences which might in the future be revealing when considered case-by-case in the light of follow-up information).

Assuming for the moment that, at the very least, the external coder data show a sufficient degree of correspondence, we can afford to consider the all-important question of establishing validity. We want to know the extent to which predictions made within the B.A.U. "hold up" after a lapse of some 12 - 24 months. Of course, there are a number of problems in this kind of research not the least of which is the fact that psychiatric recommendations (based at least in some cases partly on estimated potential for future dangerous behaviour) influence the Court (see Jackson et al, 1979). That is, it is reasonable to assume that the Court does not act independently of judgments formed by clinicians. This kind of bias is simply inherent. There is, too, the point that when clinicians make judgments about dangerousness these very judgments may induce, in subtle ways, that very behaviour. ¹

The problem is that as researchers we are trying to estimate the likely eventual outcome from clinical judgment when part, or perhaps

1. We are simply trying to recognize that, even though the psychiatrist may not mention the word "dangerousness" in his report to the Court, there may nonetheless be a form of influence on legal officials (i.e., based on other content in the letter, the very non-mention of the term in some instances, etc.) And of course, at the end of assessment the psychiatrist himself discusses the outcome with the patient.
even all, of that very clinical opinion is being passed to the judicial system which, in turn, makes the actual decision as to the kinds of possibilities for future dangerous behaviour open to the individual. And indeed, the issue is further complicated by the fact that the judiciary has within its power the opportunity to make many different kinds of dispositions. Some individuals will receive outright release by being found not-guilty, by having charges dropped, by paying fines, etc. Some individuals will also return to their community but under conditions of probation. Some persons will receive prison or penitentiary terms. A very few will be sent to special secure hospitals because they were unfit to stand trial or found not guilty by reason of insanity.

Thus it is that those thought to be most dangerous by society are likely to commit few offences during a relatively short follow-up period simply because they have remained under lock and key.1 There is too the point that in regard to the seriously (certifiably) mentally disordered, it is not in fact necessarily the case that they will re-engage with the Court-Correctional system (i.e., they may simply be retained in hospital for psychiatric reasons).

We mention these various complications simply to remind the reader of the difficulties which inhere in our present venture. It seems that, even what on first consideration appears to be a large sample (242)

1. But of course offences are possible in prison too. These must be ascertained in any follow-up study of the kind planned here.
may not in fact be so.1 Allowing that former patients will settle themselves into one of the several channels outlined above, and granting that an appreciable number not only can be traced but will agree to participate in a follow-up interview, we may wonder about the number of patients which may be found in each of the various cells.

Given the state of affairs mentioned above, what might be the best research strategy? The data have already been collected from a sample of 242 patients. We may be well advised to draw upon a sample larger than that originally envisioned. Fortunately for us, we have data on another 594 patients assessed previous to our study. While the rating scheme we have described at present was not in use at the time, predictions on future dangerousness were recorded on a similar type of form. To a degree we are guided in our decision to increase the sample size by the outcome of a recently-reported study by Cooke (1979). Cooke has adopted a view similar to our own when he says: "We think we can do better (predict better) than these (previous) studies indicate". Cooke's study, based in the U.S.A., was based on 709 persons sent to forensic centres for competency assessments. As in our work, he was at pains to gather background data on his patients (age at first conviction, offence history) as well as psychiatric and psychological opinion about those persons (fitness to stand trial, MMPI scores, etc.). Also, clinicians in this study made future dangerousness ratings on a 5-point scale. In recent months Cooke has gathered data from State Police and F.B.I. records. He knows how many had further charges during the 7-year follow-up period and, when

1. We know, for example, that four of the patients are now dead.
given, length of sentences. It is the case that 51 out of 709 were still hospitalized or in prison seven years later. Apparently, 39 percent of the sample had been released from confinement and had had no further charges. A total of 220 had further charges in the 7-year follow-up period. The time from assessment to next minor charge was 28.2 months, and the time to the next serious charge was 19.3 months. One of the difficulties with Cooke's study, one which we have to circumvent, was that 149 entered the mental health stream and were lost to his follow-up. Cooke's study, unreported in any form at the time our original plans were laid, will be important to us as we develop our plans for follow-up research. Even though we do not as yet have the details from this study, it has already influenced us in the direction of increasing the size of our study. It has also shown us what good data can be obtained from police and other such records.
CONCLUDING REMARKS

This paper aimed to acquaint the reader with the rating scheme for predicting dangerous behaviour used in the current project at METFORS. We have attempted to outline the development of this scheme into an acceptable and workable format, in addition to presenting post-study clinical opinion of the scheme and its implementation in the Brief Assessment Unit.

The data collected from both clinical and nonclinical ratings are presently being analyzed for the purpose of examining inter-rater reliability. This analysis will, in a sense, test the internal consistency of the rating scheme, but it will also investigate interdisciplinary agreement, clinician-nonclinician comparisons, changes in inter-rater reliability over time, etc. A follow-up phase of the project involving all those patients assessed and rated in the Brief Assessment Unit is planned and will be a crucial test of the external applicability of the rating scheme in terms of its predictive value for future dangerous behaviour.
REFERENCES


REFERENCES ... 2


Webster, C.D., Butler, B.T., Jensen, F.A.S. and Turrall, G.M. Constructing interview-based models for the assessment and prediction of dangerous behaviour: 1, Notes on the dimensions of the problem and some suggested criteria against which new models might be evaluated. METFORS Working Paper, No.3.

APPENDIX A: METFORS PSYCHIATRY BRIEF ASSESSMENT SUMMARY SHEET

PATIENT'S NAME: ____________________________ M.R.#: ____________________________
DATE: ____________________________ Sequential or Group Interview (circle): ____________________________
RATER'S NAME: ____________________________ If Sequential - "Contamination of blind condition: Yes[ ] No[ ]"

REFERRING COURT: [ ] OCH [ ] Scar [ ] Will [ ] Etob [ ] Oth REFER. JUDGE: ____________________________

CHARSES: 1. ____________________________ 2. ____________________________ 3. ____________________________ 4. ____________________________

Psychiatrist's Opinion
Fit to be granted bail at present [ ] [ ] [ ] [ ] [ ]
Fit to stand trial at present [ ] [ ] [ ] [ ] [ ]
Fit to receive sentence at present [ ] [ ] [ ] [ ] [ ]
Patient mentally disordered at present [ ] [ ] [ ] [ ] [ ]
Certifiable at present [ ] [ ] [ ] [ ] [ ]
Inpatient hospital treatment needed now [ ] [ ] [ ] [ ] [ ]
Further analysis of patient needed now [ ] [ ] [ ] [ ] [ ]
Outpatient care required [ ] [ ] [ ] [ ] [ ]
Locked Hospital / Incarceration required [ ] [ ] [ ] [ ] [ ]
Co-operation in treatment likely in future [ ] [ ] [ ] [ ] [ ]

DANGEROUSNESS: XL QL FL M FH QH EH NA DK
1 2 3 4 5 6 7

Personality Factors:
1. Passive Aggressive 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
2. Hostility 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
3. Anger 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
4. Rage 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
5. Emotionality 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
(under-controlled) [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
(over-controlled)
6. Guilt 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
7. Capacity for Empathy 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
8. Capacity for Change 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
9. Self Percept. as Dangerous 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
10. Control over Actions 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
11. Tolerance 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]

Situational Factors:
12. Environmental Stress 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
13. Environ. Support 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]

Additional Factors:
14. Dang. increased under Alcohol 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
15. Dang. increased under Drugs 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
16. Is indiv. manipulative during interview? 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
17. Did individual provide accurate information? 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
18. Received sufficient informat. to make accurate assess.? 1 2 3 4 5 6 7 [ ] [ ] [ ] [ ] [ ]
Global Ratings of Dangerousness:

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Explanatory Comments: Circle the appropriate statement and indicate your reasoning in a few short points.

23. This individual:
   - is dangerous
   - may be dangerous
   - is not dangerous

   because:

24. This individual's strengths are:

PSYCHIATRIC CLASSIFICATION(S): 1. 
2. 
3. 

PSYCHIATRIST'S RECOMMENDATIONS:

(12/12/78)
### APPENDIX B: DETAILED INTERPERSONAL ANALYSIS OF BEHAVIOUR

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**Duration - Interview:** _____ minutes

**Question Period:** _____ minutes

**No. of External Questions:**

**Noteable Interactions:** (Non-routine eg. threatened assault, assault, acting-out behaviour)
### Dangerousness Project - Feedback Questionnaire

**The Rating Scheme**

1. On a 7-point scale (1 = Extremely low; 2 = Quite low; 3 = Fairly low; 4 = Medium; 5 = Fairly high; 6 = Quite high; 7 = Extremely high) please indicate for each of the categories:

   (a) The ease with which you generally made judgements of this factor.
   (b) The amount of extrapolation you generally had to employ to choose a rating value for this factor.
   (c) The relative importance you placed on this factor when assessing (and describing) an individual's potential (or lack of potential) for engaging in dangerous behaviours.
   (d) The frequency with which this factor was not (and/or could not) be addressed in the interview situation.
   (e) The consistency with which you applied the standardized (manual) definition of this factor.
   (f) An overall "comfort" index reflecting the confidence you have in the judgements you made of this factor, the ease with which such judgements were made, the value you placed on this factor, etc.

### DANGEROUSNESS:

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<td>6. Guilt</td>
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<td>13. Environ. Support</td>
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<td>15. Dang. increased under Drugs</td>
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<td>16. Is indiv. manipulative during interview?</td>
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<td>17. Did individual provide accurate information?</td>
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<td>18. Received sufficient informat. to make accurate assess.?</td>
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<td>19. Self at Present</td>
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<td>20. Self in Future</td>
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<td>21. Others at Present</td>
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<td>22. Others in Future</td>
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2. From your experience, which 3 factors (including the global ratings of dangerousness and the write-in sections) did you consider most useful in providing a profile of a patient's potential for dangerousness?

1. ______________________
2. ______________________
3. ______________________ (Rank order)

3. Were there particular patients for whom the scheme seemed inadequate? (Describe briefly)

4. Were there one or two categories which consistently were not addressed in the course of the interview session? (Please name)

5. Are there any definitions you wish to see revised? (Please name and provide alternative definition)

6. Were there any categories you were uncertain about or for which you subsequently realized you had not employed the standardized, manual definitions? (Please indicate the name of the category and the error made)

7. Did any of the categories seem to "cluster" together consistently in the sense that your rating for one category would influence your rating on the other category? (Please name)
8. Did you find that the impact of alcohol and drugs could be clearly and adequately represented in this framework?

9. What additions/omissions would you wish to see in a revised scheme or alternatively, is there a scheme you would like to propose?

General Questions About the Project

10. At which stage of the assessment process had you generally completed at least 2/3 of the ratings?

- First half of the interview
- Last half of the interview
- Just prior to the discussion period

11. How confident typically are you about your ability to predict dangerousness? (Using 7-point scale)

- To self
- To others

12. Did the imposed scheme adversely or advantageously affect the clinical decision-making process? (Elaborate briefly)

13. Did the presence of research observers have: (a) no impact (b) some impact - not serious (c) definite impact - more formal or (d) definite impact - distraction on the clinical process?

14. Any additional comments and/or suggestions you wish to make.
DOING VIOLENCE: 
PSYCHIATRIC DISCRETION AND THE PREDICTION 
OF DANGEROUSNESS 

VOLUME I 

By 

Robert John Menzies 

A Thesis submitted in conformity with the requirements 
for the Degree of Doctor of Philosophy in the 
University of Toronto 

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1985
ABSTRACT

DOING VIOLENCE:
PSYCHIATRIC DISCRETION AND THE PREDICTION
OF DANGEROUSNESS

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This study undertakes a sociological analysis of clinical decision-making in a pretrial forensic agency located in a major Canadian city. Psychiatric discretion reflects the relative autonomy of practitioners from formal legal norms and medical standards. Clinical typifications of accused persons and predictions of dangerousness are geared to fulfilling the pragmatic occupational mandates of medicolegal agents. Psychiatrists' power to define reality comes from their creative use of recipe knowledge, their adoption of widely-shared assumptions about deviance and danger, their strategic evasion of legal, medical and organizational rules, and their ability to persuade judges that their decisions are both clinically valid and judicially relevant.

The medicolegal careers of 592 subjects were traced from their initial arrest, through their evaluation in the Northtown One-Day Assessment Clinic (a maximum-security unit providing brief assessments for the criminal courts), to their ultimate legal disposition. Further, the longitudinal outcome experiences of 571 defendants were pursued over a two-year period following their brief assessment, allowing a systematic documentation of
criminal and dangerous conduct as well as patterns of institutionalization. Records of police, courts, psychiatric and correctional institutions were subjected to both quantitative and qualitative analysis.

An examination of decisions about dangerousness revealed that medicolegal officials were poor predictors of violent conduct. Prognostications were based primarily in the idiosyncratic discretionary practices of clinicians, and were only marginally related to the levels of assaultiveness displayed by subjects during followup. Nonetheless, the recommendations formulated by clinicians had a major impact on the subsequent sentencing decisions of criminal court judges.

The Northtown patients were caught up in a circular pattern of control that extended across both legal and mental health institutions. Their followup careers were characterized by multiple confrontations with criminal justice officials and psychiatric experts. The pretrial assessment clinic contributes to the extension of legal control over these subjects by providing convenient definitions that can be recurrently applied, and by lending a sense of scientific legitimacy to the ordering practices of judicial authorities. In so doing, the forensic remand represents the expanding ambit of state power over deviant and "dangerous" populations.
ACKNOWLEDGMENTS

This project was brought to completion through the collective efforts of many people. First, I would like to acknowledge the financial support of the Department of Justice, Canada, and the Ontario Ministry of Health, for funding the original research programme out of which this study eventually emerged. Over the course of the past six years, additional resources were made available by the Law Foundation of Ontario, and by the University of Toronto Centre of Criminology (through a grant provided by the Solicitor-General of Canada). I am especially indebted to the Social Sciences and Humanities Research Council for awarding me a doctoral fellowship that allowed me to focus my energies on developing this project during the 1981 academic year.

I benefitted greatly from the tireless efforts put in by a number of able research assistants, several of whom were put at my disposal by the forensic agency described in this study. Among the many people who were involved in the collection, compilation and organization of the clinical data, Roy Gillis, Val Cattelan, Carrie Broughton and Steve Wellford deserve special mention. I am also thankful to Aileen Sams, Kay Cooper and Mary Sutherland for their help in the presentation of tabular data, to Alison Hatch and Dr. William Glackman for their technical assistance, and to Denise Foisy for word processing the final draft manuscript.
The anonymous representatives of the various mental health and correctional institutions surveyed in this study are to be acknowledged for their cooperation in providing access to records and other documents under their jurisdiction. Although many of these persons cannot be identified for the sake of preserving confidentiality, I would like to give special thanks, for their role in supplying materials that were invaluable in the construction of followup profiles, to Inspector R.C. Jackson of the Royal Canadian Mounted Police, to Dr. D. Craigen, Director General of the Medical and Health Care Services, Correctional Services Canada, and to the Chief Coroner in the jurisdiction under study. In addition, Ms. Diana Sepejak and Ms. Jill Thurston were responsible for collecting most of the preliminary followup data from the provincial correctional records, and from the six forensic psychiatric institutions in the region.

I want to express my gratitude to the 592 Northtown patients whose experiences are recounted in the following pages. As well, this study would not have been undertaken in the first place without the cooperation of the many psychiatrists, psychologists, social workers, nurses and correctional officers whose work is described below. I expect they will be troubled by many of the findings reported in this volume. Still, I am confident that they will read this work not as a polemic or personal assault on their professional skills, but instead as a vehicle for increasing our understanding of clinical
decision-making, and for developing more humane systems for dealing with mentally disordered defendants.

During my doctoral residency at the University of Toronto, I was fortunate to work in the stimulating environment provided by the Department of Sociology, and by the Centre of Criminology under the directorship of Dr. Anthony Doob. I would also like to thank my colleagues and friends in the School of Criminology, Simon Fraser University, and especially Ehor Boyanowsky, Neil Boyd, Ray Corrado, Douglas Cousineau, Ezzat Fattah, Shelley Gavigan, Bill Glackman, Curt Griffiths, John Lowman, Ted Palys and Ron Roesch. I reserve special mention for Simon Verdun-Jones, Director of the School, for his wise counsel and steadfast support, and for Margaret Jackson, who has been involved in this work from its inception, and who has been a good friend and comrade through our shared terms in pre-Ph.D. academic limbo.

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Dr. Christopher D. Webster, of the Departments of Psychology and Psychiatry, and the Centre of Criminology at the University of Toronto, conceptualized, organized and directed the project that spawned this volume, and sat as a member of the thesis committee. Without his friendship, intellect, unflagging confidence and commitment to research, this manuscript would never have been written. Dr. Richard V. Ericson, of the University of Toronto Department of Sociology and Centre of Criminology, supervised the dissertation, and more than anyone else is responsible for the merits of what follows. I have benefitted greatly and learned much from his intellectual integrity, critical understanding, good humour and sound advice.

A final thank-you to Dorothy Chunn, whose companionship, counsel and tolerance have kept me sane.
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Physical Attractiveness, Dangerousness, and the Canadian Criminal Code

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Abstract

The Canadian Criminal Code contains provisions for labelling certain convicted criminal offenders as Dangerous Offenders. Sentences of indefinite duration are usually imposed on these offenders in place of the fixed sentences which would normally be imposed. The present study examined one potential source of bias in the use of the Dangerous Offender provisions, the physical attractiveness of an offender. Two hundred and eighty-four adults were given information about a hypothetical offender, including a facial photograph and a conviction record. They responded to questions about the dangerousness of the offender, including questions drawn from the Dangerous Offender criteria. Subjects perceived physically unattractive sexual offenders as significantly more likely to fulfill the Dangerous Offender criteria than average-looking and attractive sexual offenders. In particular, unattractive sexual offenders were seen as significantly less likely to restrain their behavior in the future. In light of the fact that there is currently no evidence that physical attractiveness is a valid predictor of sexual offender recidivism, this finding provides grounds to question whether the Dangerous Offender provisions of the Canadian Criminal Code, as they now stand, can be administered impartially.
Physical Attractiveness, Dangerousness, and the Canadian Criminal Code

The Criminal Code of Canada contains provisions for labelling certain convicted criminal offenders as Dangerous Offenders. When an offender is convicted of a 'serious personal injury offense' (other than first degree murder, second degree murder, or treason), application can be made to the court to sentence the individual as a Dangerous Offender, instead of imposing the usual sentence for the offense in question (Section 687). If the offender is found to be a Dangerous Offender, the sentence is almost always indeterminate detention in a penitentiary (Section 688), with parole review after the first three years of custody and every two years thereafter (Section 695). The current Dangerous Offender provisions were enacted in 1977 and none of the 60 or so offenders who have been held on indeterminate sentences since that time have yet been released (Jakimiec, Porporino, Addario, & Webster, in press).

A number of individuals within the criminal justice system are involved in the process of determining whether an offender is tried and eventually found to be a Dangerous Offender. Whether the Dangerous Offender hearing takes place at all is influenced by police officers, psychiatrists, prosecutors, and the provincial Attorney General. It seems that cases are selected in which an application is likely to succeed, the majority of cases to date having been successful (Jakimiec et al., in press). If a Dangerous Offender hearing does take place, at least two
psychiatrists, one for the defense and one for the prosecution, must provide expert testimony regarding predicted future dangerous behavior, and a judge decides on the outcome of the hearing (Sections 689 and 690). Thus, whether an offender is sentenced as a Dangerous Offender is based on the cumulative decisions of a number of individuals. Most of these individuals do not definitively have to decide whether the offender is dangerous or not; they need only estimate the likelihood of the offender being dangerous. The purpose of the present study was to find out whether the physical attractiveness of an offender can influence this process.

The suggestion that the physical attractiveness of an offender may have an effect on this process is supported by a recent report by Wormith and Ruhl (1986) on offenders detained under the Dangerous Sexual Offender provisions which preceded the 1977 Dangerous Offender legislation. At the time of the review, 97 offenders were remanded under the ambit of the earlier Dangerous Sexual Offender law. Fifty-three (more than 1/2) were found to have documented physical abnormalities, including facial and bodily scars.

Two explanations may be provided for this type of effect. First, the physical appearance of offenders may directly influence the Dangerous Offender process, such that unattractive offenders are thought to be more dangerous simply because of the way they look. Alternatively, this type of effect may be mediated by a relation between the physical appearance of offenders and the severity of their offenses. That is,
unattractive offenders may be more likely than others to commit the kinds of acts that lead to Dangerous Offender sentences. Unfortunately, the discretionary nature of the Criminal Code makes it possible that physical attractiveness per se may even influence the severity of offenses for which individuals are accused and convicted. This makes the second explanation difficult to disentangle from the first because it has embedded within it a potential physical attractiveness bias. Therefore, it is necessary to begin by examining the direct role of physical attractiveness in Dangerous Offender decisions, while holding severity of offenses constant.

Previous research has demonstrated that physical attractiveness may play a direct role in decisions within the judicial process. In simulated jury settings in which nature of offense is held constant, physically unattractive defendants are often treated more harshly than are physically attractive defendants. In these simulation studies, unattractive defendants are usually evaluated with more certainty of guilt and more severe recommended punishment than are attractive defendants (Efran, 1974; Friend & Vinson, 1974; Solomon & Schopler, 1978). However, there is research to suggest that under certain circumstances, subjects may attempt to correct for this bias. Friend and Vinson (1974) demonstrated that when subjects are given specific instructions to be impartial and are required publicly to commit themselves to this position, unattractive defendants are actually sentenced more leniently than attractive defendants. It seems that in an attempt to appear
unbiased, subjects overcorrect in the direction opposite to their normal inclination. In addition, it has been shown that when the crime committed is seen to involve physical attractiveness used to obtain illicit ends, unattractive and attractive defendants are sentenced equivalently (Sigall & Ostrove, 1975). This may occur because attractive defendants are seen as more likely than unattractive defendants to commit similar transgressions in the future, and so are treated more harshly than usual.

An observational study of the sentencing of defendants in criminal court, covering a broad range of offenses, provides additional evidence that the physical attractiveness of defendants can influence judicial decision-making. Stewart (1980) found that the physical attractiveness of defendants was predictive of the sentences imposed by real judges, such that the less attractive the defendant, the more severe the sentence. This effect was partially mediated by a negative relation between the physical attractiveness of the defendants and the seriousness of the offenses for which they were being tried. Stewart (1980) suggests two alternative explanations for this finding. First, unattractive individuals may be more likely to be suspected of criminal activity than are their more attractive counterparts, and consequently are charged with more serious offenses. Alternatively, unattractive individuals may actually be more likely to engage in criminal activities because their negative physical appearance lessens legitimate means of value-access. However, physical attractiveness also had a direct influence on sentencing decisions. When the effect of seriousness of offenses
was partialled out, the negative correlation between the physical attractiveness of defendants and the length of sentences imposed remained significant.

In the present study, we examined the role of physical attractiveness in perceptions of convicted criminal offenders as Dangerous Offenders while holding severity of offenses constant. Subjects were recruited from the general public and three levels of offender physical attractiveness were manipulated (attractive, average, unattractive). The Dangerous Offender provisions include a subsection which applies specifically to sex offenders (Section 688b). In fact, a majority of current Dangerous Offenders have records of sexual offenses (Jakimiec et al., in press). Nature of conviction record was therefore also manipulated in this study (sexual offenses, nonsexual offenses) in order to determine whether physical attractiveness would interact with nature of conviction record in affecting perceptions of dangerousness.

This study was not a typical simulation study of the sort previously reviewed because subjects were not asked specifically to play the role of jurors or judges and decide on a sentence for a defendant (or in the present case, decide whether to sentence an offender as a Dangerous Offender). Instead, subjects were presented with the type of information normally made available to the individuals involved in the Dangerous Offender decision-making process and were then asked to respond to items regarding the perceived dangerousness of the offender, including the specific Dangerous Offender criteria as laid out in the
Canadian Criminal Code. In this way, we were able to determine the usual inferences which are drawn about the dangerousness of criminal offenders based on their physical attractiveness. These inferences may be reflected in the decisions of the individuals who are involved in the Dangerous Offender process. Attempts to predict future dangerous behavior are based on rather subjective evidence (see Monahan, 1981, for a review of the relevant literature). Therefore, in assessing the likelihood that offenders will commit further serious offenses, Dangerous Offender decision-makers are likely to be susceptible to the usual biases in person perception.

The physical attractiveness of offenders may influence the perceptions of each of the many officials who are involved in the Dangerous Offender process. Most of these officials are not required to make binary dangerous or not dangerous decisions, but instead estimate the likelihood of future dangerous behavior. For example, psychiatrists tend to provide probability estimates of future dangerousness, rather than all or none predictions. It was therefore necessary to determine whether physical attractiveness influences the perceived degree of dangerousness of offenders, rather than whether it influences perceptions of offenders as dangerous or not. In fact, physical attractiveness biases in officials' perceptions of offenders could have an additive effect in the Dangerous Offender process.

It was hypothesized that unattractive offenders would be seen as more likely to fulfill the Dangerous Offender criteria than would attractive and average-looking offenders. This
general type of effect had been found in previous research, and was expected to be especially evident in the Dangerous Offender context in which predictions of dangerousness are conjectural.

The predicted effect of physical attractiveness was expected to be more pronounced when the conviction record contained sexual offenses, leading to an interaction between physical attractiveness and nature of conviction record. Physical attractiveness is more likely to be salient when sexual offenses are involved because normal sexuality is usually defined as involving mutual attraction between consenting adults (Quinsey, 1984). We therefore predicted that the physical attractiveness of offenders would be especially likely to be taken into account in a sexual context. Unattractive sex offenders may be perceived as more likely than other sex offenders to repeat sexual offenses in the future, due to their inability to attract sexual partners in the usual, legally and socially acceptable ways. In addition, given equivalent records of sexual offenses, unattractive individuals may be seen as having inflicted relatively more damage on victims than are other individuals. The nature of their previous offenses may thus be viewed as more heinous. For example, being raped by an unattractive man may be perceived as more traumatic than being raped by an attractive man, due to the prevalence in our society of the myth that women secretly want to be raped by handsome strangers (Malamuth & Donnerstein, 1982).
Method

Overview

Subjects were presented with information about a criminal offender and were requested to respond to questions regarding the perceived dangerousness of the offender, including the specific Dangerous Offender criteria as laid out in the Canadian Criminal Code. The offender's physical attractiveness and the nature of the offender's conviction record were manipulated in a between-subjects design.

Subjects and Design

Subjects were 284 adults (18 to 80 years old) recruited at the Ontario Science Centre in Toronto, Canada. They were randomly assigned to one of six conditions in a 3 X 2 completely randomized factorial design with 46 to 48 subjects in each condition. The between-subject independent variables were offender's physical attractiveness (attractive, average, unattractive) and nature of the offender's conviction record (sexual offenses, nonsexual offenses). Four individuals failed to complete the experiment and were therefore eliminated from the study. These individuals are not included in the group of 284 subjects whose data were analysed.
Materials

The instructions and materials necessary to complete the experiment were presented to subjects in a booklet. All subjects were provided with identical booklets, except that the information about the criminal offender differed, depending on the condition to which the subject had been assigned.

The first section of each booklet contained a set of instructions. Subjects were informed that (a) the study was concerned with perceptions of criminal offenders, (b) they would be asked to read a summary of an offender's background, and (c) when they were finished reading the information provided, they would be asked to complete a number of questions regarding it.

The next section of the booklet presented the manipulation of the independent variables, under the heading "summary of information available in an offender's file." The offender's physical attractiveness was manipulated through the use of a facial photograph. The nature of the offender's conviction record was manipulated through a listing of present and previous convictions. (See below for specific details.)

In the third section of the booklet, subjects were asked to respond to 18 questions regarding the offender (see below for specific details). These questions included the dependent measures of the experiment and the manipulation checks. Subjects were instructed to answer each question to the best of their ability, based on the information provided, and were informed that they could go back and look at the offender's file whenever...
they wished.

In the final section of the booklet, subjects were informed that when they had completed all of the questions, they should turn to the next page for additional information about the study. They were instructed not to go back and change any responses once they had read this additional information, which constituted the debriefing.

**Independent variables.** All the characteristics of the offender, presented to subjects in the summary of information available in an offender’s file, were selected to conform as closely as possible to available information about present Dangerous Offenders in Canada (e.g., sex, age, conviction record) (Mackay, 1983).

Physical attractiveness was manipulated through the use of a facial photograph. At present, all Dangerous Offenders in Canada are male. In order to select the photographs to be used in the study, 27 photographs of males (20 to 45 years old) were rated for physical attractiveness on seven-point scales by 30 adults. The three photographs that consistently obtained the highest ratings were selected for the physically attractive condition and the three photographs that consistently obtained the lowest ratings were selected for the physically unattractive condition. The overall mean rating of these two groups was then determined and the three photographs from the pool that were rated closest to this mean were selected for the physically average-looking condition. Analyses demonstrated that, as expected, the physical attractiveness ratings differed significantly between
the selected conditions but did not differ within conditions. Each subject was presented with a photograph of one offender. To ensure that physical attractiveness was manipulated, rather than irrelevant attributes, the three photographs selected for each condition were randomly assigned to subjects within that condition.

Nature of the offender's conviction record was manipulated through a listing of present and previous convictions. Two different listings were presented to different subjects for each type of conviction record. Each conviction record listed one present conviction and five previous convictions. These conviction records were developed using information available on present Dangerous Offenders in Canada: type and number of previous offenses and type of offense leading to a Dangerous Offender hearing (Mackay, 1983). Offenses such as rape, indecent assault, and forcible confinement were included in the sexual offenses condition. Offenses such as attempt murder, wounding, and common assault were included in the nonsexual offenses condition. In order to ensure that the seriousness of the conviction records was held constant (so that any effects obtained would not be attributable to seriousness of conviction record), 30 adults rated each conviction record for seriousness on seven-point scales. Analyses indicated that seriousness ratings did not differ between or within conditions.

Dependent variables. Subjects were asked to respond to 18 questions regarding the offender on seven-point rating scales (ranging from 0 to 6). Ten questions were derived directly from
the Canadian Criminal Code (Sections 687 and 688) and addressed the specific criteria for a finding that an offender is a Dangerous Offender (see Table 1). Six additional questions asked about more general perceptions of the offender, including one question that directly asked subjects to rate how dangerous the offender was. The remaining questions were manipulation checks.

Insert Table 1 about here

Results

Manipulation Checks

Physical attractiveness. An analysis of variance of subjects' ratings of the physical attractiveness of the offender revealed a significant main effect of photo physical attractiveness condition, F(2, 270) = 24.35, p<.001. A Newman-Keuls analysis demonstrated that the physical attractiveness manipulation was successful (i.e., attractive > average-looking > unattractive), p<.05. No other significant effects were evident.

Seriousness of conviction record. An analysis of variance of subjects' ratings of the seriousness of the offender's conviction record revealed no significant effects. Subjects perceived the sexual and nonsexual conviction records to be
equally serious, $F(1, 268) = 1.55$, ns.

**Dangerous Offender Criteria**

**Initial analysis.** In order to examine subjects' perceptions of how likely the offender was to fulfill the Dangerous Offender criteria of the Criminal Code of Canada, the responses of each subject to the questions listed in Table 1 were averaged to produce a mean dangerousness rating. An analysis of variance of mean dangerousness ratings revealed a significant interaction between nature of the offender's conviction record and offender physical attractiveness, $F(2, 278) = 3.12$, $p < .05$. Planned comparisons (Dunn test) revealed that the unattractive sexual offender was seen as significantly more likely to fulfill the Dangerous Offender criteria than were the average-looking and attractive sexual offenders, $p < .05$. The perceived dangerousness of nonsexual offenders did not differ significantly as a function of physical attractiveness. (See Figure 1)

____________

Insert Figure 1 about here

____________

**Factor analysis.** A factor analysis of the Dangerous Offender criteria revealed three factors (factor loading criterion = .4). The factor structure is indicated in Table 1: A=lack of future behavioral restraint (6 items), B=threat to physical well-being
of others (2 items), C=threat to mental well-being of others (2 items).

To gain additional insight into subjects' perceptions of the offender, we performed further analyses using the three factors of the Dangerous Offender criteria. For each subject, a mean rating on each of the factors was calculated separately. An analysis of variance was then conducted for each factor. No significant effects were evident for Factors B and C. However, for Factor A, which constitutes the majority of the Dangerous Offender criteria, there was a significant interaction between nature of the offender's conviction record and offender physical attractiveness, $F(2, 278) = 3.24, p<.05$ (see Figure 2). A comparison of Figure 2 with Figure 1 demonstrates that taking out Factors B and C from the complete set of questions made very little difference to the pattern of results. Planned comparisons (Dunn test) of the means from Factor A revealed that the unattractive sexual offender was seen as significantly less likely to restrain his behavior in the future than were the average-looking and attractive sexual offenders, $p<.05$. Nonsexual offenders were not perceived as significantly more or less likely to restrain their future behavior as a function of their physical attractiveness.

------------------------

Insert Figure 2 about here

------------------------
Summary. These analyses demonstrate that the unattractive sexual offender is perceived as more likely to fulfill the Dangerous Offender criteria of the Canadian Criminal Code than are the average-looking and attractive sexual offenders. In particular, the unattractive sexual offender is seen as less likely to restrain his future behavior. This effect of physical attractiveness is not evident for nonsexual offenders.

How Dangerous Is This Person?

In addition to the questions derived from the Dangerous Offender provisions of the Canadian Criminal Code, subjects were asked directly to rate how dangerous the offender was. An analysis of variance of subjects' responses to this question revealed no significant effects. Thus, the effect obtained on the questions derived from the Dangerous Offender provisions was not evident when subjects were asked simply how dangerous the offender was.

Discussion

The results of this study demonstrate that unattractive sexual offenders are perceived to be more likely to fulfill the Dangerous Offender provisions of the Criminal Code of Canada than are average-looking and attractive sexual offenders. In particular, unattractive sexual offenders are seen as less likely to restrain their behavior in the future. The concept of future
behavioral restraint forms the central core of the Dangerous Offender provisions and therefore may be seen as the crucial determinant of Dangerous Offender decision-making.

The effect of physical attractiveness was not evident when participants were asked merely to rate how dangerous the offenders were. Two possible explanations may be offered for this finding. First, the single question of dangerousness may not have been sensitive enough to pick up a subtle effect of physical attractiveness. In addition, it is unclear how subjects were defining the term dangerous for purposes of this question. It seems likely that they were following the everyday usage of the term and were rating the amount of harm caused by the offenders. Thus, the question of future behavioral restraint, which is a fundamental part of the legal definition of dangerousness in the Canadian Criminal Code, may not have been assessed.

A recent review of the files of current Dangerous Offenders in Canada has led to the suggestion that "relative to other violent offenders, persons eventually sentenced as Dangerous Offenders may be an odd appearing, perhaps 'dangerous looking', group" (Webster, Dickens, & Addario, 1985, p. 46). The results of the present study may shed some light on this observation. Although this study can not rule out the possibility that unattractive offenders are especially likely to commit the kinds of offenses that lead to Dangerous Offender sentences, it does offer evidence that physical attractiveness per se can influence the Dangerous Offender process. Given equivalent records of past offenses, the participants in our study perceived unattractive
sexual offenders to be less likely to restrain their future behavior than are average-looking and attractive sexual offenders.

We suggest that the inferences drawn by our general sample of subjects may be reflected in the decisions of the individuals who are actually involved in establishing and conducting Dangerous Offender proceedings. These decision-makers include not only those who participate in Dangerous Offender hearings, but also those whose initial decisions determine whether such hearings occur. These officials, like members of the general population, may be susceptible to the influence of physical attractiveness demonstrated in the present study. Given that predictions of future dangerousness are based on subjective evidence, it seems likely that it would be difficult to disregard completely the inclination to predict future sexual behavior on the basis of physical attractiveness. Although the size of the effect demonstrated in the present study is moderate (a mean difference in perceived lack of future behavioral restraint of less than one unit on a seven-point scale), it could have a strong influence on Dangerous Offender sentencing decisions when cumulated over the numerous officials involved in this process.

The finding that unattractive sexual offenders are perceived to be less likely to restrain their future behavior than are average-looking and attractive sexual offenders may be interpreted in two ways. First, this prediction may be warranted; unattractive sexual offenders may, in fact, be especially likely to recidivate. If this were to be the case,
consideration of physical attractiveness would contribute to accurate predictions of dangerousness. However, research examining the relation between physical attractiveness and sexual offender recidivism is currently lacking. Such research would need to take into account potential physical attractiveness biases in measures of recidivism. For example, unattractive sexual offenders may be especially likely to be suspected of new offenses because of their physical appearance.

Alternatively, the effect of sexual offender physical attractiveness on predictions of future behavioral restraint may be considered an unwarranted bias which can detract from the impartial administration of the Dangerous Offender provisions of the Canadian Criminal Code. Because there is currently no evidence that physical attractiveness is a valid predictor of sexual offender recidivism, unattractive sexual offenders must be given the benefit of the doubt. Until this issue is resolved, Dangerous Offender decision-makers should be wary of being influenced by the physical attractiveness of sexual offenders.
References


Author Notes

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Footnotes

1. The findings regarding treatment of average-looking defendants are less reliable. Different studies have shown that they may be treated like attractive defendants (Friend & Vinson, 1974) or like unattractive defendants (Solomon & Schopler, 1978). These conflicting findings may be a result of differences in the operationalization of the concept 'average-looking'.

2. We also attempted to independently manipulate the offender's physical normality (normal, abnormal) through a written description of 'identifying features'. In the normal condition, the offender was described as average height and weight, and features included such things as birthmarks, moles and appendectomy scars. In the abnormal condition, the offender was described as overweight or extremely tall, and features included such things as tattoos, missing fingers and twitches. The manipulation checks demonstrated no effects of the physical normality manipulation on perceived physical attractiveness of the offender. However, the physical attractiveness manipulation confounded the physical normality manipulation, such that the only significant difference in rated normality between the normal and abnormal descriptions occurred for the physically attractive offender, p<.05. Full analyses revealed no significant main effects of the physical normality manipulation nor any interactions with the other independent variables on the dangerousness dependent measures. The physical normality independent variable was therefore excluded from all further
analyses presented here.

3. Subjects with missing data for any analysis were not included in that analysis. Therefore, the degrees of freedom vary slightly from one analysis to another.
Table 1

Question Derived Directly from the Dangerous Offender
Provisions of the Canadian Criminal Code

1. Is this person a threat to the life, safety, or physical well-being of other persons? (B)
2. Is this person a threat to the mental well-being of other persons? (C)

*3. Is this person likely to control his impulses in the future? (A)
4. Is this person likely to repeat similar offenses in the future? (A)

*5. Is this person concerned about the consequences to other persons of his behavior? (A)
6. Is this person likely to cause death, injury, or pain to other persons in the future? (A)
7. Is this person likely to inflict severe psychological damage upon other persons in the future? (C)

*8. Is this person likely to restrain his behavior in the future? (A)
9. Does this person demonstrate a pattern of repetitive aggressive behavior? (A)
10. How serious is this person's conviction record? (B)

Note. Questions marked with a * are scored in the opposite direction to the other questions. Factors are marked (A), (B), and (C): (A)=lack of future behavioral restraint, (B)=threat to physical well-being of others, (C)=threat to mental well-being of others.
Figure Captions

Figure 1. Perceived fulfillment of Dangerous Offender criteria as a function of nature of offender’s conviction record and offender’s physical attractiveness.

Figure 2. Perceived lack of future behavioral restraint as a function of nature of offender’s conviction record and offender’s physical attractiveness.
5.40

PERCEIVED DANGEROUSNESS

SEXUAL OFFENDER

NONSEXUAL OFFENDER

4.60

OFFENDER'S PHYSICAL ATTRACTIVENESS

ATTRACTION

AVERAGE

UNATTRACTIVE

ATTRACTIVE AVERAGE UNATTRACTIVE

OFFENDER'S PHYSICAL ATTRACTIVENESS
OFFENDER'S PHYSICAL ATTRACTIVENESS

PERCEIVED LACK OF FUTURE BEHAVIORAL RESTRAINT

SEXUAL OFFENDER

NONSEXUAL OFFENDER