Empirically Assessing Individuals with Sex Offenses & Major Mental Illness (SOMMI)

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Credit

SOMMI team includes Gina Ambroziak who is responsible for the excel version of the SRA-FV and data management (huge task!)

Overview for Workshop:

We will explore how criminogenic needs are present in SOMMI, how the expression of needs might be affected by their MMI, and the implications of this for assessment

Background: Predicament of SOMMI; prior research on psychosis & offending; assessment of static risk and criminogenic needs for SOMMI – can you use existing tools with SOMMI?

Hitting a Moving Target: Description of a project to assess criminogenic needs more reliably? Were we able to improve reliability?

Criminogenic Need Profile: How common are different Needs in a SOMMI population

Symptom Profile: How common are different psychotic/manic symptoms in a SOMMI population

Relation of Symptoms to Offending: Do symptoms influence offending behavior?

Relation of MMI to Criminogenic Needs: How does acuity of symptoms impact criminogenic needs? Are some individuals with SOMMI more impacted?

Background

- For a review see: Kelley, SM & Thornton, D. (2015). Assessing risk of sex offenders with major mental illness: integrating research into best practices. *Journal of Aggression, Conflict, and Peace Research*, 7(4), 258-274.
- The SOMMI population is underserved and under-researched
  - Underserved by traditional mental health system that lacks expertise in sexual deviance
  - Underserved by traditional sex offense-specific treatment programs that struggle in addressing the responsivity issues related to the MMI
  - Under researched because it comprises only a small proportion of either MMI or SO populations
- Psychosis is more related to violence than are internalizing disorders (Douglas et al., 2009)
- Externalizing disorders and empirically validated risk factors are more consistently related to general violence than psychosis (Bonta et al., 2014)
- Increased risk in MMI appears to be best accounted for by static and dynamic risk factors (Kingston et al., 2015; Lee & Hanson, 2016; Skeem et al., 2013).
- Medication appears to be a protective factor for MMI individuals (Van Dorn et al., 2013) suggesting some relationship between psychosis and violence

Background – Relationship to SO

- Psychotic symptoms appear most often to be either unrelated (only coincidentally present at the same time) to violence and sexual offending or only indirectly related (Peterson et al., 2014; Smith & Taylor, 1999). Direct causal relationships have been reported ranging for from 8% to 18% of offenders with psychosis.
- Direct causal relationships would be
  - Command auditory hallucinations
  - Delusions containing sexual elements that are clearly congruent with committing the SO
- Several ideas have been proposed regarding possible indirect effects
  - Onset of psychosis occurs at the age when individuals are in the process of sexual development and practicing intimacy. This may disrupt the progression of learning prosocial intimacy skills for individuals with MMI who maintain sexual interest (Sahota & Chesterman, 1998; Phillips et al, 1999)
  - Psychosis may exacerbate risk by reducing effective self-regulation (Greenall & Jellicoe-Jones, 2007)
  - MMI is a mediating variable leading to increased risk for those who have already been identified as needing Sex Offense-specific Treatment – MMI is predictive of treatment drop-out (Olver et al., 2011)

Background – Recidivism Studies

- Recidivism studies show inconsistent results ranging from marked effects to little/no effect
- Possible reason for inconsistent results: Lack of clear diagnostic info and differentiation in current samples: Mixed with MDO samples including various personality disorders, substance abuse disorders, ADHD, etc.
- Hanson & Bussiere's (1998) meta-analysis found a relationship between severe mental illness and sexual recidivism but this was largely attributable one sample (Hackett et al, 1971)
- Hanson & Morton-Bourgon's (2004) meta-analysis again found a significant effect of severe mental illness on sexual recidivism, now with 9 studies and N= 2,783, but this was mainly carried by one very large study with a large effect (Langstrom et al,. 2004) while there were small/no effects in several studies
- Langstrom et al. (2004): N=1,215 convicted sex offenders in Sweden
  - Sexual recidivism was found to be associated with psychosis, any psychiatric disorder, and any inpatient care
  - Much stronger relationship for substance abuse and personality disorder
- Kingston et al. (2015) found no relationship between mental illness and sexual recidivism; however, there were only 6 cases with MMI in each of the two studies (mostly included mood disorders and adjustment disorders).

Background – Recidivism Studies

- Looman & Abracen (2013) found that psychiatric impairment predicted recidivism after controlling for static risk. However, they included a mixed general mental disorder sample (ADHD, PD, etc)
- Lee & Hanson (2016): N = 947 SO's on community supervision.
  - After controlling for static and dynamic risk, the association between psychiatric history and sexual recidivism was no longer significant
  - However, they used history of overnight psychiatric hospitalization, as diagnosis was not available (e.g., sample may include PDs, depression, etc).
- Singer et al. (2013) found that parolees with mental illness were more likely to sexually recidivate even after homelessness, neighborhood, and employment were controlled
- Moulden et al. (2012): psychosis, antisocial personality disorder, and paraphilias each make a significant independent contribution to the prediction of sexual recidivism
- Overall, MMI appears to increase the risk for sexual recidivism, but it is likely that it does so by exacerbating the underlying dynamic risk factors

Background – Use of Static Tools

- Original Static-99 validation study includes 2 samples from secure psychiatric facilities, one of which (Oak Ridge) includes psychosis as a primary diagnosis. Moderate predictive accuracy at AUC = .67
- AUCs for the Static-99 among SOMMI ranged from .65 to .73 for two other samples
- Static-99R had good predictive accuracy for those with a history of psychiatric hospitalization in the DSP sample (AUC = .75)
- Overall, the Static-99R can be used with SOMMI to predict relative risk. However, the absolute predictive accuracy for this group is largely unknown since there are few SOMMI in the normative samples.
- Static-99R does not fully capture external risk factors/criminogenic needs and is not intended to assess change in response to treatment or environmental effects of offending

Background – Structured Assessment of Criminogenic Needs

- It would be highly desirable to supplement static risk factors with structured assessment of Criminogenic Needs
- So far, structured measures of Criminogenic Needs have worked poorly with SOMMI:
  - DSP study (Hanson et al., 2007): AUC for STABLE-2007 = .60
  - Craissati & Blundell (2013): AUC for STABLE-2007 = .63
  - Multiple studies with SVR-20:
    - AUCs have an extensive range; median AUC of .63
    - Unweighted mean AUC for the samples with the majority of MMI = .60
- Perhaps this is due to difficulty reliably rating the level of Criminogenic Need for MMI

Background – Structured Measures of Criminogenic Needs

Sachsenmaier et al. (2011)

- Examined the Inter-rater reliability of the SRA-FV v. 1 in Wisconsin
- N = 69 sex offenders evaluated for SVP
- n = 21 cases were identified as "low functioning" due to having cognitive deficits and/or MMI
- Overall, ICC = .55
- When the "low functioning" cases were excluded, ICC increased to .68
- This implies that IRR for these "low functioning" cases would have been well below 0.55
- Examination of scoring differences revealed that some raters discounted evidence that would have supported a factor because the rater attributed the evidence to low IQ or MMI
- Recommendation of further coding instructions for dynamic risk tools.

Sand Ridge SOMMI Study

There are four potential issues in using structured assessments of criminogenic needs within the SOMMI population:

1. The inter-rater reliability within these instruments may be lower in the SOMMI population, as raters struggle with knowing how to code behavior that they attribute to mental illness;
2. Norms are not currently available for the SOMMI population and it is not known what is an unusually high or unusually low level of criminogenic need for this population;
3. It is not clear whether the SOMMI population may have a unique set of criminogenic needs that differ from a non-mentally ill sex offender population; and
4. It is not known whether and how the presence of major mental illness symptoms may moderate or exacerbate independently existing criminogenic needs.

Sand Ridge SOMMI Study

Aims and Hypotheses:

1. To determine the frequency with which different specific criminogenic need factors are present for the SOMMI population.
2. To identify groupings of criminogenic needs within the SOMMI population.
3. To develop supplementary scoring guidance and training to facilitate the reliable application of the Structured Risk Assessment – Forensic Version (SRA-FV) to the SOMMI population.
4. To develop norms for the Structured Risk Assessment – Forensic Version (SRA-FV) for the SOMMI population. This would include determining their recidivism rates.

Sand Ridge SOMMI Study

Methodology:

- Identified any Sand Ridge patients who were diagnosed with a major mental illness by either the Sand Ridge psychiatrist or the current Ch. 980 evaluator
  - MMI = Either a psychotic spectrum disorder or Bipolar Disorder Type I
- Coded the SRA-FV v.2 and SOMMI Coding Form based on archival file review
- File review included any relevant records in the file but usually included
  - Arrest reports
  - DOC records
  - Psychiatric records
  - Sand Ridge records

SOMMI Coding Form

- Captured demographic data
- Age of onset of offending versus age of onset of mental illness symptoms
- Characteristics of past offenses
  - Victim type
  - Substance use at time of offense
  - Level of planning
  - Emotional state
  - Presence of MMI symptoms
  - Medication compliance near time of offense
  - Effect of MMI symptoms on offense (direct, indirect, coincidental, none)
- Relationship between MMI and LTVs
  - LTV pre-existed MMI? MMI exacerbate, mitigate, or have no effect on LTV?

Sand Ridge SOMMI Study – 1 – Hitting a Moving Target

A PROJECT TO ASSESS CRIMINOGENIC NEEDS MORE RELIABLY

LETITIA JOHNSON & RYAN MATTEK

Instrument: SRA-FV - 2

Based on the instrument reported by Knight & Thornton (2007) but extensively revised and modified to improve reliability

Article

Construction and Validation of SRA-FV Need Assessment

Sexual Abuse: A Journal of Research and Treatment
XX(X) 1–16

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SAGE

David Thornton[1] and Raymond A. Knight[2]

Abstract
This article describes the construction and testing of a newly designed instrument to assess psychological factors associated with increased rates of sexual recidivism. The new instrument (Structured Risk Assessment–Forensic Version or SRA-FV) was based on previous research using the SRA framework. This article describes the results of testing SRA-FV with a large sample (N = 566) of sexual offenders being evaluated for an early civil commitment program. SRA-FV was found to significantly predict sexual recidivism for both child molesters and rapists and to have incremental predictive value relative to two widely used static actuarial instruments (Static-99R; Risk Matrix 2000/S).

Keywords
criminogenic need, risk assessment, recidivism, prediction, sex offenders

The past two decades have seen the development of multiple statistical risk assessment tools for sexual offenders. Actuarial instruments that provide a mechanical combination of statistically identified static risk indicators have proven themselves able to create groups that reliably differ in their relative risk for sexual recidivism (Hanson & Morton-Bourgon, 2009). Some of these instruments have become very widely used. Whereas the Risk Matrix 2000 (RM2000/S; Barnett, Wakeling, & Howard, 2010; Thornton et al., 2003) has notably been the standard instrument used in the United Kingdom by prison and probation services, as well as by police forces, the original Static-99 (Hanson & Thornton, 2000) is likely the most widely used actuarial instrument across the Unites States and Canada.

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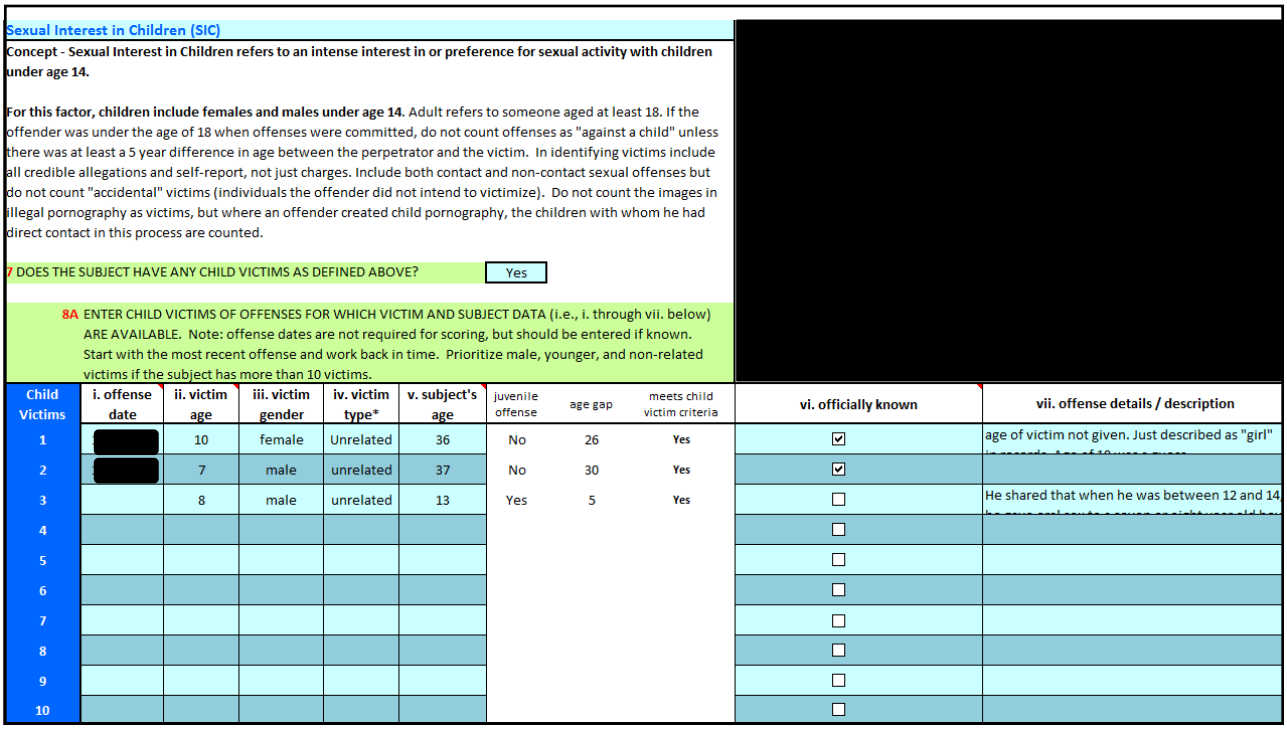
Changes to SRA-FV

- Etiological guidelines – coders encouraged not to discount evidence because it's explained by MMI but to focus on whether it indicates enduring characteristics
  - Guidelines provided in how to determine whether an item is a generalized trait or expressed only in narrow contexts
- Items with poor IRR have been re-written and tested. Those that continue to result in poor IRR are dropped.
- Items are accompanied with case examples that anchor upper and lower bound scores
- Coding is made directly into an Excel program, which identifies and/or blocks potential scoring errors
  - New coding areas pop up depending on responses given by examiner. This allows the examiner to breeze through items that are irrelevant for that particular case.
  - The software provides prompts, notes, clarifications, and completes the math



Sexual Interest in Children (SIC)

Concept - Sexual Interest in Children refers to an intense interest in or preference for sexual activity with children under age 14.

For this factor, children include females and males under age 14. Adult refers to someone aged at least 18. If the offender was under the age of 18 when offenses were committed, do not count offenses as "against a child" unless there was at least a 5 year difference in age between the perpetrator and the victim. In identifying victims include all credible allegations and self-report, not just charges. Include both contact and non-contact sexual offenses but do not count "accidental" victims (individuals the offender did not intend to victimize). Do not count the images in illegal pornography as victims, but where an offender created child pornography, the children with whom he had direct contact in this process are counted.

7 DOES THE SUBJECT HAVE ANY CHILD VICTIMS AS DEFINED ABOVE? Yes

8A ENTER CHILD VICTIMS OF OFFENSES FOR WHICH VICTIM AND SUBJECT DATA (i.e., i. through vii. below) ARE AVAILABLE. Note: offense dates are not required for scoring, but should be entered if known. Start with the most recent offense and work back in time. Prioritize male, younger, and non-related victims if the subject has more than 10 victims.

Child Victims	i. offense date	ii. victim age	iii. victim gender	iv. victim type*	v. subject's age	juvenile offense	age gap	meets child victim criteria	vi. officially known	vii. offense details / description
1	[redacted]	10	female	Unrelated	36	No	26	Yes	☑	age of victim not given. Just described as "girl"
2	[redacted]	7	male	unrelated	37	No	30	Yes	☑	
3		8	male	unrelated	13	Yes	5	Yes	☐	He shared that when he was between 12 and 14
4									☐	
5									☐	
6									☐	
7									☐	
8									☐	
9									☐	
10									☐	

48 HAS THE SUBJECT COMMITTED ANY **SEXUAL OFFENSES** * THAT INVOLVED OVERT BRUTALITY †? Yes

** Include attempted sexual offenses and sexually motivated offenses.*

Sexual Offenses

Examples of Overt Brutality †	Do NOT count examples of Lesser Cruelty, such as:
a. sexual murder or attempted sexual murder	victim protests, says "no", or begs him to stop
b. poisoned victim	drugged victim
c. stabbed victim/victim required multiple stitches	victim only acquiesces under threat
d. broke victim's bones	slapped victim
e. knocked victim unconscious	pushed victim to the ground/held victim down
f. victim suffered extensive bruising	victim suffered minor bruising
g. victim was crying/screaming over some extended period of time throughout offense	victim only cried out/screamed at outset of offense (e.g., the victim screams when the subject grabs her)
h. put a gun to victim's head or a knife to throat	brandished a gun, knife, or other weapon
i. choking, strangling, or drowning victim	grabbed victim by neck
j. kicked a pregnant woman in the stomach	the victim is drunk or asleep
k. penile penetration of a child age 10 or under	penile penetration of a child **if** the subject is under 15
l. digital penetration of a child age 5 or under	digital penetration of a child **if** the subject is under 15
m. penetration with an object	the victim did not show obvious distress (e.g., a child
n. penetration causing physical damage	who had been groomed to accept without protest /
o. gang rape	go along with the abuse)
p. repeated escape attempts are thwarted or victim's resistance is ongoing throughout offense	the victim initially resists or attempts to escape, but rather quickly desists resistance
q. other severe overt brutality - e.g., burning, electric shocks, etc. (describe):	
r. other marginal overt brutality (describe):	the victim's display of distress led to the subject terminating the offense (e.g., the victim started crying and the subject stopped)

49 ENTER DETAILS REGARDING THE SUBJECT'S SEXUAL OFFENSES WITH OVERT BRUTALITY BELOW. START WITH THE MOST RECENT OFFENSE AND WORK BACK IN TIME.

Sexual	Date of Sex Offense	Types of Overt Brutality Inflicted † (see table above)	Officially Known	Details or Comments
1	[redacted]	☐a ☐b ☐c ☐d ☐e ☐f ☐g ☐h ☐i ☐j ☑k ☐l ☐m ☐n ☐o ☐p ☐q ☐r	☑	[redacted] took 9-year old, 10-year old, and 11-year old boys whom he knew to a house
2	[redacted]	☐a ☐b ☐c ☐d ☐e ☐f ☐g ☐h ☐i ☐j ☑k ☐l ☐m ☐n ☐o ☐p ☐q ☐r	☐	[redacted] grabbed a 10-year-old boy, took him to a house, where he told him to take
3		☐a ☐b ☐c ☐d ☐e ☐f ☐g ☐h ☐i ☐j ☐k ☐l ☐m ☐n ☐o ☐p ☐q ☐r	☐	
4		☐a ☐b ☐c ☐d ☐e ☐f ☐g ☐h ☐i ☐j ☐k ☐l ☐m ☐n ☐o ☐p ☐q ☐r	☐	
5		☐a ☐b ☐c ☐d ☐e ☐f ☐g ☐h ☐i ☐j ☐k ☐l ☐m ☐n ☐o ☐p ☐q ☐r	☐	
6		☐a ☐b ☐c ☐d ☐e ☐f ☐g ☐h ☐i ☐j ☐k ☐l ☐m ☐n ☐o ☐p ☐q ☐r	☐	
7		☐a ☐b ☐c ☐d ☐e ☐f ☐g ☐h ☐i ☐j ☐k ☐l ☐m ☐n ☐o ☐p ☐q ☐r	☐	

THE SUBJECT HAS COMMITTED 2 SEX OFFENSES WITH OVERT BRUTALITY.

50 RECORD ADDITIONAL COMMENTS REGARDING CRUEL BEHAVIOR DURING SEXUAL OFFENSES HERE:

per 2011 SRA-FV: No indication that violence used during offenses were motivated other than to gain compliance of

Sexual Interest in Children - Summary of Evidence For and Against

Evidence For	*Evidence Against*
• # of Child Victims = 3	
• Offenses against children span > 6 months	
• Male victim under 14	
• Unrelated victim under 14	
• ≥ 2 victims under 14	
• ≥ 1 victim under 11	
• Self-report of sexual fantasies about children (3+)	
• Self-report of sexual attraction to children (3+)	
	• Has had sex with 3+ adults
	• No use of child pornography
• Use of other child-focused materials	

Compulsive Sexuality - Summary of Evidence For and Against

Evidence For	*Evidence Against*
	• No or moderate levels of pornography use
	• No history of predatory stalking
	• No history of sexual harassment
• 3 or more sex acts within an offense event	
	• No history of high masturbation frequency
	• No history of a high rate of sex acts with others
• Other types of offense-related sexual fantasies	
	• < 2 of the relevant Paraphilic Disorders
• Rapid sexual re-offense following sanction for sexual offense	
• Contact sexual offenses against ≥ 3 victims within 6 months	
• Conditional Release revoked for sexual misconduct	
	• No sexual offenses committed in institutions
	• No fraternization attempts following sanction

A series of small scale studies (about 25 cases double scored) with SOMMI and Non-SOMMI cases have led to the scale being simplified with some factors dropped as too hard to assess reliably when doing ratings from files

Results shown are for the reduced/improved version of the scale. Retained factors were reliable in non-SOMMI samples and were predictive of sexual recidivism

SOMMI Sample

- N = 55 individual cases
- 3 Research Coders
- 29 cases have been double coded

Sample Diagnostic Characteristics (available on 51 cases)

PRIMARY

35% - Schizophrenia

31% - Schizoaffective Disorder

7% - Bipolar I Disorder

26% - Other psychotic disorder

COMORBID

51% - Antisocial Personality Disorder

47% - Pedophilic Disorder

6% - Sexual Sadism Disorder

24% - Other Specified Paraphilic Disorder

Static-99R = 5.4 (SD = 1.9)

Age = 50.8 (SD = 10.1)

SRA-FV v.2 Inter-Rater Reliability with SOMMI For Overall Need Score *IRR = .74*

IRR FOR SEXUAL LTV SCALES

Sexual Interest in Children	= 0.94
Sexualized Violence	= 0.44
Compulsive Sexual Behavior	= 0.62
Number of Sexual LTVs	=0.81

IRR FOR ANTISOCIAL NON-SEXUAL LTV SCALES

Hostility to Women	= 0.69
GT / Poorly Managed Anger	= 0.53
Resistance	= 0.71
Number of Antisocial Non-sexual LTVs	=0.51

Some IRR Issues encountered

Differences in Information used for Scoring
- Sometimes one rater might have reviewed the file more thoroughly or had more info because they had previously evaluated the case

Files don't contain sufficient information
- Sometimes there was limited information and there were rater differences in how this was interpreted. At an extreme this might turn into "inferential scoring" which we tried to discourage
- This issue applied more to some items than others

Occasionally there were different understandings of the scoring rules
- We have tried to clear these up for the future by adding notes

Poor Fit between case presentation and scoring rules
- Some individuals with SOMMI had unusually shaped belief systems (resulting from their symptoms) – for example, a patient suspects that female staff are having sex with all the patient except him, he becomes very angry in response to this, ruminates about how unfair it is, and assaults a female staff member. So he was suspicious in a very specific (but persistent) way. Is this "generalized and persistent"?

Comparison of Present Reliability to that of earlier Versions of the Scale

Clearly the present scale is producing much more reliable results for SOMMI than was obtained with version 1

We had a longer version 2 (results presented at ATSA in 2015) and that produced similar IRR to the present, shorter version.

Usually, the longer a scale is, the more reliable the scores produced by it are so we are pleased to have been able to shorten SRA-FV-2 substantially while retaining an acceptable IRR

Our Raters now have more experience with the scale and have gone through reconciliation exercises to produce consensus scores. We anticipate that they may be able to produce more reliable scores in the future.

Some factors are easier to rate if you have clinical contact with the individual.

Sand Ridge SOMMI Study – 2 – Criminogenic Need Profiles

HOW COMMON ARE DIFFERENT CRIMINOGENIC NEEDS FOR SOMMI?

Need Profile from SRA-FV-2

SRA-FV-2 has mechanical rules that determine whether there is enough evidence to say a Need Factor is present. There are also global ratings made for each factor.

Each individual can be characterized in terms of which factors apply to them. The six factors retained in SRA-FV-2 for this study are shown on the next slide

After that we show how common these six factors were for our SVP SOMMI sample

Sexual Criminogenic Need Factors

- Sexual Interest in Children is sexual interest in prepubescent and early pubescent children
- Sexualized Violence is sexual interest in coercion, brutality, humiliation, fear etc.
- Compulsive Sexual Behavior denotes sexual behavior having a driven, compulsive quality as indicated by such things as a high frequency of masturbation

Antisocial Non-Sexual Criminogenic Need Factors

- Hostility to Women – Distrust of; Domineering Behavior towards; Hostile Behavior towards
- Grievance Thinking & Poorly Managed Anger – Suspiciousness, Angry Rumination, Angry Behavior
- Resistance – Resistance to supervision & control

Note that the current version of SRA-FV-2 also includes a factor for Misuse of Alcohol and Stimulant Drugs but this wasn't scored for all the SOMMI cases so results for it are not included here.

Profile from SRA-FV-2

SEXUAL LTVS		ANTISOCIAL NON-SEXUAL LTVS	
Sexual Interest in Children	= 49%	Hostility to Women	= 31%
Sexualized Violence	= 16%	GT & Poorly Managed Anger	= 84%
Compulsive Sexual Behavior	= 66%	Resistance	= 93%

Nearly half (44%) had two or more sexual LTVs

Four-fifths (84%) had two or more antisocial non-sexual LTVs

Relationship between Sexual and Antisocial Non-Sexual Need Factors

Correlation = -0.26

In other words the two kinds of Need factor are largely independent of each other in this population with a slight tendency for the more sexually deviant to be less generally antisocial

In practice, in an SVP population, everybody has some criminogenic needs, true, low Need individuals don't get committed as SVPs so most individuals in this sample fall into two categories:

- Very Highly sexually deviant with moderate levels of antisociality
- Highly Sexually deviant with high levels of antisociality

SRA Clinical Rating Scheme

We also used a more comprehensive SRA Clinical Rating Scheme

- This covers a broader range of factors and involves clinical ratings of whether they were persistent and generalized features of the individuals
- We used this because we were concerned that the narrowing of SRA-FV-2 to focus on more reliably scorable factors might have led us to miss something important for individuals with SOMMI

Profile from SRA Clinical Ratings

Offense-related Sexual Interests (ORSI)= 67%

Hypersexuality/Sex Preoccupation = 93%

Difficulty with Romantic Relationships = 93%

Emotional Congruence with Children = 16%

Grievance Thinking = 87%

Poor Empathy = 93%

Oppositional = 96%

Poor Emotional Control = 87%

Poor Problem-solving = 98%

Added Value of the The Clinical Rating Scheme

It identified some factors as either being largely present for SOMMI individuals or largely absent

It is hard to differentiate between individuals on these factors reliably since the sample are pretty much all the same on them but they add to the picture of what SOMMI individuals as a group are like

- Almost all showed poor emotional control and poor problem-solving
- Almost all had problems with relationships
- Very few showed emotional congruence with children

Summary

Most had some specifically sexual problem (ORSI or Hypersexuality) but this was particularly severe in about half of them

Difficulties with romantic relationships with adults were common but few had "solved" this by seeking emotional connection with children

Most had multiple antisocial non-sexual problems (Oppositional Reactions; Hostility etc)

It is not clear how much this is a consequence of their being SVPs. Non-SVP SOMMI might be different.

Sand Ridge SOMMI Study – 3 – Symptom Profiles

HOW COMMON ARE PSYCHOTIC AND MANIC SYMPTOMS FOR SOMMI? – CODED BASED ON EVER BEING PRESENT IN THEIR HISTORY

DAVID THORNTON

History of Hallucinations (N = 55)

Type of Hallucination	How common?
Auditory without Command	78%
Auditory with Command	51%
Visual (as reported – ID & ASPD)	46%

History of Delusions

Type of Delusion	How common?
Erotomanic	16%
Grandiose	46%
Paranoid	75%
Jealous	7%
Somatic	22%
Other	20%

History of Disorganized and Negative Symptoms

Symptom	How common?
Disorganized Speech	42%
Grossly disorganized behavior or catatonia	33%
Negative symptom presentation	53%
Other psychotic symptoms	20%

History of Manic Symptoms

Type of Manic Symptoms	How common?
Inflated self-esteem or grandiosity	51%
Needing less than 3 hours a night sleep	42%
More talkative / Pressured speech	42%
Flight of Ideas / Racing Thoughts	38%
Distractibility	62%
Increase in Goal Directed Activity	24%
Excessive involvement in pleasurable experiences (buying sprees, sex etc.)	47%
Other Manic Symptoms	24%

Sand Ridge SOMMI Study – 4 – The Voices made me do it

RELATION OF SYMPTOMS TO OFFENDING

Smith & Taylor (1999) – to give a context to our results

84 pts with Schizophrenia were hospitalized after conviction for a sex offense

- 80 pts committed sex offense when actively psychotic
- 4 pts had onset of psychosis following offense

	Direct	Indirect	Coincidental	Not present	Total
Delusions	18%	25%	51%	6%	N=80
Hallucinations	15%	18%	45%	22%	N=80

Effect of Psychiatric Symptoms for Offenses

	Offense #1	Offense #2	Offense #3
N	48	49	41
Direct	15%	18%	7%
Indirect	6%	6%	20%
Coincidental	4%	6%	12%
No symptoms present	71%	63%	61%

Motivation for Offenses

Motivation	Offense #1	Offense #2	Offense #3
Part of general antisocial/criminal behavior pattern	35%	29%	33%
Expression of deviant arousal pattern	53%	58%	56%

Sand Ridge SOMMI Study – 5 – Effect of Symptoms on Risk Factors

HOW DOES ACUITY OF MMI SYMPTOMS AFFECT PSYCHOLOGICAL RISK FACTORS?

LTV & Mental Illness: Sexual Interests Domain

LTV	Pre-existed MMI	Made worse by MMI
Offense-related Sexual Interests	71%	26%
Sexual Preoccupation	63%	41%

LTV & Mental Illness: Relational Style Domain

LTV	Pre-existed MMI	Made worse by MMI
Difficulty with Marital Relationships	74%	53%
Emotional Congruence with Children	78%	20%
Poor Empathy	67%	45%
Grievance Thinking	59%	75%

LTV & Mental Illness: Self-Management Domain

LTV	Pre-existed MMI	Made worse by MMI
Resistance to Rules and Supervision	71%	55%
Poor Problem-Solving	63%	72%
Poor Emotional Control	64%	60% (mitigated for 8%)

Relationship Summary

Made worse in Two-Thirds or more of Cases where present	Made worse in about half of Cases where present	Made worse in a third or fewer Cases when present
Grievance Thinking Poor Problem-Solving	Sexual Preoccupation Difficulties with Marital Relationships Poor Empathy Resistance to Supervision Poor Emotional Control	ORSI

Cumulative Impact of MMI

It is not clear from the above tables how the effect of MMI is distributed across people

Is everyone affected?

Is everyone affected but people differ in which factors are affected?

Are some people not affected and other markedly impacted?

Cumulative Scale Assessing Effect of MMI

Can we create an overall index of how much worse acute MMI makes psychological risk factors?

For each factor add one point if the factor is coded as present and clearly made worse by MMI

Resulting scale appears to be reasonably reliable

- **Inter rater r = 0.70**

- Just under a quarter score zero on the scale, indicating no effect of MMI on psychological risk factors
- About a quarter score 1-3, meaning that a few psychological risk factors are impacted by MMI
- Over half score 4 or more (up to 8), meaning many psychological risk factors worsen when their MMI becomes more acute

Reflections and Suggestions

- In this population of SOMMI many LTVs are markedly present; only Emotional Congruence with Children is rare
- It is rare for Command Hallucinations to result in sexual offenses, even in a SOMMI population, though this does happen occasionally
- Psychological risk factors often pre-exist MMI but typically are made worse when MMI symptoms are more acute
- Individuals with SOMMI vary considerably in the degree to which their Psychological risk factors are made worse when MMI symptoms are more acute
- Systematic assessment of this appears to be possible and should become a regular part of the assessment of individuals with SOMMI

SOMMI Beyond Sand Ridge

Data coding has been completed at Sand Ridge.

Two additional SOMMI studies are underway:

- Archival coding of the SOMMI cases identified in the old and new Bridgewater data (about N =100) and project collaboration with Ray Knight
- A prospective SOMMI research project by the Connecticut Valley Hospital in Middletown, CT. They will start coding their own cases at the end of June. This is a secure psychiatric hospital for both forensic and civil commitments (non-SVP).

Hopeful future collaborations:

- Mendota Mental Health Institute