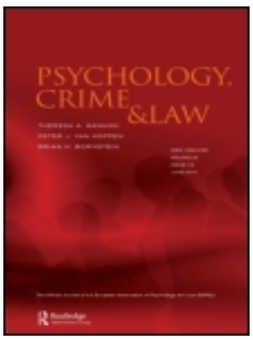

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Dynamic risk factors: a theoretical dead-end?

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While the quality of empirical research on risk predication, assessment and management in the sexual offending field has been of a high standard, relatively little attention has been paid to theoretical issues related to risk and its conceptualisation. In this paper, we develop alternative ways of understanding dynamic risk factors and their utility in theory construction and case formulation. We would stress that this work is of a preliminary nature but believe that it is crucial that standard clinical and research practices are critically challenged from time to time, and their underlying theoretical assumptions evaluated. Our aim is to encourage researchers and practitioners to look at the issue of dynamic risk factors from a different viewpoint; one that we hope can help move the sex offender field forward.

Keywords: sexual offenders; risk assessment; aetiology

Introduction

Researchers in the correctional and sexual offending fields have given considerable thought to the development and validation of risk assessment measures and protocols in an attempt to streamline assessment and subsequent treatment (Mann, Hanson, & Thornton, 2010; Ward, in press). Historically, there has been a move from the use of unstructured professional judgement to the employment of actuarial methods. Furthermore, recently, there has also been increasing emphasis on the construction of risk formulations using structured professional judgement (Cooke & Michie, 2013). The information gathered in the risk assessment process covers most areas of human functioning and ranges from offenders' psychological and developmental characteristics to the explicit utilisation of biomarkers such as low levels of monoamine oxidase-A (MAO-A; see Baum & Savulescu, 2014). If there are improvements in the quality of risk assessment instruments then assessment and intervention can be more precisely targeted. In line with this viewpoint, several recent theorists have tried to strengthen the relationship between risk assessment and clinical assessment by explicitly integrating risk and psychological variables in forensic case formulations (Hart, Sturmey, Logan, & McMurran, 2011; Sturmey & McMurran, 2011).

In brief, risk assessment is the process of using risk factors (i.e., any variable that is measurable and predictive) to estimate the likelihood of a hazard occurring to a person or persons in the future (Cooke & Michie, 2013). The process of risk assessment may vary in terms of its degree of structure and reliance on professional judgement and/or a set of explicit rules (Douglas, Blanchard, & Hendry, 2013). The nature of the risk factors used

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in research and clinical assessment varies in a number of ways including their degree of changeability (static vs. dynamic), duration (stable vs. acute), content (e.g., relational style, attitudes and biomarkers), form (risk vs. protective) and function (causal, contributing or contextual).

While the quality of empirical research on risk predication, assessment and management has been of a high standard, relatively little attention has been paid to risk-related theoretical issues (Beech & Ward, 2004; Cooke & Michie, 2013; Douglas et al., 2013; Ward, in press). In particular, the structure of dynamic risk factors and their relationship to the aetiology of offending has been neglected (see Mann et al., 2010). This is unfortunate because as noted by Sturmey and McMurran (2011) a comprehensive forensic case formulation relies on causal inferences as well as an accurate description of clinical phenomena and risk variables. In order to successfully treat individuals who have committed serious offences against other people, it is necessary to modify, or at the very least manage, offence-related dispositions and traits.

From our perspective, the marked discrepancy between the quality and the quantity of research on risk assessment compared to that on the aetiology and nature of risk is puzzling and unfortunate. One reason for the neglect of theoretical issues may be that the prevailing theory of scientific method accepted by researchers in the area is narrowly empiricist and heavily committed to the formulation of empirical generalisations and prediction at the expense of explanation (Haig, 2005, 2014; Ward, Polaschek, & Beech, 2006). If so, this is a misguided strategy as research without clearly articulated concepts and theories will rapidly lose direction.

A key reason for the neglect of theoretical issues associated with risk assessment seems to be that there is little communication between researchers working in adjacent areas within the offending field. Individuals investigating risk assessment and those researching the causes of offending – or the features of offenders – do not appear to read papers outside their narrow area of speciality or, for that matter, believe that they have anything useful to learn from each other. There also appears to be an inherent failure to critically evaluate prominent rehabilitation theories. For example, the Risk-Need-Responsivity model (currently the premier rehabilitation theory in North America and the UK) directly indicates risk-related offender treatment targets such as intimacy deficits, offence supportive attitudes and self-management difficulties using research examining criminogenic needs (Thornton, 2013). Thus, it *appears* that the exact causes of offending have been validly identified and underwritten by science. Unfortunately, this is far from the case and as we will argue below, dynamic risk factors are best conceptualised as clusters of clinical features or 'symptoms' generated by underlying causal mechanisms, rather than being causes themselves.

In this paper, we concentrate on dynamic rather than static (i.e., fixed or unchangeable) risk factors for sexual offending because of their association with contemporary treatment and research (Thornton, 2013). We have chosen to concentrate on sexual offending because this is our primary field of expertise although the argument and conclusions presented in this paper extend to other offenders. First, we analyse dynamic risk factors and argue that they are complex constructs containing both phenomena ('symptom') and causal aspects. We also argue that the concept of dynamic risk factors evident in the literature is inherently ambiguous and contains contradictory elements. Dynamic risk factors as currently conceptualised do not accurately depict the nature of offending and the situations in which sexual offences occur. At best, they are psychometric predictive devices that loosely refer to or are markers of genuine underlying causal mechanisms. In the second section of the paper,

we conceptualise dynamic risk factors as attributes of *exemplars* (i.e., symptoms, psychological problems) that have unique temporal trajectories. In the third section, we explore the utilisation of dynamic risk factors in the formulation of explanatory models of sexual offending. We argue for a multilevel, interfield conception of scientific explanation and outline a role for dynamic risk factors in this process. Finally, we discuss the clinical and research implications of our depiction of the relationship between dynamic risk factors and etiological factors in the sexual offending field. Our key idea is that researchers should break dynamic risk factors into two parts and after fleshing out the descriptive component, employ the causal one to construct an explanation of the risk-related problems, and in conjunction with other causes, the whole exemplar.

The nature of risk

Quite often there appears to be a misunderstanding of risk assessment. What it is not is the prediction of changes in offending behaviours (typically ramping up in seriousness, or crossover). What it is about is predicting repetition. Hence, risk assessment with any offender group is concerned with estimating the likelihood of a reoccurrence of offending in situations of uncertainty.

Variables that are associated with the onset, or reoccurrence, of offending are typically called *risk factors*. According to Monahan (2014) such risks factors are:

> (a) any variable that statistically correlates with the outcome; and (b) precedes the outcome in time. There is no implication in this definition that the risk factor in any sense 'causes' the occurrence of the outcome. (p. 63)

Risk factors are heterogeneous in nature and include offender characteristics such as attitudes and beliefs, developmental experiences and contextual factors such as relationship conflict, biomarkers or substances such as alcohol (Beech & Ward, 2004). In recent years, researchers have supplemented risk assessment measures with what have been called *protective factors* (Thornton, 2013).

In an attempt to conceptually integrate risk factors with more aetiological factors, Beech and Ward (2004) mapped the causal relationships between risk factors (static and dynamic) and the clinical problems identified in sexual offenders. According to Beech and Ward, historical and static risk factors such as *number of victims* function as markers of underlying psychological vulnerabilities to commit a sexual offence. They argued that the reason why risk assessment instruments for sex offenders, such as the Static-99 (Hanson & Thornton, 2000), are good predictors of future offending is because the static (i.e., fixed or unchangeable) factors mark offence-related proclivities in certain individuals (Beech & Ward, 2004). In Beech and Ward's risk-aetiology model, stable dynamic risk factors are viewed as psychological traits or properties that create vulnerabilities for sexual offending (e.g., intimacy deficits). Acute dynamic factors are conceptualised as acute mental states that emerge out of – or are caused by – stable dynamic factors and are activated in specific contexts such as social rejection. Beech and Ward argue that the major explanatory work is accounted for by stable dynamic risk factors.

In a recent paper, Mann et al. (2010) raise questions concerning the validity of the distinction between dynamic and acute risk factors and identify a number of what they call *psychologically meaningful* risk factors which they believe to be prima facie causes

of sexual offending and validated predictors of recidivism. They propose that to qualify as psychological meaningful risk factors: (1) there should be plausible reasons for regarding the factor in question as a cause of sexual offending and (2) strong evidence should exist that it actually predicts sexual offending. Mann et al. state that:

> another way to understand risk factors, instead of classifying them as static or dynamic, is by adopting the concept of psychologically meaningful risk factors. Such risk factors can be conceptualized as individual propensities, which may or may not manifest during any particular time period. (p. 194)

The list of empirically supported meaningful risk factors for child sexual abuse in their paper includes: sexual preferences for children, emotional congruence with children, offence supportive attitudes and lack of adult intimate relationships. Mann et al. conclude that: 'the causal factors for sexual recidivism will ultimately be drawn from variables similar to those included in our list. We believe that it is these variables that should be emphasized in treatment' (p. 210).

A difficulty with the papers by Beech and Ward (2004) and Mann et al. (2010) as well as subsequent papers (see Thornton, 2013) is that they have not really theoretically reflected on the nature of dynamic risk factors and their role in theory construction. By 'nature' we are referring to the structure and functions of dynamic risk factors. Researchers appear to have neglected the fact that causal claims need to be underpinned by an understanding of causal processes (i.e., theory formulation). Furthermore, it is likely that there will be a number of causal mechanisms resulting in sexual offending and most probably they will interact with each other. With respect to determining what factors are genuinely causal, it is not sufficient to manipulate variables experimentally (Haig, 2005, 2014; Ward et al., 2006).

Even if one can demonstrate that a set of effects regularly follows from the manipulation of an independent variable, one will not necessarily understand what the causal mechanisms are. What is required is an attempt to specify the underlying causal entities and their relationships with each other, and by doing so, an account of how the clinical features associated with sexually abusive actions are generated (see below). Theorists such as Beech and Ward (2004) and Mann et al. (2010) have established dynamic risk factors such as deviant sexual preferences or intimacy deficits as *conceptual markers* or a combination of state and nascent causal factors. Positing dynamic risk factors as possible causes does not clarify their internal structure and runs the risk of conflating quite distinct concepts (i.e., causal entities versus clinical features, see below).

Furthermore, as stated above, the construction of explanatory theories and clinical case formulations rests on judgements concerning the *interaction* between multiple causal mechanisms, and simply referring to a list of dynamic stable and acute risk factors is insufficient for this cognitive task. In our view, practitioners need to draw from exemplars or descriptions of features associated with particular sexual offending trajectories or types, and models that at least in general terms depict the causal mechanisms that result in their occurrence.

The structure and function of dynamic risk factors

It is apparent from the above discussion that some researchers regard dynamic risk factors as (potentially) *psychologically meaningful causes* to use Mann et al.'s (2010) vivid

phrase. But it also seems to us that the dynamic factors listed in research papers on risk assessment are not causal factors in any straightforward sense. In their list, Russell and Darjee (2013) identified social influences, intimacy deficits, general self-regulation problems, sexual self-regulation difficulties, pro-offending attitudes and lack of cooperation with supervision as stable dynamic factors. Each of these stable factors is subdivided into more specific factors; for example, intimacy deficits incorporate emotional identification with children, lack of concern for others and general social rejection. While acute dynamic factors associated with sex offending are divided into the categories of *triggers* (e.g., deteriorating relationships, increased access to victims) and *situational* state variables (e.g., increased sexual preoccupation, isolation, lowered mood).

Russell and Darjee's description of dynamic risk factors is vague; appearing to include both trait and state aspects. For example, the stable dynamic factor of general self-regulation includes negative emotionality (a mental state) and poor problem-solving (a trait or enduring psychological feature). It is also not clear how the components of each stable dynamic factor relate to each other or what method was used to group them.

Lists of risk factors compiled by researchers such as Russell and Darjee are usually derived from measurement and statistical analyses rather than causal models. Furthermore, some of the conceptual subcomponents of stable dynamic factors identified by researchers seem to be inconsistent with one another. In his recent summary of risk and protective factors in adult male sexual offenders, Thornton (2013) listed sexual violence and sexual interest in children as subdomains of the general dynamic risk factor of sexual interests. The problem is that the 'umbrella', so to speak, of deviant sexual interests consists of qualitatively different variables, which arguably refer to distinct causal processes and their associated problems.

The conflation between surface features, symptoms or problems evident in sexual offender theorising raises another poorly addressed problem in the area: the need to decide exactly what it is theorists are trying to explain (Ward, in press). Focusing inquiry on the *behaviour* that constitutes sexual offending is too vague, and is likely to result in overly general and weak explanations. Rather the focus should be on the clusters of 'symptoms' or clinical problem that typically accompany sexual offending. The basic idea underlying this line of thinking is that a suite of 'symptoms' caused by dysfunction in psychological, behavioural and biological systems are evident in sexual offenders prior to committing an offence and/or as a consequence of offending. It makes sense to direct clinical and scientific attention to these clusters of difficulties rather than just sexual offending actions.

Another issue poorly dealt with by researchers concerns the *functions* of dynamic risk factors. Understanding the functions of dynamic risk factors should clarify why they result in the kinds of problems sex offenders exhibit and explain how different types of risk factors interact with contextual variables and each other to cause sexual offending. Beech and Ward's (2004) mapping of risk factors onto an aetiological framework does begin the attempt to represent the causal (functional) links between sexual offending, offender psychological problems and contextual features. However, this is rare in the field and influential researchers such as Mann et al. (2010), and Thornton (2013), do not address the issue of functional relationships. While there has been an encouraging recent emphasis in the forensic and correctional risk literature on the use of structured professional judgement and case formulations, the appeal to explanations of risk factors (phenomena) is inconsistent and unsystematic (see Cooke & Michie, 2013; Hart et al., 2011, for a discussion of these issues).

Attention to the function of dynamic risk factors is important because it helps researchers and practitioners to grasp the links between sexual offending, assessment and treatment. In order to effectively treat sexual offenders, it is necessary to construct a case formulation in which problems and their development and interrelationships are clearly spelled out. And, in order to formulate cases, it is necessary to draw from aetiological theories of some kind. In the absence of access to etiological theories, the danger is that practitioners will merely (re)describe a case and are left with little understanding regarding what is actually driving the offence process.

Thus, dynamic risk factors are complex clinical constructs with multiple, sometimes contradictory, conceptual strands to them. Researchers have tended to adopt a bottom-up strategy and arrive at risk domains through an informal conceptual factor analysis once empirical research has identified a number of recidivism predictors. While this strategy is useful in revealing clusters or domains (Thornton, 2013) of risk factors, it is unable to distinguish between questions of structure and process.

Furthermore, because the descriptive aspects of dynamic risk factors are muddled up with their causal aspects, it can create the impression that they represent genuine causal explanations when in fact they do not. This can mislead both researchers and clinicians, in different ways and imposing different costs. The question remains, is there a way of conceptualising dynamic risk factors that avoids these problems? In our view, a possible way forward is to ensure that research on risk factors is embedded within a systematic theory of scientific method that discriminates between detecting and describing clinical phenomena.

Dynamic risk factors as exemplars

As argued above, it makes sense to separate out the symptom-like or descriptive aspects of dynamic risk factors from their causal components, and to concentrate explanatory efforts on the latter (i.e., use the nascent causal strands of dynamic risk factors to construct explanatory theories). However, before this is possible it is first necessary to tidy up the conceptualisation of the phenomenal or 'symptom-like' aspects of dynamic risk factors. To this end, we suggest that a useful (i.e., by way of analogy) way to regard dynamic risk factors is as attributes of clinical *exemplars*. In his book on the conceptualisation and classification of mental disorders from a cognitive neuroscience perspective, Murphy (2006) states that:

> An exemplar is a representation of the typical course and symptoms of a mental illness, whereas a model is a representation of those symptoms, that course, and the causal determinants of both of them. A model is an exemplar together with an explanation. (p. 206)

For example, a major depressive disorder consists of a number of symptoms such as sad mood, loss of pleasure, disturbed sleep, poor appetite, lowered energy levels and low self-esteem that coexist for a specified length of time. According to Murphy, exemplars are idealisations and are based on a composite patient who has, in an acknowledged form, the disorder we wish to explain. The various attributes or symptoms/signs of an exemplar are somewhat flexible as mental illness typically takes slightly different forms in different patients. Once an exemplar for a specific disorder has been constructed, and the various problems (symptoms, signs, etc.) carefully noted, it is possible to start the process of developing models to explain it. In the psychopathology domain, explanations of

abnormality are derived from models of how the psychological systems in question normally work.

In fact, without some kind of idea of how a system ought to function, it is virtually impossible to be confident that it is disordered in some respects. From this perspective, risk assessment measures most likely work because they track the underlying causal processes specified in the explanation of the exemplar.

The first goal for theoreticians and researchers is to reliably identify exemplars of disorders and then to set about the job of creating explanatory models for them. A particular strength of the exemplar approach is that the variations in symptoms and course of clinical presentation allow for the specification of subtypes of disorders and different trajectories.

Translating this line of thinking to the sexual offending area, an important initial task for researchers is to arrive at an agreed set of problems (analogous to signs and symptoms) evident in sexual offenders as a group. In our view, risk assessment measures and clinical assessment indicate that (at least) the following clusters of problems can be reliably discerned in sexual offenders: distorted thinking, social difficulties and intimacy problems, problems with controlling mood, negative mood, inappropriate sexual thoughts and fantasies, substance use problems and difficulty problem solving and goal setting. This list of problems is relatively descriptive and there has been no attempt to conceive of them in terms of psychologically meaningful causes. However, and this is an important step, all of these 'symptoms' or clusters of problems can be conceptually linked to dynamic risk factors of some kind or another that have been identified in the research literature (see Mann et al., 2010; Russell & Darjee, 2013; Thornton, 2013).

To illustrate, we have linked clinical attributes of sex offenders to the descriptive aspect of dynamic risk factors as follows:

- The clinical attribute of distorted thinking is conceptually linked to the dynamic risk factor of *pro-offending attitudes*. Descriptively, this dynamic risk factor is concerned with the mental state or experiential aspects of beliefs and attitudes associated with sexual offending.
- The clinical attribute of social difficulties and intimacy problems is conceptually linked to the dynamic risk factor of *intimacy deficits*. Descriptively, this dynamic risk factor is concerned with the experiential aspects of struggles with intimacy associated with sexual offending.
- The clinical attribute of negative affectivity is conceptually linked to the dynamic risk factor of *self-regulation* deficits. Descriptively, this dynamic risk factor is concerned with the mental state or experiential aspects of cognitive and behavioural control associated with sexual offending.
- The clinical attribute of substance abuse is conceptually linked to the dynamic risk factor of *self-regulation* deficits. Again, this factor linked to the mental state or experiential aspects of cognitive and behavioural control associated with sexual offending.
- The clinical attribute of inappropriate sexual desires, thoughts and fantasies is conceptually linked to the dynamic risk factor of *deviant sexual interests*. Descriptively, this dynamic risk factor is concerned with the mental state or experiential aspects of sexual desire, preferences and arousal associated with sexual offending.

Once a set of symptoms or problems have been provisionally formulated and listed as attributes, a second important research task is to identify any variations in trajectory or offence course, possibly highlighting subgroups and victim preferences. This could result in the creation of an additional exemplar or set of exemplars for sexual offending. The theory and research on self-regulation pathways conducted by Ward and his colleagues is a helpful way to think about sexual offence and relapse trajectories and their associated goals and regulatory strategies (Ward & Hudson, 1998b; Ward et al., 2006). This work can help to determine the temporal course of an exemplar. For example, research suggests that some sexual offenders have enduring, entrenched deviant sexual interests, feel safer emotionally with children and are anxious in adult relationships, while others do not display these characteristics. They hold offence-related approach goals and often possess excellent planning and organisational skills. What is noticeable about the former group is that their sexual offending and related problems emerge early and are likely to be lifetime persistent and stretch back to adolescence. While the 'ideal' exemplar of this type of sexual offender may not fit any one person perfectly, it is likely to capture well in general terms what have been termed preferential child sexual offenders (Ward et al., 2006).

It is possible that there may be several exemplars created for the sexual offending group as whole, which for example, might include one for preferential child sexual offenders, rapists and incest offenders. Alternatively, researchers could decide that once each of the descriptive aspects of dynamic risk factors has been hived off into a set of problem clusters, the resulting exemplar may be able to handle variations in clinical presentations.

Once the clinical attributes or symptoms of an exemplar have been described, its temporal course noted and any subtypes identified, the next research task is to create an explanatory model that is based on psychological, social and biological constructs. The explanatory model will draw from any causal elements contained in the standard list of dynamic risk factors, as well other theoretical concepts.

To make the above analysis a little more concrete, we will take one dynamic risk factor, general self-regulation or self-management difficulties and rework it as an exemplar. Most writing on self-regulation problems in sexual offenders lists a number of features that make up this dynamic risk factor, for example, impulsivity, poor problem-solving, negative emotionality, social instability (e.g., unemployment) and recklessness (Mann et al., 2010; Thornton, 2013; Russell & Darjee, 2013). The numbers and specific labels for each of these features do not matter much for our purposes so we will stick with the above names.

In order to construct an exemplar, it is necessary to first separate out the descriptive features inherent in the dynamic risk factor of self-regulation from the causal elements. For example, an individual may act in ways that put the person or others in harm's way, which may reflect the causal element of alcohol abuse-impulsivity. Or, an individual may have difficulty reflecting on situations where goals are threatened, which may reflect poor problem-solving. The second task in creating an exemplar from a dynamic risk factor is to make a judgement concerning its temporal course.

After the exemplar(s) has been constructed, theorists can then take the causal components of the dynamic risk factors and use them to build explanatory models. In the case of the self-regulation example outlined above, causal factors that could explain the occurrence of clinical features associated with self-regulation difficulties include *impaired problem-solving abilities* (e.g., lack of relevant knowledge, dysfunctional core beliefs, difficulty integrating information, problems anticipating future possibilities, etc.), *lack of*

emotional competencies (e.g., poor identification of emotions, inability to control emotions, lack of soothing strategies, faulty emotion related secondary appraisals, etc.) and *lack of normative responsiveness and awareness* (e.g., disconnection between cognitive and emotional systems, poor metacognitive abilities, low levels of conceptual thinking ability, antisocial core beliefs and attitudes, etc.). These are just some of the possible causal mechanisms drawn from contemporary research on self and emotional regulation.

We will look more carefully at the above phases in the section on the creation of causal models below. But hopefully the way that dynamic risk factors can add in theory construction is clear in at least a general sense.

Dynamic risk factors and scientific explanation

The Abductive Theory of scientific method

In our view, it is helpful to use an explicit theory of scientific method to structure research into dynamic risk factors and the explanation of sexual offending. Method in science functions to counter cognitive and motivational biases and to compensate for our cognitive limitations (Haig, 2014). An overall theory of scientific method provides researchers with a plan of inquiry that can guide the search for clinical phenomena (i.e., symptoms, clinical attributes) and the construction of explanatory theories. There are different theories of scientific method evident in the methodological literature, including *Inductivism* (constructing theories on the basis of empirical generalisations), *Hypothetico-deductivism* (arriving at theories through conjectures and testing via deductive reasoning processes) and *Abductive method* (Haig, 2005, 2014). In this paper, we utilise Brian Haig's (2005, 2014) Abductive Theory of Method (ATOM) to organise our discussion. In our view, it has the theoretical resources to guide sexual offender researchers through the different phases of inquiry into the nature of risk, and ultimately, the explanation of sexual offending (see Haig, 2014 for systematic description and defence of ATOM).

According to ATOM, there are a number of conceptually distinct phases in scientific inquiry: establishing the focus of inquiry; detecting and describing phenomena (what we have earlier called clinical attributes or features); inferring the underlying causal mechanisms generating each phenomena; and finally the development and evaluation of integrated theories. It is possible to roughly divide the different phases into descriptive and explanatory phases. In the *descriptive phase*, researchers explore data gathered from a number of specific methods (e.g., psychometric instruments, rating scales, self-report, etc.) and search for patterns indicating the existence of distinct *phenomena*: relatively stable features of the world or persons that we seek to explain.

Phenomena can be construed as *effects* of a set of causal processes and are the features of the world and people that are relatively accessible to us. Data are pieces of basic information that are always concrete and method bound and provide evidence for the phenomena under investigation. Clinical examples of phenomena are low self-esteem, dysphoric mood, thought disorder, deviant sexual fantasies, cognitive distortions, loneliness and unassertiveness. Once a set of phenomena has been detected, the second major cognitive task for researchers is to *explain* their occurrence and interrelationships.

In our view, research in the area of sexual offending risk demonstrates three major types of problems from a scientific inquiry perspective. First, there is a tendency to focus primarily on data analysis and to not think clearly enough about the relationship between data and the detection of phenomena. Unfortunately, the preoccupation with data gathering

rather than clinical phenomena has resulted in an over emphasis on measurement within risk assessment at the expense of the formulation and testing of causal models. Second, when theories have been constructed there is insufficient attention to exactly what it is they are intended to explain, namely clinical phenomena. This has led to poorly directed explanations and the selection of overly vague targets. Third, theories themselves are frequently conceptually thin (and their component concepts such as dynamic risk factors), are not developed adequately and are rarely evaluated against competing explanations. The utilisation of a systematic method of scientific inquiry such as ATOM should help researchers to minimise these types of problems and to separate out the descriptive and explanatory phases of research more clearly (Ward, in press). In our view, one of the reasons why dynamic risk factors are increasingly (mistakenly) used as explanations in research and practice is due to a failure to make this distinction, and as a result, to conflate their descriptive and causal aspects.

Integrative pluralism

To recap our argument so far, we have argued that a component of dynamic risk factors as traditionally understood should be conceptually reformulated as features of the exemplar(s) of sexual offending, essentially clusters of phenomena (to use the language of ATOM) that share a common trajectory. By the term 'trajectory', we mean something like the offence pathways depicted in the self-regulation model (Kingston & Yates, 2012; Ward & Hudson, 1998b).

It is clear that formulating dynamic risk factors as attributes (phenomena, from a scientific perspective) of exemplars will take quite a lot of preliminary conceptual and classificatory work. It will be important to focus on the descriptive component of each dynamic risk factor and place the causal or theoretical component to one side for the theory-generating phase of inquiry (Haig, 2014, see below). As things currently stand in the sexual offending field, research on dynamic risk factors is rather messy and in danger of stalling because of its disconnection from theoretical work. Detecting and clearly describing dynamic risk factors as exemplars is an important and demanding task and will require careful attention. Moreover, because of a lack of theory integrating risk factors and the causes of offending, the process of case formulation is: (1) overly complex and unreliable or (2) defaults back to a listing and crude integration of dynamic risk factors. The lack of guidance concerning how the causal aspects of dynamic risk factors interact to actually generate observed clinical features and subsequent sexual offending makes the task even harder.

In the second phase of scientific inquiry into dynamic risk factors, researchers need to ask themselves the following kinds of questions in order to develop explanatory theories: what are the causal processes that result in this type of clinical phenomena (i.e., 'symptom' component of a dynamic risk factor)? What are the different levels of analysis required to fully understand it? What types of factors are needed to provide a comprehensive explanation? How should the different levels and fields of inquiry be linked? The resulting explanation may be rather general and consist initially of factors that are loosely connected. For example, Ward and Siegert's (2002) theory of child sexual abuse postulates five sets of causal mechanisms that interact to create different etiological pathways. The mechanisms are described in fairly general terms, primarily at the level of psychological agency and adaptive skills. There is little attention to explanatory domains such as neurobiology or culture. However, if the theory proves to be of heuristic value,

the mechanisms are likely to be elaborated on via the use of analogical models and conceptual analysis, resulting in a more tightly linked and richer theory.

In our view, integrative pluralism provides an excellent guide to theory construction in the sexual offending field, in conjunction with Haig's ATOM. It recommends constructing local theories at multiple of levels of analysis and across different domains of inquiry (e.g., psychological, developmental, cultural, biological, etc.), loosely incorporating them within an overall conceptual structure. Kendler (2005), an academic psychiatrist whose work on the aetiology of depression is an example of integrative pluralism, states that:

> In integrative pluralism, by contrast, active efforts are made to incorporate divergent levels of analysis. This approach assumes that, for most problems, single-level analyses will lead to only partial answers. However, rather than building large theoretical structures, integrative pluralism establishes small 'local' integrations across levels of analysis. … Our field may be in particular need of integrative pluralism, where scientists, without abandoning conceptual rigor, cross borders between different etiological framework or levels of explanation. (p. 437)

Applying this idea to the sexual offending area, we propose that researchers strip away the causal assumptions contained in traditional conceptions of dynamic risk factors and recruit them to build explanatory models of the sex offending exemplar(s) and its (their) constituent phenomena. Integrative pluralism's norms of theory construction and the ATOM norms directing the phases of scientific inquiry should guide this process. For example, Beech and Mitchell's (2005) theoretical work on intimacy deficits in sexual offenders can be viewed as (implicitly) illustrating the use of integrative pluralism to explain the phenomena associated with intimacy deficits in sexual offenders. They infer mechanisms at a number of different levels and across varying explanatory domains in an attempt to build a comprehensive understanding of intimacy deficits. They refer to the neurobiology of attachment behaviour as well as specifying the psychological mechanisms constituting attachment strategies. Beech and Mitchell explicitly incorporate the agency or common-sense level of explanation by referring to issues of trust and perceptions of safety. There are also references to environmental processes and developmental variables in their attachment theory. Note that there is no attempt to reduce one level to another. This is not what interlevel theories try to do as often they are targeting *different* processes rather than the *same process* at different levels of organisation. As stated earlier, the first phase of scientific inquiry is a descriptive one, in the case of intimacy deficits, carefully describing its psychological and social manifestations such as social isolation, aloneness, feelings of insecurity, etc. In the second phase, a set of possible causal factors is presented as a potential explanation, for example, maladaptive beliefs concerning the trustworthiness of other adults. The model is gradually deepened and additional levels of explanation are added to develop a richer account of the intimacy difficulties experienced by many sexual offenders. The cluster of intimacy phenomena that are partly constitutive of the sexual offender exemplar will contain a range of values and should be able to accommodate different types of problems such as lack of anxiety versus excessive interpersonal anxiety. The explanatory attachment model developed by Beech and Mitchell can account for these variations in phenomena or symptom presentation by referring to distinct internal working models, and at a more biological level, variable levels of oxytocin (Beech & Mitchell, 2005). Of course, ultimately the aim is to construct what Ward and Hudson (1998a) have termed level 1 or comprehensive theories of sexual offending, and this will require the conceptual integration

of a number of interacting mechanisms within a coherent theory to explain the exemplar and its typical permutations.

In summary, we have argued that in the current state of research dynamic risk factors are really hybrid concepts containing 'symptom' or phenomena aspects and etiological aspects. In our view, the conflation of the descriptive and explanatory elements within a single concept is confusing and runs the danger of derailing research and practice into dead ends. We have argued that viewing the descriptive aspects of dynamic risk factors as attributes of an exemplar(s) and introducing a separate explanatory phase of research that concentrates on developing causal explanations of the exemplar and its associated phenomena and course are ways forward. The concept of integrative pluralism is presented to remind theorists that causal models need to operate at different levels and across different domains of inquiry. This should ensure that the phenomena associated with the onset and reoccurrence of sexual offending are adequately explained and as a result, practice is better placed to address each offender's range of needs.

Research and clinical implications

A strong interpretation of the argument of this paper is that the current concept of dynamic risk factors evident in the sexual offending field should be withdrawn from research contexts and be replaced with the construct of a sex offending exemplar(s), and causal models that explain the emergence of the phenomena associated with the exemplar(s). It is time to abandon a concept that has outlived its usefulness, and more worryingly, is directing the sex offending field into conceptual and practice cul-del-sacs. A weaker reading would be to concede that while the concept of dynamic risk factors currently utilised in our field is internally inconsistent and explanatorily impoverished, it still has value on pragmatic grounds. It is a language we all know and use and its abandonment might create practical difficulties. A recommendation from this weaker interpretation would be to continue using the concept of dynamic risk factors in routine assessment and practice situations but to put it to one side in research contexts and adopt the conceptual structure outlined above. From a clinical perspective, risk assessment measures would still look pretty much the same but it would be clear that the utilisation of a risk factor framework in clinical and research contexts is not in itself explanatory; it is (merely) descriptive. We are sanguine about which reading of the argument outlined in this paper is adopted but are clear that there are major problems in the current use and understanding of dynamic risk factors.

The conceptual connection between dynamic risk factors, etiological theories and classification systems is an issue that needs to be briefly addressed at this point. We hope the link with etiological theories is clearer now. In essence, we propose breaking dynamic risk factors into two parts and after fleshing out the descriptive component, employ the causal one to construct an explanation of the risk-related problems, and in conjunction with other causes, the whole exemplar. In other words, dynamic risk factors can be actively enlisted to assist with the construction of explanations of sexual offending and its associated problems. The relationship between dynamic risk factor and classification systems is a little more complex. In a nutshell, we suggest that once a good exemplar of sexual offending has been formulated, its various phenomena and their range of values (clinical attributes) are clearly described; this should help to classify offenders. Existing sexual offending classification schemes are not universally accepted and often default back to ones based on victim type or sexual preferences.

An advantage of conceptualising dynamic risk factors as clinical attributes or phenomena of the sexual offender exemplar is that it makes it easier to separate the descriptive and explanatory components of research and clinical work. The first task in any practice and research domain is to be crystal clear about what cognitive task you are currently engaged in, description/diagnosis or explanation. To run, the two together is to invite confusion and run the risk of constructing vacuous case formulations. It is anticipated that the construct of sex offending exemplars and the use of the ATOM methodological guidelines will result in a more accurate understanding of the mechanisms causing the clinical features of sexual offenders. This increased understanding should be directly beneficial when constructing risk and case formulations as clinicians will not have to create their own clinical explanations of the case on the fly, so to speak.

Conclusions

This paper represents an initial step in developing an alternative way of understanding dynamic risk factors, one that has potentially far-reaching research and practice implications. In our view, the current use of the concept of dynamic risk factors in research and practice domains is leading the sex offending field into a theoretical dead end. They are hybrid concepts with little explanatory power and are arguably clinically blunt instruments. While, the concept of exemplars as used in the paper is overly general and needs detailed elaboration and application to each of the dynamic risk factors and risk assessment, hopefully the general thrust of our argument is clear. It is crucial for scientific progress that standard clinical and research practices are critically challenged from time to time, and their underlying theoretical assumptions evaluated. Our aim is to encourage researchers and practitioners to look at the issue of dynamic risk factors from a different viewpoint; one that we hope will ultimately result in more effective practice.

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