Models of Sexual Offender Treatment

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Sexual offending is a serious problem that has significant impacts on victims, their families, and society at large and continues to garner increased attention among the public, legislators, and media. This impact and increasing attention has resulted in the development and implementation of interventions designed to reduce the likelihood of re-offending. The availability of treatment programs for sexual offenders has increased dramatically with greater attention to this issue, as has empirical research designed to assess the effectiveness of these interventions. Although there is debate among researchers with regard to treatment efficacy, current best practice involves the application of cognitive-behavioral interventions that target risk and that adhere to specific correctional and clinical principles. Recent meta-analyses (Hanson et al., 2002; Lösel & Schmucker, 2005) have found cognitive-behavioral treatment to be most effective in reducing re-offending in comparison to both other types of treatment and to criminal sanctions. Furthermore, research indicates that treatment is most effective when it adheres to the principles of effective correctional intervention (Andrews & Bonta, 2010) with various types of offender groups (Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990; Dowden & Andrews, 1999a, 1999b, 2000, 2003), including sexual offenders (Hanson, Bourgon, Helmus, & Hodgson, 2009). Finally, best practice also includes the use of effective therapists and therapeutic techniques (Beech & Fordham, 1997; Marshall, Anderson, & Fernandez, 1999; Marshall et al., 2002; Shingler & Mann, 2006; Yates et al., 2000). In this chapter, I will review these principles of intervention and describe cognitive-behavioral treatment methods and targets with a focus on two treatment models—the good lives model and the self-regulation model—that have been proposed as alternatives and enhancements to traditional approaches to sexual offender treatment.

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Principles of Effective Correctional Intervention

In their original work, Andrews and Bonta (2010) proposed four principles as essential to ensuring that interventions with correctional populations are effective in reducing re-offending rates: *risk*, *need*, *responsivity*, and *professional discretion*. Although originally intended to apply to sanctions as well as treatment (Andrews & Bonta, 1998), these principles have predominantly been applied in practice to treatment implementation and are collectively referred to as the risk/need/responsivity (RNR) model.

The *risk principle* states that, in order to be maximally effective, the intensity of correctional interventions must be matched to the level of risk posed by the offender, with the most intensive levels of service, including treatment, reserved for higher-risk offenders. Lower levels of intervention, or no intervention, should be applied to lower-risk offenders. More specifically, this principle states that intervention (i.e., treatment and supervision) should be longer in duration, applied more frequently, and include a greater number of treatment hours as levels of risk increase. While there is little direct research with respect to the appropriate duration of treatment and practice varies considerably, the research on both general and sexual offenders suggests a duration of 100–200 h for moderate-risk sexual offenders and a minimum of 300 h for sexual offenders with high risk and high needs. Low risk offenders may not require specialized treatment at all (Hanson & Yates, 2013).

Research indicates that, in addition to being the best use of limited resources (Prentky & Burgess, 1990), treatment is most effective when intensity level is matched to risk (Andrews & Bonta, 2010; Gendreau & Goggin, 1996, 1997; Gendreau, Little, & Goggin, 1996; Gordon & Nicholaichuk, 1996; Nicholaichuk, 1996). Furthermore, research indicates that mismatching risk and treatment intensity can result in

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increased offending, both among higher-risk offenders who receive lower-than-required treatment intensity and among lower-risk offenders who receive higher-than-required treatment intensity (Andrews & Bonta, 2010; Lowenkamp & Latessa, 2002; Lowenkamp, Latessa, & Holsinger, 2006).

The *need principle* states that interventions should target the criminogenic needs of offenders—that is, the specific risk factors that can be changed through intervention and that are associated, both empirically and in individual cases, with risk and recidivism (Andrews & Bonta, 2007). This principle further argues that treatment should not focus on *non-criminogenic needs*—those factors not known to be associated with risk and recidivism—as such a focus is unlikely to impact re-offending. Among sexual offenders, criminogenic needs include such risk factors as sexual deviance and antisocial lifestyle, which represent the two strongest predictors of recidivism among sexual offenders (Hanson & Morton-Bourgon, 2004, 2005), with dynamic risk factors such as intimacy deficits and lack of social supports representing additional factors that have weaker relationships to recidivism (Hanson et al., 2009). Non-criminogenic factors include such areas as self-esteem and personal distress, which have not been found to be associated with recidivism (Hanson & Bussière, 1998).

The *responsivity* principle is concerned with the interaction between the individual and treatment, and it states that treatment should be delivered in a manner that is responsive to various characteristics of the individual, such as language, culture, personality style, intelligence, anxiety levels, learning styles, and cognitive abilities (Andrews & Bonta, 2010). Such factors can affect individuals' engagement with the treatment process and their ability to understand and apply information presented in treatment to their own personal circumstances. According to the responsivity principle, treatment methods should be varied and adapted to an individual's styles and abilities in order to maximize their potential effectiveness.

The principle of *professional discretion* states that clinical judgment should override the other principles if circumstances warrant and allows for flexibility and innovation in treatment under certain circumstances. Because this principle has received comparatively little attention in both research and practice, it is not discussed further, although it is suggested that recent theorizing and developments in sexual offender treatment allow for greater adherence to this principle than has traditionally been the case.

Empirical support for the application of the RNR model to offender populations is strong, clearly indicating the superiority of treatment complying with these principles over criminal sanctions, inappropriate treatment, or unspecified treatment. Specifically, in a series of meta-analyses, treatment adhering to these principles has been found to be effective for offenders in general (Andrews et al., 1990), juvenile delinquents (Dowden & Andrews, 1999a, 2003), violent offenders (Dowden & Andrews, 2000), and female offenders (Dowden & Andrews, 1999b). With respect to sexual offenders, a recent meta-analysis (Hanson et al., 2009) found that adherence to the RNR model was associated with reduced sexual re-offending, with the most significant treatment effect found among treatment programs that adhered to all three principles. Specifically, treatment effectiveness increased as a function of adherence to none, one, two, or all three principles (odds ratios of 1.17, .64, .63, and .21, respectively). Finally, adherence to the RNR principles provides a context within which increased program integrity, organizational adherence to integrity standards, and better staff practice can improve treatment outcomes (Andrews & Dowden, 2005; Dowden & Andrews, 2004).

Despite this strong empirical support, criticisms of the RNR model have been put forward regarding its underlying theory, implications for practice, and lack of scope (Ward & Brown, 2004; Ward & Gannon, 2006; Ward, Melser, & Yates, 2007; Ward & Stewart, 2003). Specifically, it has been argued that, while necessary, the focus in treatment on addressing dynamic risk factors (criminogenic needs) is not sufficient to ensure treatment effectiveness and that it is necessary to broaden the theoretical formulation of the RNR model, its application in practice, and the scope of interventions stemming from the model. In addition, it has been suggested that the RNR model, through its sole focus on risk management, is unable to provide therapists with sufficient tools to engage and work with offenders in therapy or to provide offenders with sufficient motivation to engage in the treatment process (Mann, Webster, Schofield, & Marshall, 2004; Yates, 2009). This is especially important given that sexual offenders tend not to be particularly motivated to participate in treatment (Thornton, 1997). In addition, it has been suggested that the RNR model pays insufficient attention to the importance of the therapeutic alliance in treatment, which has been shown in both general clinical practice and with sexual offenders as essential to treatment and as accounting for a significant portion of the variance in treatment outcome (Marshall et al., 2003; Yates, 2003). This research highlights the importance of attending to non-criminogenic needs such as motivation and low self-esteem, which are important to the treatment process yet not directly concerned with targeting risk. Finally, it has been suggested that the RNR model is often translated in practice in a "one size fits all" manner that fails to take individual needs into account and thus fails to fully adhere to the principles of risk, need, and responsivity (Ward & Stewart, 2003).

Cognitive-Behavioral Treatment

Cognitive-behavioral treatment is currently the most widely accepted model of intervention for individuals who have offended sexually (Barbaree & Seto, 1997; Becker & Murphy,

1998; Freeman-Longo & Knopp, 1992; Grubin & Thornton, 1994; Hall, 1995; Laws, 1989; Looman, Abracen, & Nicholaichuk, 1999; Marshall et al., 1999; Yates, 2002) and has demonstrated the greatest effectiveness in reducing recidivism (Hanson et al., 2002; Lösel & Schmucker, 2005). Treatment within this model is based on behavioral learning models such as classical (Pavlov, 1927) and operant (Skinner, 1938) conditioning, cognitive theory (Beck, 1964, 1967, 1976), and social learning theory (e.g., Bandura, 1986). Sexual offending is viewed as a behavioral and cognitive pattern that has developed and been maintained during development over time via processes such as modeling, observational learning, and reinforcement, resulting in entrenched maladaptive responses, coping mechanisms, and cognitive schema. The focus of cognitive-behavioral treatment is to alter patterns of behavior and cognition that support sexual offending, such as maladaptive or deviant responses, and replace them with pro-social beliefs, attitudes/schema, behavior, and responses. This is accomplished by targeting specific risk factors known to be linked to risk for re-offending.

Briefly, cognitive-behavioral treatment typically involves changing attitudes; altering cognitive distortions and schema; developing effective problem-solving abilities; improving sexual, intimate, and social relationships; managing affective states; reducing deviant sexual arousal; and developing adaptive thinking processes, affect, and behavior (Barbaree & Marshall, 1998; Marshall et al., 1999; Yates, 2002, 2003; Yates et al., 2000). This is typically done via group therapy in which offenders address specific deficits and develop and rehearse new skills and ways of thinking that ultimately result in reduced risk of re-offending. Common treatment targets, matched to established dynamic risk factors (e.g., Hanson, Harris, Scott, & Helmus, 2007), include attitudes supportive of sexual offending, cognitive distortions that facilitate offending, deviant sexual preference and arousal, intimacy and attachment deficits, deficits in sexual and general self-regulation, emotion regulation, and posttreatment follow-up to maintain treatment gains, monitor risk, and allow for the provision of support (Marshall, Marshall, Serran, & Fernandez, 2006; McGrath, Hoke, & Vojtisek, 1998; Wilson, 2007; Yates et al., 2000). Treatment also typically addresses factors such as empathy deficits, accountability or responsibility for offending, and denial. Despite an absence of research suggesting that such factors are associated with risk for re-offending, these areas are included, as they are often considered moderating factors in offending and may interact with other criminogenic needs related to offending. In targeting known risk factors, cognitive-behavioral treatment should incorporate extensive rehearsal because new cognitive and behavioral skills require considerable practice and repetition in order to become well entrenched in the individual's repertoire (Hanson, 1999; Hanson & Yates, 2004). Finally, cognitive-behavioral interventions may be implemented in conjunction with adjunctive therapy, such as pharmacological interventions designed to reduce levels of arousal or to address mental health concerns, or treatment targeting substance abuse problems for those offenders warranting these interventions (Wilson & Yates, 2009; Yates, 2002).

The most common cognitive-behavioral approach used in sexual offender treatment programs has been the relapse prevention (RP) model (e.g., Laws, 1989; Pithers, 1990; Pithers, Kashima, Cumming, & Beal, 1988; Pithers, Marques, Gibat, & Marlatt, 1983). Adapted to sexual offender treatment from the treatment of alcoholics, the original RP model (Marlatt, 1982, 1985) was intended as a posttreatment follow-up program for motivated patients who successfully ceased alcohol use but who experienced difficulty maintaining abstinence. RP was applied to the treatment of sexual offenders and underwent some revisions to adapt the model to this population (Laws, 1989; Marlatt & Gordon, 1985; Marques, Day, & Nelson, 1992; Pithers, 1990; Pithers et al., 1988). Because of its intuitive appeal and likely as a result of a lack of available information regarding the risk of sexual aggression, dynamics of offending, and treatment at that time, the model was unquestioningly embraced as the approach to the treatment of sexual offenders (Laws, 2003; Laws & Ward, 2006; Yates, 2005; Yates & Ward, 2007).

The goal of treatment using RP with sexual offenders is to assist them in identifying and anticipating problems and high-risk situations that could lead to a *lapse*, defined in the original model as a temporary return to the problematic behavior (Marlatt, 1982), and to a *relapse* (i.e., a return to sexual offending behavior) and to teach them a variety of skills to cope with these problems when they arise and to mitigate skill deficits (Laws & Ward, 2006; Marques et al., 1992; Pithers, 1990, 1991). Despite a lack of empirical research supporting its use and problems with the theoretical model (Hanson, 1996, 2000; Laws, 2003; Laws, Hudson, & Ward, 2000; Laws & Ward, 2006; Yates, 2003, 2005; Yates & Kingston, 2005; Yates & Ward, 2007), the RP model gained wide acceptance as a treatment approach for sexual offenders.

The RP model has been criticized for theoretical inadequacies, incoherence, inconsistencies, lack of scope, problematic definitions of its constructs, and practical limitations (Laws, 2003; Laws & Ward, 2006; Yates, 2003, 2005; Yates & Kingston, 2005; Yates & Ward, 2007). Problems with the model include: a narrow view of behavior that does not adequately address the heterogeneity of sexual offenders and the pathways they follow to offending; its reliance on a single pathway to offending; the lack of applicability of core constructs of the model to sexual offenders; an inaccurate conception of sexual offending behavior as identical to addictive behavior; its focus on negative affective states as necessary, sufficient, and essential to the offense process; an

inadequate conceptualization of offense planning; and a nearly sole focus on avoidance strategies to manage risk to re-offend. Two alternative models, the good lives model (GLM; Ward & Gannon, 2006; Ward & Stewart, 2003) and the self-regulation model (SRM; Ward & Hudson, 1998), have been proposed as alternative approaches that address problems inherent in both the traditional RP approach and the RNR model and are described later in this chapter.

Within treatment, in addition to targeting known risk factors associated with risk to re-offend, attention has been paid to the importance of the therapeutic processes and methods by which treatment is implemented (Beech & Fordham, 1997; Hanson et al., 2009; Marshall et al., 1999, 2002; Shingler & Mann, 2006; Yates, 2002; Yates et al., 2000). Research indicates that specific therapist characteristics and techniques, and establishing a positive therapeutic relationship between the client and therapist, account for a significant proportion of the variance in treatment outcome, both among sexual offenders and in general non-offender therapy for such problems as depression, mental health, and addictions (Marshall et al., 1999, 2003).

Creating a positive and therapeutic treatment atmosphere requires that clinicians avoid taking punitive, aggressive, or confrontational styles of relating to the offender, as this leads to increased resistance, argumentativeness, denial, lack of cooperation and compliance with treatment, a negative effect on treatment progress, and premature termination or dropping out of treatment (Beech & Fordham, 1997; Kear-Colwell & Pollack, 1997; Marshall et al., 1999; Miller, 1995). Since research clearly indicates that offenders who do not complete treatment re-offend at significantly higher rates than offenders who complete treatment (Hanson & Bussière, 1998; Hanson et al., 2002), the importance of treatment processes that function to retain offenders in treatment is immediately evident. A variety of therapist characteristics and behaviors have been shown to maximize treatment gains (Fernandez, 2006; Marshall et al., 1999, 2002). These include empathy, respect, warmth, friendliness, sincerity, genuineness, directness, confidence, and interest in the client. An effective therapist is also one who is a pro-social model; who communicates clearly; who is appropriately self-disclosing, reinforcing, encouraging, and non-collusive; who deals appropriately with frustration and other difficulties which offenders present in treatment; who asks open-ended questions; and who is appropriately challenging without being aggressively confrontational. Effective therapists actively listen to their clients, support their clients without being collusive, are open and interested in their clients, hold and express the belief that the client is capable of change, create opportunities for success, motivate the offender to change, and create a treatment atmosphere which is secure for the offender.

Good Lives Model of Sexual Offender Rehabilitation

As indicated above, the RNR model of sexual offender intervention has been criticized as being insufficient and narrow in scope, and it has been suggested that interventions within this model be broadened (Ward, Melser, & Yates, 2007). This broadening of scope would include taking into account the promotion of basic human goods alongside risk management as emphasized in the good lives model (Ward & Gannon, 2006; Ward & Stewart, 2003). A principal criticism of the RNR model has been that the focus on criminogenic needs is a *necessary* but not *sufficient* condition for effective treatment (Ward & Gannon, 2006, emphasis added). Specifically, the model is unable to provide clinicians with sufficient tools to engage and work with offenders in therapy as a result of (a) difficulty motivating offenders by focusing primarily on avoidance goals and risk reduction (e.g., Mann et al., 2004); (b) ignoring the importance and role of personal or narrative identity and agency (i.e., self-directed, intentional actions designed to achieve valued goals) in the change process (e.g., Maruna, 2001); (c) paying insufficient attention to the therapeutic alliance; and (d) failing to acknowledge that human beings naturally seek and require certain goods in order to live fulfilling and personally satisfying lives (e.g., Ward & Stewart, 2003).

While a comprehensive review of the GLM is beyond the purview of this chapter, briefly, the model proposes that, like other human beings, sexual offenders are goal directed and seek to acquire fundamental primary human goods—actions, experiences, and activities that are intrinsically beneficial to individual well-being and that are sought for their own sake. Examples of primary human goods include relatedness/intimacy, agency/autonomy, happiness/pleasure, and emotional equilibrium. The GLM proposes that sexual offending results not from the desire to obtain these goods but from the methods and strategies offenders use to attain these. These maladaptive strategies derive from offenders' backgrounds, developmental histories, and internal and external capabilities to attain these goods in non-offending ways. For example, an offender may desire intimacy but, as a result of discomfort and fear of adults, turns to children to meet this need. The problem, therefore, is not the desire to attain intimacy, but the manner in which the individual attempts to achieve this desire (i.e., with children rather than age-appropriate partners). Viewed this way, dynamic risk factors and criminogenic needs are seen as symptoms or markers of ineffective or inappropriate strategies employed to achieve primary goods or goals. Although this is a very cursory overview of the GLM, this model has significant implications for the treatment of sexual offenders (see below).

It is important to note that the GLM is not a treatment program itself, but represents an overarching rehabilitation framework for the treatment of sexual offenders. While the particular focus in treatment is on the promotion of goods (see below), it is essential that this is done in conjunction with risk management. It is suggested, however, that the addition of a GLM focus to the treatment of sexual offenders will contribute to further reductions in risk and that its inclusion will increase offender motivation and engagement with treatment via increased attention to responsivity needs and the creation of a stronger therapeutic alliance (Ward & Stewart, 2003; Yates, 2009). In fact, although at preliminary stages, research to date indicates that the application of the GLM to a risk-based program improves motivation to participate in treatment, treatment progress, and completion rates (Simons, McCullar, & Tyler, 2008; Yates, Simons, Kingston, & Tyler, 2009) and that good lives constructs are differentially associated with offense characteristics (Yates, Kingston, & Ward, 2009), as well as static risk to re-offend, dynamic risk factors, and sexual offense pathway (Kingston, Yates, Simons, & Tyler, 2009). Thus, initial data support the potential utility of the GLM with sexual offenders.

Finally, the GLM approach is consistent with both the responsivity principle and with effective clinical practice, as discussed above. In order to ensure the inclusion of risk factors and risk management, the GLM has recently been integrated with the self-regulation model (SRM) of the offense process as a comprehensive approach to treatment (Ward, Yates, & Long, 2006; Yates, Kingston & Ward, 2009; Yates & Ward, 2008) that is consistent with the principles of effective correctional and clinical practice with sexual offenders. The SRM is described below.

Self-Regulation Model of the Sexual Offense Process

Alongside the development of the GLM has been the application of the self-regulation model (Baumeister & Heatherton, 1996; Karoly, 1993; Thompson, 1994) to sexual offending (Ward & Hudson, 1998). The SRM began as a nine-stage model of the sexual offense process, developed specifically for sexual offenders, that explicitly takes into account variability in offense-related goals and the manner in which individuals regulate their behavior in order to achieve these goals. Within the SRM, offense-related goals include both the attainment of desired states and outcomes (appetitive or approach goals) and the avoidance of undesired states and outcomes (inhibitory or avoidance goals). The model acknowledges that some sexual offenders may attempt to refrain from offending, whereas others will actively seek out opportunities to offend. In addition, in attempting to achieve these goals, the SRM proposes that individuals demonstrate differences in self-regulation capacity, with some offenders failing to control behavior (*under-regulation/disinhibition*), others attempting to actively control behavior using strategies that are ultimately counterproductive and ineffective (*mis-regulation*), and others having intact self-regulation abilities but holding inappropriate goals, such as the explicit desire to harm others, which motivate offending in the absence of self-regulation deficits.

The original SRM delineates a nine-phase offense progression model that results in four distinct pathways that lead to sexual offending. The nine phases of the offense process are illustrated in Fig. 1 and are briefly described below. For a comprehensive description of the nine phases and four pathways, see Ward and Hudson (1998) and Ward, Bickley, Webster, Fisher, Beech, and Eldridge (2004).

In the SRM, the offense progression is triggered by a life event and resultant appraisal of this event based on individuals' cognitive schema, goals, needs, and implicit theories (Phase 1). The life event may be a major event, such as the loss of a relationship or a job, or it may be a relatively minor event, such as an argument or the presence of a child in the individual's environment. Consistent with cognitive theory, this appraisal is hypothesized to occur relatively automatically, to influence the information to which the individual attends, and to activate entrenched cognitive and behavioral scripts and emotional states (positive or negative) developed during the individuals' lives via their learning experiences and associated with previous offending history. The life event and its appraisal trigger the desire for offending or for behaviors associated with sexual offending (Phase 2). This desire may be explicitly related to sexual offending, as when deviant sexual urges or fantasies are triggered, or may represent a desire to achieve other states that are indirectly related to offending, such as the desire for intimacy, dominance, or the expression or release of anger. In our recent reconstruction of this model (Yates & Ward, 2008), these desires have also been expanded to include goals related to the attainment of primary goods.

In response to the desire to offend, the individual establishes an offense-related goal (Phase 3). As indicated above, individuals may establish an avoidance goal, in which they desire to prevent offending, or an approach goal, in which they work toward offending. At this phase, individuals also evaluate the acceptability of this goal and their ability to tolerate the affective states associated with the desire to offend. The offense-related goal determines the manner in which the individual next proceeds in the offense progression (Phase 4), in which the individual selects strategies that will achieve the goal of either avoiding offending or approaching offending. In selecting strategies, individuals with avoidance goals will implement either no strategies or strategies that they

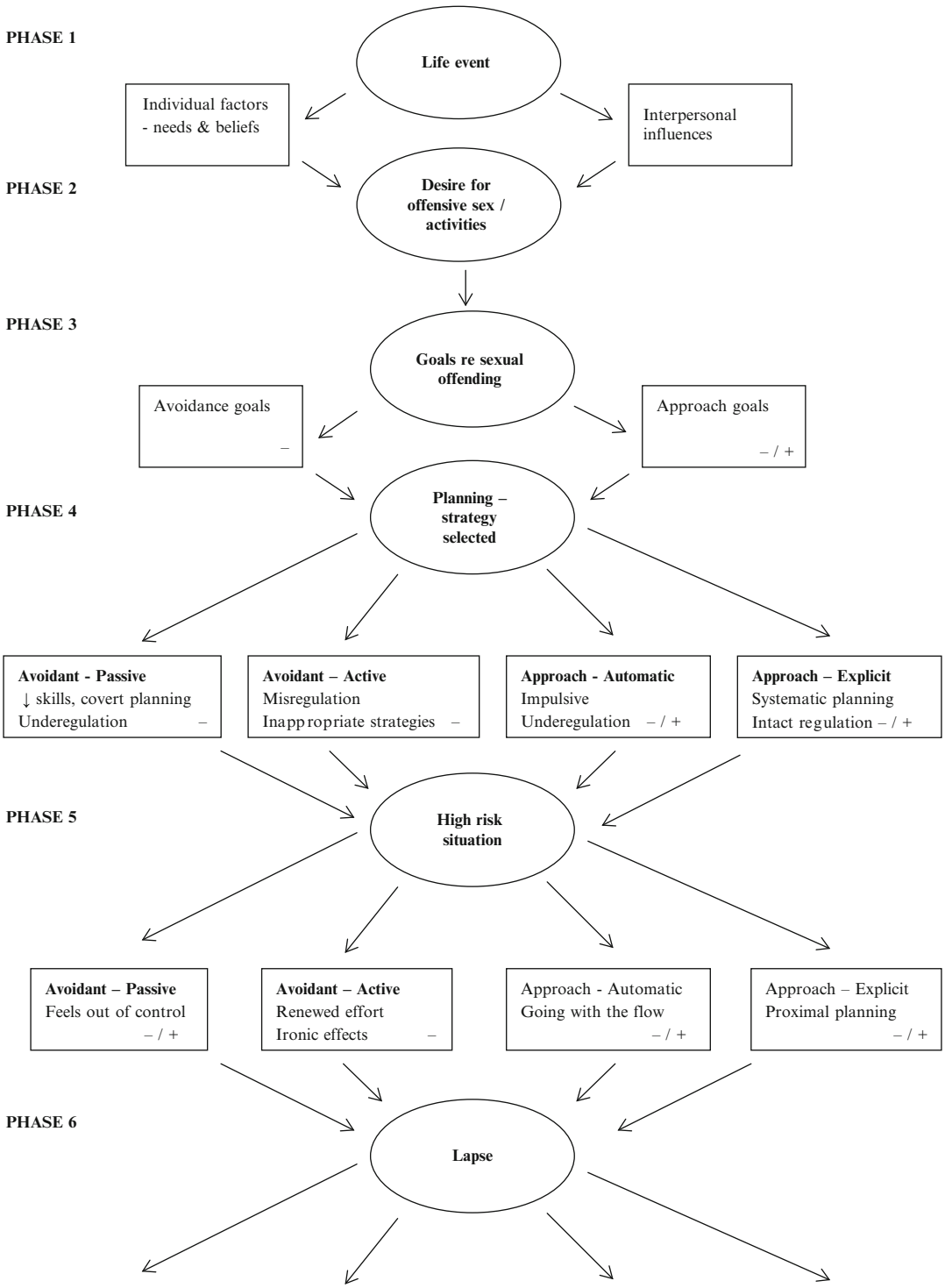

Fig. 1 A self-regulation model of the relapse process [*Note* From Ward et al. (2006), *The Self-Regulation Model of the Offense and Relapse Process. Vol. 2: Treatment* © 2006, Pacific Psychological Assessment Corp. Reprinted with permission]

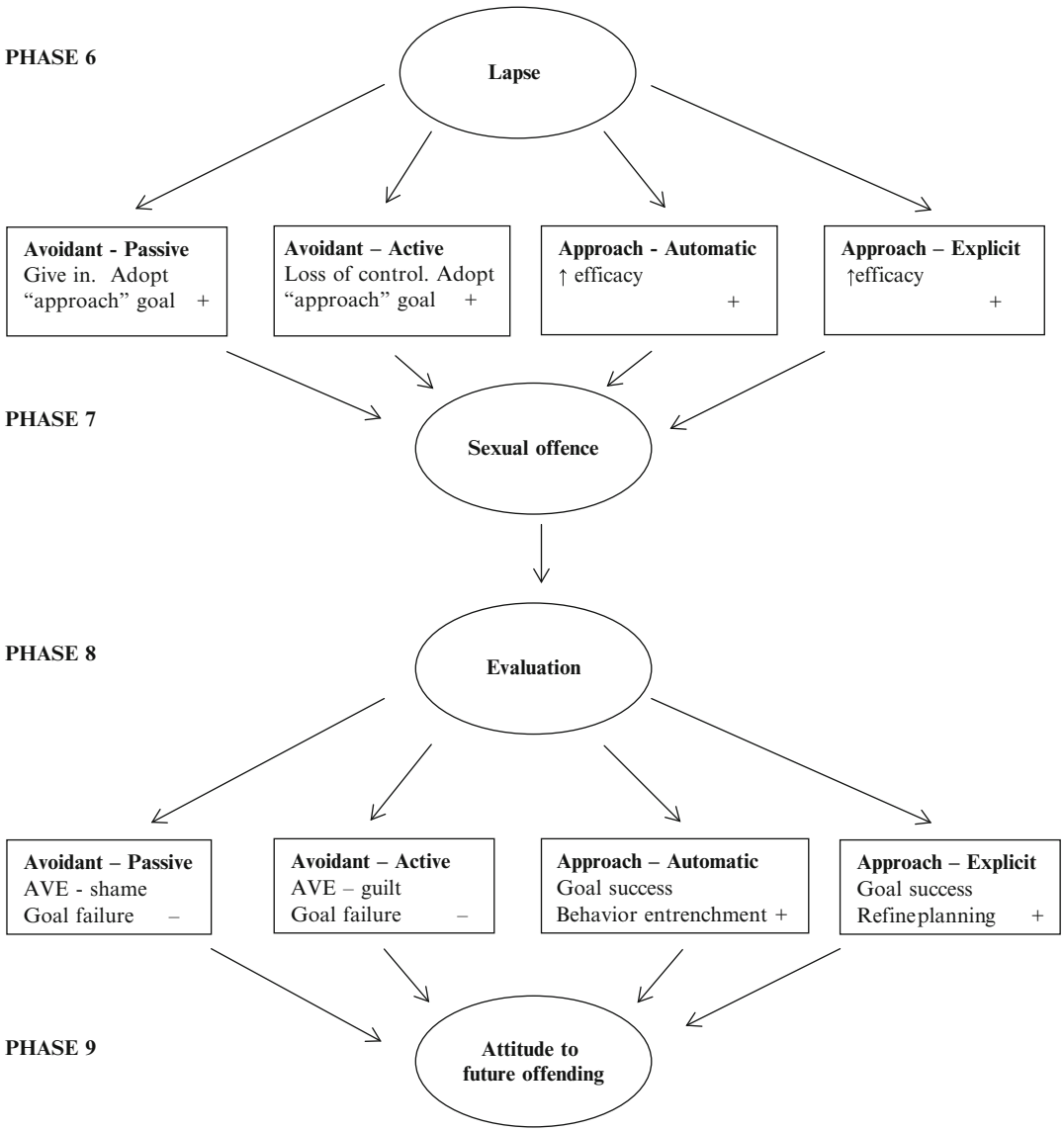

Fig. 1 (continued)

expect will reestablish self-control and that will prevent offending, whereas individuals with approach goals implement strategies that will serve to achieve the goal of offending. The combination of offense goals (Phase 3) and strategy selection (Phase 4) determines the pathway the individual follows to offending (see below).

In the next phase of the offense progression (Phase 5), individuals encounter a high-risk situation, such as access to a potential victim. Depending upon individuals' goals and strategies, such access may be accidental, incidental, or opportunistic or may result from either implicit or explicit planning. The individuals evaluate this situation in light of their offense-related goals and expectations regarding the likely effectiveness of strategies selected to achieve the goals. For individuals holding avoidant goals, this situation signals a failure to control behavior, whereas for offenders holding approach goals, this situation signals progress toward achieving the goal and is an indicator of success.

Once individuals have encountered the high-risk situation, the next phase in the offense progression (Phase 6) is the occurrence of a lapse, defined in the SRM as pre-offense behaviors that are likely to lead to sexual offending. For offenders with avoidant goals, the SRM proposes that, via processes such as cognitive deconstruction and failure to achieve this goal, individuals abandon the higher-order goal (avoidance) in favor of more proximal goals in the immediate situation (e.g., sexual gratification, achievement of intimacy). It is hypothesized that these individuals temporarily switch to an approach pathway, leading to the commission of a sexual offense (Phase 7). For individuals holding

avoidance goals, engaging in lapse or pre-offense behaviors is consistent with their offense-related goals, leading to the commission of the offense.

Unlike other offense process models, the SRM also considers individuals' experiences following the commission of a sexual offense via two post-offense phases during which individuals evaluate themselves and their behavior immediately after the offense (Phase 8) and develop intentions and expectations with respect to future offending (Phase 9). Following the offense, at Phase 8, individuals holding avoidant goals are expected to experience guilt, shame, a sense of failure, and cognitive dissonance associated with the disparity between their behavior (offending) and their goal (to avoid offending). They are likely to attribute the cause of offending to stable, internal, uncontrollable factors, to have cognitive distortions that justify offending based on these causes, and to regard the commission of the offense as a failure experience. Conversely, individuals holding approach goals are hypothesized to attribute their offending behavior to external causes and to have cognitive distortions that place responsibility for offending outside themselves, such as blaming the victim. Individuals with approach goals regard the commission of the offense as a success experience with respect to achieving the offense-related goal.

Finally, the SRM posits that, based on the offense experience and its evaluation, individuals form intentions with respect to future offending (Phase 9). Individuals holding avoidant goals may resolve not to offend again in the future, or alternatively, they may conclude that they lack the requisite skills to prevent offending and, consequently, adopt an approach goal with respect to future offending. Conversely, offenders holding approach goals are reinforced as a result of their "success" in achieving offense-related goals and may use the offense experience to refine offense strategies in the future.

Within this nine-phase offense process, the combination of offense-related goals and the strategies used to achieve these goals (i.e., self-regulation capacity) reflects four distinct pathways to sexual offending, each associated with varying degrees of awareness and planning associated with decision-making with respect to offending. These four pathways include:

1. *Avoidant-passive pathway.* Offenders following this pathway desire to refrain from sexual offending (avoidance goal) but lack the awareness and the required skills to effectively control their behavior in order to achieve this goal. Offending is associated with negative emotional states and disinhibition of behavior, loss of control, impulsivity, and anxiety when the individual is confronted with offense-related desires and opportunities to offend. These individuals may attempt to manage the desire to offend but do so typically by simply denying its existence or attempting to distract themselves from offense-related urges and desires (under-regulation). Negative affective states are the predominant emotional states throughout the offense progression, cognitive dissonance is evident, and offending is poorly or only covertly planned and is associated with goal failure.
2. *Avoidant-active pathway.* Similar to the avoidant-passive pathway, offenders following this pathway hold an avoidance goal with respect to offending (i.e., they desire to refrain from offending), but, unlike the avoidant-passive pathway, these individuals actively implement strategies to cope with the desire and opportunities to offend. That is, rather than simply denying or ignoring desires and urges, they attempt to regulate behavior via the use of specific strategies. However, the strategies they select are ineffective (mis-regulation) and, in some instances, result in the ironic effect of increasing the likelihood of offending. For example, individuals may engage in behavior such as masturbating to deviant images to avoid committing a hands-on offense or may use substances to regulate mood. Such behavior, however, functions to disinhibit the individual or to further entrench deviant arousal, thus increasing risk to offend. Predominantly negative affective states are evident throughout the offense progression, as is cognitive dissonance, and offending results from the implementation of ineffective strategies to prevent offending and is associated with goal failure
3. *Approach-automatic pathway.* This pathway is associated with approach-motivated goals with respect to offending and is characterized by *under-regulation* in achieving these goals. These individuals do not desire to prevent offending nor do they attempt to refrain from pursuing offense-related goals. Their self-regulation style is relatively automatic and impulsive, as they respond to situational cues in the immediate environment based on well-entrenched cognitive and behavioral scripts that guide behavior. Offense planning is rudimentary and unsophisticated, and offending is typically associated with positive emotional states, such as anticipation of sexual gratification, or may be associated with the attainment of specific negative goals, such as achieving revenge or dominance. Following offending, these individuals view their behavior positively, as they have achieved their goals, and are unlikely to experience cognitive dissonance, as their goals and behavior are consistent with each other.
4. *Approach-explicit pathway.* This pathway is associated with intact self-regulation. That is, individuals following this pathway do not have deficits in their ability to regulate their behavior, nor do they experience the disinhibition or loss of control evident in other offense pathways. Sexual offenses are explicitly and overtly planned in order to achieve a desired objective, such as sexual gratification,

and offending is associated with attitudes and core beliefs that support sexual aggression as an appropriate means by which to achieve these goals. Offending tends to be associated with positive affective states, and cognitive dissonance and goal conflict are absent.

As can be seen from the above brief overview, the SRM is more comprehensive than previous offense process models in that it acknowledges the heterogeneity in offense pathways and motivations for offending. The model is also consistent with the RNR principles, as treatment can be explicitly varied and adapted to individual offenders' needs, and is amenable to treatment using cognitive-behavioral methods. For example, within the SRM, dynamic risk factors can be more fully integrated with offense motivations, dynamics, and planning and can be linked to self-regulation capacity, offense-related goals, and offense strategies. This is discussed further in the following section.

Research to date on the SRM supports the validity of the model and its use in treatment. Specifically, there is support for the validity of the self-regulation model, including the existence of multiple pathways to sexual offending; offense characteristics such as offense planning and victim type; variability in pathways across different types of offenders (Bickley & Beech, 2002, 2003; Kingston, Yates, & Firestone, 2012; Proulx, Perreault, & Ouimet, 1999; Simons et al., 2008; Ward, Louden, Hudson, & Marshall, 1995; Yates & Kingston, 2006), as well as variations in actuarially measured static and dynamic risk (Stotler-Turner, Guyton, Gotch, & Carter, 2008; Kingston et al., 2012; Kingston et al., 2009; Leguizamo, Harris, & Lambine, 2010; Simons et al., 2008; Yates & Kingston, 2006); association with offense specialization (Leguizamo et al., 2010) and psychopathy (Gotch, Carter, & Stotler-Turner, 2007); and differential association with recidivism (Kingston, Yates, & Olver, 2013 under review; Webster, 2005). In addition, different pathways have been found to be differentially associated with treatment participation, compliance, motivation, progress, and outcome (Simons, Yates, Kingston, & Tyler, 2009). Taken together, research support is considerable for the use of the SRM in the treatment of sexual offenders.

An Integrated Approach to Cognitive-Behavioral Treatment with Sexual Offenders

As indicated above, research indicates that cognitive-behavioral treatment is the most effective approach to the treatment of sexual offenders, and adherence to the principles of risk, need, and responsivity shows the greatest treatment effect with respect to reduced recidivism. Recently, the GLM and SRM have been integrated into a comprehensive treatment approach (Ward et al., 2006; Yates, Prescott, & Ward, 2010; Yates & Ward, 2008) that can be delivered in a manner that effectively addresses risk, adheres to the RNR model, and utilizes cognitive-behavioral methods but that is also motivating to participants and that increases engagement with treatment. Integration of models also acknowledges the heterogeneity of offenders, the pathways they follow to offending, and the primary goods they seek to obtain via offending. Within this integrated model and in keeping with the RNR model, risk is assessed prior to treatment and appropriate treatment intensity levels are determined and applied. Based on the evaluation of both static and dynamic risk, higher-risk offenders are assigned to more intensive intervention, offenders posing a moderate risk to re-offend are assigned to moderate intensity interventions, and lower-risk offenders are assigned to minimal or no intervention. Also, in keeping with the RNR model, dynamic risk factors are explicitly assessed and treatment targets established accordingly and on an individualized basis. In addition to the evaluation of risk, individuals' good lives goals and self-regulation pathways are explicitly assessed using a structured protocol (Yates, Kingston & Ward, 2009), which also forms part of the treatment plan (Ward et al., 2006; Yates & Prescott, 2011; Yates et al., 2010; Yates & Ward, 2008).

In assessing good lives goals, part of the assessment process involves evaluating both that which the individual values and hopes to achieve in life generally and the goods the individual was attempting to acquire via offending, either directly or indirectly via a formal assessment protocol (Yates, Kingston & Ward, 2009). Attempts to attain these goods are reflected in dynamic risk factors. Thus, for example, individuals seeking to attain intimacy (a primary human good) may do so via sexual and intimate activity with children, manifesting as the dynamic risk factor of intimacy deficits and possibly deviant sexual interest. Individuals seeking to attain personal autonomy may have attempted to achieve this via sexual and/or physical aggression against an adult female, such as violent rape. The key activity in determining goods sought through offending is to establish the overarching good the individual sought to attain via offending.

Similarly, assessment of offense pathway, using the nine-phase SRM offense process model described above, assists in evaluating the route individuals have followed to offending and in delineating both good lives and offense-related goals implicated in offending, such that these may be targeted in treatment (Yates, Kingston & Ward, 2009, 2010; Yates et al., 2010). Furthermore, different offense pathways prescribe different approaches to treatment and different treatment objectives. For example, as is clear from the above discussion of offense pathways, some individuals require awareness raising and skill development in order to refrain from offending and to manage risk, whereas others require interventions designed to alter attitudes and core belief systems and cognitive schema that support offending.

In this integrated approach, the aim is not to change individuals' overarching goals (i.e., primary goods sought) but rather the methods used to attain these goods and the associated offense-related goals and strategies. Thus, treatment does not aim to eliminate offenders' needs for intimacy but to alter the manner in which they attempt to achieve intimacy such that it is sought with age-appropriate partners rather than with children and to develop the requisite skills and capabilities to achieve this. Similarly, treatment does not aim to eliminate offenders' need for autonomy, but helps them to achieve autonomy without dominating, controlling, or aggressing against others and to alter the belief that such behaviors are appropriate means to meet this need.

As is evident from this brief description, dynamic risk factors such as intimacy, interpersonal aggression, and problems with general or sexual self-regulation are addressed in treatment, thus adhering to the requirement of effective intervention to target known dynamic risk factors for offending. Furthermore, this integrated model represents a more positive approach to treatment than previous models such as RP and traditional RNR approaches that tend to focus on deficits and on the avoidance of problematic situations rather than inculcating positive approach goals. Within the integrated GLM/SRM model, there is at least equal importance placed on positive approach goals as on offense-avoidance goals—assisting the offender to achieve that which they value in life and enhancing well-being by actively working toward achieving important goals via pro-social, non-offending means in addition to managing risk. This is an important feature of treatment, particularly since such approach goals are more motivating and are more easily attained than are avoidance goals (Mann, 1988; Mann et al., 2004).

In treatment using this integrated model, treatment targets and methods also vary in accordance with offense pathways. Each of the four pathways described above is associated with different offense-related goals, strategies to achieve these goals, and self-regulation capacity. As such, treatment needs to be tailored to the specific goals and strategies of individual offenders. As indicated above, avoidant pathways are associated with the desire to refrain from offending, an objective that should be reinforced in treatment with offenders following this pathway. However, the two avoidant pathways, and their treatment requirements, differ in that individuals following an avoidant-passive pathway tend to be unaware of the offense progression as it unfolds, whereas individuals following an avoidant-active pathway demonstrate the capacity to monitor their behavior and responses to particular situations. Thus, treatment with offenders following the former pathway must focus on raising awareness of the offense progression in addition to assisting the individual to develop skills to monitor the environment and cope with circumstances and risk factors. By comparison, treatment of offenders following the avoidant-active pathway will focus less on raising awareness of the offense progression and more on awareness that strategies to achieve the avoidance goal are ineffective, as well as assisting the individual in developing skills and strategies that will be effective in managing risk. By contrast, as noted above, individuals holding approach goals with respect to offending actively work toward offending. A major target of treatment, therefore, is altering offense-supportive goals, beliefs, and attitudes and changing cognitive schema. In addition, because offenders following an approach-automatic pathway tend to respond relatively rapidly to situational and environmental cues and because this pathway is associated with general criminality (Kingston et al., 2012; Yates & Kingston, 2006; Kingston et al., in press), impulsivity typically needs to be targeted in treatment with these individuals, in addition to offense-supportive attitudes and cognitive schema. By contrast, individuals following an approach-explicit pathway tend to plan offenses carefully and explicitly and typically do not require intervention for impulsivity or other skills deficits. With these offenders, the primary treatment focus is on attitude and goal change.

As can be seen from the above discussion, using an integrated GLM/SRM model in treatment is consistent with the RNR model and principles of effective intervention and is amenable to the use of cognitive-behavioral methods and procedures. Adopting a GLM focus in particular also adheres to the principles of effective clinical intervention described above. Specifically, the GLM, with its positive approach, is more likely to motivate offenders to engage with treatment and with the change process via the establishment of mutual treatment goals that serve not only to reduce risk but also to improve well-being and life satisfaction. Adopting an SRM focus is also consistent with the principles of risk/need/responsivity, and it allows treatment to be better tailored to individual risk and criminogenic needs and to be responsive to individual offense pathways and motivation for offending.

Regardless of the approach that is followed in treatment, the principles of risk, need, and responsivity are important in determining treatment intensity and targets, as well as additional interventions that may be required, such as mental health interventions. For example, treatment may need to be longer in duration when significant risk factors such as sexual deviance or psychopathy are present. In such cases, additional risk management may be required, such as external supervision and monitoring.

Implementing a GLM/SRM treatment intervention may initially appear difficult, given how well-entrenched deviant sexual and criminal behavior may be among some clients. It is suggested, however, that these models will still apply in such challenging cases. In terms of the integrated GLM/

SRM model, sexually sadistic or psychopathic offenders may highly value such primary goods as happiness (under which is subsumed sexual pleasure) as well as autonomy and a sense of power, which is attained by manipulating, abusing, or controlling others. Similarly, such offenders may be more likely to follow approach pathways, such as the approach-explicit pathway, a pathway that is associated with higher levels of risk and that challenges current treatment methods generally (Ward et al., 2004). In such cases, it is suggested that the SRM can be of additional benefit, given that it better takes into account such factors as offense planning, positive affect, and positive reinforcement for offending, than does the traditional RP model. It is also suggested that the GLM can be of added value in such cases in addition to cognitive-behavioral treatment, as the origins of the behavior can be linked to what is important to the individual in his life, and alternative methods to attain such states as personal power and sexual gratification can be an integral part of treatment. Furthermore, by focusing on what the individual will gain from treatment (an essential element of the GLM approach), treatment is expected to be more motivating for individuals who may not view their behavior as problematic and who may be more amenable to an approach that focuses explicitly on what they personally have to gain by not offending and by engaging in treatment. As indicated above, regardless of the inclusion of the GLM and SRM in a specific treatment program, engaging offenders in treatment regardless of risk factors is essential to ultimate success, as is addressing risk and need. As with any treatment program, the right series of interventions is necessary to reducing risk to re-offend. It is suggested that the addition of the GLM and SRM to existing approaches will enhance treatment and lead to better achievement of this objective.

Conclusions

This chapter provided an overview of effective intervention with sexual offenders, with a focus on cognitive-behavioral intervention designed to alter patterns of behavior and cognition associated with sexual offending. The GLM and SRM models that have recently been developed and integrated into the treatment of sexual offenders hold promise to increase treatment effectiveness while adhering to research and established best practices. It is suggested that an integrated approach incorporating comprehensive assessment, the principles of risk/need/responsivity, cognitive-behavioral methods, effective clinical/therapeutic methods, and a positive approach that incorporates offender heterogeneity and variability in offense pathway will assist in increasing the effectiveness of sexual offender treatment and reducing the risk of future sexual violence.

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