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THE TREATMENT OF OFFENDERS: CURRENT PRACTICE AND NEW DEVELOPMENTS WITH AN EMPHASIS ON SEX OFFENDERS

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ABSTRACT

Despite some dissenting views, most recent comprehensive reviews of what works in the correctional domain agree that some types of rehabilitation programmes are particularly effective in reducing the reoffending rate. In this paper, we review rehabilitation and treatment approaches utilized historically and presently, with a specific focus on 'what works'. We examine the most widespread and successfully used rehabilitation principles (e.g., the Risk/Need/Responsibity Model), and then we turn our focus to specific treatment methods that are effective in reducing recidivism with sex offenders, paying particular attention to the relapse prevention model, and recent adaptations to this model (e.g., the self-regulation model).

Key words: offender rehabilitation — sex offenders

INTRODUCTION

The issue of offender rehabilitation is a controversial and contested one. The flashpoints include debate over the effectiveness of rehabilitation and the view that, even if treatment does reduce reoffending, offenders do not deserve the opportunity to learn new skills and ultimately a chance at better lives. Instead, the argument goes, they should be humanely contained and the focus of sentencing should be on retribution rather than treatment (Garland, 2001). However, what is increasingly clear is that it is possible to reduce reoffending rates by treating or rehabilitating offenders as opposed to simply incarcerating them (Andrews and Bonta, 1998; Hollin, 2004). Furthermore, treatment can be cost-effective (Prentky and Burgess, 1990) as well as harm reducing. Over the past two decades, a series of rigorous meta-analyses have shown, quite consistently, that it is possible to reduce reoffending rates by treating or rehabilitating offenders (Andrews and Dowden, 2006; Antonowicz and Ross, 1994; Hanson and Bussière, 1998; Hanson *et al*., 2002; Lipsey, 1992). Empirical research has also shown that intuitively appealing deterrence-based

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interventions such as boot camps, scared straight programs, and punitive prison sentences, have no discernable pay-off in terms of recidivism, and, in fact, have been shown to increase recidivism rates (Andrews and Bonta, 2003; Gendreau *et al*., 1999; MacKenzie *et al*., 2001; Pearson and Lipton, 1999).

In this paper, we review rehabilitation and treatment approaches utilized historically and presently, with a specific focus on 'what works' (McGuire, 1995). First, we examine the most widespread and successfully used rehabilitation strategy used in a number of western countries (i.e., the Risk-Need-Responsibity Model [RNR]; Andrews and Bonta, 1998; 2003), and then turn our focus to specific treatment methods that are effective in reducing recidivism, paying particular attention to cognitive-behavioural methods, the relapse prevention (RP) model, and recent adaptations to the cognitive-behavioural model (e.g., the self-regulation model; SRM). Although we refer to offenders generally when talking of overarching rehabilitation principles, in line with our expertise, we will specifically focus on sexual offenders when discussing treatment approaches such as cognitive-behavioural therapy, relapse prevention, and self-regulation. In particular, we intend to discuss current practice and highlight new models that appear to effectively resolve problems apparent in the RNR and RP approaches.

Before continuing, it is important to define what we mean by the terms 'rehabilitation' and 'treatment'. In our view, the term 'rehabilitation' is wide-ranging in nature and refers to the overall aims, values, principles, and etiological assumptions used to guide the treatment of offenders, and translates *how* these principles should be used to guide therapists. Without a rehabilitation theory, therapists would be unaware of the broad aims of treatment (i.e., to reduce risk and enhance functioning) and their relationship to the causes of offending. Treatment, on the other hand, for us refers to specific theoretically informed methods and concrete strategies used in forensic settings to change offenders' behaviour.

TREATMENT GUIDANCE: THE RISK-NEED-RESPONSIVITY MODEL OF OFFENDER REHABILITATION

The Basic Principles

The RNR model of offender rehabilitation is deservedly the premier treatment model for offenders generally. It has constituted a revolution in the way criminal conduct is managed in Canada, Britain, Europe, Australia, and New Zealand, and has led to the development of a suite of empirically derived interventions for a range of crimes. The principal architects of the RNR model of offender rehabilitation are the Canadian researchers James Bonta, Don Andrews, and Paul Gendreau (e.g., Andrews and Bonta, 2003; Andrews *et al*., 1990, 2006; Andrews and Dowden, 2006; Gendreau and Andrews, 1990). In brief, the *risk principle* suggests offenders at higher risk of reoffending will benefit most from

higher levels of intervention, including high intensity treatment, than will lower risk offenders. The *need principle* proposes that those variables associated with reductions in recidivism (i.e., dynamic risk factors or criminogenic needs) should be targeted to maximise the likelihood of reducing recidivism. The *responsivity principle* states that correctional programmes should be matched to offender characteristics such as learning style, level of motivation, and the individual's personal and interpersonal circumstances, in order to ensure that intervention is personally relevant and to maximise engagement with treatment.

The first two principles (risk and need) are used to select treatment intensity and targets, and the whole set of principles is used to guide the way practice is actually implemented. A fourth principle, the principle of *professional discretion*, states that clinical judgment should override the above principles if circumstances warrant. This principle allows for treatment flexibility and innovation under certain circumstances, as in cases in which an individual explicitly indicates a plan to offend against a specific victim, or when an offender is incapacitated and unable to carry out offending, regardless of assessed level of risk. However, as this plays a limited role compared to the other principles in the RNR model, we will refrain from discussing professional discretion here.

In conjunction with the RNR principles, Andrews and Bonta (2003) stress that there are six main elements required in correctional programmes if they are to be effective. Specifically, they must be: (1) cognitive-behavioural in orientation; (2) highly structured, specifying the aims and tasks to be covered in each session; (3) implemented by trained, qualified, and appropriately supervised staff; (4) delivered in the correct manner and as intended by programme developers to ensure treatment integrity, (5) manual based; and (6) delivered within settings with personnel committed to the ideals of rehabilitation and a management structure that supports rehabilitation and program integrity (Andrews and Bonta, 2003).

Empirical Evidence

An impressive body of meta-analytic research has been conducted on the RNR model with a wide range of offenders. This evidence has largely been derived from retrospective meta-analytic examination of rehabilitation evaluation research, beginning with Andrews *et al*.'s (1990) seminal paper. The purpose of this paper was to demonstrate that the effectiveness of correctional treatment depends on what is delivered, to whom, and in what setting. Here, we examine evidence for each of the RNR principles (see Ward *et al*., 2006 for a more detailed review).

Risk

The risk principle suggests that offenders assessed as being at higher risk for offending should receive higher levels of intervention, including high intensity treatment, than offenders who are at lower risk. Many empirical studies have provided support for the risk principle (e.g., Andrews and Dowden, 2006; Lowenkamp *et al.*, 2006) but perhaps the most comprehensive of these is Andrews and Dowden's (2006) meta-analysis. These authors examined the number of studies that differentiated between risk levels *within* their samples (i.e., they divided their sample into two or more groups based on level of risk). Andrews and Dowden found that only 44 of 374 available comparisons differentiated their samples according to this method. For the other 330 comparisons, the established aggregate approach was applied. Within this approach, whether or not the majority of the sample had prior convictions was used as the measure of risk. Andrews and Dowden suggested that reliance on the aggregate method has resulted in a dampening of the risk effect in the empirical analyses conducted thus far, yielding weaker effect sizes. For example, there is a stronger relationship between effect size and risk in studies using a within-sample differentiation of risk than among those in which the aggregate approach is used. Thus, empirical support for the risk principle may be somewhat diluted, as a result of the coding strategies utilised in individual studies.

In research utilising the aggregate approach, support for the risk principle has been moderate. Andrews and Dowden (2006) found that studies using high risk participants had mean effect sizes of $r = 0.10$ compared to $r = 0.03$ for those that targeted lower risk clients (according to Cohen (1960), an effect size of $r = 0.10$ is small, $r = 0.30$ is medium, and $r = 0.50$ is large).** Interestingly, support for the risk principle has been greater among juvenile offenders than among adult offenders. Andrews and Dowden (2006) reported that the benefit of targeting high as opposed to low risk offenders was much greater for juveniles ($r = 0.26$ for high risk samples versus $r = 0.07$ for low risk samples) than for adults ($r = 0.15$ high risk samples versus $r = 0.13$ for low risk samples). These positive findings are consistent with other reports of juvenile delinquents benefiting from the application of the risk principle. For example, in a sample of juvenile offender comparisons, treatments that targeted groups of delinquents with a high proportion of prior offences were more effective than treatments that did not (mean effect sizes of $r = 0.12$ and $r = 0.03$, respectively; Dowden and Andrews, 1999a). Lipsey (1992) reported similar findings, although the effect was small

** The symbol 'r' stands for correlation coefficient and represents the relationship between two variables. A positive relationship means that an increase in one variable is associated with an increase in the strength of the other and a negative relationship depicts the reverse.

and non-significant. In a sample of 200 studies targeting serious juvenile delinquents, treatment effects were larger for more serious offence types and in studies where all (as opposed to most) delinquents had prior offences (Lipsey and Wilson, 1998). Similarly, Latimer (2001) concluded that treatment may be more effective for repeat offenders. Clearly, the risk principle is strongly supported in the juvenile group and points to the importance of intervening early in the criminal careers of offenders in a way that appropriately considers their developmental tasks (i.e., autonomy, identity formation, relationship development etc). This raises the question as to why support for the principle remains so scarce in the adult offender population. This difference may be due, in part, to an interaction between age and the aggregate coding method. Specifically, the aggregate coding method may be less appropriate for adults since a greater proportion will already have prior offences (Andrews and Dowden, 2006).

Need

The concept of risk includes both static (unchangeable) and dynamic (changeable) factors. The need principle proposes that only those factors empirically associated with criminal behaviour should be targeted in treatment, since targeting these factors for change is most likely to be associated with reductions in recidivism. The need principle is based on a subset of risk factors — dynamic risk factors or criminogenic needs (Bonta, 2002; Bonta and Andrews, 2003). Dynamic risk factors are changeable features of the offender and his or her situation that are associated with criminal behaviour, such as pro-offending attitudes, aspects of antisocial personality, poor problem-solving abilities, substance abuse, high levels of hostility and anger, and criminal associates (Andrews and Bonta, 1998). These dynamic risk factors are assumed to result in criminal behaviour (see Andrews and Bonta, 2003; Gendreau *et al*., 1996; Hanson and Morton-Bourgon, 2005) and so are critical for managing risk. By contrast, aspects of the individual or his/her circumstances that are changeable but are *noncriminogenic needs* (e.g., self-esteem) should not be targeted in treatment, as changing these factors does not directly impact upon recidivism.

Different offence types are characterised by different dynamic risk factors, although there is some overlap among different groups of offenders on some factors. For example, dynamic risk factors associated with persistent sexual recidivism include deviant sexual interests and sexual self-regulation problems (Hanson and Harris, 1998; 2000), as well as the more general factors of antisocial personality disorder and employment instability (Hanson and Morton-Bourgon, 2005).

In the meta-analyses of Andrews, Dowden and colleagues, adherence to the need principle is generally coded according to whether or not there were more criminogenic needs than non-criminogenic needs targeted in treatment (e.g.

Dowden and Andrews, 1999a). Note that this operationalisation of the need principle does not provide any indication of the adequacy of the treatment or the amount of time spent on the needs, simply that they were targeted in greater number than were noncriminogenic needs. The list of criminogenic needs upon which these judgments were based can be found in Andrews and Bonta (2003).

There has been strong empirical support for the need principle. In Andrews and Bonta's (2003) updated meta-analysis of general offender populations (including 374 comparisons), they found that programs targeting a greater number of criminogenic needs than noncriminogenic needs have mean effect sizes of r = 0.19 compared with r = –0.01 if they do not target criminogenic needs. The positive effects of adherence to the need principle have been found in a variety of offender populations, including female offenders (Dowden and Andrews, 1999b) and juvenile offenders (Dowden and Andrews, 1999a).

Other findings of note regarding the need principle relate to the greater gains evident when treatment adheres to certain programme features (PF) noted earlier (e.g., manual based, utilising behavioural interventions, etc.) or are targeted at higher risk cases. First, when at least one feature of PF is present, the gains from adherence to the need principle are greater than when no PF components are present (increases from r = –0.04 to r = 0.24 versus r = 0.07 to r = 0.15, repectively; Dowden and Andrews, 2004). Thus, the provision of PF may provide the context within which the need principle is most effective, suggesting that the RNR model is clearly a higher order model that requires effective treatment practices in order to have optimal impact (we discuss treatment practices in more detail below). According to the evidence described above, programmes targeting more criminogenic needs than non-criminogenic needs have greater effect sizes than those that do not.

As well as focusing on the need principle, Andrews, Dowden and colleagues have provided some detailed examinations of the effectiveness of treatment that targets specific criminogenic needs. Andrews and Bonta's (2003) updated meta-analysis of 374 general offender comparisons provided support for the efficacy of targeting a number of personal criminogenic needs, including antisocial cognitions, self-control deficits, and school or work interventions. Interestingly, programmes targeting substance abuse did not result in significantly greater treatment effects. Furthermore, focusing on modifying noncriminogenic needs such as personal distress or family processing (other than nurturance and supervision), and on invoking fear of official punishment, were not effective in reducing recidivism.

Responsivity

The responsivity principle represents the interaction between treatment and the individual, and states that correctional programmes should be matched to offenders' learning styles, level of motivations, culture, and personal and interpersonal circumstances. The principle of responsivity directs that

interventions that are capable of making the desired changes and that match the offenders' learning styles be selected (Andrews *et al*., 1990). Responsivity may be usefully partitioned into specific and general responsivity. General responsivity describes the role of treatment-level issues in the match between treatment modality and offenders' learning styles. As we noted earlier, the cognitive behavioural treatment method is considered the best way to influence people's behaviour, and so this should be the method used to bring about change (Andrews and Bonta, 2003). Specific responsivity refers to individual characteristics of offenders which will make them more or less likely to engage with treatment. These characteristics typically include such factors as language skills, interpersonal skills, motivation, and anxiety. For example, an unmotivated offender may be less likely to benefit from treatment and will require additional treatment elements in order to increase engagement with treatment than a more motivated offender. In contrast to the voluminous research on general responsivity, and despite numerous calls for closer examination (e.g., Andrews *et al*., 2006), the effects of specific responsivity on treatment outcome remain unexplored. This has largely been due to the difficulty in coding specific responsivity in meta-analyses.

In Andrews and colleagues' meta-analyses, general responsivity is coded based on whether or not the programme was based on social learning or cognitive-behavioural theory and used role-playing, reinforcement and graduated practice (e.g., Dowden and Andrews, 1999a,b, 2004). In Andrews and Bonta's (2003) updated meta-analysis of the effectiveness of correctional treatment for general offender groups, studies that met this criterion had larger effect sizes than studies that did not (mean r = 0.23, compared to 0.04). These same results have been found in samples of juvenile delinquents (mean r = 0.24, compared to 0.04), female offenders (mean r = 0.27, compared to 0.08), and violent offenders (mean r = 0.19, compared to 0.01; Dowden and Andrews, 1999a,b, 2000). These findings are consistent with a robust literature suggesting that cognitive-behavioural programmes are the most effective treatment modality in reducing recidivism across a wide variety of offender groups (e.g., Hanson *et al*., 2002; Lipsey *et al*., 2001; Redondo *et al.*, 2002; Pearson *et al*., 2002; Salekin, 2002; Wilson *et al.*, 2003).

It is important to note that general responsivity does not impact in isolation from offender responsivity. Rather, general factors in combination with specific offender characteristics may impede or facilitate offenders' readiness to change (Serin and Kennedy, 1997). In other words, responsivity is concerned with how the individual interacts with the treatment environment, and covers a range of factors and situations (see Ward *et al.*, in press). Research suggests that therapist characteristics such as warmth, humour, expressions of empathy, and appropriate modelling and reinforcement may also be critical to treatment outcome (Dowden and Andrews, 2004; Marshall and Serran, 2004). These features and methods are hypothesised to be important to the development of the

therapeutic alliance, viewed as an essential vehicle for change among offenders (Fernandez *et al.*, 2002; Marshall *et al*., 1999; Yates, 2003; Yates *et al.*, 2000).

Taken together, the empirical support for the RNR model looks promising, although we propose that it is possible to do better and that improvements can be made to both the RNR model and to specific treatment methods by the inclusion of the Good Lives Model (GLM; see Ward and Gannon, 2006; Ward *et al*., 2006; Ward and Stewart, 2003) and changes to the cognitive-behavioural approach to treatment. We argue that the typical approach to the treatment of general and sex offenders based on risk management is insufficient to guide therapists when working with offenders. That is, the focus on reducing dynamic risk factors (i.e., criminogenic needs) is necessary but not sufficient for effective treatment. Our criticisms have been outlined in considerable detail elsewhere (see Ward and Brown, 2004; Ward and Gannon, 2006; Ward *et al*., 2006; Ward and Stewart, 2003) but in brief we argue: (a) motivating offenders by concentrating on eliminating or modifying their various dynamic risk factors is extremely difficult. One thing individuals want to know is how can they live better lives, what are the positive rewards in desisting from crime?; (b) The RNR model tends to neglect or underemphasize the role of narrative identity and agency (i.e., self-directed, intentional actions designed to achieve valued goals) in the change process. Thus an important component of living an offence free life appears to be viewing oneself as a different person with the capabilities and opportunities to achieve personally endorsed goals; (c) The RNR model appears to be associated with a rather restricted and scientifically obsolete view of human nature. It seems to ignore the established fact that human beings are biologically embodied organisms who quite naturally seek and require certain kinds of experiences and activities (i.e., human goods) in order to live balanced and personally fulfilling lives; (d) The RNR model does not appreciate the relevance and crucial role of treatment alliance in the therapeutic process. Any type of enduring change depends on the capacity of the offender to trust his or her therapist enough to absorb the skills and 'lessons' imparted in therapy. This means that despite the claims of proponents of the RNR model, so-called noncriminogenic needs such as personal distress and low self-esteem are essential clinical targets; failure to address them is likely to result in a weak therapeutic alliance. Researchers have demonsrated that the creation of a sound therapeutic alliance requires an array of interventions that are not directly concerned with targeting risk and it has been established that a good therapeutic alliance is a necessary feature of effective therapy with offenders (Marshall *et al*., 2003); (e) The RNR model is fundamentally a psychometric model (i.e., derived from and in part based on data from reliable and valid measures of criminal behaviour) and tends to be preoccupied with offenders' risk profiles (or traits) and downplays the relevance of contextual of ecological factors in offender rehabilitation. This is a serious mistake and ignores the fact that offenders like all human beings are embedded in various social and cultural systems that facilitate and constrain their behaviour; (f) Finally, the RNR model

is often implemented in practice in a 'one size fits all' manner and fails to adequately consider the specific needs, values, and issues of individual offenders. Indeed, the typical way in which the RNR model is operationalized is at variance with its own principle of responsivity! At the very least, the fact that the RNR model is implemented in a large scale, heavily manualized and prescriptive manner makes it hard to accommodate the unique characteristics of offenders.

The GLM is based around two core therapeutic goals: to promote human goods and to reduce risk. According to Ward and his colleagues, a focus on the promotion of specific goods or goals in the treatmnet of offenders is likely to automatically eliminate (or reduce) commonly targeted dynamic risk factors (i.e., criminogenic needs). By contrast, Ward argues that focusing *only* on the reduction of risk factors is unlikely to promote the full range of specific goods and goals necessary for longer term desistence from offending. As such it is able to address many of the problems faced by the RNR, not least how best to motivate offenders to participate actively in the demanding process of behavior change.

The Good Lives Model

As stated above, proponents of the *Good Lives Model* of offender rehabilitation have argued that the RNR model does not provide treatment providers with a strong enough repertoire of core principles and values needed for optimal treatment success (Ward and Gannon, 2006). More specifically, Ward and his colleagues argue that the RNR model carries with it the assumption that offenders have responded to their life circumstances in a *maladaptive* manner.This assumption has led to treatment methods that are problem-focused and that seek to eliminate offenders' deficits and to overcome their various deficiencies. Yet, it has been quite reasonably suggested (Marshall *et al.*, 1999) that, given their problematic life histories, offenders have responded, to the extent possible, to their circumstances in an adaptive, albeit antisocial, manner. Furthermore, positive psychology has shown that individuals work better when motivated by approach goals (Aspinwall and Staudinger, 2003; Mann, 2000; Mann *et al.*, 2004). This is one of the core assumptions underlying the Good Lives Model (Ward and Gannon, 2006; Ward and Stewart, 2003; Ward *et al*., 2006, 2007). Within this model, intervention methods still adhere to the RNR principles, but they are enveloped within a positive, approach goal philosophy. More specifically, offenders are seen as psychological agents who seek to live meaningful, satisfactory, and worthwhile lives. The fact that they fail to do this suggests that there are problems in the ways they are seeking human goods — problems embodying a number of flaws in their good lives plans (i.e., inappropriate means, lack of scope, incoherence or conflict, and lack of capacity). Thus, an important level of analysis when working with offenders

revolves around their sense of personal identity and the value commitments and aspirations that comprise this important psychological factor.

Until recently, treatment methods have ignored offenders' strengths, goals, and aspirations, and have failed to incorporate positive psychology (Aspinwall and Staudinger, 2003; Linley and Joseph, 2004; Ward and Gannon, 2006; Ward and Stewart, 2003) or to situate their offending behaviour and risk management in the context of their lives (Ward *et al.*, in press; Ward and Gannon, 2006). At present, Good Lives proponents are working hard to establish follow-up evaluations for preliminary Good Lives programmes. Ultimately, this will help to establish whether this approach is a significant improvement over treatment guided only by the RNR. The Self Regulation Model of treatment to be outlined later in this paper has been recently integrated with the GLM and as such has a much broader focus than the traditional RP approach (Ward and Gannon, 2006; see below).

A CLOSER LOOK AT TREATMENT APPROACHES THAT WORK: INTERVENTIONS WITH SEXUAL OFFENDERS

Cognitive-Behavioural Treatment

As we have already noted, the treatment of choice for a variety of offender groups conforms to the rehabilitative principles outlined by Andrews and Bonta (1998), in which treatment is matched to the risk posed by individual offenders (*risk principle*), specifically targets their criminogenic needs (*need principle*), and is tailored to the individual learning styles and abilities of offenders (*responsivity principle*). Effective treatment also follows the cognitive-behavioural model, which demonstrates the greatest impact on the re-offence rates of offenders generally, and of sexual offenders specifically (Hanson *et al*., 2002; L*ö*sel and Schmucker, 2005; Redondo *et al*., 2002; Wilson *et al*., 2003). Other treatment approaches have been used including general psychotherapy, behaviour therapy, and, for sexual offenders specifically, surgery and pharmacological interventions. With the exception of the use of pharmacological agents with specific interventions, either alone or in combination with cognitive-behavioural treatment, none of these methods appear to be as benefecial as cognitive-behavioural interventions (see Yates, 2002, for a review). Below, we describe cognitive behavioural treatment in more detail, and focus our discussions directly on sexual offender treatment.

Generally, cognitive-behavioural interventions are based on the premise that cognition, emotion, and behaviour are linked and that each influences the other in the development, shaping, and maintenance of behaviour (Yates, 2003). Treatment based on this model traditionally attempts to replace offenders' maladaptive and/or deviant responses and attitudes with 'adaptive' beliefs and behaviour by focusing on eliminating deficiencies and improving a variety of skills via reflection, cognitive restructuring, and behavioural rehearsal.

Common methods of intervention include identifying high risk situations, identifying coping and other skills deficits, challenging cognitive distortions utilised by offenders in the commission of their offences, coping with negative emotional states, developing effective problem-solving strategies, and additionally for sexual offenders specifically, developing empathy (either in general or toward the vicims of sexual crimes), enhancing social and intimate relationships, and reconditioning deviant sexual arousal (Marshall *et al*., 1999; Yates, 2003; Yates *et al.*, 2000). The above techniques are usually implemented within specific treatment modules which typically include the following components: establishing treatment norms, understanding the offence process and cognitive restructuring, empathy retraining, sexual reconditioning, emotional regulation and stress management, social competency, and relapse prevention/safety planning (Marshall *et al*., 1999).

In treatment of offenders, cognitive-behavioural intervention has commonly taken the form of relapse prevention (RP), both for offenders in general and for sexual offenders specifically. However, it must be noted that evidence for a pure RP approach is rather weak while there is more support for the cognitive-behavioural model as a general therapeutic approach (Yates, 2005). That is, while RP does utilise cognitive behavioural treatment techniques it is somewhat narrower in its focus and is not to be equated with CBT.

Relapse Prevention Tehniques

Treatment of sexual offenders in many jurisdictions purports to follow the cognitive-behavioural model. Adherence to the principles of this model may vary considerably, but a consistent trend among treatment programs is the inclusion of the RP approach to treatment (Freeman-Longo *et al*., 1994; Laws e*t al*., 2000; Polaschek, 2003). Historically, the goal of treatment for sexual offenders using RP was to assist them to identify and anticipate problems that could lead to *relapse* (i.e., a return to sexual offending behaviour) and to teach them a variety of cognitive and behavioural skills to cope with these problems when they arose (Laws and Ward, 2006; Marques *et al.*, 1992; Pithers, 1990; Pithers et al., 1983, 1988). Sexual offending behaviour was viewed as a cycle or sequence of events that could be interrupted by the individual, thus preventing re-offending, when the individual became aware of the cycle and developed the ability to intervene in the sequence. Sexual offenders following RP-based programs were taught to identify *high risk situations* that would place them at risk for a *lapse,* originally defined (Marlatt, 1982, 1985) as a return to the problematic behaviour (e.g., substance abuse) and re-defined in sexual offender treatment as behaviour approximating or preceding sexual offending, such as the re-emergence of deviant sexual fantasy or the use of pornography (Laws and Ward, 2006; Ward and Gannon, 2006). In encountering high risk situations, individuals were purported to make a series of *seemingly irrelevant decisions*, embarking on a course of action that, while appearing innocuous, was in reality

subconsciously purposive and would lead to offending behaviour. Once in the situation, it was then that offenders would experience the *problem of immediate gratification*, essentially being unable to resist offending due to anticipation of its positive rewards. When a lapse occurred, the individual would then experience the abstinence violation effect, a series of negative emotions, expectations of failure, and ultimately, abandonment of the abstinence goal and an increased risk to re-offend. In treatment using a narrow RP perspective, the individual would be taught a variety of skills in order to implement adaptive coping responses at various points in the sequence, which would function to further increase self-efficacy and positive outcome expectancies, and reduce risk via a return to abstinence behaviour.

The evidence for the effectiveness of the pure (or what we have termed the 'narrow') RP treatment model is somewhat mixed and overall it appears that it is not that useful. On the positive side, Gallagher *et al.* (1999) found that RP cognitive-behavioural programmes were particularly successful in the reduction of recidivism. Interestingly, the two RP treatment approaches of highest methodological quality showed the largest reductions in recidivism. In a qualitative review including a wide variety of studies (N = 79), Alexander (1999) found that cognitive-behavioural approaches which included relapse prevention were most effective in reducing sexual recidivism. This may be due to the focus of these approaches on cognitive and behavioural skill development.

On the negative side, the results from what is widely acknowledged as the best controlled trial of RP with sexual offenders were disappointing (Marques *et al*., 2000, 2005). The RP program under consideration, the Sexual Offender Treatment and Evaluation Project (SOTEP), did not lead to reduced recidivism rates in treated offenders, and this has caused widespread debate about the limitations of RP. The SOTEP researchers have themselves published a critical analysis of the application of RP to sexual offenders. In brief, they suggest that the RP model, although operationalised faithfully, was too highly structured and limited individualization. Thus, the project did not give offenders enough motivation to change, and did not allow for all relevant targets to be addressed (Marques *et al*., 2005). Other research (Hanson, 1996, 2000; Marshall and Anderson, 1996) also supports findings of the lack of effectiveness demonstrated by RP approaches to the treatment of sexual offenders.

However, overall there is evidence that cognitive behavioural treatment techniques (as opposed to the narrow RP model outlined above) can result in reduced sexual offending rates. One of the most comprehensive examinations of the efficacy of sexual offender treatment is Hanson *et al*.'s (2002) report from the Collaborative Outcome Data Project Committee, which was formed to organise existing evaluation literature and included general as well as sexual recidivism measures. Of the 43 studies included (almost twice that of the Gallagher meta-analysis), only three random assignment studies were found. However, 17 studies met the criteria for incidental assignment, the next-best quality of methodology. The results showed that treatment was effective in reducing both

sexual and general recidivism, particularly appropriate (i.e., cognitive-behavioural) treatment. However it remains possible that these positive results reflect a hidden bias not yet discerned in the studies in which incidental methodology was utilised (Hanson *et al.*, 2002). Another systematic analysis of the treatment outcome literature was undertaken recently by Losel and Schmucker (2005) covering 69 different studies with a combined total of over 22,000 offenders. Essentially, their findings replicated those of Hanson *et al* with CBT and biological treatments demonstrating significant treatment effects (i.e., 37% less recidivism for treated offenders versus controls). One of the first priorities for research, then, is to develop greater quality evidence upon which decisions of treatment efficacy may be based.

In addition to the minimal evidence for the effectiveness of the RP method, in recent years, this model has been criticised for a number of theoretical and practical problems (see Laws, 2003; Laws *et al*., 2000; Laws and Ward, 2006; Ward and Gannon, 2006; Yates, 2005; Yates, in press; Yates and Kingston, 2005; Yates *et al.*, 2000; Yates and Ward, 2007). For example, the RP model is viewed as insufficient to account for the heterogeneity evident among sexual offenders and their multiple motivations for engaging in sexually offensive behaviour. In addition, the RP model assumes that all sexual offenders are motivated to change their behaviour and to abstain from sexual offending (Laws, 2000; Thornton, 1997), an assumption simply not borne true in clinical practice. Thus, RP-based treatment appears wholly inappropriate for individuals who are unmotivated to change at the start of treatment, and we would expect this problem to manifest with other offender groups in addition to sexual offenders.

Another problem with the RP model as it has been applied to sexual offenders, is its reliance on predominantly negative affect as a motivation for offending behaviour (Ward and Hudson, 1998; Yates, 2005, in press). While negative emotional states certainly play a role in offending for some individuals, others are motivated by positive affect, such as anticipation of offending, sexual gratification, successfully achieving revenge or causing harm, and achieving 'intimacy'. Such individuals are unlikely to experience an abstinence violation effect, as their offending behaviour indicates successful progression toward a desired end. Again, we would expect this critique of RP with sexual offenders to generalise to the treatment of other offender groups.

Finally, the RP model as applied to sexual offending also fails to account adequately for variations in the degree of planning of sexual offending which, for some individuals, is quite extensive and explicit. In fact, if the offender is working toward a desired end, the applicability of the construct of seemingly irrelevant decisions is itself questionable — that is, the decisions they make may in fact be quite relevant to the achievement of the desired end resulting from sexual offending. Once again, we view this as a generalised problem with the RP approach.

Beyond Relapse Prevention: The Self-Regulation Approach

Recent research suggests that, while some sexual offenders comnmit their offences as a result of self-regulatory failure, others do so via careful and systematic planning (Laws *et al*., 2000; Ward *et al*., 1995; see below). As a result of this research and the problems with RP identified above, Ward and Hudson (1998, 2000) developed an alternative approach to the treatment of sexual offenders, based on self-regulation theory (Baumeister and Heatherton, 1996; Karoly, 1993; Thompson, 1994). The self-regulation model of offending was explicitly developed to account for the variety of offence pathways evident in sexual offenders and to provide therapists with a more comprehensive treatment model (Ward *et al*., 2004). Consistent with research on best practice in correctional and sexual offender therapy, the model follows a cognitive-behavioural orientation (Hanson *et al*., 2002), utilizes a skills-based approach (Hanson and Yates, 2004), and is designed to assist offenders to work toward positive (approach) goals (Mann, 2000; Mann *et al*., 2004) and to gain a sense of agency (Ward *et al*., 2006), and encourages the use of effective therapeutic techniques (Fernandez, 2006; Fernandez *et al*., 2002; Marhsall *et al*., 1999).

Nine-Phase Self-Regulation Model of Offending

The Self-Regulation Model (SRM) posits nine phases in the offence progression and four distinct pathways that lead to sexual offending. The nine phases of offending are briefly described below. A comprehensive description of the nine phases and four pathways can be found in Ward and Hudson (1998, 2000) and in Ward *et al*. (2004).

In Phase 1, the individual experiences a life event that triggers an appraisal of the event based on existing cognitive schema, goals, needs, and implicit theories. This appraisal occurs relatively automatically, influences the information to which the individual attends, and activates entrenched cognitive and behavioural scripts and emotional states (positive or negative) developed during the individual's life via his learning experiences. The appraisal of the life event triggers the desire for offending or for behaviours associated with sexual offending (Phase 2). These desires may be explicitly related to sexual offending (direct route to offending), such as deviant sexual urges or fantasy, or may be related to other states (indirect route to offending), such as anger, hostility, suspicion, or anticipation, that are associated for the individual with sexual offending.

After this desire is triggered, the individual establishes an offence-related goal (Phase 3). He evaluates the acceptability of this goal and his ability to tolerate the affective states associated with the desire to offend. Specifically, some offenders may be motivated to refrain from offending (avoidance goal), while others are motivated to progress toward offending (approach goal). This

offence-related goal determines the manner in which the individual next proceeds in the offence progression. In the next phase (Phase 4), the individual selects the strategy that will achieve his goal to either avoid offending or to approach offending. In selecting strategies, individuals with avoidance goals will implement strategies that they expect will re-establish self-control and that will prevent offending. Individuals with approach goals implement strategies that will serve to achieve the goal of offending. The combination of offence goals (Phase 3) and strategy selection (Phase 4) determines the pathway the individual follows to offending (see below).

When the individual encounters a high risk situation (Phase 5), he has gained access to potential victims. Access may result from implicit or explicit planning or from chance or opporutnity. The individual evaluates this situation in light of offence-related goals and the expected effectiveness of strategies selected to achieve these goals. For individuals with an avoidance goal, encountering a high risk situation signals failure to control behaviour, whereas for offenders with an approach goal, encountering this situation signals progress toward achieving the goal and is an indicator of success. This leads to a lapse (Phase 6), defined in the SRM as pre-offence behaviours that are likely to lead to sexual offending. Once the individual has reached this phase, it is hypothesized that he intends to offend and that individuals following avoidance pathways switch to approach pathways, at least temporarily, attributing the lapse to personal failure or the inability to exercise self-control. If the offender has experienced negative affective states in previous phases, these may be replaced or supplemented by positive emotional states, such as anticipation, while for offenders having approach goals, a lapse signals continued success in achieving the desired end and is typically associated with positive affect.

In the commission of a sexual offence (Phase 7), the SRM suggests (Ward *et al*., 1995) that individuals' perceptions of the victims of their offences are related to distinct goals with respect to offending. Specifically, in committing the offence, different offenders will have a *self-focus* (in which their own needs are paramount), a *victim focus* (in which they view the offence as justifiable based on a 'caring' perspective toward the victim), or a *mutual focus* (in which the offender views the offence as constituting a 'relationship' with the victim). These foci are hypothesized to be associated with differences in the duration and intrusiveness of the offence (Ward *et al*., 1995).

One innovation in the SRM is the addition of two post-offence phases, in which individuals evaluate their behaviour immediately following the offence (Phase 8) and develop intentions and expectations with respect to future offending (Phase 9). Following the commission of the offence, individuals following an avoidance goal are likely to experience guilt, shame, a sense of failure, and cognitive dissonance associated with the contrast between their behaviour and their goal of avoiding offending. They are likely to attribute the cause of offending to internal factors that are uncontrollable and stable and to engage in cognitive distortions that justify their offending behaviour based on

these causes (e.g., 'I don't know what happened to me', 'I tried to stop, but I couldn't'). Conversely, individuals with an approach goal are likely to attribute their offending behaviour to external causes and to engage in cognitive distortions that focus outside themselves, such as blaming the victim. In the final phase, the SRM posits that offenders with avoidance goals may resolve not to offend again in future, or, alternatively, they may conclude that they lack the requisite skills to prevent offending and so adopt an approach goal with respect to future offending. Offenders with approach goals are reinforced for their 'success' in achieving their offence goals, and may use the offence experience to refine their offence strategies in future.

Four Self-Regulation Pathways

In brief, the SRM contains four pathways, representing different combinations of offence-related goals (i.e., is the aim to approach or avoid the sexual offence), and the use of distinct self-regulation styles in relation to sexually offensive contact (under-regulation, mis-regulation, and effective regulation). Each pathway is then further divided into implicit and explicit sub-pathways according to the varying degrees of awareness associated with each. These pathways are reviewed briefly below and are summarized in Table 2. For additional information, the reader is referred to Ward and Hudson (1998, 2000), Ward *et al*. (2004) and Yates and Kingston (2005).

The *avoidance-passive* pathway is characterized by the desire to avoid sexual offending; however, the individual lacks the coping skills to prevent this from occurring (i.e., under-regulation). The *avoidance-active* pathway is characterized by mis-regulation. There is a direct attempt to control deviant thoughts and fantasies but use of ineffective or counterproductive strategies. The *approach-automatic* pathway is characterized by under-regulation, the desire to sexually offend, and impulsive and/or poorly planned behaviour. Finally, the *approach-explicit* pathway is charactierized by the desire to offend sexually, the use of careful planning to execute offences, and the presence of harmful goals concerning sexual offending.

Empirical Support for the Self-Regulation Model of Offending

Because the SRM has been developed relatively recently, there has been little opportunity to evaluate its practical application. Although implemented as the model of treatment in several jurisdictions (Yates, 2005), data on treatment effectiveness and impact on recidivism are not yet available. But the fact that it is explicitly cognitive-behavioural in orientation, adheres to the RNR model, and also avoids the problems noted in traditional narrow RP model, indicates its promise. Furthermore, several empirical studies have been conducted to validate the theoretical constructs of the model. This research is summarized

TABLE 1
Summary of the four pathways proposed by the self-regulation model

Pathway	*Self-regulatory Style*	*Description*
Avoidance-passive	Under-regulation	Desire to avoid sexual offending but lacking the coping skills to prevent it from happening
Avoidance-active	Mis-regulation	Direct attempt to control deviant thought and fantasies but use of ineffective or counterproductive strategies
Approach-automatic	Under-regulation	Overlearned sexual scripts for offending, impulsive and poorly planned behaviour
Approach-explicit	Effective regulation	Desire to sexually offend and the use of careful planning to execute offences; harmful goals concerning sexual offending

below. For a more detailed review of this research, the reader is referred to Ward *et al*. (2004), Yates and Kingston (2005), and Yates (in press).

In an initial qualitative analysis of the self-regulation model that yielded the nine-stage model of offending described above, Ward *et a*l. (1995) found that the model was able to accommodate two distinct types of child molesters. Specifically, the first type of child molester ($N = 5$) fit the profile of a typical paedophile (i.e., preferential), whose offence progression incorporated explicit planning, high levels of positive emotion during offending, and an explicit desire to re-offend (i.e., an approach-type pathway). The second group of child molesters ($N = 6$) was characterized by high levels of anxiety and negative affect, implicit rather than explicit planning of the offence, and a desire to avoid future offending (i.e., an avoidance-type pathway). This pathway was consistent with child molesters who are situational rather than preferential.

Proulx *et al*. (1999) similarly found evidence of two offence pathways, which they termed 'coercive' and 'noncoercive'. In a study of untreated extra-familial child molesters (N = 44), the coercive pathway (*N* = 30; 68%) was associated with unplanned offending against a female victim who was well known to the offender and whom the offender did not perceive as vulnerable. By contrast, the noncoercive pathway (*N* = 14; 31%) was associated with planned offences against unfamiliar male victims whom the offender perceived as vulnerable, significantly more deviant sexual fantasies, significantly greater use of pornography, and greater use of psychoactive substances.

In a study of treated intrafamilial and extrafamilial child molesters (*N* = 59), Bickley and Beech (2003) found that offenders could be reliably classified as following an approach (*N* = 44) or avoidance (*N* = 15) pathway. As compared to offenders following an avoidance pathway, offenders following an approach pathway were less likely to be involved in a stable marital or long-term relationship, were more likely to have offended against either extrafamilial or both intrafamilial and extrafamilial victims, and were more likely to have had offended against boys or against both boys and girls (see also Bickley and Beech, 2002). This study also found differences between offenders following different pathways with respect to pre/post change on treatment targets, with offenders following an approach pathway demonstrating significantly greater improvements in cognitive distortions and victim empathy.

Webster (2005) examined the offence pathways of sexual recidivists (*N* = 25) who had participated in sexual offender treatment prior to reoffending. This study found that recidivists following an avoidance-active pathway were characterized by substance use and use of pornography to cope with deviant thoughts. Offenders following an approach-automatic pathway demonstrated a tendency to respond rapidly to situational cues and to hold offence-supportive cognitions activated upon meeting the victim. Offenders following an approach-explicit pathway were characterized by deviant behaviour that was carefully planned, while all recidivists with approach goals expressed a desire to offend sexually.

In a study designed to evaluate the relationship between risk to re-offend sexually and offence pathways, Yates *et al*. (2003) found significant differences in offence pathways amaong various types of treated incarcerated sexual offenders (*N* = 80). Rapists were more likely to follow either an approach-automatic (58%) or approach-explicit (36%) pathway than an avoidance pathway, while child molesters with male victims were most likely to follow an approach-explicit pathway (83%). Child molesters with female victims were equally likely to follow either an approach-automatic or approach-explcit pathway (43%). Finally, while half of intrafamilial (incest) offenders followed an approach-explicit pathway, a considerable number of these offenders also followed an avoidance-passive pathway to offending (38%).

In a follow-up analysis, Yates and Kingston (2006) examined differences in static and dynamic risk among offenders following the four self-regulation pathways. Offenders following an avoidance-passive pathway scored significantly lower on the Static-99 (Hanson and Thornton, 1999) than did offenders following either an approach-automatic or approach-explicit pathway. Dynamic risk was assessed using the Violence Risk Scale: Sex Offender Version (Gordon *et al*., 2000), which yields three dynamic risk factors, including sexual deviance, criminality and treatment responsivity. Offenders following the approach-automatic or approach-explicit pathway scored significantly higher on the dynamic risk factor, criminality, than offenders following an avoidance-passive pathway. Criminality scores were significantly higher for the approach-automatic pathway as compared to the approach-explicit pathway. Finally, higher static risk significantly predicted membership in the approach pathways, and there was a non-significant tendency for higher criminality scores to be predictive of membership in the approach pathways.

Integration of the SRM and GLM

Limited space precludes describing the embedding of the SRM with the larger rehabilitative framework of the GLM in this chapter and interested readers are referred to the publications cited above. However, in brief, we have broadened the range of approach goals likely to be directly or indirectly associated with both initial offending and with subsequent re-offending. For example, individuals may be seeking intimacy, emotional relief, retribution, pleasure, or a sense of agency (i.e., via dominating or controlling another person) through the commission of a sexual offence. Thus, treatment within the GLM/SRM focuses not only on self-regulation deficits, problem areas, and risk factors, but also on that which they seek to attain via offending. In addition, treatment within the integrated GLM/SRM explicitly focuses on individuals' strengths and the goals they seek to achieve in life, with the aim of working toward the achievement of these goals in prosocial, non-offending ways, while adhering to the principles of the RNR model.

CONCLUSIONS AND FUTURE DIRECTIONS

In this paper we have described what works for offenders in terms of rehabilitation and treatment, with a specific emphasis on sexual offenders. In our view, forensic psychology has made some impressive progress in these arenas over the past two decades. The RNR model has focused on the elimination and reduction of dynamic risk factors for sexual offenders; a sensible and empirically supported approach to offender management. The guiding principles of this approach have typically been translated into effective cognitive-behavioural therapy, as well as a strong relapse prevention approach that has proved popular, if problematic, in its application and usefulness.

However, although current methods appear moderately successful, we believe that there is still some room for improvement. For example, the Good Lives rehabilitation stance and the Self-Regulation treatment approaches appear to show promise for further improving recidivism rates. We hope that future empirical and theoretical work will continue to evaluate and refine these approaches so that we enjoy a further 20 years of successful rehabilitative practice with offenders.

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