



The Explanation, Assessment and Treatment of Child Sexual Abuse

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Abstract

Sexual offending against children remains a socially significant and complex problem. It is becoming increasingly evident that the psychological and emotional costs to victims and their families are profound, with many victims experiencing major difficulties in adjusting to the demands of adult life. In this paper I focus on a number of significant current issues associated with sexual offending and attempt to give a brief overview of these domains: the causes and types of sexual offending; assessment and risk evaluation; the principles of effective intervention; best practice treatment of sexual offenders; and a consideration of treatment effectiveness. I conclude by arguing that we also need to pay more attention to the relationship between normative theories and empirically validated therapeutic techniques. Any understanding of rehabilitation is underpinned by values and assumptions about the kind of lives available to offenders.

Keywords: Assessment; Treatment; Sex-Offenders; Sexual Offending; Risk

INTRODUCTION

Sexual offending against children remains a socially significant and complex problem. It is becoming increasingly evident that the psychological and emotional costs to victims and their families are profound, with many victims experiencing major difficulties in adjusting to the demands of adult life (Davis & P. Petretic-Jackson, 2000). In addition, the high reoffending rate and financial costs of incarceration underlines the need to both understand, and to effectively treat, men who sexually abuse children (Hudson & Ward, 1997).

In the past two decades a number of innovations have led to improved treatment of these difficult men (Marshall, Anderson, & Fernandez, 1999). Factors such as low self-esteem, intimacy deficits, problems empathising with victims, distorted beliefs, and deviant sexual preferences have all been suggested as causal strands in the genesis of

sexual abuse (Marshall, 1999). From a cognitive-behavioural perspective, the problems child molesters present with can be addressed by teaching them more adaptive ways of thinking about children, establishing core social competencies, and increasing their repertoire of coping skills.

In this paper I focus on a number of significant current issues associated with sexual offending and will attempt to give a brief overview of these domains: the causes and types of sexual offending; assessment and risk evaluation; the principles of effective intervention; best practice treatment of sexual offenders; and a consideration of treatment effectiveness. In the theory section I will outline my recent theory of child sexual abuse as it arguably represents the most comprehensive theory available and is built on the excellent work by

Finkelhor (1984), Marshall and Barbaree (1990), and Hall and Hirschman (1992).

CAUSES OF SEXUAL OFFENDING: THE PATHWAYS MODEL

In recent years, a number of multifactorial theories of child sexual abuse and rape have been developed to account for this serious social problem. The most influential are Finkelhor's (1984) Precondition Model of child sexual abuse; Hall and Hirschman's (1992) Quadripartite Model of rape and child sexual abuse; and Marshall and Barbaree's Integrated Theory (1990). While all three of these important theories have a number of strengths, each has weaknesses that limit its ability to provide a satisfactory explanation of child sexual abuse. Of some concern however, is the fact that there has been almost no debate concerning these theories in the literature, nor attempts to establish their explanatory adequacy (Ward & Hudson, in press). In addition, the lack of sustained critique and subsequent theory development has meant that researchers often remain in splendid isolation, unaware that another theory may overlap with their own or contain valuable ideas (Ward & Siegert, in press).

This strategy of proliferation and neglect has a number of unfortunate consequences. First, it is inefficient and wasteful. Interesting ideas are often not developed to their full extent, and other theorists may, inadvertently, duplicate them. Second, it results in a fragmented and uncoordinated theoretical landscape. Third, theorists and empirical researchers are frequently unaware of where the explanatory gaps exist and may ignore fruitful avenues of inquiry.

In a recent paper we attempted to integrate the best elements of each of these theories into a comprehensive etiological theory we call the *Pathways Model* (Ward & Siegert, in press). Our aim was to identify areas of conceptual overlap and also differences between the three theories to construct a conceptual framework that incorporated both the common features and unique contributions each makes to the explanation of child molestation.

A good way to start constructing a theory is to ask what phenomena a theory of child sexual abuse is attempting to explain? The target population of offenders in this paper is adult child molesters and not child or adolescent offenders. A careful consideration of all three theories and the literature on child sexual abuse suggests that there are four

clusters of problems or symptoms typically found among adults who sexually abuse children: emotional regulation problems; intimacy/social skill deficits; deviant sexual arousal; and cognitive distortions (Marshall, 1999). I consider empathy deficits to be subsumed under cognitive distortions and emotional dysregulation difficulties. These core clusters of phenomena are typically the foci of interventions in sex offender treatment programmes (Marshall, 1999). Each of the problem clusters can be further broken down into subcategories, for example, intimacy deficits may manifest as excessive approval seeking or emotional detachment.

I suggest that sexual offenders may exhibit different types of psychological characteristics, each profile associated with variations in the four problem clusters mentioned above. Thus differences between offenders will be a function of the severity, direction, and pervasiveness of the problems rather than simply whether or not they are absent or present. In other words, all offenders display problems in each of these four domains. However, the type of deficit is a function of the particular causes generating each individual's behaviour.

Outline of the Pathways Model

I suggest that four distinct, and interacting, types of psychological mechanism generate the above clinical phenomena evident among child molesters: intimacy and social skill deficits; distorted sexual scripts; emotional dysregulation; and cognitive distortions. Learning events, biological, and cultural factors exert an influence through their effects on the structure and functioning of these sets of mechanisms.

The offence pathways described below are associated with different psychological and behavioural profiles, each reflecting separate etiologies and underlying deficits. Each pathway has a distinctive profile in that the relevant primary causal mechanism will result in a unique set of symptoms. By "primary" I simply mean that the causal mechanism in question impacts more on other mechanisms than they act on it, that is, they have more causal influence. In my model each etiological pathway has its own unique array of causes. The number and type of cause will vary depending on a pathway's particular developmental trajectory.

Although each pathway is hypothesised to be

associated with a unique set of primary mechanisms and cluster of symptoms or problems, they (i.e., the mechanisms) always interact to cause a sexual crime. *Every* sexual offence involves the presence of all the symptom clusters and the activation of their underlying mechanisms. Thus all sexual crimes will involve emotional, intimacy, cognitive, and arousal components. It is hypothesised that each distinct pathway will have at its center a set of primary dysfunctional mechanisms that impact on the others. The core causal processes may recruit or enlist other types of mechanism in order to generate the range of symptoms typically seen in child molesters. But these additional causal mechanisms may be functioning normally and only exert a dysfunctional effect because of the driving force of the primary set of mechanisms. For example, an offender with good interpersonal skills may use these in the service of deviant sexual arousal. Therefore, it is more accurate to say that each of the four clusters of symptoms or problems (generated by the different sets of mechanisms)-emotional regulation, intimacy deficits, cognitive distortions, and sexual arousal- collectively constitute sexual actions. You simply cannot have a sexual offence without sexual arousal, emotionality (in some form or degree), a relationship context (even if a stranger), and cognition. But, the mechanisms producing these phenomena may not all be dysfunctional in the sense that there are enduring deficiencies in their structure and functioning. In my theory there is a complex relationship between learning history, psychological mechanisms, clinical phenomena, and the sexual abuse of a child.

Pathway One-Intimacy Deficits

The *first etiological pathway* contains individuals who are hypothesised to possess normal sexual scripts and only offend at specific times, for example, if a preferred partner is unavailable. An offender who prefers to have sex with adult women or men may, in certain situations, be prepared to substitute a child in the place of an adult. The child is regarded as a “pseudo-adult” and effectively functions as a surrogate partner. There is no confusion of sex and intimacy (as in pathway two), but rather an inappropriate choice of a sexual partner. The primary cause of the sexual abuse of a child in this situation resides in intimacy deficits, loneliness leading to a need to engage in a sexual relationship with another person. For such individuals their (normal) needs for sex and closeness will be transferred to children, because of their perceived acceptance of the offender. The

types of intimacy deficits experienced by this group of child molesters are likely to be related to their attachment style. Ward, Hudson, and Marshall (1996) found that sex offenders exhibited a wide range of insecure attachment styles, each associated with different psychological problems. For example, child molesters with a preoccupied attachment style were characterised by emotional neediness and profound doubts about their ability to elicit love and support from partners. Alternatively, the fearful-dismissively attached offenders tended to emotionally distance themselves in relationships because of their fear of rejection. Both groups of child molesters experience problems with intimacy and may turn to sex with children if their adult relationships are compromised or unsatisfactory.

The primary causal mechanism underlying this pathway is insecure attachment and subsequent problems establishing satisfactory relationships with adults. Therefore, offenders following this route to becoming a sex offender will expect intimate relationships with adults to be unsuccessful and so develop maladaptive interpersonal strategies to escape from, or avoid, this outcome. The substitution of children for adult sexual partners will also be accompanied by cognitive distortions concerning the rights or entitlement of the offender to have sex with whom he pleases. This will result in sexual arousal in the context of a sexual encounter with a child, possibly intimate and “loving” emotions, and an attempt often to create an adult-like relationship with the child. The onset of sexual offending is expected to be in adulthood and triggered by a period of rejection or sustained emotional loneliness (Marshall, 1999). Self-esteem may be low or high depending on the domain in question and the particular psychological make-up of the individual concerned.

Pathway Two-Deviant Sexual Scripts

The *second etiological pathway* contains individuals who have subtle distortions in their sexual scripts that interact with dysfunctional relationship schemas (Ward & Siebert, in press). Sexual scripts are the mental representations individuals acquire during the course of their development that facilitate the interpretation of intimate or sexual encounters, and guide subsequent sexual behaviour (Gagon, 1990). Gagon (1990) suggests that “Sexual scripts are involved in learning the meaning of internal states, organizing the sequences of specifically sexual acts, decoding novel situations, setting the limits on

sexual responses and linking meanings from nonsexual aspects of life to specifically sexual experience” (p. 6).

Thus the core causal mechanism is a distorted sexual script, and there is also hypothesised to be some degree of dysfunction in offenders’ relationship schemas (attachment style). These individuals may have experienced sexual abuse as children and as a consequence become prematurely sexualised. However, unlike the fifth group, there is hypothesised to be no major distortions resulting in the development of sexual preferences for children and/or sexually abusive behaviours. The major script flaw is expected to reside in the *context* in which sex is viewed as desirable. As adults they are likely to seek reassurances through sex and equate sex with intimacy (Marshall et al., 1999). This occurs through the confusion of sexual cues with those signalling affection and closeness, and a fear of rejection by others if they were to establish intimate relationships. Interpersonal closeness is, therefore, only achieved via sexual contact and feelings of vulnerability are misinterpreted as indicating sexual need. The avoidance of intimacy, coupled with a drive for impersonal sex, is likely to lead to ultimately unsatisfying encounters and relationships that do not last. Sexual offenses against children may occur following periods of rejection by adults, if they are perceived as more trustworthy and accepting. The primary mechanism associated with this pathway resides in scripts that represent relationships purely in sexual terms. The fear of intimacy and tendency to view romantic relationships as sexual encounters, are also caused by dysfunctional mechanisms and result in unhappiness and frustration. The fact that children are chosen as sexual partners is largely a question of opportunity and sexual and/or emotional need.

The sexualisation of relationships will result in the four clusters of problems evident in child sexual abusers, namely, deviant sexual arousal, intimacy deficits, inappropriate emotions, and cognitive distortions. Cognitive distortions will emerge in the attempt to justify or excuse the sexual abuse and problems differentiating intimacy and sexual desires result in enduring relationship problems. The onset of sexual offending is expected to typically start in adulthood and be episodic in nature; associated with periods of rejection, disappointment or extreme loneliness. Self-esteem in the interpersonal domain is anticipated to be low, reflecting this group’s sensitivity to rejection and craving for love and approval.

Pathway Three-Emotional Dysregulation

The *third etiological pathway* contains individuals who are hypothesised to possess normal sexual scripts but have difficulties (dysfunctional mechanisms) in some aspect of the emotional regulation system. There may be problems identifying emotions, a lack of capacity to modulate negative emotions, or an inability to utilise social supports in times of emotional distress. Other individuals might primarily have problems controlling their anger and sexually abuse children as a way of punishing partners. Alternatively, strong negative mood states could result in a loss of control, which, in conjunction with sexual desire, leads an individual to opportunistically use a child to meet his sexual needs. Individuals following this pathway offend if unable to effectively manage negative emotions and either become disinhibited or else use sex as a soothing strategy. Thus, the primary dysfunctional mechanisms might reside in defects in emotional and behavioural control or relate to the inappropriate utilisation of sex as a coping strategy. They are likely to prefer sex with age appropriate partners but will engage in the sexual abuse of a child under certain circumstances. Exposure to sexual activities such as compulsive masturbation during early adolescence, and the absence of alternative means of increasing self-esteem or mood, will create a profound link between sex and emotional well being. If such individuals are stressed it is probable they will look to sex as a means of ameliorating their mood. On such occasions, this may involve sex with children or coercive sex. Sexual fantasies will typically accompany sexual behaviours (e.g., masturbation, sex with a child etc) and function to increase the offenders’ sense of well being. For example, narratives in which the offender is loved, powerful, important, or vengeful. Although the fantasies should not reflect entrenched deviant sexual preferences due to the possession of normal sexual scripts. Emotional need rather than sexual deviancy, is hypothesised to drive the choice of sexual outlet and partner. Adolescence will be a difficult time because of the hormonal and emotional challenges, and the frequency of sexual thoughts and impulses (Marshall & Barbaree, 1990). It is anticipated that child molesters characterised by emotional dysregulation problems may offend at any time during adolescence and adulthood, and when not under stress are likely to exhibit normal sexual interests and behaviours, although their base level of masturbation may be

high and typically occur in response to periods of emotional dysphoria.

Enduring problems with emotional regulation will result in an attempt to rationalise the offence once it has occurred (e.g., "I lost control"), little attempt to create an "intimate" relationship with a child, and sexual arousal in the context of strong emotional states. This might be due to an association between certain negative emotions and sex or simply the presence of sexual desire in conjunction with poor impulse control. Self-esteem may be low or high depending on the domain in question and the particular psychological makeup of the individual concerned. Their preferred sexual fantasies will revolve around adults and they should not exhibit deviant or paraphiliac features.

Pathway Four-Antisocial Cognitions

The *fourth etiological pathway* contains individuals who have no distortions in their sexual scripts (i.e., child-adult sex as template) but possess general pro-criminal attitudes and beliefs, and whose offending reflects this general antisocial tendency. Offending in these situations may be further facilitated by the existence of patriarchal attitudes towards children and offenders' sense of their own *superiority*. Research supports the existence of child molesters who have extensive criminal histories in addition to their sexual offenses (Soothill, Francis, Sanderson, & Ackerley, 2000). Although there is disagreement concerning the extent to which child molesters as a whole are specialists or generalists, it is generally accepted that there is a subgroup who commit a wide variety of offences. This group will not necessarily possess distorted sexual scripts, although they are expected to have pro-crime attitudes and other criminogenic needs frequently associated with illegal acts, for example, substance abuse problems and impulsivity (Andrews & Bonta, 1998). It is hypothesised that this group of child molesters will frequently engage in criminal actions as children and adolescents, and may receive a diagnosis of conduct disorder. Their sexual offences against children will be part of this general picture of antisocial behaviour and may not reflect any enduring deviant sexual preferences.

The major type of mechanisms for this group resides in their antisocial attitudes and beliefs. These cognitive distortions (for want of a better term), in conjunction with sexual desire and opportunity, will result in the sexual abuse of a child. Such individuals disregard social norms forbidding sex with children and are expected to

exploit any opportunity for self-gratification if it presents itself. They are likely to experience positive emotional states when abusing a child because of the pleasure experienced and the fact that they are meeting their needs in a personally acceptable manner.

Pathway Five-Multiple Dysfunctional Mechanisms

The *fifth etiological pathway* will contain individuals who have developed distorted sexual scripts, usually reflecting a history of sexual abuse or exposure to sexual material or activity at a young age. Coinciding with the acquisition of deviant sexual scripts will be pronounced flaws in all the other primary psychological mechanisms. Thus this group are likely to exhibit a multitude of offence related deficits and constitute "pure" pedophiles. In the case of uncomplicated pedophilia, the sexual scripts of offenders will contain distortions in the specification of preferred or ideal sexual partners. The "ideal relationship" will be depicted as one between an older person and a child. However, the other elements comprising sexual scripts (i.e., sequence of behaviours associated with sexual encounters and the context of sex) may also contain distortions and it is expected that such additional flaws will be correlated with additional sexually deviant behaviour. For example, a specified action or sequence of sexual behaviours might contain sadistic and aggressive elements or unusual practices.

The predisposition to sexually abuse children is hypothesised to only be translated into offending behaviour under certain circumstances. These will include the presence of a victim (i.e., opportunity to offend) and the absence of any conflicting goals. However, individuals who manage to restrain the impulse to sexually violate a child will always be at risk of ultimately acting on them; sexual scripts will activate pedophilic fantasies and inclinations. It is expected that in the majority of cases deviant scripts will be associated with incidents of childhood sexual abuse, although the onset of sexually abusive behaviour may only occur in adulthood. Whether or not this happens will be a function of the coexistence of problems with emotional regulation and impulsivity, although the abuse of a child does not require these additional vulnerability factors. It is predicted that offenders whose abusive behaviour is generated by distorted sexual scripts will engage in deviant fantasies prior to their first offence. This is due to the fact that sex has become salient at an early age and will be

activated in a variety of contexts, precipitating sexually abusive memories and fantasies.

As stated above, offenders following this pathway will also have marked dysfunctions in all the other mechanisms. They will have dysfunctional implicit theories about children's sexuality and their ability to make informed decisions about sex, inappropriate emotional regulation, and impaired relationship and attachment mechanisms (Ward & Siegert, in press). The existence of distorted sexual scripts, in conjunction with the other distorted mechanisms, will create all four clusters of problems evident in child sexual abusers, namely, deviant sexual arousal, intimacy deficits, inappropriate emotions (an emotional regulation problem), and cognitive distortions. Sexual scripts contain cognitive components referring to the features of a preferred partner and therefore incorporate distorted beliefs concerning their needs and inclinations. Additional belief systems concerning children's needs in general, the threat posed by others, and the offenders' ability to effect change on himself and others, will also be involved in the production of sexually abusive behaviour. The same follows for the nature of sexual activities, where certain sexually deviant behaviours will be enlisted in the goal of achieving pleasure or other primary or secondary goals (e.g., a sense of control). Deviant sexual arousal is generated in certain contexts (when confronted with sexual, affective or situational cues) by the activation of the sexual script. Just as the activation of a restaurant script will lead to the desire for, and actions designed to consume, food, so a sexual script contains goals concerned with the achievement of sexual satisfaction. Intimacy problems may occur as a function of the fact that an individual's preferred sexual partners are children and therefore it is probable that he would be unable to relate to adults in a way likely to lead to an open and mature relationship. The mechanisms generating intimacy deficits are suggested to be independent although causally interactive with sexual scripts.

Thus, the offending career of abusers characterised by the presence of distorted sexual scripts will frequently start early and be correlated with entrenched cognitive distortions, deviant sexual arousal, and positive affect in the context of offending. They are likely to have deviant sexual fantasies generated by sexual scripts. The scripts may develop and change in response to different types of sexual experience. Self-esteem in the interpersonal domain will often be high because of

this group's entrenched preferences for children as sexual partners and their accompanying beliefs that these interests are legitimate and healthy.

Conclusions

In the pathways described above, situational triggers interact with the various predispositions of individuals to violate children, and thus result in sexually abusive behaviour. The nature of the situational trigger should vary according to each type of offender, or more accurately, according to his particular array of vulnerability factors. For offenders who have distorted sexual scripts, sexual need in conjunction with the judgement that it is safe to abuse a child, will result in sexual abuse. While for another individual it might be the existence of a strong affective state such as when rejected by a partner.

Concerning the maintenance of subsequent sexual offending, it is possible that the simple fact of sexually abusing a child may alter or distort the sexual scripts of individuals who previously had relatively adaptive attitudes about sex. This is especially likely to occur when the offender has had little chance of establishing alternative relationships with adults. Thus, according to the Pathways Model some offenders may develop deviant sexual scripts as a *consequence* of the (continued) sexual abuse of children. The five etiological pathways outlined above only explain why some individuals start to sexually abuse children, not why they continue. While continuation is likely to be related to individuals' vulnerability factors, this should not be assumed. It is anticipated that subsequent sexually abusive behaviour will be maintained through a combination of positive and negative reinforcement. The specific types of reinforcers will be a function of the vulnerability factors evident in different types of child molesters. For example, individuals whose initial offending is a function of deviant sexual scripts should find subsequent sexual encounters with children rewarding. While those who have difficulties with emotional regulation may continue sexually abusing children (and/or fantasizing about it), because it enables them to escape from, or avoid, aversive affective states.

ASSESSMENT

Risk Assessment

Risk assessment can be undertaken for a variety of reasons ranging from initial decisions concerning the nature of treatment (i.e., intensity and duration), civil commitment hearings, and in order to plan for post-treatment support (Hanson, 2000). Different types of risk decisions rely on different types of risk factors. For example if the primary goal is to provide an estimate of an individual's chances of reoffending in the future, then static or unchangeable factors typically provide the best indicators. These include, offending history, onset of offending, age, gender, and race. However, if the intent is to treat an offender then identifying dynamic (i.e., changeable) risk factors is of more value. For example, sexual preoccupations, deviant sexual preferences, intimacy deficits, attitudes supportive of sexual offending (cognitive distortions), negative peer influences, problems with emotional/sexual regulation, and general self-regulation (Hanson, 2000).

It is also important to be clear about exactly what type of recidivism is under consideration, for example, general offending, any sexual offence, or a reoccurrence of the initial sexual offence. Furthermore, a method of estimating level of risk should be carefully considered. There are at least three plausible approaches to risk assessment currently discussed in the literature. In the *guided clinical approach* knowledgeable clinicians take into account empirically validated risk factors and then arrive at an overall estimate of risk. Second, in the *pure actuarial approach* an offender's level of risk is estimated by the administration of a specifically constructed scale using a predetermined numerical weighting system. A risk level is arrived at by applying objective rules to the relevant data and there is no attempt to use clinical experience or judgement. Third, the *adjusted actuarial approach* represents an integration of the two previous approaches. Once an actuarially generated prediction is made the clinician considers factors not included in the measure (e.g., intent, motivation, personal circumstances etc) and if necessary adjusts the score upwards or downwards. Best practice currently favours the third option in view of the rather modest performance of the best actuarial measures. However, this may change in the near future but in any event, clinicians should always use a validated risk measure in their assessments of risk. Well-validated risk scales in the sexual offending area include the Static-99 (Hanson & Thornton, 1999), the Sex Offender Risk Appraisal Guide (Quinsey, Harris, Rice, & Cormier, 1998) and the Rapid Risk Assessment for Sexual Offense Recidivism (Hanson, 1997).

According to Hanson (Hanson, 2000; Hanson & Bussière, 1998) currently the most well-established risk factors (in order of predictive power) for future sexual offending are deviant sexual interests, prior sexual offences, any stranger victims, early onset, any unrelated victims, any boy victims, diverse sexual crimes, antisocial personality, any prior offences, age, single status, and being a treatment dropout. The major predictors of general recidivism in sexual offenders are a history of juvenile delinquency, adult criminal history, antisocial personality, age (young), and substance abuse. Some exciting work with dynamic factors is currently underway and early results indicate that negative mood, substance abuse, social isolation, lack of remorse, lack of cooperation with supervision, and immediate sexual preoccupations are significant predictors of sexual recidivism (Hanson & Harris, 2000). However, this work is in the preliminary stages and needs to be replicated.

Clinical Assessment

Effective treatment of child molesters requires a dedicated and systematic assessment period targeting a number of domains, and utilising a number of methods to collect clinical information (Marshall, 1996). These methods include a clinical interview, the administration of psychological scales, and phallometric testing (Laws & Osborne, 1983). It is important to use multiple methods to gather clinically relevant data; relying on just one source of data, for example self-report, is risky. While self-report is a valuable source of information, limitations in cognitive processing and the distorting effects of psychological defences and memory, make it likely that exclusive reliance on this type of data might result in a formulation that bears little resemblance to an individual's real problems. The assessment process should culminate in a clinical formulation that serves to guide the customisation of the program content to the individual. A comprehensive clinical formulation of sexually aggressive behaviour needs to consider an individual's background, psychological vulnerabilities, current stresses and the problem behaviour itself.

Comprehensive coverage of the important content areas (as identified in the empirical literature and with clinical experience) will enable the clinical decisions that arise from assessment, to be based on the most accurate and scientific information available. These areas include developmental history, social competency, self-regulation, sexual functioning and preferences, beliefs and attitudes towards children and women, capacity for empathy

and perception of victim harm, and offence related information (Marshall, 1999). The latter category includes degree of denial and cognitive distortions related to the sexual offence, offence antecedents, degree and type of planning, amount of force used to subdue the victim, and emotional states evident throughout the offence process.

The clinical interview is the most common assessment device available to the clinician. However, as noted above, data collected in this fashion, especially from men accused of sexual assault, may be unreliable. This means that collateral information is essential for corroborating or challenging the material obtained during the interview. For example, any records held by the police, including details provided by victims or mental health professionals' reports at the time or during previous arrests, are extremely useful. It is also invaluable in helping formulate interview strategies, as well as predict relevant issues and the excuses given by an offender (Ward, Hudson, Johnston, & Marshall, 1997). Ethical standards require informed consent, which means that the offender, or accused, understands the purpose of the interview and the inevitable limits to confidentiality. Offender disclosure is likely to be enhanced by an honest discussion of the benefits and risks of co-operation.

TREATMENT

Principles of Effective Treatment in Corrections

A consensus is starting to emerge in the correctional literature that the rehabilitation of offenders should focus on modifying criminogenic needs. Criminogenic needs, as defined by Andrews and Bonta (1998), are dynamic attributes of offenders and their circumstances that, when changed, are associated with reduced rates of recidivism. For example, pro-offending attitudes and values, aspects of antisocial personality (e.g., impulsiveness), poor problem solving, substance abuse, high hostility and anger, and criminal associates. Thus, criminogenic needs are a subset of factors predictive of recidivism. Other risk factors include static or unchanging factors such as gender, age, and offending history. While static factors play an important role in determining initial levels of risk, they are of lesser value in guiding treatment. The fact that they are unmodifiable means they fail to reveal whether a person has changed as a result of treatment, by how much, what has changed or inform us whether an offense is likely to occur. Therefore, the utility of static risk factors

is limited once an initial risk assessment has been performed. By way of contrast, dynamic risk factors (i.e., criminogenic needs) can provide clinicians with information concerning the impact of treatment on an individual's level of risk and also indicate where change has occurred. Noncriminogenic needs are dynamic attributes of offenders and their circumstances, which when changed, are not associated with reduced recidivism. For example, low self-esteem, anxiety, personal distress, or group cohesion (Andrews & Bonta, 1998). Andrews and Bonta acknowledge the importance of noncriminogenic needs but argue that priority should be given to targeting criminogenic needs because of their positive impact on recidivism rates. While they do not explicitly state this, the implication is that noncriminogenic needs are *discretionary* intervention targets.

Andrews and Bonta formulate four general principles of classification to guide effective correctional treatment, the utility of each principle supported by empirical research. First, the *risk*-principle, which is concerned with the match between level of risk and the actual amount of treatment received. For example, according to this principle high risk individuals should receive the most treatment, typically at least 100 hours of cognitive behavioural interventions over a three to four month period (Hollin, 1999). Second, according to the *need* principle programmes should target criminogenic needs, that is, needs associated with recidivism and that can be changed. Strictly speaking, criminogenic needs should be detected for each type of crime rather than simply for crimes in general. For example, recently Hanson and Harris identified a number of criminogenic factors for sexual offending which included deviant sexual arousal, intimacy deficits and loneliness, and problems with emotional regulation (Hanson & Harris, 2000). Third, the *responsivity* principle is concerned with a programme's ability to actually reach and make sense to the participants for whom it was designed. In other words, will offenders be able to absorb the content of the programme and subsequently change their behaviour? Examples of factors that if not taken into account may impede learning include gender, learning styles, ethnicity, and treatment motivation. Finally, the principle of *professional discretion* states that clinical judgement should override the above principles if circumstances warrant it. This principle allows for treatment flexibility and innovation under certain circumstances.

These principles prescribe how treatment should proceed and are intended to provide a coherent framework that will enable policy makers and treatment providers to design effective rehabilitation programmes. In addition to these principles, Andrews and Bonta have identified a number of features of rehabilitation programmes associated with reduced rates of recidivism. This include being: based on learning and cognitive-behavioural principles; focused on skill acquisition; structured and time limited; and delivered by qualified and trained staff who work from detailed treatment manuals (Andrews & Bonta, 1998; Hollin, 1999).

Treatment Modules

The principles of effective rehabilitation in general offenders also apply to sex offenders. As stated earlier, four clusters of problems have been consistently identified in sex offenders: cognitive distortions, emotional dysregulation social competency/intimacy problems, and deviant sexual arousal. Arguably these problems constitute criminogenic needs, a proposal supported by the work of Hanson and Harris on dynamic predictors in sex offenders (2000).

The majority of cognitive-behavioural treatment programs for sex offenders are entirely group-based with individual therapy kept to a minimum, that is, sufficient only to enable a resident to participate in group (Marshall, 1996; Marshall et al, 1999). Group treatment is more effective both in terms of use of time in that more men can be dealt with at once, and, I believe, in terms of efficacy in that processes such as credible challenges by other offenders and vicarious learning are not available in individual treatment.

While the use of structured cognitive-behavioural group programmes for sex offenders is widely accepted several clinical issues remain unresolved. First, groups may be run on a closed or rolling basis. Some clinicians prefer the former because it confers flexibility concerning the introduction of new members to the group; basically they can join at any time. While the latter option is supported by other clinicians who stress the capacity of closed groups to engender a sense of trust and thereby facilitate the group process. At this point, there is no clear evidence favouring one or other of the two options (Marshall et al., 1999). Second, the degree to which treatment should be delivered in a fixed format using structured manuals or implemented in an individually tailored way is unresolved. In a recent paper we argued that the most defensible

position is to initially use manual-based treatment for sexual offenders (Ward, Nathan, Drake, Lee, & Pathé, 2000). However, we also believe that there are at least four situations where formulation-based treatment represents a valuable strategy, namely: when confronted with particularly complex or unusual cases, when standardized treatment has failed, or when there are significant threats to the therapeutic relationship. Case formulation is a relatively high risk but valuable decision-making strategy and ought to be reserved for those situations where it appears to advance the treatment of sexual offenders. It may be possible for some treatment agencies to specialize in FBT for these exceptional groups. A final issue concerns the degree to which treatment should be administered according to level of risk, with high risk sex offenders receiving an intensive and comprehensive intervention package and low risk offenders, minimal clinical input (Marshall, 1999).

In the following description of treatment components I have drawn upon my experience with the Kia Marama treatment program for child molesters in New Zealand (Hudson, Marshall, Ward, Johnston, & Jones, 1995; Ward, Hudson, & Keenan, 2001). It presents best practice in the treatment of child molesters and is very similar in content to the excellent programmes run in Australia. I suggest that seven core components or modules underlie effective cognitive-behavioural treatment for child molesters.

Module 1: Norm Building.

The primary aim for this module is to establish the rules of conduct that are essential if the group is to function effectively, and to provide an overview of the treatment philosophy, that is the "the big picture". At the first session, the underlying social learning model of human behaviour change is described. The men are told that the therapists do not intend to cure them of their problems, but rather to teach them to control their behaviour by helping them break dysfunctional habits and learn prosocial ways of satisfying their needs. Although each group generates its own set of rules which are in sense unique to the group, most groups would typically include rules covering confidentiality (prohibiting the discussion of issues raised in group concerning other group members, with people outside the group) and communication procedures (using "I" statements, one person speaking at a time, speaking to each other not about each other, and demonstrating active listening skills). Additional rules may emphasise the importance of accepting responsibility for one's own issues (by

facing up to challenges, and by asking questions when something is not understood) and challenging other members constructively and assertively rather than aggressively or colluding.

Module 2: Understanding Offending (Cognitive Restructuring)

Sexually aggressive behaviour is often facilitated and justified by distorted thinking. In this module the distorted views these offenders so frequently have of their offences are challenged and more accurate and constructive alternative ways of thinking about these issues developed. This process is partially facilitated by encouraging the man to fully understand his offence cycle. This process is based on the understanding we have developed regarding the typical offending pathways (Ward, Loudon, Hudson, & Marshall, 1995). Using a collaborative approach, with help from group members, the man is expected to develop an understanding of how background factors, such as low mood, lifestyle imbalances, sexual difficulties, intimacy difficulties set the scene for offending.

The next two sections of the chain, distal planning and entering the high risk situation, in which both proximal planning and the offence behaviours occur, are distinguished by the presence of a potential victim or being in a situation where the presence of a potential victim is highly probable, for example being in a park at around 3pm on a school day. The final part of the chain involves a description of the types of reactions the man has to having offended, and how these reactions inevitably add to his difficulties and therefore increase the likelihood of the chain continuing. Each man completes this task during one group session. After receiving feedback from the therapist and other group members he then has a further opportunity to refine his understanding during a further session.

Module 3: Arousal Reconditioning

Inappropriate or deviant sexual arousal to children is hypothesised to be an important factor causing and maintaining sexual offending (Marshall & Barbaree, 1990), and indeed is described as an important part of the problem behaviour process. Even where there is no phallometric evidence of sexual arousal to children, and this is not uncommon, my belief is that any extensive pairing of orgasm and children means that it is likely that under circumstances of risk (for example, a negative mood state and the presence of a potential

victim) the man will experience deviant sexual arousal.

In terms of the procedures used in this module, there is a limited amount of evidence suggesting that reconditioning strategies can reduce inappropriate sexual arousal in some categories of child molesters (Marshall, 1999). There are three components to this intervention. Covert sensitisation comprises the first of these. Each man identifies the process or sequence involved in his most recent or most typical sexual assault and operationalizes this by preparing a personalised fantasy divided into four parts: 1) a neutral scene involving boredom; 2) a scene involving gradual build-up to hands-on contact with a victim, but which ends before sexual contact is actually made; 3) a scene involving detection, arrest, going to jail, humiliation etc., that is negative consequences; 4) an escape scene involving "coming to his senses" and getting out of the situation, feeling relieved and "very pleased with himself". Scenes 1 and 2 are repeatedly paired with both scenes 3 and 4. The men are encouraged to activate the escape scene progressively earlier points in the previous scenes. These are then written on pocket-sized cards and the offender is required to regularly review these behaviour sequences.

The remaining components in this module are designed to decrease deviant sexual arousal, on the one hand, and to strengthen sexual arousal to appropriate images and thoughts on the other. Directed masturbation, where the man is encouraged to become aroused by what ever means is necessary, but once aroused to masturbate to consensual images involving an adult, is designed to pair arousal with thoughts of appropriate sexual activity in order to strengthen these associations. Once the man has ejaculated, and becomes at least relatively refractory to sexual stimulation, he is asked to carry out the satiation procedures suggested by Marshall (1979). These involve him repeatedly verbalising components of his deviant sexual fantasies, for at least 20 minutes, whilst in this state of minimal sexual arousal. This pairing of deviant sexual material with both low arousal and arousability is likely to reduce its positive valence.

Module 4: Victim Impact and Empathy

A lack of empathy for their victims, and an inability or refusal to seriously consider the traumatic effects of sexual abuse appear to be common features of sex offenders. We attempt to enhance each man's understanding of the impact of

offending on victims by having the group "brainstorm" immediate effects, post abuse effects and long-term consequences. Any gaps in understanding are filled by the therapist.

Typically, a general deficiency in the capacity to be empathic is seen as facilitating offending, where things that are manifestly harmful are done to others. I doubt this is the case and indeed there is evidence (Marshall, 1999) that the deficit is quite selective to the man's own victim, and as such most likely reflect dysfunctional cognitions specifically related to his own offending (Ward, Hudson et al., 1997). The victim impact material may serve to reinstate their capacity to empathise with potential victims, and reduce the future risk of reoffending.

To enhance this process therapists have the men engage in several other tasks. They have them read aloud accounts of sexual abuse and view videotapes of victims describing their experiences. Some programmes also have an abuse survivor come in to the group, as a guest speaker; she facilitates a discussion about the impact of abuse, both in general and specifically to her. They then write an "autobiography" from their own victim's perspective. This covers the distress they suffered and the ongoing consequences to having been abused by him. Finally, each individual role-plays a carefully designed (by the therapists) interaction between himself and his victim. The group assists in these processes, challenging and suggesting additional material, and provides, along with the therapist, final approval.

Module 5: Mood Management

Negative mood states are a frequent precipitating stimulus for the offence chain, usually depression or feelings of rejection, or more rarely anger (Ward & Siegert, in press). Therefore deficiencies in affect regulation are a critical part in the management of risk. However, it is important to keep in mind that positive mood states can also be associated with sexual offending for some individuals. The men are presented with a cognitive-behavioural model of mood as an overarching framework. They are taught to identify and distinguish between a range of affects including anger, fear, and sadness. They are then asked to identify particular moods that are, for them, especially associated with their offending process and are then taught the physiological, cognitive and behavioural skills to manage these moods. Cognitive strategies include techniques aimed at challenging or interrupting negative thoughts and include stress inoculation.

Behavioural techniques include teaching, and role playing, effective communication styles for expressing emotions, including assertiveness training, anger management and conflict resolution techniques. Lastly, problem solving and time management strategies are briefly introduced.

Module 6: Relationship Skills

In my clinical and research work I have been struck by the apparent difficulty child molesters have in the area of social competence (Ward & Siegert, in press). Not only do these difficulties in relating to others result in unmet needs, they also relate to difficulties in regulating affect. It is therefore of considerable importance to enhance interpersonal functioning. In this module the focus is typically on intimate relationships, first establishing their benefits and then examining ways in which they can be enhanced. The four main areas focused upon involve: conflict and its resolution; the constructive use of shared leisure activities; the need to be communicative, supportive and rewarding of each other; and finally, intimacy, which is the key issue around which all the others revolve. I have argued that sex offenders are particularly deficient in their capacity for intimacy and have provided evidence to support this as well as the existence of the related negative emotional states such as loneliness and anger (Ward, Hudson, & Marshall, 1996).

Therapists pay attention to the relationship style described or exhibited by each man, and identify aspects which may serve to block the development of an intimate relationship. They then examine approaches to relationships, which might more effectively serve to develop intimacy. This is completed through the use of brainstorming, role-playing, discussion of prepared handouts and homework assignments. Therapists also traverse issues relevant to sexuality and sexual dysfunction as part of this module, providing educational material, through handouts and videos, as required to correct misinformation or challenge unhelpful attitudes. They discuss sexuality as an aspect of intimacy, and consider attitudes and behaviours that make for a mutually fulfilling encounter.

Module 7: Relapse Prevention

The overarching framework of the program is that of a relapse prevention view of offending, and we introduce RP constructs early in treatment. In this sense the final intervention module of the program comes as no surprise to the men, and forms a natural extension of the earlier components. The

distinction between internal and external management (Pithers, 1990) has utility and therapists make use of it in structuring this module.

The internal management component involves the man presenting a more refined understanding of his offence chain, and describing the skills he has acquired to manage his risk factors. This approach is based on the assumption that the goal of treatment is to enhance self-monitoring and control over sexually abusive behaviour, rather than to cure the offender. The acquisition of behavioural and cognitive skills and attitudes is designed to enable individuals to meet their needs in more prosocial ways. The emphasis upon understanding the various links in the offence process also encourages attempts to "break the chain" as early as possible. Thus this module helps the offender to identify the external and internal factors that put him at risk for further sexually abusive behaviour, and to ameliorate these by utilising appropriate coping responses.

The external management aspect involves the man identifying friends and/or family who are prepared to support him in his goal of avoiding re-offending, and the preparation, and presentation, of his personal statement. This critical component is the bridge between the whole intervention effort and the community in which the offender plans to live. The personal statement articulates the factors or steps in his offending cycle and outlines a plan for both the avoidance of high risk situations and ways to escape from one if it develops. It also describes the external cues or signs signifying to others that he is at risk for further offending, for example, irritable behaviour. This process serves to facilitate good communication between the sex offender and those responsible for his management upon release (community corrections officer), as well as those people who have agreed to assist his self-management process.

Treatment Effectiveness

The evaluation of treatment outcomes has recently received considerable attention, particularly since the Furby, Weinrott, and Blackshaw (1989) review of recidivism, which argued that because of profound methodological inadequacies in existing data it was not possible to establish whether treatment reduced recidivism (e. g., Quinsey, Harris, Rice, & Lalumière, 1993). However the most optimistic evaluators have concluded that despite numerous methodological problems inherent in the best of the existing research, there is

evidence that comprehensive cognitive-behavioural programs, and those that combine antiandrogens with psychological treatment, are associated with ecologically significant reductions in recidivism for treated sex offenders (Hall, 1995; Marshall, Jones, Ward, Johnston, & Barbaree, 1991; Marshall & Pithers, 1994).

For example, in a recent chapter Marshall, Anderson, and Fernandez (1999) reviewed the literature on treatment outcome in rapists and other sex offenders and concluded that on balance it is reasonable to accept that treatment is effective in reducing reoffending. One paper they cited in support of this conclusion was a meta-analysis by Hall (1995) of twelve studies that did meet relatively stringent research criteria (e.g., reported recidivism rates, and included data from a comparison or control group). Hall reported a small but robust treatment effect with 19% of treated offenders and 27% of comparison or control offenders recidivating during an average of 6.85 years follow-up (Hall, 1995). Cognitive-behavioral and hormonal treatments were associated with a larger effect than behavioral programs, as were studies with higher recidivism base rates and outpatient treatment studies. Thus despite a number of methodological problems evident in the outcome literature I believe that there are grounds for cautious optimism with respect to whether treatment works with child molesters. On a final note, that fact that cognitive-behavioural treatment programmes are effective in reducing sexual reoffending rates is entirely consistent with the more general correctional rehabilitation literature. This research suggests that structured cognitive-behavioural interventions can reduce recidivism rates by 10-50% providing they are guided by the principles of rehabilitation outlined earlier (Hollin, 1999).

FUTURE ISSUES

As discussed above, over the last two decades empirical evidence has increasingly supported the view that it is possible to reduce reoffending rates by treating or rehabilitating offenders rather than simply punishing them (e.g., Andrews & Bonta, 1998; Gendreau, 1996). In fact, the shift from a punishment to a rehabilitation model is arguably one of the most significant events in modern correctional policy (Gendreau Andrews, 1990). This perspective rests on a number of important assumptions about crime and the characteristics of offenders. First, that crime is caused by distinct patterns of social and psychological factors that

increase the chances a given individual will break the law. Second, targeting these factors will decrease reoffending rates. Third, that individuals vary in their predisposition to commit deviant acts and this should be taken into account when planning rehabilitation programmes; treatment should be tailored to meet each offender's unique needs (Cullen & Gendreau, in press).

There appear to be two broad models of offender rehabilitation, each committed to changing the characteristics of individuals associated with criminal acts, but possessing a different orientation. These models are not typically differentiated and may even coexist to some degree. The first is concerned with *risk management*, where the primary aim of rehabilitating offenders is to avoid harm to the community rather than to improve their quality of life. While the enhancement of offenders' functioning may be viewed as desirable, it is not the primary objective of programme developers and policy makers. The relationship between offenders' level of functioning and recidivism rates is an instrumental one: it is a means to the end of reduced risk to the community. In contrast, the second model is concerned with the *enhancement* of offenders' capabilities in order to improve the quality of their life, and by doing so, reduce their chances of committing further crimes against the community. By focusing on providing offenders with the necessary conditions (e.g., skills, values, opportunities, social supports etc.) for meeting their needs in more adaptive ways, the assumption is that they will be less likely to harm themselves and others. In this model the primary end or goal is not the reduction of crime, although it is argued that this will reliably follow from individual flourishing. The enhancement model is more widely accepted in clinical psychology and its presence in corrections has occurred through the incorporation of clinical psychological models into work with offenders.

We believe that the risk management model has tended to dominate correctional psychology and offender rehabilitation policy (see Andrews & Bonta, 1998; Ashford, Sales, & Reid, 2001). Even when the focus has been on offenders' needs, policy makers tend to be concerned with reducing further crimes or the incidence of disruptive behaviour within prisons rather than the enhancement of their well being and capabilities. For example, Ashford, Sales, and Reid (2001) have distinguished between the subjective needs of the offender and the objective needs of the Justice and Correctional system, and Society at large. They make the point that offender needs not linked to reduced recidivism are considered comparatively

unimportant. They also argue that such decisions are at least partly normative and reflect the overarching values of the institutions in question. Another example is the notion of criminogenic needs (Andrews & Bonta, 1998), where only those offender characteristics associated with a reduction in recidivism are directly targeted in rehabilitation programmes (see below).

I argue that the notion of need should be used to guide the construction of rehabilitation programmes and their implementation. However, I suggest that there is a sense of need that is more fundamental than that currently used to underpin rehabilitation policy in the correctional domain (that is primarily concerned with risk reduction). This understanding of need forges a link between basic needs and human nature and stipulates that effective rehabilitation ultimately requires articulating a view of human flourishing, albeit in a naturalistic and humanistic manner. In this sense, needs are always embedded in a model of human flourishing and a view of human nature; they are inherently normative. The term "normative" refers to values and value judgements concerning the desirability of situations (e.g., a fair distribution of resources), activities (e.g., caring behaviour), characteristics (e.g., self-control, empathy), and objects (e.g., a beautiful picture). A normative judgement reflects an individual's beliefs concerning what is of significance and importance in his or her life and the world and constitutes a standard against which situations and individuals can be evaluated.

In a recent paper we developed a needs based framework to further the understanding of the causes of crime and to guide the assessment and rehabilitation of offenders (Ward & Stewart, in press). In our theory the goals and desires of individuals are partially determined by their fundamental interests and concerns, that is, their basic needs. Basic needs are usefully construed as innate propensities to engage in certain activities that, if not met, result in harm or increased risk of harm in future. Examples of basic or categorical needs are relatedness, autonomy, and competency. Whether or not basic needs can be met in a manner that will promote an individual's well being depends crucially on the existence of specific internal and external conditions. Internal conditions refer to psychological characteristics such as skills, beliefs, attitudes and values. External conditions refer to social, cultural, and interpersonal factors that facilitate the development of the above psychological characteristics and include effective parenting, education, vocational training, social supports and the opportunity to pursue valued

goals. Criminogenic needs are associated with the distortion of these conditions and can be viewed as internal or external obstacles that prevent basic needs from being met in an optimal manner. Human goods reflective of a flourishing or fulfilling lifestyle are derived from, or made possible by, the meeting of basic psychological needs and the possession of the necessary internal and external conditions. These goods include friendship, enjoyable work, loving relationships, creative pursuits, sexual satisfaction, positive self-regard, and an intellectually challenging environment. The presence of internal and external obstacles results in impaired social and psychological functioning and therefore a less fulfilling life. Rehabilitation should focus on identifying the various obstacles preventing offenders from living a balanced and fulfilling life (human flourishing) and to then equip them with the skills, beliefs, values, and supports needed to counteract their pernicious influence.

CONCLUSIONS

In this paper I have reviewed a number of issues in the sexual offending area currently the focus of intensive research and discussion. I have attempted to provide an indepth overview of some of these issues and to also suggest areas for future development. Certainly the construction and testing of more powerful theories is of prime importance, as is the development of increasingly specific and effective interventions. However, I argue that we also need to pay more attention to the relationship between normative theories and empirically validated therapeutic techniques. Any understanding of rehabilitation is underpinned by values and assumptions about the kind of lives available to offenders. As stated above, an enhancement model, not a harm avoidance one, should drive the rehabilitation of offenders. This does not entail ignoring the needs of the community for security and safety; it simply reminds us that all human lives should reflect the best possible outcomes rather the least worst possibilities.

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