



## Practical and Theoretical Roles for the Formulation Based Treatment of Sexual Offenders

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### Abstract

Treatment for a given disorder is typically derived from a theory outlining its development and maintenance over time. In the child sexual offender literature, current theories suggest a specific range of treatment targets that, delivered in a manualised group based approach, have been broadly shown to reduce recidivism. However, we argue that this is unlikely to deliver the most effective treatment outcomes for two major reasons. First, most theories that currently inform treatment fail to account for individual differences in the development of sexual offending behaviour and the actual execution and relapse of a sexual offence. Second, the manualised group based approach fails to take into account a number of situations that may occur in the context of treatment. In this paper we explain how a formulation-based approach, in conjunction with a more comprehensive theory of sexual abuse and a model of the offense process, can resolve these difficulties.

*Keywords:* Formulation Based Treatment; Offence Chains; Etiology of Sexual Offenses

### INTRODUCTION

The sexual abuse of children and an awareness of its negative impact upon victims have become increasingly acknowledged by both the community and the judicial system as a serious public health concern requiring intervention (McMahon, 2000). Furthermore, the accumulation of evidence indicating that perpetrators frequently have large numbers of victims, suggests that the treatment of offenders is a crucial step in reducing the risk of victimization to children and women. In response to these perceptions, there has been an increased focus on the treatment of sexual offenders. Research and clinical theory development has focused predominantly on determining the most appropriate interventions for sexual offenders, and related to this issue, the best way to implement such treatments (Marshall, 1996). Therefore, researchers and clinicians have been attempting to construct more adequate theories of sexual offending and

critically examined the issue of treatment delivery and structure (Ward & Siegert, in press).

Treatment models for sexual abuse are typically derived from a clinical theory that explains the development and maintenance of sexually abusive behaviour. Most recent theories of sexual abuse have been cognitive behavioural or social cognitive in origin. Such theories specify the psychological dispositions thought to play a role in sexual offences and also outline the proximal causes that, in conjunction with these vulnerability factors, lead to a sexually abusive act. For example, Finkelhor (1984) proposed that factors such as emotional congruence with children, deviant sexual preferences, and an inability to meet emotional and sexual needs in prosocial ways, may motivate individuals to sexually abuse a child. Furthermore, he argued that the motivation to sexually abuse a child was the first step in a causal chain leading to an offence, followed by the overcoming of both the

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offender's and a child's inhibitions, circumventing external obstacles such as the presence of a watchful parent, and finally the occurrence of a sexual crime. Treatment guided by this etiological theory would focus upon reducing the motivation for offending, level of deviant sexual arousal and increasing the offender's ability to achieve appropriate social goals. Similarly, using Pithers' (1990) Relapse Prevention model offenders would learn to understand their pattern of offending, more specifically, how they move from a state of abstinence or control over their sexually abusive behaviour to high risk situations, and ultimately a sexual offence. From the perspective of this model, treatment would focus on equipping individuals with the skills necessary to cope with negative affective states and to recognize and counter offense supportive cognitions and desires.

Although these clinical theories have resulted in popular and broadly effective treatment interventions, they (and most other theories to date) suffer from a number of conceptual weaknesses that undermine their ability to adequately inform clinical work (Ward & Siegert, in press). The most serious shortcoming of all the current etiological theories is the tendency to talk about the offense and relapse processes as if they occurred in the same way for every offender (Ward & Hudson, 1998a; 2000). However, work by Ward and his colleagues has indicated that there are quite distinct offense and relapse pathways, each associated with different psychological characteristics and clinical issues (Hudson, Ward, & McCormack, 1999; Ward, Loudon, Hudson, & Marshall, 1995). In addition, research on the classification of offenders by Knight and Prentky has revealed that there are subtypes of child molesters and rapists who exhibit different kinds of psychological characteristics, for example, varying degrees of social skills (Knight, 1999; Prentky & Knight, 1990). This new work points to the utility of developing theories that explicitly incorporate distinct offence trajectories within their network of concepts and ideas. This will enable therapists to match treatment strategies to the specific developmental and relapse factors associated with each individual's pattern of offending.

In addition, there are a number of issues related to the delivery of treatment that arguably determine its effectiveness and therefore merit discussion. Arguably, the most popular mode of treatment for sex offenders involves the implementation of manual based strategies in a group format (Marshall, 1996). Despite the modest success of treatment programs using this approach, we argue

that there are situations where adopting a fixed set of interventions is unwarranted and likely to result in poor clinical outcomes (Ward, Nathan, Drake, Lee, & Pathe, 2000). Further, although some authors imply that they construct a clinical formulation to guide the customizing of the program to the individual (e.g. Hudson, Wales & Ward, 1998), there are few suggestions as to how this should be done. We believe that issues such as exploring the possible limitations of manual based treatment for sex offenders and the benefits of formulation-based approaches have not been adequately addressed in the area of treatment of sexual offenders. Perhaps the idea of formulation based treatment for sexual offenders requires further development.

In this paper we argue that a formulation-based approach, in conjunction with the utilization of more adequate etiological and offense chain theories, can overcome potential difficulties of administering a set series of interventions to groups of sexual offenders. It should be stated from the outset that we are not advocating wholesale changes in the treatment of sexual offenders. We believe that treatment in this area has developed to the point where most of the psychological problems such as empathy, intimacy and emotional regulation deficits that have been demonstrated in empirical literature (Ward & Siegert, in press) are adequately addressed by cognitive behavioural approaches in most treatment programs at present. These hard earned findings need to be retained in any developments in the field. However, we also believe that a well constructed theory based formulation that is consistent with current empirical data can build upon this work. In conjunction with empirical validation, this could lead to improvements in treatment by increasing understanding of the developmental factors giving rise to offending, the specific steps involved in the process of offending, and clarify how offending has been maintained over time for individuals. It can also provide clinicians with guidance when there is a paucity of treatment options for certain types of offenders or where previous treatment has been unsuccessful.

First, we will compare manual based and formulation based treatment approaches, specifying the clinical situations where a formulation-based approach is warranted. Second, we will outline a recently developed model of the offense process, and a multi pathway etiological theory of the onset of child sexual abuse. These theories extend upon current theory and empirical data and arguably more clearly represent the variations in

development of offending as well as the offence process. Third, we will demonstrate the clinical utility of combining a formulation-based perspective in conjunction with these recent theories. It will be argued that the current manualised group-based treatment approach is presently insufficient to accommodate individual differences highlighted in these theories; hence the need for the further development of treatment approaches.

#### FORMULATION VERSUS MANUAL BASED TREATMENTS

Formulation-based approaches assume that in order to treat sexual offenders effectively, therapists need to develop a comprehensive understanding of their psychological vulnerabilities and problems (Ward, Vertue, & Haig, 1999). The result of this process is a conceptual model representing the client's various problems, the hypothesized underlying mechanisms, and their interrelationships. In essence, this clinical theory specifies how the symptoms or problems are generated by psychological mechanisms, for example, dysfunctional core beliefs or behavioural deficits. In one example of a formulation model, the first phase of the clinical reasoning process aims to use various types of data to detect the existence of clinical phenomena (Ward et al., 1999). In the second phase, these phenomena become the focus of inquiry and an attempt is made to infer causes (i.e., hypothesized underlying mechanisms) for them. Thirdly, the phenomena, their causal mechanisms and factors that have contributed to the development of these mechanisms are fashioned into an integrated case formulation or clinical theory that has explanatory coherence.

A case formulation represents the clinicians' explanatory theory and functions to guide subsequent therapeutic interventions. It provides an ideographic understanding of the individual in question; different interventions will follow different case formulations. It goes beyond diagnosis as two individuals may have the same diagnosis or cluster of difficulties but different vulnerabilities or mechanisms that play a role in the subsequent development of particular symptoms.

A case formulation for a sex offender may detail the developmental factors that made that person vulnerable to sexual offending such as being a victim of sexual abuse, experimenting sexually at an early age, or compulsively masturbating as an adolescent. For another individual, a lack of capacity to modulate negative emotions, or an

inability to utilise social supports in times of emotional distress might be causally related to behaving in a sexually abusive manner. Strong negative mood states could result in a loss of control, which, in conjunction with sexual desire, lead an individual to opportunistically use a child to meet his sexual needs. From a clinical perspective, the presence of different deficits or vulnerability factors requires the application of distinct therapeutic strategies. For example, some individuals may need to acquire increased levels of relationship skills while others would benefit from learning how to manage their moods more effectively.

Despite the apparent sophistication that the above approach appears to offer, there have been a number of well-documented criticisms of the formulation-based approach (for detailed criticisms see Ward et al., 2000). In general terms, inaccurate judgments, problems with inter-rater reliability, and undue reliance on heuristics have been noted (Ward et al., 2000). Decision makers may develop habitual ways of making decisions and, if these are relied upon excessively, errors in decision making can result. Errors can also result from overconfidence in one's decisions, difficulty integrating large amounts of data and the tendency to seek confirmatory rather than disconfirming evidence.

However, despite these difficulties we suggest that the above problems can be countered by the application of a systematic method for clinical reasoning, keeping issues such as the importance of base rates in mind, and developing multiple hypotheses to explain a set of phenomena (Ward et al., 1999). These difficulties can also be reduced by explicitly evaluating the efficacy of interventions resulting from a given formulation. This may require making changes to the formulation and treatment. Another related point is that it is not assumed that all formulations and resulting treatments are equally efficacious. Where possible, the choice between the theoretical approach to formulation and treatment should arguably be guided by empirical evidence.

Arguably, another solution to the above difficulties is to forgo the construction of individual case formulations and simply allocate individuals to treatment based on diagnosis or risk estimates. The emphasis is on the categorization of an individual as an offender of a particular type (or subtype, for example, a preferential pedophile), a decision that essentially rests on the careful description of symptoms and overt psychological problems rather than a clinical explanation or case formulation.

Once allocated to a group (e.g., sex offenders) all individuals receive the same treatment; this can be broadly classified as the manualised approach.

Manual-based treatments are time-limited, structured, and contain standardized treatment interventions; they are essentially coherent packages of interventions. In manual-based treatments, all individuals receive the same treatment components by virtue of their membership in a diagnostic category (Wilson, 1996). The assumption is that such individuals will share many of the same symptoms and problems and therefore have similar treatment needs. Because all individuals receive the same treatment, a detailed case formulation is not necessary. For example, all women with a diagnosis of bulimia nervosa would receive interventions designed to restructure their eating, reduce bingeing and vomiting, change their dysfunctional attitudes toward their weight and shape, and acquire relapse prevention skills (Wilson, 1996). Treatment manuals specify the content, sequencing, and delivery of different interventions, although there may be some flexibility with regard to these factors. However, they are not "cookbooks" and their effective implementation requires clinical skill and knowledge. The major goal of assessment is to ascertain whether or not an individual belongs to a certain diagnostic category. This is achieved by describing the symptoms or problems a person is experiencing and using this information as the basis of a diagnostic decision. It essentially represents the first phase of the clinical process, the detection of clinical phenomena or problems. There is no attempt to develop a comprehensive case formulation in order to explain the relationship between the clinical phenomena and hypothesized underlying causes.

Despite the longstanding view that treatment for sexual offenders is ineffective, more recent research has suggested that a small but stable treatment effect in the form of reduced recidivism has been demonstrated using a constant set of treatment modules, at least for child sexual offenders (Grossman et al., 1999; Marshall, Jones, Ward, Johnston & Barbaree, 1991). These include controlling deviant sexual preferences, social skill training, developing victim empathy, cognitive restructuring, mood regulation and relapse prevention training (Marshall, Anderson & Fernandez, 1999). Thus, it would appear on the surface that administering the above treatment modules in a relatively constant manner would decrease the need for complicated assessment and formulation regimes and result in a reduction in

recidivism for groups of offenders. However, it is likely that individual offenders have treatment needs that are not adequately addressed using the above approach.

Each approach to the treatment of sex offenders has its strengths and weaknesses. On the one hand manual based treatment has the advantages of standardisation, less reliance on clinicians' judgment, and may be a more efficient use of scarce resources. On the other hand formulation based treatment has the advantages of greater flexibility, a more individualistic focus, and arguably is better equipped to deal with more complex clinical presentations. Overall we believe that formulation based treatment is of immense value in tailoring treatment to the specific needs and problems evident in different sex offenders. We will now describe these situations and demonstrate how case formulations may assist.

#### SITUATIONS WHERE FORMULATION BASED APPROACHES ARE USEFUL

Clinical experience suggests that case formulation can provide a rich understanding of individual clients and result in rational and effective treatment planning (Eels, 1997). We argue that a comprehensive understanding of an individual client is especially important when an offender has multiple problems, failed to respond to existing treatment, when no manual based treatment exists for a particular group, or where there is a breach of the therapeutic relationship (Ward et al., 2000).

The first situation occurs when an offender has such an array of problems that it is difficult to decide what the primary focus of treatment should be. For example, when an offender has a co-existing mental disorder such as major depressive disorder, schizophrenia, or drug and alcohol abuse. In such cases it is useful to develop a formulation to provide a coherent conceptualization of the individual's problems and interactions between the different hypothesized causal mechanisms. Treatment would then focus upon the common mechanisms in order to ameliorate as many of the clinical phenomena as possible. In this clinical scenario, the complex interaction between the various causal mechanisms and the subsequent clinical phenomena is the crucial factor and simply instituting a manual based treatment for each of the above problems may be ineffective and inefficient (Ward et al., 2000).

Second, formulation-based treatment is particularly helpful for problems about which we know

relatively little (e.g., such as female offenders or internet child pornography users), or where there is an unusual combination of features that appear confusing. In these situations, a case formulation can help the clinician to identify the offender's problem areas and to construct hypotheses concerning the underlying causal mechanisms that have generated the presenting problems. This is especially useful in developing treatment for groups of offenders where no existing treatment exists or when current interventions are inadequate.

The third situation in which formulation based treatment is beneficial is where an accepted treatment regime has already been delivered and has failed to eradicate the problem(s) or not resulted in an optimum level of clinical improvement. This may have occurred because important clinical features had not been identified or unique problems had not been adequately addressed by standard treatment. In these situations, formulations can assist with the identification of problem areas and clarify how they relate to offending. For example, clinical experience suggests that sexual dysfunctions can play an important role in the development of offending for some offenders. However, these are rarely, if at all, addressed adequately in present treatment approaches. For example, in one case seen in our clinic an offender experienced a number of unusual sexual experiences when young that played a role in causing premature ejaculation and erectile difficulties in his adult sexual relationships (Ward et al., 2000). These problems continued and eventually resulted in reduced sexual desire and relationship conflict. The individual concerned attempted to engage in sexual activities with his partner's children as a way of seeking sexual satisfaction and reinstating his sexual potency and interest. He attended a group treatment program in prison and was reported to have made good progress in relation to the traditional treatment targets. However, his sexual dysfunctions remained and he was evaluated as constituting a significant risk of further deviant sexual behaviour. A case formulation helped to clarify the role his early experiences played in his sexual and relationship difficulties and also outlined the contribution of his sexual dysfunction to his sexually abusive behaviour. It was decided to directly target his sexual dysfunction in treatment and as a result of this intervention, in conjunction with further therapeutic strategies, he made significant clinical progress. Furthermore, he was observed to have maintained the treatment gains over time and developed more satisfactory relationships with

adult women. The success of the treatment supported the formulation in this case.

The final instance in which the formulation-based approach can be beneficial is when the therapeutic relationship between the offender and clinician is damaged or problematic. In this situation, a person may be disruptive in-group treatment, or despite initial positive progress, develop a lack motivation to participate in further treatment. This may develop due to lack of trust in the therapists or excessive shame that prevents the offender from exploring personal issues related to his offending. Hence, a formulation may help to develop an understanding of the reasons for this lack of progress and suggest possible interventions for improving the situation.

In summary, the above scenarios represent a subset of client groups for which manualised group treatment may be less than optimum. The case formulation approach may be best used in the above situations as a "stop-gap" measure until manualised approaches are developed to account for their occurrence. Alternatively, it is possible that manualised approaches are insufficient to adequately account for the full range of problems evident in offenders.

#### THEORETICAL ADVANCEMENTS AND DEVELOPMENT OF TREATMENT

We have argued above that there are a number of clinical situations in which it is imperative to individually tailor treatment to the clinical needs of specific offenders. We would like to advance our argument by suggesting that there are a number of distinct pathways leading to the sexual abuse of children. Different offenders sexually abuse children for different reasons and therefore should receive treatment that is relevant to their particular problems. Theories provide clinicians with an understanding of the mechanisms that generate sexual abuse and directly influence the assessment and treatment process. Most treatment providers assume that in order to treat sexual offenders effectively it is necessary to develop a comprehensive understanding of their psychological vulnerabilities and problems (Hudson et al., 2000). The result of this process is a conceptual model representing individuals' various problems, their hypothesised causes, and interrelationships. In essence, a case formulation specifies how symptoms or problems are generated by psychological mechanisms, for example, dysfunctional core beliefs or behavioural deficits (see above). The actual choice of explanatory

hypotheses in a case formulation is guided by the theories of psychopathology and research literature favoured within a particular area. This helps clinicians to narrow down the search for plausible causes and ensures that theories with the most research support are initially considered as possible explanations.

The above discussion suggests that theories are a prerequisite for clinical work with sex offenders and can span quite different levels and focus on distinct domains of interest. In a recent paper Ward and Hudson (1998b) outlined a meta-theoretical framework for classifying theories based on their level of generality of focus, and the extent to which the relevant factors were anchored in either developmental or contemporary experiences and processes; the distal/proximal distinction. In this framework we distinguished between level I (multi-factorial), level II (single factor), and level III (micro-level or offence process models) theories. Level I theories represent comprehensive or multi-factorial accounts of sexual offending. Level II or middle level theories have been proposed to explain single factors thought to be particularly important in the generation of sexual crimes, for example, the presence of empathy deficits (Ward & Siegert, in press). Level III theories are descriptive models of the offence chain or relapse process. These micro-models typically specify the cognitive, behavioural, motivational and social factors associated with the commission of a sexual offence.

We argue that treatment should be updated to match current and emerging theory that highlights individual differences in the development of sexual offending, as well as the actual process of offending among different offenders. In particular, we suggest that Level I and Level III theories are particularly important as they specify why individuals sexually abuse children and describe how this offense unfolds over time. We will outline an example of a Level I and Level III theory and demonstrate how they can be applied clinically.

#### *Multifactorial Theory*

The first theory, the "Pathways Model" (Ward and Siegert, in press), attempts to outline a general range of factors thought to play a role in sexual offending, specifically, differences in offenders' developmental progression towards offending. Consistent with the focus in sexual offender literature on cognitive behavioural based treatment, the theory is explicitly cognitive behavioural in approach. This theory clearly distinguishes between distal (long term) and proximal (short term) causes

of offending and describes a process by which distal vulnerability factors result in a range of deficits that predispose a person to offend in a sexual manner. It also describes how different factors can trigger a sexual offence and assists in development of individual treatment goals. A summary of this theory follows.

According to the Pathways Model there are four distinct, and interacting, types of psychological mechanisms generating the clinical phenomena evident among child molesters: intimacy and social skill deficits; distorted sexual scripts; emotional dysregulation; and cognitive distortions.

#### Intimacy and Social Skills Deficits

These have frequently been reported in child molesters and hypothesised to occur as a result of insecure attachment. Those with deficits in this area tend to see others as emotionally unavailable and are unwilling to disclose to them. They tend to have difficulties exploring the environment and developing a sense of trust in others and a sense of personal power. These difficulties make it difficult for individuals to develop the skills necessary to establish intimate relationships and are often seen by others as aloof and cold. These deficits may play a role in the offender not being able to meet his needs in socially appropriate ways and increase the risk of inappropriate sexual behaviour.

#### Deviant Sexual Scripts

These are mental representations individuals acquire during their development that facilitate the interpretation of intimate or sexual encounters, and guide subsequent behaviour (Gagon, 1990; Money, 1986). They are proposed to span internal, interpersonal and cultural contexts and incorporate knowledge, norms, values, rules and beliefs. It is proposed that inappropriate early sexual experiences can result in distorted sexual scripts that include inappropriate partners, contexts and behaviours, eventually increasing risk of later sexually deviant behaviour.

#### Emotional Dysregulation

Many offenders have difficulties monitoring and controlling their affective states to produce desired goals. This may lead to problems in the development of dysfunctional goals (ignoring feelings), inadequate coping strategies (use of substances leading to disinhibition) or poorly modulated affective states (Ward & Hudson, 1998a). These difficulties may result in feelings of

distress that play a role in the development of deviant sexual behaviour.

### Cognitive Distortions

Broadly defined as maladaptive beliefs and attitudes and problematic thinking styles, cognitive distortions can represent preexisting underlying beliefs about the self, future victims and the world in general, leading to beliefs about the sexual nature of children or the inherent dangerousness of the world (Ward, 2000; Ward & Keenan, 1999). Alternatively, cognitive distortions can represent rationalizations designed to excuse offending behaviour after it has occurred (Ward, Hudson, Johnston & Marshall, 1997) and are associated with excuse giving and self-esteem maintenance.

### Multiple Deficits

Some offenders have enduring underlying problems in more than one, or all, of the above areas. These are proposed to represent a more entrenched form of sexual deviant and antisocial behaviour. Each of the above five factors are proposed to have specific developmental precursors and constitute increased vulnerability to offending at a later date.

The second aspect of the theory suggests that components of all of the above deficits are required for a sexual offence to occur. They argued that, in the context of sexual need and opportunity to offend, the remaining dysfunctions are "recruited" to result in a common set of primary dysfunctions (proximal causes). Thus, Ward and Siegert argued that although all sexual offences involve problems in the above four areas, offenders are likely to have a specific, or primary, deficit that constitutes vulnerability to offending. Therefore, each primary deficit constitutes a distinct developmental pathway towards sexual offending. The focus on individual primary dysfunctions allows increased focus on the individual vulnerability factors and their development and, thus, this increased understanding can lead to more focused treatment that is better targeted to individual deficits. We will now outline the five primary deficit areas, their possible development, and their possible treatment foci.

### **Pathway 1**

This describes those who offend because they have primary deficits in intimacy and social skills. This is likely to be caused by various forms of insecure attachment that, in turn cause problems in difficulty trusting others, difficulties in adult relationships,

low self-esteem and reduced sense of personal autonomy. Although it is argued that sexual offenders must have deficits in intimacy and social skills in order to offend, for those who offend primarily as a result of this deficit, it is suggested that these deficits will be more marked in this group.

At this point it is unclear how treatment will differ for each of the distinct groups of sexual offenders. Clinical guidance is likely to result from empirical validation of the proposed pathways and investigation of how the needs of the various groups differ from the others. This caveat holds for each of the five pathways. However, it is reasonable to assume that differences in treatment foci will follow from the primary deficit(s) exhibited by an individual. It is hypothesised that if intimacy and social deficits are the primary dysfunctional mechanisms, then treatment should focus on the underlying reasons for the above problems and the acquisition of the skills necessary to overcome such deficits. This may include exploring issues related to insecure attachment (e.g., difficulty in developing trust), identifying problems in adult relationships and learning how to overcome them. For example, offenders can be encouraged to increase their engagement with others by involving themselves in more trusting relationships. This will arguably lead to greater satisfaction in relationships and a reduced sense of alienation from others.

### **Pathway 2**

This pathway describes those who offend primarily because of deficits in one or more components of their underlying sexual scripts. More specifically, seeking sex in inappropriate situations (e.g., when angry), having preferences for inappropriate partners (e.g., a child), or engaging in inappropriate or harmful activities (e.g., sadistic practices). Maladaptive scripts may result from early and inappropriate sexual experiences or deviant learning. Deviant sexual scripts may also be associated with victimization issues, such as believing that because the offender was abused as a child it is acceptable to inflict the same behavior upon others, or deficits such as equating sex with intimacy. Finally, deviant sexual scripts may lead to a misreading of sexual cues and the interpretation of children's everyday behavior as revealing sexual intent (Ward, 2000; Ward & Keenan, 1999). It would then follow that individuals with these primary deficits would require additional treatment to address the identified problems in their sexual scripts. This may include a specific focus on

reducing deviant arousal, challenging the need for deviant sexual behaviors and encouraging the engagement in more adaptive sexual behaviours in appropriate contexts. For those offenders with victimisation issues that relate to their offending behaviour, it might be necessary to deal with these issues first in order to enable them to address their own offending behaviour more effectively. Alternatively, individuals who equate the need for intimacy with sexual desire can be taught to differentiate the two states and learn to achieve intimacy in more appropriate ways. Although a difficult area, offenders with specific deficits in reading sexual cues may be taught to discriminate the different meanings of sexual cues and to be cognizant of how they can be misread.

### **Pathway 3**

This pathway describes offenders who primarily offend due to emotional dysregulation. These individuals may have problems recognizing and naming emotions or have difficulties resulting from inadequate coping skills or the inappropriate use of coping strategies. Consequently, sex can be utilized as a preferred coping strategy and a sexual offence may be committed as a result of the "acting out" of emotional problems. This group is also likely to have problems with disinhibition. Consequently, individualised treatment aimed at reducing the specific deficits in this group is likely to be beneficial. This may include assisting offenders to recognize and name emotions. Specific cognitive behavioural treatments for mood or anxiety disorders may also be useful (e.g. Andrews, Crino, Hunt, Lampe & Page, 1994; Barlow, 1993). They can be taught to improve coping skills and to use these effectively when required. If offenders actually have good coping skills, but choose not to use them in specific situation, this can also be addressed in more detail. Related treatment goals might be to increase appropriate social supports and use them more effectively in times of stress, and to develop improved anger management skills (Novaco, 1997).

### **Pathway 4**

This accounts for those individuals who primarily offend as a result of cognitive distortions. These may consist of maladaptive implicit theories or schemas about the offender, potential victims and the world that make someone vulnerable to behaving in a sexually abusive manner and also function maintain offending after it has occurred. Alternatively, cognitive distortions may comprise more general antisocial cognitions and behaviours.

Those with this primary deficit may hold the belief that the world is a dangerous place and that they have to fight to have their needs satisfied. Others may have a sense of entitlement and believe that they have the right to have their needs met irrespective of the interests and desires of other people (Ward, 2000; Ward & Keenan, 1999). It is hypothesised that this group has a more entrenched set of cognitive distortions that make the offenders vulnerable to offend and to justify their sexually abusive actions after they have occurred. In contrast, those in other pathways are proposed to have less entrenched distortions that function to primarily justify offending after it has occurred. Therefore, for those with primary cognitive distortions, it is proposed that there are specific belief systems (or implicit theories) that are causally related to their sexual offences. These should be a primary treatment target and require intensive and focused cognitive interventions. For those without entrenched distortions, treatment would more effectively focus primarily upon identifying and challenging excuse giving and the minimization of offending behaviour.

### **Pathway 5**

The final pathway is where an offender has deficits in all of the above areas. Thus there would be multiple maladaptive developmental processes and all of the above factors would need to be addressed in depth in treatment.

## **MICRO-LEVEL THEORY**

In addition to multifactorial theories of sexual offending, there are also finer grained, micro-level, theories that attempt to explain what offenders actually do in the lead up to and during the commission of their offences. The consideration of this type of theory can assist in more accurate assessment and treatment of offenders. Pithers' relapse prevention model is a popular example of a micro-level theory that is used in treatment (Pithers, 1990; Pithers, Marques, Gibat & Marlatt, 1983). This model outlines a set of internal and external events that, if not altered, result in a sexual offence.

Lifestyle imbalance is hypothesized to lead to a sense of subjective deprivation resulting in feelings of depression and/or anger, facilitating the entry of the offender to a high risk situation that includes the presence of a potential victim. This may lead to a lapse where the individual engages in deviant sexual fantasy and, finally, a relapse, where the individual engages in overt, deviant sexual activity. The transition between these stages is proposed to

be mediated by a number of cognitive and affective mechanisms such as the abstinence violation effect (negative cognitive and emotional reaction in response to a lapse that increases the risk of relapse) and the problem of immediate gratification. Despite the widespread use of this theory in treatment, it suffers from a number of conceptual and practical limitations. For example, Ward, Hudson and Marshall (1994) found that when an abstinence violation effect occurs, it often occurs after a relapse rather than a lapse, as stated in the theory. Other difficulties include the likelihood that the model does not account for all the possibilities involved in re-offending. For example, the model emphasizes skill deficits in the progression towards relapse and fails to account for those who consciously decide to engage in sexually deviant behaviour (Ward, 1999; Ward & Hudson, 1996).

A recent theory that accounts for these deficits is Ward and Hudson's Self Regulation Model of the Relapse/Offence Process (Ward & Hudson, 1998a). The empirical base for this theory was established in a number of studies that examined the offense chain in sex offenders (Hudson et al., 1999; Ward et al, 1995). Aspects of this model have also been empirically supported in a recent study (Bickley & Beech, in press). The most important aspect of the Self-Regulation Model is that it clearly links differences in the manner in which individuals' carry out their offences with their primary offense related goal (to avoid or approach offending), self-regulation strategies, and dominant affective states. An outline of the theory and how it might relate to treatment will follow.

The first step - life event - results in the activation of knowledge structures related to salient goals and needs that, in turn, trigger specific patterns of thoughts and emotions. The life event and its subsequent appraisal results in the second step - desire for deviant sex or activity. In the following stage - establishment of offence related goals - an offender considers the acceptability of his maladaptive desire and what, if anything, he should do about it. Broadly, these can be classified as avoidance or approach goals. The former is associated with the desire to avoid sexually re-offending while the latter is associated with a desire to offend.

The next stage - strategy selected - describes the self regulation strategy that relates to either the approach or avoidance goals for the individual. These are classified as either active (conscious) or passive (unconscious or resulting from

disinhibition) and result in four distinct pathways are as follows.

1. *Avoidance - Passive.* Some offenders wish to avoid offending but fail to actively attempt to prevent it from occurring. This represents under-regulation or disinhibition. These individuals are likely to lack coping skills, be more impulsive, have low efficacy expectations and use covert planning in their offences.
2. *Avoidance - Active.* Some offenders wish to avoid offending and attempt to use strategies to reduce their risk of re-offending. However, their strategies are inappropriate and result in an increased risk of re-offending. For example, an offender may respond to a desire for deviant sex by using alcohol or masturbating to deviant fantasies, in attempt to satisfy his urge without actually offending. However, these strategies are likely to increase the risk of re-offending because of the resulting disinhibition or the inadvertent reinforcement of deviant sexual desires.
3. *Approach - Passive.* Some offenders wish to continue offending. However, their goals are not under attentional control and their offences tend to be activated by situational features. This could be conceived as a covert readiness to commit a sexual offence if the opportunity presents itself. Offences committed under this pathway tend to be planned in a rudimentary manner and unfold rapidly with the input of limited cognitive resources.
4. *Approach - Active.* Finally, some offenders wish to offend and use conscious explicit planning and well-crafted strategies that result in a sexual offence. These include skills related to choosing a victim, grooming and offending in a manner that decreases the chance of detection. Thus, there is intact self regulation, but harmful goals such as sex with children or abusive sex with women. Those offending using this pathway are likely to believe that their behaviour is a legitimate way of achieving desirable ends.

In the fifth stage – high-risk situation entered – the offender makes contact with the victim as a result of the earlier implicit planning or counterproductive strategies. In the following stages – lapse and sexual offence – all offenders are proposed to "switch" to an approach goal and desire sexual activity with the about to become victim, regardless of previous decisions whether to offend or not. They begin to engage in immediate preparatory activity to facilitate a sexual offence and carry it out. The final stages – post offence evaluation and attitude toward future offending – involve evaluation of the deviant sexual activity. Those who wished to avoid offending are likely to judge that their efforts have failed whereas those wishing to offend will have succeeded. Their resulting cognitive and affective reactions play a role in development of further plans to continue offending or avoiding offending.

In terms of affective states, for those who desire not to offend (avoidance goals), their offences are usually precipitated by negative emotional states that shift to positive emotions as the offence is about to be committed. Offences tend to be followed by guilt and a desire to stop offending in the future. In contrast, those with a desire to offend (approach goals) are proposed to have more positive emotions throughout the offence chain. Early stages of the offence are characterized by positive emotions associated with the expectations of sexual satisfaction. The period after each offence tends to be characterized by positive emotions and a desire to continue offending in the future.

Clearly, the above model has several advantages over the Pithers model including its ability to account for more variations in the offence process. These distinctions in the process of offending have clear implications for assessment and treatment of sexual offenders. The first focus of assessment is determining whether offenders have approach or avoidance goals (Ward & Hudson, 1998a) and the second is whether offenders have intact or otherwise self regulation skills (Hudson & Ward, 2000).

Assessment. Clinicians can assess aspects of the above by gathering detailed offence data. Goals related to sexual offending can be assessed by asking questions such as, "In the period before you last offended, did you want to avoid offending or did you want to continue?", "When you realized that you were thinking of deviant sex, what did you want to happen?" and "When did you decide to have sex with the victim?" If the offender says that they wanted to avoid offending, they can be asked

what strategies they used to prevent it from occurring. Conversely, if the offender says that they wanted to continue offending, they can be asked how they intended to continue their deviant sexual behaviour. Answers to the above and follow-up questions concerning such topics as self regulation skills in other aspects of functioning, can reveal helpful information about goals and self regulation strategies. Further questions can be used to assess affective states and cognitive distortions at various points in the chain (Drake, Ward, Nathan & Lee, 2001). The information obtained from the above assessment data can be used to indicate the most appropriate treatment approach for a particular offender.

Treatment strategies. For those who wish to avoid offending but lack strategies to achieve this goal, (avoidance - passive pathway), their avoidance goals require support and strengthening. Perhaps, some may have partial avoidance goals that require strengthening to increase the chance they can cope with a wider range of more tempting high risk situations. It is particularly important to note the way this group effectively changes their decision not to offend in the context of a high risk situation, a lapse and associated deviant sexual arousal. Increasing individuals' awareness of the way they shift their attention from the rightness and wrongness of their actions towards the satisfaction of the immediate goal of sexual satisfaction, is likely to be helpful. It may be that those in this group do not believe that they can maintain their desire to refrain from offending in the context of opportunity and increased sexual arousal. For such individuals, it is necessary to learn appropriate strategies for exiting high risk situations and to also increase their capacity (e.g., via role plays) to maintain preexisting commitment in the face of temptation. If strong emotional states are implicated in the decision to offend, then increasing individuals' ability to recognise and manage these affective states would be beneficial. Some offenders may believe that they have nothing really to live for and therefore might be strongly inclined to capitalize on an offence opportunity, despite a previous decision to avoid offending. For these offenders, increasing self-confidence and engaging in satisfying daily activities may assist. This will also increase the sense that they have something to lose if caught, thus strengthening their decision to refrain from sexual offending. Those with low efficacy expectancies may believe that they have no control over their sexual arousal and the resultant desire to engage in sexually deviant sexual activity and could benefit from improved problem solving skills that are practiced in vivo.

Individuals in this group are also likely to require more intensive treatment in the area of impulse control and dealing with unexpected high risk situations. An aim of intervention would be to develop more explicit meta-cognitive control, that is, increase awareness of the selection, monitoring and evaluation of actions as they occur (Ward & Hudson, 1998a). This may be facilitated by increasing knowledge of the offence chain and the utilization of strategies to prevent progression towards offending. In a more general sense, increasing awareness of more general aspects of everyday behaviour, its consequences and associated emotional concomitants can also be generalized to sexual offending behaviour. Similarly, emotional states that correspond with everyday events can be recognized and these may respond to emotional coping strategies. Finally, those with documented organic factors such as neurological disease, head injury or major mental illness that may result in more severe form of impulsivity and disinhibition may require more specialized intervention and high intensity monitoring.

Those who wish to avoid offending but have inappropriate strategies to prevent this from occurring (avoidance – active pathway) should be supported to maintain their avoidance goals using some methods above. However, the tendency to use inappropriate strategies should be highlighted. Psycho education linking alcohol abuse and masturbation to deviant fantasies and eventually resulting in increased risk of sexual offending may be helpful. Similarly, they may also require learning of more effective coping strategies and effective self-control strategies.

Those who wish to offend but have not well formed strategies (approach – passive pathway) require initial challenging of their inappropriate goals. They are likely to have associated beliefs regarding the legitimacy of sexual contact with children, lack associated victim empathy and require intensive intervention in these areas. As per those in the avoidant passive pathway, these are likely to require more intensive treatment in the area of impulse control, mood management and dealing with unexpected high risk situations, as well as strategies to develop more explicit meta-cognitive control.

Those who wish to offend and have conscious strategies to offend (approach–active pathway) also require challenging of their inappropriate goals. These offenders are likely to have more entrenched deviant sexual arousal and require treatment to

reduce its intensity and frequency. Persistent offenders with deviant sexual arousal they find to control may require referral to medical personnel for sex drive reducing medication (Bradford, 1997). It is evident that the application of the Self Regulation Model to clinical work with sex offenders differs in important respects from the utilization of the Pithers' perspective. The attention to distinct offence chains and their attendant clinical issues is particularly useful. Adoption of this model requires a shift in the way therapists evaluate, and respond to, offender's verbal responses during therapy. For example, therapists following the standard model of the offence chain typically regard any attempt by an offender to deny a desire to offend, the existence of prior fantasies, or explicit planning as denial. This may lead to attempts to influence the offender to falsely acknowledge these factors in their offences. However, the present theory suggests that consistent and meaningful reports of absence of these factors be afforded more credibility, as there are specific interventions for this group that are likely to successfully reduce their chance of re-offending.

Adoption of the above theories also gives clinicians a framework for understanding the development and commission of offending, and how these can assist in tailoring treatment to particular individuals in either a group or individual format. The above theories both expand clinicians understanding of the phenomena associated with offending, as well as restricting the primary mechanisms in formulation and treatment to those that have at least some empirical support.

## CONCLUSIONS

In this paper we have argued that most current treatment programmes for child sexual offenders assume that they have a common set of dysfunctions that could be effectively treated by a comprehensive manual based treatment approach. All offenders are proposed to have dysfunctions in intimacy, deviant sexuality, emotional dysregulation, and cognitive distortions. Certainly, recent research into the effectiveness of the treatment suggests there are enough commonalities amongst offenders to partially support treating the average offender with the standard cluster of interventions. While we agree that there is merit in this position, it does not tell the whole story. The relatively modest treatment effect of cognitive-behavioural programmes for sex offenders suggests that present treatment is weak and poorly targeted. We argue that there are two major reasons to

support more a fine grained, tailored treatment approach.

First, the research and clinical literature in the general psychotherapy domain indicates that there are a range of situations that require more detailed assessment, formulation, and ultimately individualised treatment in order to result in the most effective outcome (Ward et al., 2000). As described above, it is unlikely that standard manual based interventions can cater adequately for those with complex problems, unusual presentations, previous treatment failures, or where there is a threat to the therapeutic relationship. In these situations, a formulation-based approach may be required and result in significant clinical improvement.

Second, recent theory and research is focusing increasingly upon individual differences in the developmental of offense related problems and vulnerabilities. These initiatives point to a variety of offense trajectories requiring distinct intervention strategies. We argue that these differences are too great to support unqualified use of pure manual based treatment approaches as they presently exist. It makes little sense to treat "expert" offenders (i.e., those with explicit goals and planning) in the same manner as the inadequate and impulsive ones. Further, treating offenders' cognitive distortions as though they were purely post offence rationalizations may result in the failure to effectively treat those with entrenched distorted beliefs and antisocial attitudes.

Adopting a case formulation framework, in conjunction with the application of multivariate etiological and offence models, is likely to result in more precisely targeted treatment. In time the application of a more complex model should lead to the development of more structured assessment and intervention strategies, allowing clinicians to benefit from the use of standardized and systematic procedures and yet be attuned to the complexities of individual offenders. We have drawn upon the pathways and self regulation models because we believe they more accurately reflect the development and occurrence of sexual offending. However, regardless of their ultimate validity, they suggests it is time to move away from fixed interventions to the idea that increased knowledge of individual differences in offending be used to assist in tailoring treatment to individual needs via theory directed assessment and case formulation. This paper represents an attempt to argue for the utility and richness of this strategy.

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