EDITORIAL

Sexual offending represents a severe challenge to contemporary society. There are enormous personal costs to the victims, their family and to the offender and his or her family. Providing accurate assessments and effective treatments is an important responsibility. The concern about preventable victimisation has lead to policy and political changes that call into question legal institutions and civil rights. The requirements on experts to validate their decision making and advice to courts and tribunals place a strong emphasis on the research process. The research data to date indicates that successful prosecutions of sexual offenders are low, and whilst the crime has a specific criminal meaning, it occurs within a social context that ends in the demonising of offenders, and oddly enough at times the persecution of survivors should they process their evidence through the courts. It is a necessity of experts that they are able to provide a strong evidence base for their opinions on risk and for the interventions that take place with offender and survivor alike. It is important that a rational voice is heard that begins and ends in supporting survivors while providing a base for the successful rehabilitation of offenders.

Sexual Abuse in Australia and New Zealand is a new journal with a number of main areas of focus. First, we are conscious of the need to take into account contextual and cultural themes in developing our evidence base and look forward to collaborations with indigenous as well as international colleagues in order to progress our goals. Second, the journal aims to provide a means for people working in the Oceania and Australasia region to know what is happening and what is best practice within their region. We hope in doing this to foster collaborations and shared solutions to what are entrenched problems. Finally, we hope to promote what is best about our practice and share it with the international stage. There are already several journals dealing with sexual violence and violence generally; our journal hopes to complement this scientific activity and provide support to our authors to have an international voice.

Our journal's first issue is well-placed to progress some of these goals. We present five papers, two concerned with treatment, two with assessment issues and one an analysis of the extended supervision orders program in New Zealand. Yates and Ward's article is a detailed rendition of the integration of Ward's theory of the Good Lives model and the Behavioural Regulation model. A need has existed to combine these approaches and the explication delivered here hopefully stimulates discussion and testing the application. The article by Toman and Hawkins shows how these authors have developed their model around modifying the chronic problems associated with a client's readiness (or not) for change and explore how two well known theories, the Transtheoretical process of change by Prochaska and Ur's Principled Negotiation approach can be combined to provide some ways forward in the engagement process with the offender.

A critical issue in forensic psychology is the assessment of risk and the application of that assessment to issues such as extended supervision and preventative detention. Watson and Vess provide preliminary findings indicating that extended supervision in the community appears, at least in the short term to reduce the potential for re-offending when compared to a less deviant group of sex offenders, found not eligible by way of risk assessment for extended supervision and released into the community.

The articles by Smallbone and by Morphett et al. deal with the important issues surrounding the assessment of offenders and the validation of techniques to assess risk. Smallbone's article deals with the validity of the Static-99 in Australia, and is one of only a few studies in our region to date that provide a validation base for the adoption of this instrument. Given the central role actuarial assessment plays in the Courts, and especially in such controversial cases as preventative detention and extended supervision orders, the addition to our local knowledge base is most welcome. Morphett's paper deals with the vexed question of the assessment of sexual deviation, and the use of penile plesythmography (PPG) in this regard. The paper sets out a cogent review of these issues and psychometric properties of the PPG.

Finally, we hope that this journal is not limited to articles by academics only, but also by clinicians and students. We encourage all members of ANZATSA to consider submitting articles based on their own data and ideas to help all of us do better work with the ultimate goals of enhancing public safety and reducing victimization. Ideas for special topic issues are welcomed and we hope this journal will foster best practice and enhance collegiality amongst our membership.

Christopher J. Lennings
The University of Sydney, Australia

Douglas P. Boer
The University of Waikato, New Zealand

ISSN 0833-8488

Sexual Abuse in Australia and New Zealand, July 2008; 1(1): 2-19

Good Lives, Self-Regulation, and Risk Management: An Integrated Model of Sexual Offender Assessment and Treatment

Pamela M. Yates
Cabot Consulting and Research Services
Ottawa, Ontario, Canada, K2C 1No

Tony Ward
Victoria University of Wellington, New Zealand

Abstract

In this article we follow-up on previous works pertaining to separate models of sexual offending as these relate to assessment and treatment: the Good Lives Model of offender rehabilitation (Ward & Gannon, 2006; Ward & Stewart, 2003), the Self-Regulation Model of the sexual offence process (Ward & Hudson, 1998), and our reconstruction (Ward, Melser, & Yates, 2007) of the Risk/Need/Responsivity Model of correctional intervention (Andrews & Bonta, 2003). Recently, the Good Lives and Self-Regulation Models have been integrated into a combined approach to the treatment of sexual offenders (Ward, Yates, & Long, 2006; Yates & Ward, 2007). In this article, we fully integrate these models into a comprehensive case formulation approach for use in the assessment, treatment, and supervision of sexual offenders. We also reconstruct here the Self-Regulation Model based on shortcomings identified in the framework, application to practice since its development, and integration with the Good Lives Model. We argue that none of these models singly is sufficient to guide the assessment and treatment of sexual offenders, and that an integrated model that draws on research and practice in the development of case formulation, is most likely to be effective in achieving the goals of reduced recidivism, risk reduction, and reduced rates of sexual victimisation.

Introduction

Treatment of sexual offenders has advanced significantly during the past several decades, with research and clinical literature yielding various approaches to intervention that demonstrate effectiveness in reducing re-offending. Currently, the two main approaches to treatment include the Risk/Need/Responsivity model (RNR; Andrews & Bonta, 2003) and cognitive-behavioural intervention that aims to alter affect, cognition, and behaviour that are linked to sexually aggressive conduct (Marshall, Anderson, & Fernandez, 1999; Yates, 2002, 2003). Although research supports both approaches to treatment (Andrews et al., 1990; Dowden & Andrews, 1999a, 1999b, 2000, 2003, 2004; Hanson, 2006; Hanson, et al., 2002; Lösel, & Schmucker, 2005), we argue that the effectiveness of sexual offender treatment can be improved by augmenting traditional approaches with enhancements to the RNR model (Ward, Melser, & Yates, 2007), the addition of a Good Lives framework for rehabilitation (Ward & Gannon, 2006; Ward & Maruna, 2007; Ward & Stewart, 2003; Wilson & Yates, 2007), and the replacement of the Relapse Prevention (RP) approach (Laws, 1989; Marlatt, 1982, 1985; Marlatt & Gordon, 1985; Pithers, 1990; Pithers, Kashima, Cumming, & Beal, 1988; Pithers, Marques, Gibat, & Marlatt, 1983) with the Self-Regulation Model (SRM; Ward & Hudson, 1998; Ward, Louden, Hudson, & Marshall, 1995), which has undergone revisions and which is described below.

Briefly, the RNR model (Andrews & Bonta, 2003) suggests that correctional interventions will be most effective when they match the level of risk to re-offend posed by the individual (i.e., the risk principle), when intervention targets specific risk factors (criminogenic needs) that can be changed through intervention and that are associated, both empirically and in an individual case, with risk and recidivism (i.e., the need principle), and when treatment is delivered in a manner which is responsive to various personal and interpersonal characteristics of the individual, such as language, culture, personality style, and cognitive abilities (i.e., the responsivity principle).

Despite the strong empirical support for the RNR model, it has been subjected to a number of critiques, primarily aimed at its underlying theoretical assumptions, their implications for practice, and its lack of scope (e.g., Ward & Maruna, 2007; Ward & Stewart, 2003; Ward et al., 2007). In summary, Ward and his colleagues have argued that a focus on reducing dynamic risk factors (criminogenic needs) is a *necessary* but *not sufficient* condition for effective treatment (Ward & Gannon, 2006). A key component of this critique has been the argument that it is necessary to broaden the theoretical formulation, application to practice, and the scope of correctional

Correspondence: Dr. Pamela M. Yates, Cabot Consulting and Psychological Services, P.O. Box 38027, 1430 Prince of Wales Drive, Ottawa, Ontario, Canada, K2C 1N0. Email: pmyates@rogers.com

ISSN 0833-8488

interventions to take into account the promotion of human goods (or approach goals) *in conjunction with* the reduction of risk variables (or avoidance goals). Critics propose that the RNR is conceptually impoverished and is unable to provide therapists with sufficient tools to engage and work with offenders in therapy (see Ward & Maruna (2007) for a comprehensive evaluation of the RNR). In response to the weaknesses apparent in the RNR, Ward et al. (2007) reconstructed it and carefully outlined its primary aims, values and principles, etiological and methodological assumptions, and practice implications. The resulting rehabilitation framework was found to be stronger but still overemphasised risk management at the expense of offender well-being and personal goals.

Treatment within the RNR model typically takes a cognitive-behavioural approach. Cognitive-behavioural treatment involves targeting dynamic risk factors for change through the use of cognitive and behavioural methods and techniques to develop skills in problematic and deficient areas, with the aim of reducing risk. As indicated above, research supports this approach in reducing recidivism; however, we note that the application of such risk-based treatment models has predominantly focussed on the use of the relapse prevention (RP) model (Laws, 1989; Marlatt, 1982, 1985; Marlatt & Gordon, 1985; Pithers, 1990; Pithers et al., 1988; Pithers et al., 1983). Our criticisms of this model include its lack of scope, its sole reliance on a single pathway to offending, the lack of applicability of core constructs to sexual offending, and theoretical inconsistencies in the model, among others. These criticisms are described in detail elsewhere (Laws, 2003; Laws & Ward, 2006; Ward & Hudson, 1998; Yates, 2005, 2007; Yates & Kingston, 2005; Yates & Ward, 2007). As a result of the significant shortcomings in this model, Ward and colleagues (Ward et al., 1995; Ward & Hudson, 1998) proposed the Self-Regulation Model (SRM) as an alternative to the RP model as an approach to understanding and treating sexual offenders.

Given the above, we propose an integrated model of sexual offender assessment and treatment that is broader in scope than previous models. This model incorporates the essential elements of risk assessment and management and the use of cognitive-behavioural intervention, as well as comprehensive case formulation and a revised Self-Regulation Model (SRM-R), using the GLM as an overarching rehabilitation framework. We first summarise the GLM and its implications for clinical practice below, followed by our reconstruction of the SRM, and lastly, describe our integrated approach to assessment, treatment, and supervision using these models.

Good Lives Model of Offender Rehabilitation

The Good Lives Model (GLM; Ward & Gannon, 2006; Ward & Stewart, 2003) is a theory of rehabilitation that endorses the viewpoint that offenders are human beings with essentially similar needs and aspirations to non-offending members of the community. The GLM is based around two core therapeutic goals: to promote human goods and to reduce risk. According to Ward and his colleagues (see Ward & Maruna, 2007), a focus on the promotion of specific goods or goals in the treatment of offenders is likely to automatically eliminate (or reduce) commonly targeted dynamic risk factors (i.e., criminogenic needs). By contrast, focusing *only* on the reduction of risk factors is unlikely to promote the full range of specific goods and goals necessary for longer term desistence from offending.

According to the GLM, offenders are naturally disposed to seek a range of primary human goods that, if secured, will result in greater self-fulfilment and sense of purpose. In essence, a primary human good is defined as an experience, activity, or situation that is sought for its own sake and that is intrinsically beneficial. The possession of primary good enhances people's lives and increases their level of functioning and personal satisfaction. The justification of personal aspirations and actions ultimately has to stop somewhere and from the perspective of the GLM it is the existence of primary goods that provides the foundation and certainty associated with individuals' most cherished beliefs and values. Examples of primary human goods are relatedness, mastery, autonomy, creativity, physical health, and play (Emmons, 1999; Nussbaum, 2000; Ward & Stewart, 2003). Primary goods are rather abstract, and generally people do not specify them as goals when talking about the things that are most important to them. In fact, what they most often refer to when asked about their reasons for acting in certain ways or engaging in personal projects are the *means* utilized in the attempt to achieve certain outcomes. Thus, instrumental goods are means for achieving primary human goods and only have value because of their association with primary goods. For example, the primary good of relatedness could be sought through different types of personal relationships such as friendships or romantic relationships. The available research indicates that all primary goods need to be present in individuals' lives to some extent if they are to achieve high levels of well-being (e.g., Emmons, 1999). However, there is also room for individual preferences with respect to the weighting of the various goods. It is typically the case that individuals vary in the importance they accord to the various goods, for example, with some placing greater importance on mastery at work and others on feeling connected to the community. This is an important issue because the differential weighting of a good tends to reveal peoples'

core commitments and, therefore, is indicative of their narrative identity. Quite literally, our fundamental value commitments give shape and direction to our lives. Individuals' overarching or more heavily weighted goods reveal the kind of person they wish to be, and the kind of lives they want. This claim is dependent on the assumption that, to some degree, people are *self-constituting* -- that is, they create themselves by the way they lead their lives and the meanings they attach to their experiences.

A good example of the relationship between identity and goods emphasis is those individuals who weigh the primary good of mastery at work highly. Such individuals tend to cultivate the development of work-related expertise and look for opportunities to tackle difficult problems and to impress others with their commitment and achievements. Therefore, it is to be expected that he or she would value attributes and experiences that are closely associated with this good. These would include spending time at work, being engaged in further training and skill enhancement opportunities, being a good communicator (depending on the job), developing a strong sense of fidelity at work, wanting to be viewed as reliable and competent, and so on. These activities and experiences, in turn, serve to constitute the person's narrative identity -- by pursuing experiences and activities that realize the good of mastery at work, the person *becomes* a certain type of individual with a specific lifestyle, interests, and goals. This is a fluid, dynamic process that draws upon each individual's personal memories and repertoire of meanings and also the opportunities and cultural resources available to him (Woolfolk, 1998). Thus, an individual living in a violent and impoverished neighbourhood may struggle to find pro-social social ways of living and, thus, has little chance of constructing a more adaptive identity. The presence of negative and *false* gender (e.g., males are "hard" and emotionally controlling), class (e.g., if you are poor, there is no escape), or racial (e.g., Maori are violent by nature) stereotypes means that there may be little opportunity to construct a different view of himself and others. There may be few discursive (meaning-creating resources: norms, knowledge, practices) and material resources he can utilize in the hope of turning his life around.

With respect to the treatment of sexual offenders, the GLM has a twin focus: (a) promoting goods; and (b) managing/reducing risk. What this means is that a major aim is to equip the offender with the skills, values, attitudes, and resources necessary to lead a different kind of life, one that is personally meaningful and satisfying and that does not involve inflicting harm on children or adults -- in other words, a life that has the basic primary goods, and ways of effectively securing them, built into it. These aims reflect the etiological assumptions of the GLM that offenders are either directly seeking basic goods through the act of offending or else commit an offence because of the indirect effects of a pursuit of basic goods. Furthermore, according to the GLM, risk factors (criminogenic needs) represent omissions or distortions in the internal and external conditions required to implement a good lives plan in a specific set of environments. Instilling the internal conditions (i.e., skills, values, beliefs) and the external conditions (resources, social supports, opportunities) is also likely to reduce risk (Ward & Maruna, 2007).

A GLM approach to sex offender treatment is informed by an explicit and particular understanding of sexual offenders and the therapeutic task. First, the GLM acknowledges that a large proportion of sexual offenders have developmental histories marked by a diversity of adversarial experiences. These adversarial experiences may involve negative developmental experiences (e.g., physical or sexual abuse, instability in the family or caregiver arrangements, and so on) and/or the absence of important developmental experiences (e.g., emotional neglect, insecure relationships, lack of positive personal and interpersonal modelling, and so on). Hence, sexual offenders are seen as individuals who have lacked the opportunity and resources necessary to develop an adequate good lives plan. Second, sexual offending represents an attempt to achieve human goods that are desired and normative, but where the skills or capabilities necessary to achieve them are lacking. Third, the absence of, or problems in, achieving some primary human goods appears to be more strongly related to sexual offending than others. These goods are agency (i.e., autonomy and self-directedness), inner peace (i.e., freedom from emotional turmoil and stress), and relatedness (i.e., including intimate, romantic, family, and community relationships; Ward & Mann, 2004). Fourth, reducing the risk of sexual re-offending is achieved by assisting sexual offenders to develop the skills and capabilities necessary to achieve the full range of primary human goods, with particular emphasis on agency, inner peace, and relatedness, and to do so in a pro-social, non-offending manner. Fifth, treatment is seen as an activity that adds to a sexual offender's repertoire of personal functioning, rather than being an activity that only removes or manages a problem. Restricting activities that are highly related to sexual offending or offence-related problems may be necessary but should not be the sole focus of treatment. Instead the goal should be to assist clients to live as normal a life as possible, where restrictions are only used when necessary.

The aims of GLM treatment are always specified as approach goals (Emmons, 1996; Mann, 2000; Mann, Webster, Schofield, & Marshall, 2004). Approach goals involve defining what individuals will achieve and gain, in contrast to avoidance goals that specify what will be avoided or what activities must cease. Specifying the aims of treatment as approach goals has

several advantages. For example, goals that are life-enhancing rather than problem-avoiding are more likely to create intrinsic motivation for change than when motivation for change is extrinsically driven (e.g., to avoid trouble with the law). Goals that focus on what the offender wants to obtain in life are more consistent with what offenders want to achieve. The reality is that most offenders are much more focused on their own problems and quality of life than the harm they have caused their victims. Hence, incorporating offenders', as well as society's, goals into treatment is more likely to tap into offenders' intrinsic motivation for change.

Research shows some advantages to using approach goal programs. Cox, Klinger, and Blount (1991) found alcohol abusers who participated in an approach-goal focused program were less likely to lapse than individuals working toward avoidance goals. Mann et al. (2004) found teaching traditional relapse prevention ideas and skills to sex offenders with an approach-goal focus rather than the traditional avoidance and risk reduction focus resulted in greater engagement in treatment (e.g., greater homework compliance and disclosure of problems). Instead of teaching offenders what risk factors to notice and avoid, offenders were taught personal and interpersonal qualities to notice and work toward for a more adaptive personal identity. At program completion, offenders in the approach-goal group were equally able to articulate their personal risk factors but were rated as more genuinely motivated for living a non-offending lifestyle than offenders in the avoidance-goal group.

Treatment using the GLM involves two broad steps. First, the offender must learn to think of himself as someone who can secure all the important primary human goods in socially acceptable and personally satisfying ways. In other words, the offender has to learn to believe that change is possible and worthwhile. Second, treatment should aim to help offenders develop the scope, strategies, coherence, and capacities necessary for living a healthy personal good lives plan. To achieve this, individuals' offending should be understood in the context of the problematic or unhealthy good lives plan operating when offending occurred, as well as current problems with the plan. In addition, treatment goals should be understood as the steps necessary to help the individual construct and achieve the healthy personal good lives plan in addition to risk management.

According to the GLM, there are at least four types of problems evident in sexual offenders' (usually implicit) good lives plans: (1) the use of *inappropriate means* for obtaining primary human goods; (2) a lack of *scope* (i.e., all the primary goods are not addressed in the Good Lives plan); (3) *incoherence* or conflict (i.e., there is conflict between the ways certain goods are pursued); (4) and a lack of *capacities* (i.e., lack of skills or resources to achieve the primary goods sought).

Many of the specific activities of traditional risk-based programs can be utilised within the GLM framework. However, the goal of each intervention will be explicitly linked to the GLM theory and offered in a style consistent with GLM principles. Ward and colleagues (Ward & Mann, 2004; Ward, Gannon, & Mann, 2007) recently reviewed the traditional targets of sex offender treatment and reinterpreted these in light of the GLM. For example, a common target of sex offender treatment is offenders' sexual preference for children. According to the GLM, sexual preferences for children points to the following potential problems and treatment approaches: (1), the offender uses inappropriate means to achieve sexual satisfaction and sexual intimacy (through which the primary human goods of *life* and *relatedness* outlined earlier are achieved, respectively). Treatment should focus on helping the offender develop a wider range of strategies for achieving sexual satisfaction and sexual intimacy (i.e., provide appropriate means to achieve these goods); (2), the offender lacks scope in his good lives plan and places too much emphasis on achieving sexual satisfaction or sexual intimacy at any cost. The offender should be helped to learn to value and invest in a broader range of primary human goods (i.e., improve the scope of the good lives plan); and (3), the offender uses inappropriate means to attain agency or mastery and attempts to achieve these through sexual domination of a minor. Treatment should help the offender develop a wider range of strategies for achieving agency and mastery in both appropriate sexual relationships and in non-sexual situations (i.e., provide appropriate means for achieving these goods). The extent to which any one of these formulations is accurate for an individual offender is ascertained through the assessment process (see below). It is also entirely feasible that a different link to a primary human good may exist. The GLM is not intended to be a rigidly prescriptive approach. Rather, what is important is that the problem area is understood in terms of the individual's good lives plan and that treatment aims to achieve a healthy good lives plan (in which offending is not necessary or compatible).

Adopting a combined GLM and risk-management treatment approach requires rethinking some of the ways that sex offender treatment programs are packaged and operationalised. Specifically, traditional programs tend to be highly structured psycho-educational programs in which a series of skills are taught in sequential modules. Although a "one-size-fits-all" program structure has advantages in terms of consistency and simplicity with respect to streaming individuals for treatment, the rigidity of such an approach is inconsistent with the emphasis on making treatment explicitly relevant and tailored to the individual offender, and violates the responsivity principle. An alternative approach is to implement individualised formulation-based GLM treatment

programs that tie intervention modules or areas specifically to offenders' good lives formulations and plans. Offering formulation-based interventions is not the same as offering unstructured treatment. Unstructured treatments have been shown to have no impact on recidivism rates (Andrews & Bonta, 2003), so obviously are not sufficient. Formulation-based treatment derives clear structure from the formulation, treatment methods, and treatment processes used, and is capable of providing a transparent program model that has treatment integrity and can be evaluated.

Within our integrated model using the GLM as a framework for treatment, we recommend abandoning RP-based models (Yates, 2005, 2007; Yates & Ward, 2007), and using a broader SRM model (Ward & Hudson, 1998). We have, however, reconstructed this model to deal with its shortcomings and to integrate GLM constructs into the model. This reconstruction is described below.

Reconstruction of the Self-Regulation Model

The SRM is a nine-phase model of the offence process that includes four distinct pathways to offending based on the combination of offence-related goals, which may be either avoidance-based or approach-based, and the strategies individuals use to achieve these goals. Offenders holding an avoidance goal desire to refrain from offending, but lack the requisite skills to achieve this goal. They are under-regulated (avoidant-passive pathway), become disinhibited when they experience the desire or opportunity to offend, and utilise passive strategies, such as distraction, to achieve this goal. A second group of offenders holding avoidance goals similarly desire to refrain from offending, but actively implement strategies to achieve this goal (avoidant-active pathway). This pathway is a mis-regulation pathway, in which the strategies utilised are ineffective in achieving the offence-avoidance goal and may, in fact, have the ironic effect of increasing risk. Two approach-oriented pathways include the approach-automatic pathway, in which individuals do not desire to refrain from offending and respond relatively automatically to situational cues via well-entrenched scripts (also an under-regulation or disinhibition pathway), and the approach-explicit pathway, in which self-regulation is intact and the individual actively implements strategies in order to offend.

The nine-phase SRM describes the development of the offence progression from the occurrence of a life event that triggers the desire to offend, through to two post-offence phases during which individuals evaluate their behaviour and formulate their attitudes and expectations with respect to future offending. The reconstruction of this model (SRM-R; see Figure 1), is a ten-phase model that takes into account the aetiology of offending behaviour and which redefines some of the constructs in the original SRM. The SRM-R is also an integrated model which was developed to include the broader GLM rehabilitation theory and framework. It is noted that specific processes and responses throughout the offence progression (e.g., the influence of implicit theories, cognitive deconstruction, cognitive dissonance, etc.) are not described in detail below. For additional information, the reader is referred to Ward, et al. (2004), Ward and Hudson (1998), and Ward, et al. (2006).

Phase 1: Preconditions to Sexual Offending

This phase of the offence progression was not included in the original SRM and has been added to the SRM-R. This has been done in order to acknowledge background and predisposing factors consistent with an integrated theory of sexual offending (Ward & Beech, 2006) and to provide an overarching framework within which to understand individuals who have committed sexual offences. For some individuals, the occurrence of a life event (see below) triggers a progression to sexual offending, whereas for other individuals, the same event will not trigger such a progression. The difference between these individuals lies in differences in their developmental and learning histories, and psychological, social, biological, and other factors. For example, individuals for whom a life event triggers the offence progression may have experienced histories of sexual or other abuse, modelling of violence and abuse during development, insecure attachment during development, or may be biologically predisposed to respond to the event in a sexual manner. Among individuals who are not so predisposed, the occurrence of the life event does not trigger a progression to sexual offending. For example, the termination of an intimate relationship may trigger the desire to regain a state of intimacy or social relatedness, or to re-establish the relationship, but in the absence of predisposing factors, the individual does not commit a sexual offence. Such background factors will also influence the manner in which individuals respond throughout the offence progression and, therefore, provides valuable information for understanding the different pathways to offending followed by individual offenders. This points to the importance of a comprehensive understanding of predisposing factors to offending, which was absent in the original SRM. Given the importance of such predisposing factors, background factors have been included in the SRM-R.

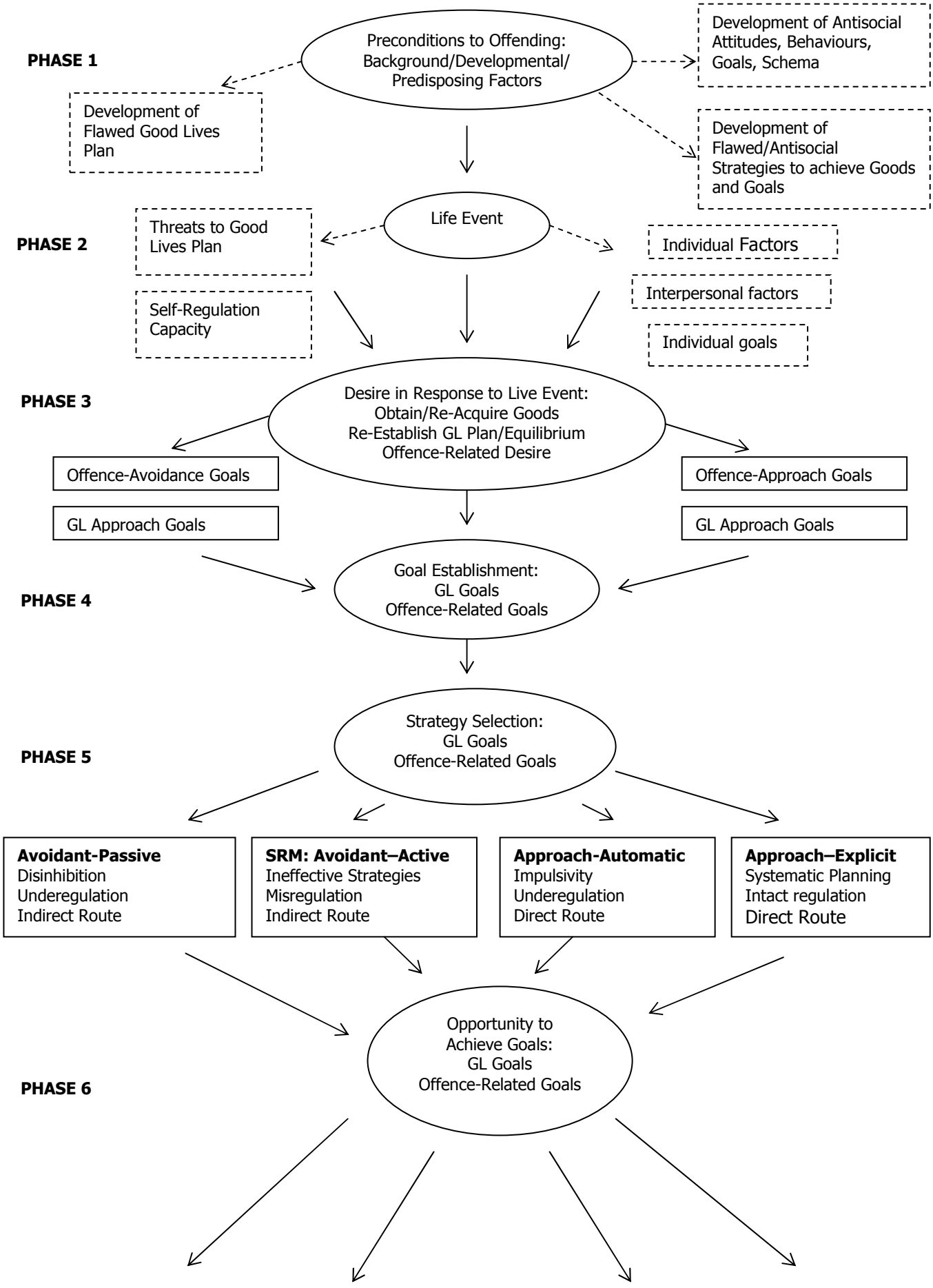

Figure continues

Figure 1 continued

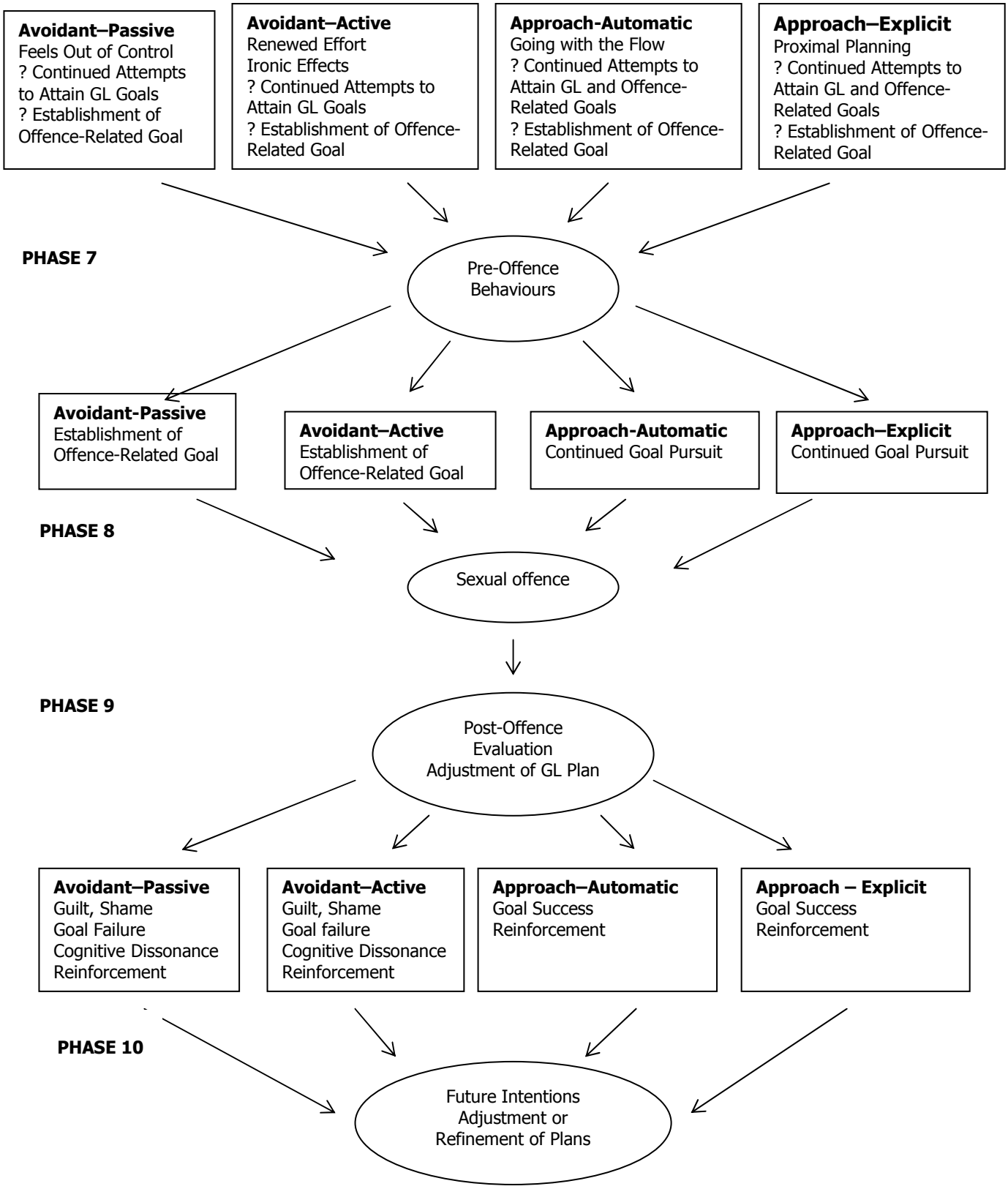

Figure 1: Revised Self-Regulation Model of the Sexual Offence

Phase 2: Life Event

Per the original SRM (previously Phase 1), in Phase 2, a specific life event occurs, which the individual appraises and evaluates relatively automatically based on experience, cognitive schema, implicit theories, goals, and the interpersonal context in which the event occurs. Goals may be specific to a particular situation or may be more abstract goals that are linked to the individual's self-concept and views of the world. The life event may be a relatively common event, such as a minor argument with a partner or co-worker, or may be a major life transition, such as loss of a relationship or the death of someone close to the individual. In this phase, individuals are hypothesised to interpret and appraise the event based on cognitive schema and implicit theories (Ward & Keenan, 1999), underlying causal theories about the world and themselves that assist the individual to explain and make predictions about the world and events. These theories cause the individual to count or discount evidence in a particular situation that supports or does not support the theory, or, in some cases, to alter the theory and schema. This process then functions to guide and direct behaviour, cognition, and affect in response to the life event.

In the original SRM, this phase focussed on life events and appraisals that directly led to offending. Although the theoretical model allowed for an indirect route, this was not well-developed and the phases of the original SRM primarily represented a direct route to offending. That is, the occurrence of the life event was presumed to trigger a desire for offensive behaviour, specifically among individuals attempting to remain "abstinent" (from what individuals were attempting to abstain is unspecified in the original SRM). In our reconstruction, consistent with the GLM, the life event may trigger the desire to achieve primary goods and important goals that are not necessarily related to offending, and which may suggest flaws or problems in the individual's good lives plan. For example, in the original SRM, it was presupposed that an argument with an intimate partner, interpreted through appraisal processes and implicit theories, signalled the loss of intimacy and resulted in the establishment of sexually-deviant goals in order to re-establish intimacy. In the SRM-R, we propose that this may in some cases signal the loss of opportunity to achieve the primary human good of friendship/relatedness (e.g., intimate and/or romantic relationships) as well as threaten the attainment of inner peace and happiness, which may or may not occur in tandem with the establishment of specific offence-related goals. Furthermore, the life event may threaten the good lives plan in a more general sense and in interaction with other concurrent threats to the good lives plan that may be simultaneously occurring in other life areas. The difference in the SRM-R is that the occurrence of the life event that triggers the offence progression is viewed from a much broader perspective and does not focus solely on direct routes to offending or that can trigger goals other than specifically offence-related goals. Thus, in the SRM-R, the triggering life event may provoke various states: (1) the desire to obtain or to re-establish a particular primary good or other positive goal; (2) the desire to re-establish equilibrium; (3) the identification of flaws in the good lives plan and the desire to address these flaws; and/or (4) the desire to offend. At this stage in the offence progression, it is hypothesised that the desire triggered may be distal to the offence or more proximal to the offence, depending upon the nature of the desire triggered, the individual's predisposing factors, and whether the route to offending is direct or indirect.

Phase 3: Desire in Response to Life Event

In the original SRM, this phase (*Phase 2 – Desire for Offensive/Deviant Sex or Activities*) included only the desire for offensive or deviant sex or activities and the maladaptive cognition, affect, and responses associated with this desire. Simply put, it was presumed that the life event triggered only one desire and that this desire was for offensive or deviant sexual activity. Within the SRM-R, we propose that the occurrence of the life event can also trigger desires that may be neither deviant nor sexual in nature. While the cognitive and other processes proposed in the original SRM (e.g., attitudes, beliefs, memories, offence scripts, and so forth), and their influence on the offence progression, are retained in the SRM-R, we have expanded the nature and type of the desire triggered by the event. Specifically, the desire may be sexual (but not deviant), as in the case of an individual for whom the event triggers the desire for consensual sexual activity or intimacy via sexual activity. This change acknowledges that, at this stage in the offence progression, particularly among offenders without a lengthy history of offending and those following an indirect route, the sexual desire may be, in fact, normal desire, despite ultimately resulting in a sexual offence later in the progression as a result of other factors. This reconstruction is supported by theory and research indicating that not all sexual offenders demonstrate deviant sexual arousal or preference (Marshall, 1996). Furthermore, the reconstruction of this phase also acknowledges that the desire experienced in response to the event may be non-sexual in nature, as in the case of individuals for whom the life event triggers a desire for intimacy, or for anger and hostility (based on the individual's pre-existing view of the world, cognitive schema, implicit theories, and so forth). In such cases, this results in a desire for retaliation or to alleviate or to express emotion (which may or may not be associated with sexual behaviour), but which manifests later in the offence progression in sexual acting out, as in the case of offenders for whom violent and sexual behaviour are cognitively and behaviourally linked. Finally, the

reconstruction of this phase acknowledges that the desire triggered by the life event may be, in fact, an appropriate desire, as in those cases in which the individual seeks to obtain primary goods or other states in response to the life event. That is, the life event may trigger the desire to regain such states as autonomy, relatedness, or intimacy, thus re-establishing equilibrium in the individual's good lives plan. In these cases, we propose that the desire for offensive or deviant sexual behaviour emerges later in the offence progression.

Phase 4: Goal Establishment

As with our reconstruction of the preceding phase, the SRM-R expands on the nature and type of goals established at this phase in the offence progression. The original SRM viewed this phase (Phase 3, *Establishment of Offence-Related Goals*) solely with respect to goals for offensive or deviant sexual behaviour arising from the desire to offend in the previous phase. In the SRM-R, we have expanded on these goals to include the establishment of goals to achieve the desired end, without limiting goals to offensive or sexually deviant behaviour (see above). In the SRM-R, the goals established during this phase are explicitly linked to desires triggered during the previous phase, including both appropriate and inappropriate desires. Specifically, at this stage in the offence progression, goals may be established either to obtain primary goods or other desired states, or may be offence-specific. As an example, for an individual for whom the life event triggered the desire to re-acquire the primary good of relatedness, the goal established at this stage will be directly in service of acquiring this good (e.g., re-establishing a relationship – a secondary good), even though this ultimately results in behaviour that leads to the commission of a sexual offence. For some individuals, such as those following an indirect route to offending, the establishment of offence-specific goals is hypothesised to occur later in the offence progression. Conversely, for those individuals for whom the life event triggered an offensive or deviant desire, the goals established at this stage will be offence-related and the route to offending may be more likely a direct route.

The constructs of approach and avoidance goals are also expanded in this phase. The original SRM conceptualised these goals as the desire to refrain from offending (avoidance goals) or to seek out offending (approach goals). In the SRM-R, these offence-related goals remain; however, it is proposed that individuals at this stage may also establish pro-social or non-offending (positive) approach goals. For example, individuals holding avoidance goals with respect to offending, may also simultaneously hold approach goals with respect to other states or goods sought. That is, individuals who desire to avoid acting on offence-related desires may, at the same time, also desire to seek out a particular state of being that is non-offensive in nature. For example, an individual who desires to refrain from acting out sexually against a child, may at the same time have the goal of obtaining intimacy or gratification in an appropriate manner with an adult, which, consistent with the GLM, he lacks the capacity or opportunity to acquire (representing the good lives plan flaw of capacity). As in the original SRM, avoidance goals with respect to offending are generally associated with negative emotional states, whereas approach goals with respect to both offending and non-offending behaviour may be associated with either positive or negative emotional states depending upon the individual and what they seek to achieve. We propose here that the individual may additionally experience positive affective states associated with concurrent pro-social approach goals. In individuals for whom both states are concurrently active, we propose that the individual will experience cognitive dissonance, and will rely on cognitive schema, and established behavioural and self-regulation patterns in order to continue in the offence progression. That is, the individual may seek to avoid offending as well as seek to obtain a primary good or other pro-social approach goal; however, individual cognitive and behavioural factors result in attempts to obtain these via offending. Finally, we propose that implicit theories will be re-activated at this stage, with the individual attending to events, stimuli, and evidence that their beliefs and behaviour in search of goal attainment are appropriate.

Phase 5: Strategy Selection

In this phase, as in the original SRM, the individual selects strategies to achieve the goal established in the previous phase of the offence progression. The selection of strategies follows the same processes in the SRM-R as in the original model, and, in combination with offence-related goals, forms the four self-regulation pathways to offending (*avoidant-passive*, *avoidant-active*, *approach-automatic*, and *approach-explicit*). These pathways are specific to the offence process, although they may also reflect individuals' overall self-regulation styles as well as pathways to other, non-sexual, offending behaviour. We propose in the SRM-R that individuals typically tend to have similar self-regulation styles across various life areas, particularly offenders following the approach pathways. For example, individuals following the approach-automatic pathway to sexual offending likely respond in a relatively automatic or impulsive manner to many life events, and are likely to demonstrate the same level of impulsivity and rapid responses to situational cues guided by entrenched cognitive schema in life areas such as employment, relationships, or general criminal conduct. Individuals who tend to utilise passive strategies to achieve offence-related goals are similarly

hypothesised to use such strategies more globally, and individuals who tend to utilise active strategies are presumed to use such strategies in multiple life areas as well. It is further suggested that individuals following avoidant pathways are more likely than offenders following approach pathways to be more pro-social in other life areas, a hypothesis supported by research indicating that these individuals tend to be lower risk (Yates & Kingston, 2006; Yates, Kingston, & Hall, 2003), have fewer prior convictions (Bickley & Beech, 2002; 2003), and demonstrate less general criminality (Yates & Kingston, 2006).

It is further suggested in the SRM-R that offenders following avoidant pathways are more likely to demonstrate approach goals and strategies with respect to the attainment of primary goods and pro-social goals, in conjunction with avoidance goals with respect to offending, as well as to follow an indirect, rather than direct, route to offending. Specifically, individuals with avoidant goals with respect to offending are more likely to be seeking to acquire a specific good or state, such as intimacy or sexual gratification, that leads to offending via a cascading effect. Conversely, individuals following approach pathways are more likely to take a direct route to offending, seeking to obtain the good or goal specifically through violent or sexually aggressive behaviour.

This reconstruction of this phase of the offence progression therefore acknowledges that individuals may seek to obtain multiple goods via offending, either separately or concurrently, and may do so directly or indirectly. Furthermore, individuals may seek to achieve a desired state while simultaneously selecting strategies to avoid offending (an undesired state) and to attain a primary good (a desired state). The SRM-R also proposes that self-regulation style is consistent in some cases across life areas and manifests in various life areas. It is proposed that offenders with less extensive criminal histories are able to manage these life areas relatively well as a result of greater opportunities to obtain goods in non-offending ways and, possibly, as a result of pro-social values in life areas not related to sexual offending. Finally, if, following from the previous two phases, the individual has not yet established an offence-related goal but rather has established a non-offending goal, the strategies selected at this phase will be in service of this goal, with the specific offence-related goal established later in the offence progression.

Phase 6: Opportunity to Achieve Goals

In the original SRM, this phase (Phase 5) referred to the occurrence of a high risk situation, defined as in the traditional RP model. Due to the problems inherent in this terminology (Yates, 2005; 2007; Yates & Ward, 2007), the SRM-R explicitly avoids the construct of high risk situations and conceptualises this phase of the offence progression as one in which the opportunity to achieve goals is presented as a result of the goals and strategies established during Phases 4 and 5. If the individual has established a non-offending goal in Phase 4, this phase represents the opportunity to achieve this pro-social or good lives goal. If the individual has established an offence-related goal in Phase 4, this phase refers to the opportunity to offend, such as access to potential victims, opportunity for contact with a potential victim, or circumstances that present which are conducive to, or which trigger, offending. As such, in the SRM-R, this phase refers to the opportunity for the individual to achieve approach or avoidance goals, both with respect to offending and/or in relation to acquiring primary goods or other desired (non-offending) states. As such, the circumstances may provide the opportunity to acquire intimacy, autonomy, or gratification, which may or may not be related to offending at this stage in the offence progression. If related to offending, this represents a more direct route to offending while, if unrelated to offending, this represents a more indirect route. Individuals who have established offence-related goals by this stage in the progression are hypothesised to experience sexual arousal or other anticipation of achieving goals, although their affective and other responses to the opportunity to achieve goals vary according to offence pathway, per the original SRM.

The affective states associated with this phase in the offence progression are similar to those in the original SRM in that, for individuals holding offence-avoidance goals, the opportunity to offend signifies a failure to achieve goals and to control or inhibit behaviour, is predominantly associated with negative affective states, and may result in goal conflict. For individuals holding approach goals with respect to offending, the opportunity signals success and is predominantly associated with positive affective states. For individuals holding non-offending goals at this stage, the opportunity presented is to achieve non-offending goals or primary goods, and is likely to be associated with positive affective states. If the individual simultaneously holds offence and pro-social approach goals, affect is likely to be mixed.

Phase 7: Pre-offence Behaviours

In the original SRM, this phase (Phase 6 – *Lapse*) represented immediate precursors to offending as adapted from the original RP model applied to sexual offenders (Pithers, 1990). It was suggested that individuals following an avoidant pathway experienced the dominance of an appetitive process (i.e., the Problem of Immediate Gratification [PIG]) and an affective shift that signalled the failure of strategies to achieve the offence-related avoidance goal. These individuals subsequently abandoned the avoidance goal, became disinhibited, and switched temporarily to an

approach goal with respect to offending. For individuals initially holding approach goals with respect to offending, the occurrence of the high risk situation in the previous phase and the subsequent lapse signalled success in the achievement of the offence-related goal.

In the SRM-R, this phase is similar, although with some refinements. First, as in the original model, the occurrence of the opportunity to achieve goals (Phase 6) signals a failure to avoid offending among individuals following an avoidant pathway and success in achieving goals for individuals following an approach pathway. In addition, however, as indicated above, the SRM-R also allows for goals and strategies that are established in order to obtain primary goods and other positive goals. As such, we propose that the opportunity to achieve goals (Phase 6) signals to the individual that these primary goods are imminently available, and may therefore signal success, regardless of self-regulation pathway. That is, actions at this phase may continue to represent attempts to achieve the primary good or pro-social approach goal that became available during the previous phase. As such, actions at this phase of the offence progression may not represent offence-related behaviours *per se*, although they ultimately function to place the individual at risk to offend nonetheless. In the SRM-R, this state is therefore viewed as existing either independently of pre-offence behaviours or as co-existing alongside pre-offence behaviours. Thus, the individual may simultaneously abandon offence-avoidance goals as well as engage in behaviour to acquire the primary good, may abandon efforts to obtain the primary good and engage solely in offending behaviour, or may attempt to obtain the primary good via offending. This is a particularly important distinction in that, in the original SRM, offenders following avoidant pathways were hypothesised to abandon avoidance goals and to adopt approach goals, without explanation as to the dynamics or cognitive or other processes that initiated this shift (other than the imminence of immediate gratification or acknowledgement of failure). In the SRM-R, such a pathway shift is not required in that, via pre-offence behaviours, the individual may be continuing to attempt to obtain other goals or goods, which are ultimately acquired through offending. It is these individuals who have not yet established an offence-related goal, but who do so at this phase, as a result of a lack of capacity or resources to obtain non-offending goals or goods via non-offending means. As such, while in the original SRM, avoidant individuals are presupposed to "give up" and to change pathway, in SRM-R, a pathway change is not required and it is suggested that some individuals may simply continue to seek to obtain a primary good or other non-offending goal. This reconstruction is consistent with research to date suggesting that offence pathways are stable and do not change (Webster, 2005).

Phase 8 – Commission of Sexual Offence

The processes, affect, and foci (self, victim, and mutual) of this phase in the offence progression remain in the SRM-R as in the original SRM. However, this phase is expanded in the SRM-R to include the inter-relationships between offence-related goals and non-offending/good lives goals. That is, the individual is hypothesised to commit the offence as a result of failure to achieve offence-avoidance goals (avoidant pathways) or success in achieving offence-related goals (approach pathways), as well as success or failure in obtaining primary goods and pro-social goals. As indicated above, the commission of a sexual offence may represent the means by which primary and other goods and pro-social goals are obtained among individuals who lack the capacity to acquire these via non-offending means and who are predisposed by various factors to obtain these via offending. Among individuals with offence-related approach goals, the commission of a sexual offence represents the intended end result of the offence progression as well as a success experience with respect to achieving goals. Furthermore, we propose in the SRM-R that the individual also incorporates the offence experience into the good lives plan as either a failure or success experience and may adjust the plan during subsequent phases.

Phase 9 – Post-Offence Evaluation and Adjustment of Good Lives Plan

In the original SRM, a post-offence evaluation phase was proposed. In the SRM-R, this phase is refined to better reflect its temporal nature as the period of time immediately following the commission of the sexual offence and the reinforcement for behaviour that occurs at this phase of the offence progression. In our view, the original SRM paid insufficient attention to basic behavioural principles by which behaviour is reinforced or punished (Pavlov 1927; Skinner, 1938). Consistent with these principles, we propose that, in addition to affective responses and evaluations that are negative or positive based on the offence pathway the individual has followed, reinforcement for behaviour necessarily occurs as a function of gratification obtained, either via positive reinforcement (e.g., sexual gratification, achievement of intimacy) or negative reinforcement (e.g., removal of negative affect). This reinforcement necessarily serves to entrench sexual offending behaviour as a means by which goals are achieved, regardless of pathway, a process which was not recognised in the original SRM. We further propose that the affective states experienced by the individual as a result of success or failure in achieving one's goal occur in addition to this reinforcement, which was not considered in the original SRM.

In the SRM-R, this phase of the offence progression also includes evaluation of behaviour with respect to

achieving the good lives plan in addition to an evaluation of offending behaviour. We suggest that individuals who have successfully obtained a primary good, regardless of a success or failure experience with respect to offending, also experience reinforcement for offending as a means to obtain good lives and other non-offending goals. For example, an offender following an avoidant pathway will experience negative affect, cognitive dissonance, and so forth, as a result of behaviour that is incongruent with goals and his view of himself. We argue, however, that the sexual offence may also simultaneously acquire the primary good, representing an indirect route to achieving the good lives plan and entrenching offensive behaviour as a means to implement the good lives plan. Offenders following an approach pathway are also hypothesised to experience similar reinforcement for offensive behaviour as a direct route to both offending (as in the original SRM) as well as a direct route to achieving the good lives plan.

Phase 10 – Future Intentions and Adjustments to Good Lives Plan

As in the original SRM, the SRM-R proposes that individuals experience a second post-offence evaluation (originally Phase 9 – *Attitudes Toward Future Offending*). At this phase, individuals utilise the offence experience to develop, refine, and formulate future intentions and expectations with respect to offending, and to entrench or alter attitudes regarding the acceptability of offending. Individuals with avoidance goals are hypothesised to reassert control and may resolve not to offend in future, but lack the requisite internal and external conditions and capacities to achieve this goal, whereas individuals with approach goals are hypothesised to learn from the offence experience to refine strategies to achieve these goals. In the original SRM, individuals following the approach-automatic pathway specifically were hypothesised to have lower level behavioural scripts associated with offending reinforced and strengthened as a result of success in achieving the offence-related goal. In the SRM-R, we argue that this reinforcement of behavioural scripts occurs among individuals following all pathways, and that this reinforcement additionally applies to cognitive scripts and implicit theories in addition to behavioural scripts. That is, through the processes of reinforcement described above in Phase 9, we argue that, for all individuals, such scripts are reinforced by the offending process and will impact on future behaviour. The difference between pathways lies in the evaluation of behaviour as positive or negative (success versus failure) in achieving the initial offence-related goals. Individuals following avoidant pathways will experience cognitive dissonance between their behaviour and goals, and, if the avoidant goal is retained at this phase, are likely to propose as causal to offending factors beyond their control, attributions which thus permit the individual to resolve to change behaviour and to refrain from offending in the future. Individuals following approach pathways will not experience cognitive dissonance (as there is no discrepancy between goals and behaviour), and will attribute behaviour in a manner which absolves them of responsibility (e.g., via blaming the victim).

In addition to this reconstruction, in the SRM-R it is proposed that individuals formulate future plans, intentions, and expectations not only with respect to offending, but also with respect to achieving the good lives plan. As with offending, individuals may conclude that they lack the requisite capacities and opportunities to implement the plan and may adjust the plan so as to abandon specific elements or goals. Alternatively, individuals may conclude that they successfully achieved the element of the plan sought (i.e., the good lives goal) and, thus, in conjunction with reinforcement for behaviour, formulate intentions that include the offence experience as a means by which to obtain that particular primary good. In this case, the individual may make adjustments to the good lives plan and to behaviour that include the offence experience as a means by which to obtain primary goods and to achieve the plan. We argue that such adjustments to the plan can occur among individuals following any of the four offence pathways, and that this process is dependent upon initial goals established with respect to achieving the good lives or pro-social approach goals.

Finally, in the original SRM, it was hypothesised that at this phase in the offence progression, some individuals may abandon offence-avoidance goals in favour of adopting approach goals with respect to offending, thereby switching from an avoidant to an approach pathway. In the SRM-R, we argue that such a change may not necessarily occur in that the individual adopts offence-approach goals, but rather the offence experience entrenches sexual offending behaviour as a means to achieve other desired ends. The individual in this case may retain the goal of avoidance with respect to offending, but comes to view their behaviour as non-offensive and to engage in cognitive reconstruction that justifies and normalises such behaviour in the service of goals and primary goods. If a pathway change does occur, we propose that this occurs slowly over time as a result of multiple offence instances and in a progressive manner over the individual's offending history, and is unlikely to occur following a single instance of offending. We further propose that individuals for whom the offence experience resulted in obtaining primary goods, pro-social approach goals, and in achieving the good lives plan, are more likely to experience a shift from an avoidance to an approach pathway. Similarly, individuals attempting to obtain primary goods and the achievement of the good lives plan via offending, but who are not successful, are hypothesised to consider behaviour consistent with an

avoidant pathway, thus potentially shifting from an approach to an avoidant pathway, again over time and in a progressive manner.

Integrated Assessment and Treatment Approach

In combining the GLM and SRM-R, we have devised an integrated approach to the assessment of sexual offenders. In this approach, intervention with sexual offenders is regarded as a broad and comprehensive process commencing with evaluation of all clinical phenomena implicated in offending, including broader good lives goals (those primary goods which the individual values and seeks to attain in life), primary goods specifically implicated in offending, secondary goods selected in order to translate primary human goods into behaviour and the manner in which these are selected, and the function served by offending for the individual with respect to their good lives plan. Assessment also includes evaluation of flaws or problems in the individual's good lives plan, its scope, individuals' internal capacity to obtain primary goods and to regulate behaviour, and the external opportunities that facilitate or constrain the implementation of the good lives plan.

With specific regard to offending, and in keeping with the principles of risk and need, evaluation begins with assessment of static and dynamic risk. This is conducted in order to evaluate the individual's long-term risk to re-offend, dynamic risk factors to be addressed in treatment, and treatment intensity and content requirements. Assessment also includes evaluation of self-regulation capacity and pathways associated with offending such that these may also be differentially addressed in treatment (Yates, Kingston, & Ward, in preparation). Consistent with the GLM, the assessment process is regarded as a collaborative investigation between the clinician and the client in which both discover the above-indicated phenomena that are important both in the individual's life and that are implicated in sexual offending.

The end result of assessment is a comprehensive case formulation which is used to guide treatment planning. This plan is both a treatment plan and the individual's opportunity to achieve greater well-being and satisfaction in life. Thus, the plan contains both risk management elements, in the form of specific treatment targets and methods to address dynamic risk factors and motivations for offending, and explicit good lives elements in order to assist the individual to obtain that which he values in life and to attain goods in non-offending ways. Consistent with current established practice, treatment intensity (length and frequency of contact) is varied to match the risk to re-offend posed by the individual, and targets known and empirically-supported dynamic risk factors for change (Andrews & Bonta, 2003; Hanson, 2006; Hanson & Yates, 2004). At present, these include such factors as intimacy deficits, general self-regulation (e.g., cognitive problem-solving capacity, hostility), sexual self-regulation (e.g., sexual deviance, sexual preference), and anti-social lifestyle orientation (Hanson, Harris, Scott, & Helmus, 2007; Hanson & Morton-Bourgon, 2005). Taken together, this evaluation should result in a good lives oriented case formulation and an associated treatment plan. The basic steps in this process are as follows.

The first step concerns the detection of the clinical phenomena implicated in individuals' offending. In other words, with what kind of problems do they present and what criminogenic needs are evident? In the second step, the function of offending is established through the identification of primary goods that are directly or indirectly linked to the criminal actions. What were they trying to achieve with their offending? In addition, the identification of the *overarching good* or value around which the other goods are oriented should also be ascertained. The overarching good informs therapists about what is most important in a person's life and hints at his or her fundamental commitments. It is strongly constitutive of personal identity and is a useful way of illuminating how the person sees his or her world.

At this phase of the assessment process, clinicians will have a good sense of the reasons for which the person committed an offence, his or her level of risk, the flaws in his or her life plan, and whether or not the link between the client's pursuit of primary goods is directly or indirectly connected to the offending behaviour. We propose that individuals who follow a *direct* route to offending are likely to have entrenched offence supportive beliefs, approach goals, and/or marked deficits in their psychosocial functioning. They are also likely to be assessed as higher risk, a factor that reflects their many years of offending. By way of contrast, individuals who have followed an indirect route are more likely to be assessed as moderate or lower risk, and to have more circumscribed psychological problems (Purvis, 2005; Ward & Gannon, 2006).

In the third step, therapists should identify the individual's particular strengths, positive experiences, and life expertise (i.e. the means available to the person to achieve their stated goals). The fourth step specifies how the identified primary and secondary goods can be translated into ways of living and functioning, for example, specifying what kind of personal relationships would be beneficial to the person. In the fifth step, identification of the contexts or environments in which the person is likely to be living once s/he completes the program is undertaken. In the sixth step, the therapist constructs a good lives treatment plan for the client based on the above considerations and information. Thus taking into account the kind of life that would be fulfilling and meaningful to the individual (i.e.,

primary goods, secondary goods, and their relationship to ways of living and possible environments), the clinician notes the capabilities or competencies s/he requires to have a reasonable chance of putting the plan into action. Lastly, this formulation incorporates findings from risk and other assessment and evaluation of self-regulation capacity and SRM-R pathway in order to gain a comprehensive picture of the individual and of offending.

Next, based on the case formulation, a treatment plan is developed that, both explicitly targets dynamic risk factors and risk management and the acquisition of primary goods, assisting the individual to uncover those goods they value and that have been implicated in offending and to achieve these in non-offending ways. For example, for individuals who have offended sexually against children in order to attain the primary good of relatedness (i.e., the dynamic risk factor of intimacy), treatment would assist these individuals to acquire this in age-appropriate relationships. Individuals who strongly value agency, and who have attained this via dominating, controlling, or abusing others, would be assisted to achieve such autonomy and personal control via other means that are personally satisfying for them, such as mastery in areas of work and leisure. Although risk management practices, such as restricting victim access, may be necessary in an individual case, we believe that current interventions place too great a focus on such avoidance and containment strategies, and that it is insufficient to simply constrain the individual without providing them with ways to attain what they value. Thus, using the above examples, it is insufficient in treatment to develop strategies to manage impulsivity and the tendency to abuse and dominate others, without assisting the individual to find alternate ways to attain agency and autonomy if this is an important facet of their personal identity, or to restrict access to opportunities that would allow the individual to engage in activities that allow for the expression of personal agency and mastery.

Treatment is also designed to resolve problems evident in the individual's good lives plan (scope, means, conflict/coherence, and capacity). With respect to scope, treatment builds on assessment evaluating the primary goods valued by the individual, and examines whether each is included in the individuals' good lives plan. If included fully, problems likely result from one of the other flaws in the plan. If certain valued goods are not included or are minimised in daily life, treatment assists the individual to uncover ways to include these goods in the plan. For example, individuals who value mastery or creativity, but who lack the capacity or opportunity to attain these goods, are assisted to develop and implement activities and endeavours that would allow them to meet these goals. For example, individuals who value mastery in work, but who lack the requisite education or training to secure satisfying employment activities, are assisted to develop their capacity in this area, as well as to identify opportunities and develop the skills to access these opportunities. Similarly, individuals who value knowledge may wish to return to school and study in an area of interest for them. It is expected that individuals who demonstrate problems in scope in the good lives plan are also likely to lack the capacity or means to obtain additional goods, and so will need to be assisted in these areas as well, such as via skill development and the creation of external opportunities in a manner which is consistent with their self-regulation capacity. As is evident, within the integrated GLM/SRM-R framework, this aspect of treatment involves the explicit development of approach goals to achieve valued objectives and goals and specific strategies the individual can use to obtain these, keeping in mind their internal capacity and external opportunities.

In addressing the means used to obtain primary and secondary goods, treatment aims to raise awareness of the manner in which the individual has sought to achieve the good and to assist them to develop appropriate means. An individual who seeks to obtain the goods of relatedness and sexual pleasure with children would learn to develop age-appropriate adult relationships. Since this may also be associated with particular dynamic risk factors, such as intimacy deficits and deviant sexual arousal or preference, treatment also utilises cognitive-behavioural methods, such as arousal and fantasy reconditioning, in order to assist the individual to develop the internal capacity to manage problematic arousal, develop appropriate arousal, and develop skills to attain and maintain age-appropriate intimate relationships. Since individuals vary in the manner by which they go about achieving these goods via offending, such methods are developed using the SRM-R as guide, as described above. As such, using the GLM/SRM-R formulation, individuals' needs for intimacy and sexual pleasure are explicitly acknowledged, approach goals are developed to assist them to achieve these, and the specific methods used to target associated dynamic risk factors are tailored to the individuals' capacities and to their self-regulation styles and pathways to offending.

With respect to conflict among goods, treatment aims to assist the individual to develop awareness of the conflict and its effects, and to evaluate and weigh the relative meaning and value of the conflicting goods in their lives. For example, individuals who desire both intimacy and autonomy with respect to sexual pleasure demonstrate a conflict between relatedness and agency. In this case, the individual may desire an intimate relationship, but simultaneously highly values sexual pleasure, which manifests in sexual activity outside their intimate relationship, leading to conflict and loss of trust within the relationship or, ultimately, the loss of the relationship entirely. In treatment, individuals in such circumstances determine which of the two goods

they value most highly and develop strategies to eliminate the conflict. Should the individual determine that he values intimate relationships more so than sexual freedom, he is assisted to develop the capacity to attain and maintain such relationships. In terms of dynamic risk factors in this example, treatment targets intimacy deficits and sexual self-regulation in order to assist the individual to develop the capacity to maintain relationships and to manage and balance sexual needs within the relationship.

With respect to the final good lives plan problem (capacity), treatment within the integrated GLM/SRM-R addresses both internal capabilities and external opportunities to implement the plan and to manage risk. This area is perhaps most closely linked with cognitive-behavioural intervention and focuses on the identification of internal skills deficits, such as problems with self-regulation, difficulty adapting to various situations and life circumstances, and the like, and on the development of skills and capacity to both attain important goods and to manage risk. In addition, our approach also includes explicit identification of external constraints and opportunities in the individual's environment that will facilitate or constrain the implementation of the good lives plan. Thus, the good lives plan is developed in such a manner as to be realistic and ultimately successful in leading to a satisfying life.

In addition to focussing on these four GLM problems, treatment also explicitly varies according to self-regulation pathway, with respect to both the attainment of goods and risk management, with treatment targets and methods tailored to different offence pathways. Briefly, treatment with individuals following the avoidant-passive pathway focuses on raising awareness of the offence progression and goods sought via offending, and works to assist the individual to develop the requisite skills to implement the offence avoidance goal. Treatment with individuals following the avoidant-active pathway focuses on raising awareness that existing strategies are ineffective in achieving the offence avoidance goal and on developing strategies that will be effective in achieving both the offence avoidance goal and positive approach goals and goods. Treatment with individuals following the approach pathways focuses on altering beliefs that support offending and changing attitudes, schema, and implicit theories associated with offending. Treatment also aims to develop an avoidance goal with respect to offending and to assist individuals to attain valued goods and goals without offending. In treatment for the approach-automatic pathway specifically, interventions to manage impulsivity and to develop cognitive and behavioural controls, are also implemented. By contrast, treatment for the approach-explicit pathway may not typically require these latter interventions, as these individuals demonstrate intact self-regulation with respect to offending.

It is noted that this provides only a brief overview of treatment methods tailored to offence pathway. For detailed information and recommendations for implementation, the reader is referred to Ward et al. (2006). It is noted, however, that because the SRM-R is an offence process model, individuals with multiple different offences (e.g., offences against both children and adults) may have followed different pathways to offending for different offences. It is, therefore, important that assessment and treatment include evaluation of offences with differing motivations and dynamics, and be tailored accordingly. As described above, although it is expected that individuals' self-regulation capacity will be somewhat stable across multiple life areas, there may be some differences across different types of offences. For example, some sexual offenders (e.g., incest offenders) may demonstrate intact self-regulation in such life areas marital relationships and employment, but demonstrate under-regulation or mis-regulation in offending. Finally, in keeping with the revised SRM-R model described above, treatment not only varies according to pathway followed, but also includes analysis and interventions pertaining to the relationship between primary and secondary goods and the offence progression, thus fully integrating the GLM and SRM-R in practice.

The last stage of treatment involves the development of a good lives plan that has the twin foci of goods promotion and risk management as described above. Unlike a traditional RP plan, the GLM/SRM-R plan specifies those activities and circumstances the individual will work to attain and not solely those that should be avoided. Although risk management is necessarily included in this plan, what is evident is that this plan is approach-based, specifying positive goals and building on strengths and aspirations, in contrast to traditional avoidance-focussed approaches.

In addition to the above, we also suggest that treatment should address some non-criminogenic needs, as these both influence the manner in which the individual engages in treatment (i.e., responsivity; Andrews & Bonta, 2003; Marshall et al., 1999) and are important to the attainment of satisfaction and well-being (Ward & Gannon, 2006; Ward et al., 2007). For example, although such "personal distress" factors as problems in areas such as self-esteem have not been found to be empirically associated with risk and recidivism (Hanson & Morton-Bourgon, 2005), the integrated GLM/SRM-R model stresses establishing a strong therapeutic alliance and attention to process or therapy factors that are likely to increase engagement with treatment and to lead to successful outcomes (Marshall et al., 1999; Ward & Maruna, 2007; Yates, 2003).

Lastly, the final phase in the integrated GLM/SRM-R model, following assessment and treatment, includes maintenance, follow-up, and supervision. Consistent

with established practice (e.g., McGrath, Hoke, & Vojtisek, 1998), this stage of treatment includes, as required, follow-up low intensity treatment designed to maintain treatment gains, to entrench newly developed skills and strategies, and to assist in risk management. In our model, this also includes assistance provided to the individual to implement the good lives/self-regulation plan, to evaluate progress in the implementation of the plan, and to revise the plan as required. As such, in our view, maintenance programming goes beyond traditional risk management and includes specific intervention to assist the individual to achieve psychological well-being and to attain a good life. Similarly, supervision of sexual offenders within this approach also assists in the implementation of the good lives plan in addition to risk management, and is viewed as supportive of the individual's efforts to implement the plan and to attain a good life.

Conclusions

In this paper we have presented a framework for the assessment and treatment of sexual offenders based on managing risk and promoting offender well-being. This framework uses a systematic and integrated approach to case formulation, treatment planning and implementation, as post-treatment follow-up and supervision. The framework also includes a revised model of the offence process that, we believe, overcomes problems with the previous treatment model and that recognises and incorporates both cognitive-behavioural and good lives elements as these are implicated in offending. At the heart of our model are three assumptions: (1) that offenders generally seek to live better lives and require internal and external resources (skills, opportunities, etc,) to achieve this; (2) that offenders are heterogeneous with respect to motivations, dynamics, and pathways to offending; and (3) that sexual offender treatment is an integrated process involving comprehensive assessment and targeted treatment and supervision that goes beyond risk management. The ability to achieve valued goals crucially depends on the possession of capabilities and an environment in which individuals are valued for their own sake alongside exhibiting concern for the well-being of others. A feature of strength-based perspectives such as the GLM/SRM-R is that there is an explicit recognition of these facts and a determination to ensure therapy is positive in nature, capitalising on individuals' existing interests and strengths in the attempt to help them to experience better lives that are incompatible with offending.

References

Andrews, D.A. & Bonta, J. (2003). *The Psychology of Criminal Conduct* (3rd ed.). Cincinnati, OH: Anderson.

Andrews, D.A., Zinger, I., Hoge, R.D., Bonta, J., Gendreau, P. & Cullen, F.T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology, 28*, 369-404.

Bickley, J.A., & Beech, A.R. (2002). An empirical investigation of the Ward & Hudson self-regulation model of the sexual offence process with child abusers. *Journal of Interpersonal Violence*, *17*, 371-393.

Bickley, J.A., & Beech, A.R. (2003). Implications for treatment of sexual offenders of the Ward and Hudson model of relapse. *Sexual Abuse: A Journal of Research and Treatment, 15(2),* 121-134.

Cox, M., Klinger, E. & Blount, J.P. (1991). Alcohol use and goal hierarchies: Systematic motivational counselling for alcoholics. In W.R. Miller & S. Rollnick (Eds.), *Motivational interviewing: Preparing people to change addictive behavior* (pp.260-271).New York: Guilford.

Dowden, C. & Andrews, D.A. (1999a). What works in young offender treatment: a meta-analysis. *Forum on Corrections Research, 11*, 21-24.

Dowden, C. & Andrews, D.A. (1999b). What works for female offenders: a meta-analytic review. *Crime and Delinquency, 45*, 438-452.

Dowden, C. & Andrews, D.A. (2000). Effective correctional treatment and violent reoffending: A meta-analysis. *Canadian Journal of Criminology and Criminal Justice, 42*, 449-467.

Dowden, C. & Andrews, D.A. (2003). Does family intervention work for delinquents? Results of a meta-analysis. *Canadian Journal of Criminology and Criminal Justice, 45*, 327-342.

Dowden, C. & Andrews, D.A. (2004). The importance of staff practice in delivering effective correctional treatment: A meta-analytic review of core correctional practice. *International Journal of Offender Therapy and Comparative Criminology, 48*, 203-214.

Emmons, R.A. (1996). Striving and feeling: Personal goals and subjective well-being. In P.M. Gollwitzer & J.A. Bargh (Eds.). *The Psychology of Action: Linking Cognition and Motivation to Behavior* (pp.313-337). New York: Guilford.

Emmons, R. A. (1999). The psychology of ultimate concerns. New York, NY: Guilford Press.

Hanson, R.K. (2006, September). *What Works: The Principles of Effective Interventions with Offenders*. Presented at the 25th Annual Convention of the Association for the Treatment of Sexual Abusers, Chicago, Ill.

Hanson, R.K., Gordon, A., Harris, A.J.R., Marques, J.K., Murphy, W., Quinsey, V.L., & Seto, M.C.

(2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14,* 169-194.

Hanson, R.K., Harris, A.J.R., Scott, T., & Helmus, L. (2007). *Assessing the Risk of Sexual Offenders on Community Supervision: The Dynamic Supervision Project*. User Report No.2007-05.Ottawa: Public Safety Canada.

Hanson, R.K., & Morton-Bourgon (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73*, 1154-1163.

Hanson, R.K., & Yates, P.M. (2004). Sexual violence: Risk factors and treatment. In M. Eliasson (Ed.), *Anthology on Interventions Against Violent Men* (pp.151-166). Acta Universitatis Upsaliensis, Uppsalla Women's Studies B: Women in the Humanities: 3. Uppsala, Sweden: Uppsala Universitet.

Laws, D.R. (1989). *Relapse Prevention with Sex Offenders*. New York: Guilford.

Laws, D.R. (2003). The rise and fall of relapse prevention. *Australian Psychologist, 38(1),* 22-30.

Laws, D.R., & Ward, T. (2006). When one size doesn't fit all: The reformulation of relapse prevention. In W.L. Marshall, Y.M. Fernandez, L.E. Marshall, & G.A. Serran (Eds.), *Sexual Offender Treatment: Controversial Issues* (pp.241-254). New Jersey, NY: John Wiley & Sons.

Lösel, F. & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology*, *1*, 117-146.

Mann, R.E. (2000).Managing resistance and rebellion in relapse prevention intervention. In D.R. Laws, S.M. Hudson, & T. Ward (Eds.), *Remaking Relapse Prevention with Sex Offenders: A Sourcebook* (pp.197-200). Thousand Oaks, CA: Sage.

Mann, R.E., Webster, S.D., Schofield, C., & Marshall, W.L. (2004). Approach versus avoidance goals in relapse prevention with sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 16,* 65-75.

Marlatt, G.A. (1982). Relapse prevention: A self-control program for the treatment of addictive behaviours. In R.B. Stuart (Ed.), *Adherence, Compliance and Generalization in Behavioural Medicine* (pp.329-378). New York: Brunner/Mazel.

Marlatt, G.A. (1985).Relapse prevention: Theoretical rationale and overview of the model. In G.A. Marlatt & J.R. Gordon (Eds.), *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive* Behaviors (pp.3-70). New York, NY: Gilford Press.

Marlatt, G.A., & Gordon, J.R. (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviours.* New York: Guilford.

Marshall, W.L. (1996). Assessment, treatment and theorizing about sex offenders: Developments during the past twenty years and future directions. *Criminal Justice and Behavior*, *23*, 162-199.

Marshall, W.L., Anderson, D., & Fernandez, Y.M. (1999). *Cognitive Behavioral Treatment of Sexual offenders.* Chichester, UK: Wiley.

McGrath, R.J., Hoke, S.E., & Vojtisek, J.E. (1998). Cognitive-behavioral treatment of sex offenders. *Criminal Justice and Behavior*, *25*, 203-225.

Nussbaum, M. C. (2000). *Women and human development: The capabilities approach.* New York, USA: Cambridge University Press.

Pavlov, I.P. (1927). *Conditioned Reflexes*. (Translated by G.V. Aurep). London: Oxford.

Pithers, W.D. (1990). Relapse prevention with sexual aggressors: A method for maintaining therapeutic gain and enhancing external supervision. In W.L. Marshall, D.R. Laws, & H.E. Barbaree (Eds.), *Handbook of Sexual Assault* (pp.343-361). New York, NY: Plenum Publishing.

Pithers, W.D., Kashima, K.M., Cumming, G.F., & Beal, L.S. (1988). Relapse prevention: A method of enhancing maintenance of change in sex offenders. In A.C. Salter (Ed.), *Treating Child Sex Offenders and Victims: A Practical Guide* (pp.131-170). Newbury Park, CA: Sage.

Pithers, W.D., Marques, J.K., Gibat, C.C., & Marlatt, G.A. (1983). Relapse prevention: A self-control model of treatment and maintenance of change for sexual aggressives. In J. Greer & I. Stuart (Eds.), *The Sexual Aggressor* (pp.214-239). New York, NY: Van Nostrand Reinhold.

Purvis, M. (2005). *Good Lives plans and sexual offending: A preliminary study*. Unpublished doctoral dissertation, University of Melbourne, Australia.

Skinner, B.F. (1938). *The Behavior of Organisms*. New York, NY: Appleton-Century-Crofts.

Ward, T.. & Beech, T. (2006). An integrated theory of sexual offending. *Aggression and Violent Behavior, 11,* 44-63.

Ward, T., Bickley, J., Webster, S.D., Fisher, D., Beech, A., & Eldridge, H. (2004). *The Self-regulation Model of the Offence and Relapse Process: A Manual: Volume I: Assessment*. Victoria, BC: Pacific Psychological Assessment Corporation. Available at www.pacific-psych.com.

Ward, T. & Gannon, T. (2006). Rehabilitation, etiology, and self-regulation: The Good Lives Model of sexual offender treatment. *Aggression and Violent Behavior, 11,* 77-94.

Ward, T., Gannon, T., & Mann, R. (2007). The good lives model of offender rehabilitation: Clinical implications. *Aggression and Violent Behavior, 12,* 87-107.

Ward, T., & Hudson, S.M. (1998). The construction and development of theory in the sexual offending

area: A metatheoretical framework. *Sexual Abuse: A Journal of Research and Treatment, 10,* 47-63.

Ward, T. & Keenan, T. (1999). Child molesters' implicit theories. *Journal of Interpersonal Violence*, *14*, 821-838.

Ward, T., Louden, K., Hudson, S.M., & Marshall, W.L. (1995). A descriptive model of the offence chain for child molesters. *Journal of Interpersonal Violence, 10,* 452-472.

Ward, T., & Mann, R. (2004). Good lives and the rehabilitation of offenders: A positive approach to treatment. In P.A. Linley & S. Joseph (Eds.), *Positive psychology in practice* (pp.598-616). New Jersey, NY: Wiley.

Ward, T. & Maruna, S. (2007). *Rehabilitation: Beyond the risk paradigm.* London, UK: Routledge.

Ward, T., Melser, J., & Yates, P.M. (2007). Reconstructing the risk need responsivity model: A theoretical elaboration and evaluation. *Aggression and Violent Behavior*, *12*, 208-228.

Ward, T. & Stewart, C. (2003). Criminogenic needs and human needs: A theoretical model. *Psychology, Crime & Law, 9*, 125-143.

Ward, T., Yates, P.M., & Long, C.A. (2006). *The Self-Regulation Model of the Offence and Relapse Process, Volume II: Treatment.* Victoria, BC: Pacific Psychological Assessment Corporation. Available at www.pacific-psych.com.

Webster, S.D. (2005). Pathways to sexual offense recidivism following treatment: An examination of the Ward and Hudson self-regulation model of relapse. *Journal of Interpersonal Violence*, *20*, 1175-1196.

Wilson, R.J. & Yates, P.M. (2007, submitted). Effective interventions and the good lives model. *Aggression and Violent Behavior*.

Woolfolk, R. L. (1998). *The cure of souls: Science, values, and psychotherapy.* San Francisco, CA: Jossey-Bass.

Yates, P.M. (2002). What works: Effective intervention with sex offenders. In H.E. Allen (Ed.), *What Works: Risk Reduction: Interventions for Special Needs Offenders*. Lanham, MD: American Correctional Association.

Yates, P.M. (2003). Treatment of adult sexual offenders: A therapeutic cognitive-behavioral model of intervention. *Journal of Child Sexual Abuse*, *12*, 195-232.

Yates, P.M. (2005). Pathways to the treatment of sexual offenders: Rethinking intervention. *Forum, Summer*. Beaverton OR: Association for the Treatment of Sexual Abusers, 1-9.

Yates, P.M. (2007). Taking the leap: Abandoning relapse prevention and applying the self-regulation model to the treatment of sexual offenders. In D. Prescott (Ed.), *Applying Knowledge to Practice: The Treatment and Supervision of Sexual Abusers*, Oklahoma City, OK: Wood and Barnes.

Yates, P.M. & Kingston, D.A. (2005). Pathways to sexual offending. In B.K. Schwartz & H.R. Cellini (Eds.), *The Sex Offender (Volume V)*, Kingston, NJ: Civic Research Institute, 3: 1-15.

Yates, P.M. & Kingston, D.A. (2006). Pathways to sexual offending: Relationship to static and dynamic risk among treated sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, *18*, 259-270.

Yates, P.M., Kingston, D.A., & Hall, K (2003). *Pathways to Sexual Offending: Validity of Hudson and Ward's (1998) Self-Regulation Model and Relationship to Static and Dynamic Risk Among Treated High Risk Sexual Offenders*. Presented at the 22nd Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers (ATSA). St. Louis, Missouri: October 2003.

Yates, P.M., Kingston, D.A., & Ward, T. (in press). *The Self-Regulation Model of the Offence and Re-offence Process: A Workbook for the Assessment and Treatment of Sexual Offenders.* Victoria, BC: Pacific Psychological Assessment Corporation. Available at www.pacific-psych.com.

Yates, P.M. & Ward, T. (2007). Treatment of sexual offenders: Relapse prevention and beyond**.** In K. Witkiewitz and G.A. Marlatt (Eds.), *Therapists' Guide to Evidence-Based Relapse Prevention* (pp.215-234). Burlington, MA: Elsevier Press.

Sexual Abuse in Australia and New Zealand, July 2008; 1(1): 20-27

Building a Golden Bridge for Resistant Sexual Offenders

Peter Toman
Owenia House, South Australia

Katherine Hawkins
Rehabilitation Programs Branch, Department of Correctional Services, South Australia

Abstract

One of the key difficulties in engaging sexual offenders in treatment is responding to denial and resistance. Prevailing methods for treating resistance in these clients involve assessing treatment readiness and utilising motivational interviewing techniques. This paper discusses an ethical therapeutic style for use with resistant offenders drawn from Fisher and Ury's (1992) Principled Negotiation and Ury's (1991) work on negotiating with difficult clients. It provides a framework and techniques to enhance the working relationship by negotiating a path through resistance with the client. 'Principled negotiation' aims to separate the client from the problem, allowing the working relationship to focus on the problem, not the client. This 'problem' of resistance is further analysed through identifying mutual interests, options for mutual gain and using objective criteria for problem-solving. This practice is not intended to replace motivational interviewing techniques but rather allow for the development of a goal-focused working relationship as a precursor and adjunct to therapy for these clients.

Introduction

One of the initial difficulties in engaging sexual offenders in treatment is responding to denial and minimisation. Clients are often mandated to attend treatment programs due to court or parole orders, or feel 'coerced' by family, the Police or lawyers. Subsequently they are often hesitant to take on responsibility and/or deny they have a 'problem'. Indeed, it remains unclear as to what factors would motivate an offender to enter treatment (Moulden & Marshall, 2005). If not managed correctly, these issues can result in distrust or open hostility to the therapist and the program. Clinicians often interpret denial and minimisation of responsibility as 'resistance' to treatment which may result in preclusion from treatment or confrontation within treatment (Day, Bryan, Davey, & Casey, 2006).

Poor motivation for treatment has also been associated with increased program drop out (Miller & Rollnick, 1991). More recently, research has indicated that drop out is likely to be associated with increases in recidivism (Howells & Day, in press, b). Categorical (or absolute) denial, by itself, has not been shown to be associated with the likelihood of re-offending nor prevent treatment gains (Marshall, Thornton, Marshall, Fernandez, & Mann, 2001). Therefore, clients who deny their offence or minimise it are still capable of gaining from the treatment process. When clinicians aim to address 'resistance' for treatment they may however, be addressing similar factors underlying risk of recidivism.

Practically, it has been suggested that 'treatment readiness' ought to replace 'resistance' as a measured characteristic of potential program participants (Day et al, 2006). Resistance as a term insinuates internal causation for low motivation and neglects the importance of external factors (Howells & Day, in press, b). Client's level of risk and criminogenic needs have received good attention within the criminal justice system, however some argue that the responsivity principle has been somewhat neglected (Howells & Day, in press, b). Readiness for treatment is specifically defined as a state of motivation, ability to respond, find the program meaningful and a capacity to enter such a program (Day et al, 2006). Research has used the Trans-Theoretical Model to explain how behaviour change can occur in this way (Prochaska, Diclemente & Norcross, 1992).

So instead of treating 'resistance', clinicians might focus on techniques aimed at increasing readiness. This would involve enhancing motivation and an analysis and support of the client's responsivity issues, personal goals and setting characteristics. This process can aim to understand where a client is at, metaphorically sitting beside them, and together 'building a golden bridge' toward treatment engagement. Ury (1991) quotes Sun Tzu as saying 'Build your opponent a golden bridge to retreat across' (page 105). Sun Tzu said, 'When you surround an army, leave an outlet free. Do not press a desperate foe too hard.' (as cited in Giles, 1994, ch. 7:36). The way out for the client is the Golden Bridge. This is the critical idea; to leave the client somewhere to go, for that place to be congruent with their goals and ours and for them to be able to see value in that move, rather than as a capitulation. This is the Golden Bridge into treatment.

Correspondence: Peter Toman, Owenia House, PO Box 2554, Kent Town, South Australia, 5071, Australia. Email: toman.peter@saugov.sa.gov.au

ISSN 0833-8488

Trans-Theoretical Model of Change

The Trans-Theoretical Model of behaviour change (TTM) aims to explain how decision-making occurs. Regarding engaging clients in treatment, this process details the stages of change, processes of change, and decisional balance necessary for increasing treatment readiness.

The Stages of Change Model postulates that individuals travel within a cycle of decision making (Prochaska, Diclemente & Norcross, 1992). A person may travel many times through his cycle before they reach a concrete decision and/or act upon it. The stages are specifically defined as 'pre-contemplation', 'contemplation', 'preparation', 'action', and 'maintenance' and the model is well documented.

If maintaining change is successful the person goes through a 'Termination' stage in which there is no further need to prevent relapse. If unsuccessful, and a person has a 'Relapse' stage, they then have a choice as to where on the cycle to return. A person is almost expected to go through relapse, and cycle throughout stages several times before long-term change is achieved (Casey, Day & Howells, 2005). Of course 'termination' is unlikely to ever occur for sexual offenders given the need for ongoing and lifelong monitoring of risk factors. According to the TTM, shifts might occur between the stages as a result of involvement in a treatment program or personal motivation (Prochaska, DiClemente & Norcross, 1992).

The second aspect of the TTM model, the 'Processes of Change', aids the movement between the stages of change. 'Consciousness Raising', 'Dramatic Relief' and 'Environmental Re-evaluation' are three such processes of change said to aid movement from pre-contemplation to contemplation. Consciousness Raising involves attaining increased information about the self and the problem. Dramatic Relief entails experiencing and expressing feelings about the problem. Environmental Re-evaluation is understanding the effects on others and the environment of one's behaviours. The process of Self-re-evaluation is suggested to likewise aid the shift from the contemplation to action stage through the analysis of the feelings and thoughts of the self with regards to the problem.

The TTM has been shown to apply to a range of addictive and problem behaviours (Day et al, 2006). There is also empirical support for applying this model to the offender context. For example, for violent offenders, stages of change measures may correctly identify those participants more likely to make positive change in treatment (Williamson, Day, Howells, Bubner, & Jauncey, 2003). Those offenders identified as in the earlier stages of change have been shown to have poorer performance in anger-management programs than those in latter stages of change (Howells & Day, 2002, as cited in Day et al, 2006). Wong and Gordon (2006) suggest that the Violence Risk Scale (VRS), is predicted on, among other things, the TTM.

The importance of matching treatment with the stage a client is at cannot be underestimated (Prochaska, DiClemente & Norcross, 1992). In terms of recruiting for treatment, a TTM perspective might suggest that 'contemplators' and 'actioners' would be the best candidates. These are the people who are giving the process of change the most thought and are therefore most likely to be engaged. However, various techniques have been put forward to increase the likelihood that people at these stages, or even at pre-contemplation, might move toward and maintain specific change. Furthermore, through this model treatment targets may be matched to the processes required to guide a client from one stage to the next (Casey, Day & Howells, 2005) although there is not consistent evidence supporting this, in particular within the sex offender population.

Regarding sex offenders, it has been suggested that the TTM can be applied well to treatment program delivery (Casey et al, 2005). Specifically, sex offender treatment programs often guide clients through topics associated with early process of change targets. For example, by providing information about cognitive distortions and victim impact the 'experiential' processes of change (in particular Consciousness Raising and Environmental Re-evaluation) are achieved, thereby aiding a shift from pre-contemplation to contemplation (Tierney & McCabe, 2005). Later treatment targets might include behavioural processes of change, such as relapse prevention. Some program providers support the notion of avoiding discussion or challenge of the offence altogether for categorical deniers in the early stages (Marshall et al, 2001). Instead, the goal of treatment becomes one of identifying behaviours, attitudes and/or feelings which are problematic and putting them in a position of increased likelihood for allegations of sexual offending to be made against them.

However, criticisms of the TTM include the difficulty in identifying a person's particular stage of change and, therefore, the relevant treatment approach (Casey, Day & Howells, 2005). In addition, there is limited research to support the existence of such stages, or the efficacy of matched treatment for them. This leads to greater importance for ascertaining *why* the offender is unwilling to enter treatment (Tierney & McCabe, 2005). For those entering treatment, responsivity factors are one method of tailoring treatment to the individual. Furthermore, through the identification of responsivity factors, the TTM may aid in an understanding of the processes required for a client to make change.

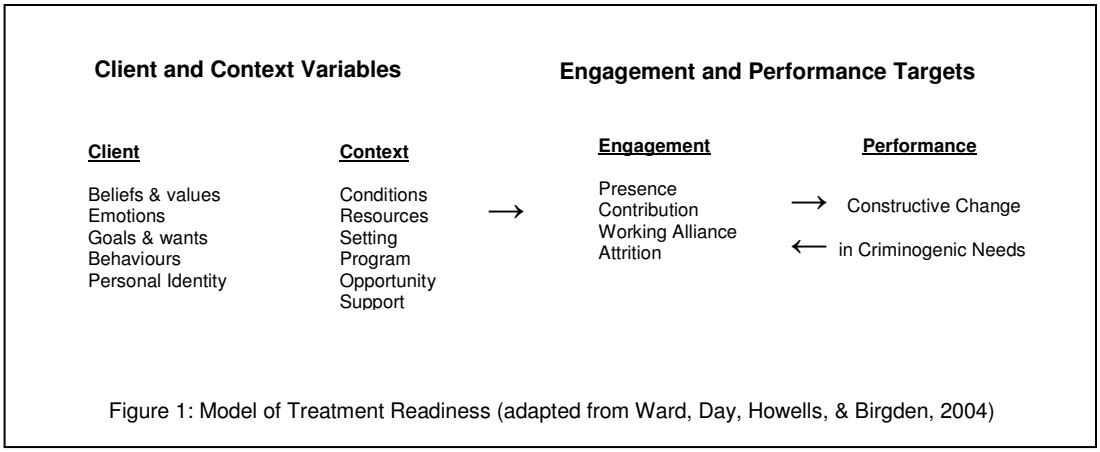

Figure 1: Model of Treatment Readiness (adapted from Ward, Day, Howells, & Birgden, 2004)

Treatment Readiness

Recent research on treatment readiness has suggested that many motivational and responsivity factors contribute to the level of treatment engagement (Ward, Day, Howells, & Birgden, 2004). The Multifactor Offender Readiness Model (MORM, Ward et al, 2004) argues against the utility of seeing clients as 'resistant' in early stages of assessment or treatment. Instead, the therapist makes an assessment of all factors which might increase readiness for treatment. Specifically, internal factors and external factors are of relevance to readiness in this model as seen in Figure 1.

Using this model, clients who are not 'ready' for involvement in treatment require appropriate targeting of relevant readiness factors. For example, if the readiness factors posing a block to treatment are cultural identity factors, modification of the program delivery may be possible. External factors, such as time remaining on sentence, might require the client to do the program within the community as opposed to within the prison setting. This model has particular relevance to treatment groups where readiness is likely to be low, such as personality disordered offenders (Howells & Day, in press, b) or sexual offenders.

Options for Therapists

The aims of initial client involvement are therefore to increase readiness for engagement in treatment. According to the processes of change, a shift between pre-contemplation and contemplation might be aided through gaining information about the self, the problem, and the effect this has on others. This knowledge may, however, produce feelings of distress and shame for sexual offenders.

Research indicates that distress may increase the likelihood of initial treatment engagement but is not associated with longer-term gains (Howells & Day, in press, a). The difference between guilt and shame relates to this aspect of initial treatment openness for sexual offenders. Where guilt has a focus on the act, shame reflects a focus on the self (Howells & Day, in press, a). Shame is associated with decreases in self-efficacy, adaptive coping strategies, and victim empathy as well as increases in personal distress, cognitive distortions, and externalisation of blame (Proeve & Howells, 2002). Hiding away in personal distress also correlates with suspiciousness, resentment and anger (Proeve & Howells, 2002), which are attitudes unsupportive of treatment engagement. Contrastingly, guilt often leads to increased victim insight, self-efficacy and the development of adaptive coping strategies. In this way, shame can be seen to be associated with risk factors for offending and guilt for protective factors. Therefore, one early treatment target becomes a focus away from the self and onto the behaviour.

"Very few people, sex offenders included, voluntarily change their behaviour, attitudes and beliefs, unless they see it is to their advantage, and probably no one enters treatment without hope the resultant changes will benefit them" (Marshall, Eccles & Barbaree, 1993, as cited in Tierney & McCabe, 2005). A client would be unlikely to devote energy to a goal that they perceive would never be realised. Moreover, offenders will reject treatment without knowing the content due to a belief that it is personally irrelevant (Langevin, 2006). As mentioned earlier, even with categorical deniers, the program may be relevant in terms of helping them to learn ways to avoid future 'allegation' which might result in behaviour change and consequent decreased risk.

Previous research indicates that at least 25% of the variance in treatment outcome is attributable to the influence of process variables (Marshall & Serran, 2004). Specifically, the therapeutic alliance and clinician's skills and authenticity have been found to be important in engaging 'resistant' clients (Howells & Day, in press, a). When a client is mandated to attend for treatment or feels coerced to attend, a more flexible approach, including allowing time to discuss emotions

Table 1: Positional Bargaining versus Principled Negotiation adapted from Fisher & Ury (1991)

POSITIONAL BARGAINING		PRINCIPLED NEGOTIATION
Soft Bargaining	**Hard Bargaining**	**Negotiate On The Merits**
Friends	Adversaries	
The goal is to agree	The goal is to win	
Make concessions	Demand concessions	**Separate the people from the problem**
Trust.	Distrust	**Focus on interests, not positions**
Be soft	Be hard	**Invent options for mutual gain**
Change your position	Dig in to your position	**Insist on using objective criteria**
Make offers	Make threats	
Disclose	Mislead	
Accept one-sided losses	Demand one-sided gains	

and the client's perspective on their situation, might be required.

Furthermore, trust in the therapist has been seen as crucial for generating change in clients. The more a client is treated with respect, the more likely they will increase in self-confidence and likewise discuss their offending past feelings of shame and distress (Tierney & McCabe, 2005). Interest in the offender's perspective, gently outlining discrepancies between their story and official records, and personal impact of their offending have been suggested as methods of aiding a shift for sex offenders from Pre-contemplation to Contemplation (Tierney & McCabe, 2005). Facilitating hope in the client regarding the treatment process allows for goals, pathways thinking and 'agentic thinking', which is defined as the belief in one's capability to achieve goals (Moulden & Marshall, 2005). Extrinsic incentives (such as parole threats) may be useful for earlier stages of change but for longer-term behaviour change the incentives must be internal (Tierney & McCabe, 2005).

A client who anticipates a negative professional opinion, particularly if primed for this by previous negative experience (e.g. through the courts or childhood mental health involvement) will anticipate rejection and limit disclosure. Particularly after a period of incarceration there comes a belief that they have served their time and it should be over for them. Strong challenges in this time frame with resistant clients are likely to increase denial and decrease efficacy of the working relationship. Moreover, harsh confrontational techniques have been negatively correlated with indices of change (Marshall & Serran, 2004).

Motivational Interviewing

'Motivational interviewing' is one technique commonly utilised to increase readiness for treatment. It is aimed to provide increased "problem awareness and self-efficacy by providing personal feedback to the client about the nature of their problems" (Day et al, 2006, p. 8). Through a range of methods the clinician aims to decrease resistance and ambivalence and promote sustained change through expressing empathy, developing discrepancy, avoiding argumentation, and supporting self-efficacy (Miller & Rollnick, 1991).

Miller and Rollnick (1991) further assert that resistance is a problem usually relating to the therapist as opposed to the client. They suggest that the therapist may be required to alter his or her style to 'roll with resistance' and describe various strategies for this. Motivational interviewing for resistance includes an emphasis on personal choice, reframing and the 'therapeutic paradox'. A client is encouraged toward self-motivational statements through paradox when the therapist might suggest 'Maybe you really should continue drinking, maybe it would be too hard for you to quit after all these years' although this clearly

involves a degree of clinical risk. Part of this process involves an avoidance of using labels or attempting to force the person to 'admit' they have a problem. Motivational interviewing with sex offenders might aim to produce cognitive dissonance to such a point where attitude and behaviour change are seen as a method of reducing such dissonance (Tierney & McCabe, 2005).

Principled Negotiation

Principled negotiation aims to enable two parties to negotiate for an outcome. Traditionally, workplace agreements were arrived at using a 'positional bargaining' technique. Fisher and Ury (1992) suggest that positional bargaining involves each party deciding on their position and defending it fiercely. Neither wants to give an inch and risk losing face but the more they stick to their position, the harder it becomes to change that position. Eventually a compromise is made but with a number of deeper concessions made along the way.

There are a number of problems associated with this form of bargaining as seen in Table 1 (Fisher and Ury, 1992). Many clinicians might utilise a confrontational 'bargaining' style with 'resistant' clients, whereas an opportunity for 'negotiation' exists where both the client and the therapist can achieve certain personal goals. If, for instance, categorical denial is grounds for preclusion, then we are in difficulty from the beginning. However, if we move away from such a position and look at what our underlying goal is and examine with the client what he/she would like to achieve in treatment we may be able to progress beyond this apparent brick wall to mutually agreed treatment targets.

Principled negotiation is an alternative to bargaining which offers a process of identifying factors relevant to a potential client and which may improve treatment readiness. Principled negotiation involves, by its very nature, a partnership or 'working alliance' with the client. Through this process of negotiation and a focus on interests, the decisional balance required for movement through the processes of change is facilitated.

Ury (1991) argued that, while there will be times when everything will fail, most individuals can be engaged. He further states that there are five barriers to cooperation in any negotiation: Your Reaction, Their Emotion, Their Position, Their Dissatisfaction, and Their Power.

To engage clients in therapy, these barriers need to be removed and a 'Golden Bridge', a metaphorical link, can provide an alternative to the resistant position and into therapy and engagement. An individual can be taken through a series of discussions about his own best interests and how they might be best served. The clinician may focus on the 'why' of resistance and aid the client to develop their own process of change toward treatment engagement. For a resistant client who is in denial, the goal is to engage him in treatment and move past barriers such as his denial of his offence and his perceived inability to engage in sex offender treatment.

The initial stages of a discussion with such a client might be around what he would be prepared to do to change his behaviour so that people do not make allegations about his future behaviour around children. These treatment targets are likely to be similar to those of a person presenting with acknowledgement of their offending such as drug and alcohol misuse or poor emotion management.

It is our own feelings that the client may be 'getting away' with not taking responsibility for his offending that are uncomfortable (Your Reaction). Rather, we can focus on the issue of getting him involved in treatment. Almost certainly a client will not wish to be precluded from treatment since this is likely to have a negative effect on his freedom or parole. We need to find a way for him to engage in treatment and for him not to lose face (Their Position). The goal becomes one of helping the client find his way (Their Power) to enter treatment and change his behaviour such that he avoids people making allegations against him in the future. They remain in power of their opposition to treatment (Their Dissatisfaction) and their future.

If we use too much of our own power, we destroy all the good work already done. Not enough power can be seen as weak and ineffective and discounted. It is possible to use our power to educate the client such that he becomes aware, without threats, that while we will move and change the focus, he is required to engage with us. The consequences for non engagement are unavoidable and it should be clear that while we do not want those, we too have parameters within which we can work. So, not only are we using our power to educate but we are moving toward the client to do so, and therefore sitting 'beside' him.

When developing these ideas, both of the authors had the experience within the same week of clients moving from denial of responsibility (blaming others) into acknowledgement of their offending and self-guided treatment planning. Both of these instances occurred after a couple of sessions of working through the options and talking about our understandings of the consequences for the client in a calm considerate manner. One client in fact interrupted to say that they had decided to acknowledge their offending since their reasons for not acknowledging it were no longer present.

Ury (1991) suggested that the ultimate goal is one of *joint* problem solving, that there are *barriers* to cooperation and that *breakthrough* negotiation is the solution. Therefore, the method is seen as a three stage

process: what is the goal, what are the barriers and what is the strategy to deal with these?

Initial Stages

In the initial stages the way to solve a problem jointly is to solve it *with* the client. A resistant client can be very challenging for a clinician with the goal for the clinician becoming to reframe negative attributions of the clients. One perspective on this is to see the individual as a person who is genuinely struggling to deal with the negative issues around his offending. The need to be positive about this cannot be undervalued, to genuinely give credit for this and accord 'unconditional positive regard' (Rogers, 1961).

The client is also likely to be angry. By the time a client attends for treatment, they may have had negative experiences from a range of sources including the police, courts, those close to him, and potentially by other offenders in prison. If a client sees their treatment provider as a part of that punishment then, for treatment to be successful, that attribution needs to change. Treating a client with genuine respect, honesty, and without judgement will most likely begin to challenge those beliefs in a non-threatening manner.

In fact, to metaphorically 'sit beside' or work with the client to help find a way out of the dilemma of resistance becomes the key approach. The client may not believe that he has a problem, or if he does, then he may not be prepared to talk about it. Ideally, the aim of the initial process is, therefore, to engage the client not only in being there, but in being there enthusiastically; or if not enthusiastically, then at least willingly and with an open mind as to what might happen. Similarly, Marshall (2005) reportedly aims for his clients to request to enter group treatment and created a 'preparatory group' for this purpose.

Alan Jenkins (1990) pointed out that the therapist must be open to the possibility that there is no truth in the allegations and/or convictions that have been made against the client. If we see this as a genuine possibility then the strategy of confrontation becomes even more problematic. Even if this is not the case, Jenkins (1990) points out that confrontation invites the client to "behave more irresponsibly" (page 124) than otherwise and is likely to escalate the denial rather than minimise it. It is in fact absolutely counter-productive. Therefore the *truth* about the offence is less of a focus than the treatment targets which may include emotions, relationships, and responsibility for choice.

Separating People and Issues

Fisher and Ury's (1992) first principle aims to separate the client from their issues. As mentioned previously, sex offenders are often deeply invested in denial. They have an investment not in the issue, but in demonstrating that the issue doesn't exist; that they do not need to be in treatment. Any challenge to this thinking may be seen as a personal attack. To separate these individuals from their problems gives room to address the issues and at the same time build a relationship with the person.

Fisher and Ury (1992) suggest that in order to attain this separation clinicians need to be able to deal with perception, emotion and communication difficulties. There is a need to ensure that the false perceptions that the client brings with him about treatment are disconfirmed. Secondly there is a need to recognise and address the emotional involvement that the client has in this issue; there may be a wide range of emotions such as anger, shame and frustration. Lastly, there is a need to listen so that the client becomes aware that he is heard, not just his problem. These three methods all aim to see the client as an individual and to focus on developing a working relationship with the individual's perceptions, emotions and communicating style, before the issues or problems can be addressed.

Focus on Interests

Focussing on interests is in contrast to focusing on positions (problems). Traditional positional bargaining was often attractive because it allowed for a matter to be decided quickly and with a seemingly equitable outcome. However, when the relationship between the bargaining parties is long term, as in treatment, one side or the other always has lost ground to recoup. It sets up a situation where one person is a winner and one a loser. Each are fighting for their 'position' and are often unprepared to make concessions or hear the other 'side's' perspective. This is the clinician who tells the client that if they don't go into treatment, they'll be sent to jail, with little time given to discuss potential reservations about entering treatment first.

The alternative then is to focus on interests. What are the interests of the client, what are the clinician's interests, and why are they both there? While it is unrealistic to expect this to be a simple process, there are likely to be some common interests shared. Regardless of their level of denial or resistance, clients are likely to want to get through treatment as quickly as possible and avoid re-incarceration! They are likely to want to be treated respectfully. These are the interests that can be focussed on. The client is also likely to enjoy the opportunity to tell what their interests might be. Once a range of such interests has been identified, discussion of these interests creates a focus on the future goals associated with them.

Generate Options

When a discussion regarding interests begins, the primary goal or interest may take precedence. Fisher

and Ury (1992) warned against deciding on key points of discussion prematurely and recommended considering alternatives. Clients may be intent on one option or one idea or content to be 'fixed' or 'told what to do'. However, it is not useful for clients to see treatment providers as the source of all knowledge, as the answer, but rather that options of moving forward may be jointly generated. In fact, this process of generating options can be an empowering one for clients and further facilitates rapport building whilst developing their individual processes of change. The question for program facilitators is whether there is time available within prescriptive programs and/or the pre-treatment assessment for this process to occur.

Use Objective Criteria

When interests diverge, or seem to be directly opposed, 'objective criteria' may be used to settle differences. There are three key methods to finding objective criteria. Firstly, the client will respond better if they have some input into these criteria for problem solving: 'What do you think would be a fair way to go here?' might produce a more favourable response than 'What do you think the courts would say?' Although either could produce useable objective criteria for a settlement. Secondly, both the clinician and the client may need to jointly consider the costs and benefits of particular interests to attain a truly objective point of view. Thirdly, negotiation does not imply that one should yield to pressure or manipulation.

The act of principled negotiation involves entering into a working relationship where both parties are encouraged to put aside notions of power and argumentation, and aim to decide on mutually beneficial interests which can be attained through a particular course of action. Of course, in this instance the goal of this process is assisting the client to see treatment as an appealing course of action.

Power to Educate

Clients see professionals in a position of power. The temptation may be to use that power to coerce a client to engage in treatment. However, Ury (1991) suggests that the power can alternatively be used to educate. The consequences of choosing not to engage in treatment are real. In effect clinicians can educate in this way from a position of power. Clients learn where they stand and what the consequences are for them. If they don't engage, the process finishes for the professional. However, the client bears the ongoing consequences.

The invitation is for assistance in dealing with a problem. Clinicians offer the opportunity to figure out ways of helping clients meet their needs and interests. When asked "How can I help you through treatment?" one client who had been an inconsistent attendee answered "Well I guess the real question is how can I help myself?" and he developed practical methods for aiding his attendance and engagement. We are in effect, helping them to build a 'golden bridge' into engagement. Importantly, when we construct this bridge with them, we deal with their own sense of disempowerment. The choices are real, and while it seems like a forced choice, it is indeed a genuine choice.

Using the techniques of principled negotiation for this clientele aims to make the 'difficult connection' (Blanchard, 1995) possible. This is a connection where judgement must be withheld in the face of resistance and denial. What is discussed here is not a revolutionary technique for therapy. It is a way to work with clients, particularly those who are not deemed 'treatment ready', in a principled and focussed manner. Through the development of their own processes of change clients effectively build their own bridges toward problem solving alongside the clinician. The clients are enabled as co-problem solvers who can be allowed to express their interests and goals for the future and encouraged to reclaim some power of their own.

References

Blanchard. G.T. (1995). The Difficult Connection: The Therapeutic Relationship in Sex Offender Treatment. The Safer Society Press.

Casey, S., Day, A. & Howells, K. (2005). The application of the Transtheoretical model to offender populations: Some critical issues. Legal and Criminological Psychology, 10, 157- 171.

Day, A., Bryan, J., Davey, L., & Casey, S. (2006). Processes of change in offender rehabilitation. Psychology, Crime and Law, 12 (6).

Fisher, R., Ury, W. and Patton, B. (Ed.) (1992). Getting to yes: Negotiating an agreement without giving in (Second Edition). Random House, London.

Howells, K. & Day, A. (2007). Readiness for treatment in high risk offenders with personality disorders. Psychology, Crime and Law, 13(1), 47-57: Special Issue: High risk offenders with personality disorders: Conceptual and scientific bases.

Howells, K. & Day, A. (2006). Affective determinants of treatment engagement in violent offenders, International Journal of Offender Rehabilitation and Comparative Criminology, 50, 174-186.

Jenkins, A. (1990). Invitations to Responsibility. The therapeutic engagement of men who are violent and abusive. Dulwich Centre Publications, Adelaide.

Langevin, R. (2006). Acceptance and completion of treatment among sex offenders. International Journal of Offender Therapy and Comparative Criminology, 50 (4), 402- 417.

Looman, J., Abracen, J., Serin, R., Marquis, P. (2005). Psychopathy, treatment change, and recidivism in high-risk, high-need sexual offenders. Journal of Interpersonal Violence, 20 (5), 549- 568.

Mann, R.E. (2004). Innovations in sex offender treatment. Journal of Sexual Aggression, 10 (2), 141-152.

Marshall, W. L. & Marshall, L. E. (2005). Workshop, Adelaide, South Australia.Marshall, W.L. & Serran, G.A. (2004). The role of the therapist in offender treatment. Psychology, Crime & Law, 10 (3), 309-320.

Marshall, W.L., Thornton, D., Marshall, L.E., Fernandez, Y.M., & Mann, R. (2001). Treatment of sexual offenders who are in categorical denial: A pilot project. Sexual Abuse: A Journal of Research and Treatment, 13 (3), 205- 215.

Miller, W.R. & Rollnick, S. (1991). Motivational Interviewing: preparing people to change addictive behaviour. The Guilford Press, New York.

Moulden, H.M. & Marshall, W.L. (2005). Hope in the treatment of sexual offenders: The potential application of hope theory. Psychology, Crime & Law, 11 (3), 329- 342.

Prochaska, J.O., Diclemente, C.C. & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviours. American Psychologist, 47 (9), 1102-1114.

Proeve, M. & Howells, K. (2002). Shame and guilt in child sexual offenders. International Journal of Offender Therapy and Comparative Criminology, 46 (6), 657- 667.

Rogers. C.R. (1961). *On becoming a person.* Boston: Houghton Mifflin.

Sunzi 6th Cent B.C. Sun Tzu on The Art of War (Giles L, Trans).The Project Gutenberg Etext of The Art of War by Sun Tzu. May 1994 Etext #132.

Tierney, D. W. & McCabe, M.P. (2005). The utility of the trans-theoretical model of behaviour change in the treatment of sex offenders. Sexual Abuse: A Journal of Research and Treatment, 17 (2), 153- 170.

Ury, W. (1991). Getting past no: Negotiating with difficult people. Random House, London.

Wakeling, H.C., Webster, S.D. & Mann, R.E. (2005). Sexual offenders' treatment experience: a qualitative and quantitative investigation. Journal of Sexual Aggression, 11 (2), 171- 186.

Ward, T., Day, A., Howells, K., & Birgden, A. (2004). The multifactor offender readiness model. Aggression and Violent Behavior, 9, 645-673.

Williamson, P., Day, A., Howells, K., Bubner, S. & Jauncey, S. (2003). Assessing offender motivation to address problems with anger. Psychology, Crime and Law, 9(4), 295-307.

Wong, S.C.P., & Gordon, A. (2006). The Validity and Reliability of the Violence Risk Scale: A Treatment Friendly Violence Risk-Assessment Tool. Psychology, Public Policy and Law, 12(3), 279-309.

Sexual Abuse in Australia and New Zealand, July 2008; 1(1): 28-37

Criterion and Predictive Validity of the Static-99 for Adult Males Convicted of Sexual Offences Against Children

Stephen Smallbone
School of Criminology and Criminal Justice, Griffith University, Australia

Richard Wortley
School of Criminology and Criminal Justice, Griffith University, Australia

Abstract

Official demographic and offence history data and confidential self-report data obtained from adult males convicted of sexual offences against children were used to produce actuarial recidivism risk prediction (Static-99) scores, four sexual deviance and general criminological predictor variables, and four (official and unofficial) offence-related outcome variables. Static-99 scores applicable at the time of the current sexual offence conviction (n = 172) predicted sexual and nonsexual offending outcomes. Regression models were improved with the addition of sexual deviance and criminological predictors not included in the Static-99. Static-99 scores applicable at the time of the first sexual offence conviction for known recidivist sexual offenders (n = 40) predicted official nonsexual offence convictions and self-reported number of sexual offence victims, but not official sexual offence convictions or self-reported total period of sexual offending. Again, regression models were improved with the addition of other sexual deviance and criminological predictors. Results provide partial support for criterion and predictive validity of the Static-99. Applied risk assessments may benefit from consideration of key self-report and official data not included in the Static-99.

Introduction

As public concern about sexual crime continues to grow, psychologists are increasingly being called upon to assess the risk of further offending by known sexual offenders. While risk assessment has broad potential application, estimations of the risk of recidivism are particularly important for the courts when considering sentencing options, and for parole boards when considering offenders' release from custody.

The Static-99 (Hanson & Thornton, 1999) is one of the most widely used actuarial sexual offender risk prediction instruments. Administration of the Static-99 has the advantage of quickness and ease over other risk instruments used with sexual offenders (e.g., the Sex Offender Risk Appraisal Guide: Quinsey, Lalumiere, Rice, & Harris, 1995), and can be applied to a broader range of sexual offender subtypes than other instruments (e.g., the Minnesota Sex Offender Screening Tool – Revised: Epperson, Kaul, & Hesselton, 1998). The accuracy of the Static-99 in predicting both sexual and nonsexual recidivism outcomes among sexual offenders has been shown to be comparable to these other more complex and/or more restrictive instruments (Barbaree, Seto, Langton, & Peacock, 2001).

Thus far, studies of the predictive validity of the Static-99, as with other sexual offender risk prediction instruments, have been largely restricted to questions concerning dichotomous outcomes – that is, whether or not recidivism has been observed to occur. Leaving aside the serious problem of the large number of false positive and false negative predictions produced by existing risk prediction instruments (including the Static-99) in applied settings there are of course other compelling questions concerning the validity of such instruments. These include questions concerning the relative *extent* of re-offending, such as the number of further offences, the number of future victims, and the period over which further offending occurs. It is of considerable practical significance, for example, that some recidivist sexual offenders may commit one further sexual offence within, say, five years, while others may proceed to commit numerous sexual and nonsexual offences over that time.

A further practical problem is that, as risk assessments in applied settings become increasingly routine, so too will practitioners increasingly be called upon to assess sexual offenders at the point of their first sexual offence conviction. While historical factors, including details about previous sexual offending, are commonly relied upon in actuarial risk assessment instruments, practitioners will increasingly be faced with the challenge of estimating recidivism risk when there is no known sexual offence history. There is therefore a need to identify and validate predictors relevant to 'first-time' sexual offenders.

Hanson and Bussiere's (1998) meta-analysis of sexual offender recidivism studies provided a much-needed empirical basis for the development of actuarial

This study was funded by research grants from the Queensland Crime Commission and the Australian Criminology Research Council. The assistance and support of the Queensland Department of Corrective Services is gratefully acknowledged.

Correspondence: Stephen Smallbone, School of Criminology and Criminal Justice, Mt Gravatt Campus, Griffith University, Queensland, 4111, Australia. Email: s.smallbone@griffith.edu.au

ISSN 1833-8488

sexual offender risk prediction instruments, including the Static-99. Some 70 variables were identified in their meta-analysis as potential predictors of sexual recidivism, although no single predictor accounted for more than 10% of the variance in sexual recidivism. The task of discovering the best combinations of predictor variables is clearly important. However, it is also important to be reminded that the retrospective, empirically-driven approach to most sexual offender recidivism research is itself subject to important constraints. Chief among these, in our view, is the absence of testing of theoretically-derived predictor variables. Instead, sexual offender recidivism research has tended to rely on archival data, the main inclusion criteria for which may simply be its availability rather than its theoretical significance. Apart from the difficulty this creates in explaining observed associations between predictor and criterion variables, there may well be important predictors that were not relevant to the purposes of the original data collection and were therefore unavailable for meta-analysis.

Nevertheless, Hanson and Bussiere's (1998) empirical observation that different sets of factors were predictive of sexual and nonsexual recidivism in sexual offenders raises important theoretical questions about the nature of sexual crime, and may provide a coherent theoretical basis for testing recidivism prediction models. Specifically, they observed that 'sexual deviance' factors (e.g., deviant sexual preferences) best predicted sexual recidivism, whereas general criminological factors (e.g., history of delinquency) best predicted nonsexual recidivism among sexual offenders. Individual differences in sexual and nonsexual offending patterns among sexual offenders may therefore be explained on the basis of the relative contributions of sexual deviance and criminological risk factors. Thus, while there is a need to extend the evaluation of risk prediction instruments beyond dichotomous recidivism outcomes, there is also both a theoretical and a practical need to continue the search for other predictors of recidivism among sexual offenders, especially those with no known sexual offending history.

Finally, given the considerable heterogeneity among sexual offenders in terms of individual characteristics and offending patterns, and given that most sexual offender recidivism research has been based on mixed offender populations, there is a need to validate risk prediction models specifically for their application to more homogenous subtypes of sexual offenders. It is possible, for example, that certain risk factors are concentrated within particular subtypes, and that these may go undiscovered in heterogonous samples. With arguably the greatest level of public policy attention, especially with increasing police attention, being given to sexual offences against children in some jurisdictions, there may be a special need for research activity to inform applied risk assessments of men convicted of sexual offences against children.

The present study aimed to address a number of questions raised from the preceding discussion. First, we aimed to test the criterion validity of the Static-99 in terms of associations between Static-99 scores and four offence-related criteria, namely the number of sexual offence convictions, the number of nonsexual offence convictions, the number of sexual offence victims, and the total period of sexual offending, among men convicted of sexual offences against children. Further, we aimed to examine whether prediction models would be improved with the addition of sexual deviance and/or criminological predictors not included in the Static-99. More specifically, we hypothesised that sexual deviance predictors (early onset of sexual contact with children; multiple paraphilic interests) would improve regression models for predicting sexual offending outcomes, and that general criminological predictors (age at first conviction; first conviction was for a nonsexual offence) would improve models for predicting nonsexual offending outcomes.

Second, we aimed to test predictive validity of the Static-99 specifically for those offenders in our sample who were known to have at least one previous sexual offence conviction. Using the four offending outcome criteria described above, we again examined whether prediction models would be improved with the addition of sexual deviance and/or criminological predictors. We also expected that for this subgroup of sexual recidivists, sexual deviance predictors would improve regression models for predicting sexual offending outcomes, and that general criminological predictors would improve models for predicting nonsexual offending outcomes.

Method

Participants

Three hundred and sixty two adult males serving sentences in Queensland, Australia, for sexual offences against children were approached individually and invited to participate in a study of offender characteristics and modus operandi. Official demographic and offence history data were obtained on all 362 prospective participants. Of these, 221 (61%) agreed to anonymously complete a 386 item self-report questionnaire designed to elicit wide-ranging data on personal characteristics, psychosocial and psychosexual histories, pornography and Internet use, paraphilic interests, offender networking, and modus operandi. Those who provided self-report data (respondents) did not differ from those who declined to do so (non-respondents) on any demographic or offence history

variable, with the exception of education level. Respondents had achieved a significantly higher level of education than had the non-respondents.

Based on their anonymous self-reports, the 221 respondents were categorised into one of four mutually exclusive groups: intrafamilial offenders (those who had offended only within family settings); extrafamilial offenders (those who had offended only outside family settings); mixed-type offenders (those who had offended both within and outside family settings); and deniers (those who denied ever having committed a child sexual offence). The self-report sample consisted of 98 intrafamilial offenders, 72 extrafamilial offenders, and 37 mixed-type offenders. Thirteen deniers of course did not provide self-report data on their offending, and so this group was excluded for the purposes of the current study.

The mean age of the total sample (n = 362) at the time of their current sexual offence conviction(s) was 41.8 years (SD = 12.10). The mean age at first conviction for any offence was 30.2 years (SD = 13.1). About half (48%) of the total sample was first convicted for a sexual offence, with the remainder (52%) first convicted for a nonsexual offence. About two thirds (64%) had at least one previous conviction recorded in their criminal histories. Of these, 35% had previous convictions for sexual offences and 92% had previous convictions for nonsexual offences.

Twenty-four respondents were re-contacted after an average two months, at which time the entire questionnaire was re-administered for the purposes of computing test-retest reliability.

Measures

Predictor Variables

The Static-99 (Hanson & Thornton, 1999) is a 10-item actuarial risk prediction instrument yielding scores ranging from 0 to 12, with higher scores indicating higher recidivism risk. Static-99 items are prior sentencing dates, prior sexual offences, any noncontact sexual offence convictions, nonsexual index and/or previous violent offence, any stranger and/or male victims, current age, and marital history. Small to moderate correlations between Static-99 scores and sexual (r = .18), "serious" (r = .28) and "any" recidivism (r = .34) have been reported (Barbaree, et al., 2001). These authors also reported strong inter-rater reliability for the Static-99, and moderate to strong correlations between Static-99 scores and other risk instruments, including the Sex Offender Risk Appraisal Guide (Quinsey, et al., 1998), and the Psychopathy Checklist - Revised (Hare, 1991).

Due to the format of available data, two modifications to the scoring rules for the Static-99 were made. First, data on the number of prior sentencing dates were unavailable (number of previous convictions, but not number of sentencing dates, were recorded), and so this item was excluded, resulting in a reduction in the range of possible scores from 0-12 to 0-11. Second, the item "ever lived with a lover for at least two years" was modified. We allocated a score of 0 if the participant was either married, defacto, divorced, separated or widowed, and a score of 1 if he had "never been married (or defacto etc)".

Two independent raters (graduate students) used coding rules described by Hanson and Thornton (2000) (modified as described above) to independently allocate Static-99 scores to 20% of cases for which all required data were available. After an initial discrepancy concerning whether "dangerous or negligent acts" constituted a nonsexual violent offence was resolved (in the affirmative), near perfect agreement was reached (r = .99). The mean Static-99 score (n = 172) was 2.44 (SD = 2.15). For the sexual recidivist sub-sample (n = 40), the mean Static-99 score applicable at the time of their first sexual offence conviction was 2.33 (SD = 1.25).

Two sexual deviance predictor variables were used – early onset, and multiple paraphilic interests. Early onset was operationalised as the self-reported age at first sexual contact with a child. Twenty-two offenders (11%) reported that their first sexual contact with a child occurred prior to age 18 years. However, six of these were excluded from further analysis because the victim was reported to have been less than three years younger than themselves. After excluding these cases, the mean self-reported onset age was 31.3 years (SD = 11.9). Test-retest reliability for this item was $\underline{r}$ = .73.

Using plain-language definitions based on DSM-IV-R criteria (APA, 1994), a series of 11 questions was developed asking whether the offender had ever experienced "intense, sexually arousing fantasies, urges, or behaviour" concerning exhibitionism; fetishism; public masturbation; frotteurism; sexual masochism; sexual sadism, transvestic fetishism; voyeurism; telephone scatologia; necrophilia; and zoophilia. Of the eleven individual paraphilic interests, zoophilia and necrophilia were discarded from further analysis because too few offenders acknowledged any interest in these. The result was a 9-item multiple paraphilic interests scale. The internal consistency of the scale proved to be adequate (Cronbach's alpha = .74), although test-retest reliability was at best moderate (r = .40). The distribution of multiple paraphilic interest scores was markedly positively skewed, and log transformation of these data was therefore used for subsequent regression analyses.

General criminological predictors were the age at first conviction for any offence, and whether the first conviction was for a sexual or nonsexual offence. Both variables were based on official criminal history data. The latter was coded as a dichotomous variable (sexual

= 0; nonsexual = 1) and treated as a continuous variable for the purposes of subsequent regression analyses.

Criterion Variables

Four offending outcome variables (two based on official data; two based on self-report data) were used. First, official sexual offending was operationalised as the average yearly number of sexual offence convictions accrued as an adult. Official sexual offending indices were calculated by adding all current and past sexual offence convictions and dividing by the period of opportunity (the period between the 17th birthday and the age at current conviction). This procedure was repeated to calculate official nonsexual offending indices. For the total sample (n = 362), the mean yearly number of sexual offence convictions was 0.47 (SD = 0.65), and the mean yearly number of nonsexual offence convictions was 0.44 (SD = 1.25).

The two self-report outcome variables were the average yearly number of sexual offence victims (M = 0.2; SD = 0.38) and the total period of sexual offending activity (the period between the age at self-reported first and last sexual contact with a child; M = 5.0 years; SD = 8.70). Test-retest reliability for total number of sexual offence victims was r = .72, and for the age at last sexual contact with a child r = .96 (test-retest reliability for age at first sexual contact with a child was r = .73). Log transformation of both self-report outcome variables was employed to correct positive skew.

Procedure

All 362 offenders were approached individually and invited to participate. They were told that their participation would not benefit them with regard to their current sentence and nor would they be penalised should they choose not to participate. Prospective participants were asked to sign a consent form, and were provided with an information sheet which emphasised that while information could be provided anonymously, participants could provide their names to be contacted at a later date for follow-up contact. Prospective participants were assured that self-report information would be kept confidential, and in particular that no identifying information would be revealed outside the research team. The entire questionnaire was re-administered to a sub-sample of 24 for the purposes of calculating test-retest reliability. The average test-retest period was approximately 2 months.

Results

Criterion Validity

The first aim of the study was to examine associations between Static-99 scores applicable at the time of the current sexual offence conviction and four offending outcome variables, and to test whether the addition of sexual deviance and general criminological predictors not included in the Static-99 would improve prediction models. Four hierarchical multiple regression analyses were computed, the results of which are summarised in Tables 1 to 4. Predictor variables were entered as blocks: Static-99 scores (block 1); sexual deviance predictors (block 2); and criminological predictors (block 3). Some moderate correlations were found among both the predictor variables and the criterion variables. The strongest correlations among predictor variables were between Static-99 scores and onset age, r = -.42, p < .001, and between Static-99 scores and age at first conviction for any offence, r = -.33, p < .001. The strongest correlations among criterion variables were between the number of sexual offence convictions and number of sexual offence victims, r = .45, p < .001, and between the number of victims and total period of offending, r = .40, p < .001. The strength or these correlations is well below acceptable limits for collinearity (Tabachnick, Fidell, & Osterlind, 2001). Participant numbers in the following analyses vary according to availability of complete data sets.

Table 1 shows that Static-99 scores accounted for a significant proportion (33%) of the variance in the average yearly number of sexual offence convictions. Consistent with our expectations, sexual deviance predictors, but not general criminological predictors, accounted for a significant additional proportion of the variance, F (2, 161) = 4.02, p = .02. Examination of univariate predictors shows that the Static-99 scores were the strongest predictor of sexual offence conviction outcomes, t = 3.45, p < .01. Although the criminological predictors did not add to the prediction of official sexual offence convictions, the first conviction being for a sexual offence was a significant univariate predictor, t = -2.09, p = .04.

Static-99 scores also accounted for a significant proportion (12%) of the variance in the average yearly number of nonsexual offence convictions (see Table 2). In this case, both sexual deviance and general criminological predictors strengthened the prediction model. Static-99 scores, t = 2.61, p = .01, multiple paraphilic interests, t = 2.40, p = .02, and the first conviction being for a nonsexual offence, t = 2.41, p = .02, all contributed unique variance.

Table 3 shows the predictions for the self-reported number of sexual offence victims. Once again, Static-99 scores explained a significant proportion (34%) of the variance in this outcome. As expected, sexual deviance predictors, but not general criminological predictors, strengthened the prediction. An impressive 50% of the variance was accounted for by the Static-99 scores together with the two additional sexual deviance predictors, with both early onset, t = - 4.89, p < .001,

Table 1. Summary of Results of an Hierarchical Multiple Regression of Static-99 Scores, Sexual Deviance and Criminological Predictors, on Average Yearly Number of Sexual Offence Convictions (n = 165)

Predictors	R^2	F	F (change)	Beta	t
Static-99	.33	19.56***		.280	3.45**
Sexual deviance predictors					
Early onset				-.149	-1.70
Paraphilic interests	.39	9.44***	4.02*	-.049	-0.67
Criminological predictors					
Age at first conviction				-.121	-1.34
First conviction nonsexual	.42	6.65***	2.24	-.182	-2.09*

p < .05; ** p < .01; *** p < .001

Table 2. Summary of Results of an Hierarchical Multiple Regression of Static-99 Scores, Sexual Deviance and Criminological Predictors, on Average Yearly Number of Nonsexual Offence Convictions (n = 168)

Predictors	R^2	F	F (change)	Beta	t
Static-99	.12	22.77***		.203	2.61**
Sexual deviance predictors					
Early onset				-.113	-1.33
Paraphilic interests	.16	10.67***	4.18*	.169	2.40*
Criminological predictors					
Age at first conviction				-.114	-1.32
First conviction nonsexual	.23	9.71***	7.08**	.199	2.41*

* p < .05; ** p < .01; *** p < .001

Table 3. Summary of Results of an Hierarchical Multiple Regression of Static-99 Scores, Sexual Deviance and Criminological Predictors, on Average Yearly Number of Sexual Offence Victims (n = 165)

Predictors	R^2	F	F (change)	Beta	t
Static-99	.34	85.56***		.422	6.71**
Sexual deviance predictors					
Early onset				-.327	-4.89***
Paraphilic interests	.50	53.87***	25.28***	.157	2.77**
Criminological predictors					
Age at first conviction				-.106	-1.55
First conviction nonsexual	.51	33.16***	1.56	-.096	-1.47

* p < .05; ** p < .01; *** p < .001

Table 4. Summary of Results of an Hierarchical Multiple Regression of Static-99 Scores, Sexual Deviance and Criminological Predictors, on Total Period of Sexual Offending (n = 172)

Predictors	R^2	F	F (change)	Beta	t
Static-99	.15	29.83***		.289	4.09***
Sexual deviance predictors					
Early onset				-.470	-6.13***
Paraphilic interests	.27	20.69***	13.87***	.054	0.85
Criminological predictors					
Age at first conviction				.327	4.21***
First conviction nonsexual				.013	0.18
	.36	18.28***	10.96***		

* p < .05; ** p < .01; *** p < .001

and multiple paraphilic interests, t = 2.77, p = .01, contributing unique variance.

Table 4 summarises the regression on self-reported total period of offending. Once again, Static-99 scores accounted for a significant proportion (15%) of the variance. For this regression equation, both sexual deviance and criminological predictors added to the strength of prediction, with 36% of the variance accounted for by the combined model. Early sexual contact with a child, t = - 6.13, p < .001, was the strongest univariate predictor, followed by the age at first conviction for any offence, t = 4.21, p < .001, and Static-99 scores, t = 4.10, p < .001. Interestingly, the *older* the offender was when he was first convicted for any offence, the *longer* the total period of sexual offending.

Predictive Validity

The second aim of the study was to test predictive validity of the Static-99 specifically for a sub-sample of known recidivist sexual offenders. These were all those offenders in the sample who had at least one previous conviction for a sexual offence and for whom all required data were available. Forty five offenders (20.5% of the self-report sample) had at least one previous sexual offence conviction. Of these, 40 (89%) had first been convicted of a sexual offence, and 5 (11%) had first been convicted of a nonsexual offence. By the age of 24, more than half (24) had been convicted of their first sexual offence. All required data were not available for five cases, resulting in a sample size of 40.

The mean number of official sexual offence convictions ranged from 3 to 51 (M = 16.2; SD = 12.1), and the mean number of nonsexual offence convictions ranged from 0 to 225 (M = 14.1; SD = 40.1). The mean self-reported total period of sexual offending activity for the sexual recidivist subsample was 13.8 years (SD = 11.6). Using data applicable at the time of their first sexual offence conviction, Static-99 scores ranged from 0 to 5 (M = 2.33; SD = 1.26). As would be expected, a strong correlation (r = .79) was obtained between Static-99 scores at the point of first conviction and at the point of the current conviction.

The available sample size for the sexual recidivist sub-sample unfortunately fell well short of recommendations for computing multiple regression analyses (see e.g., Tabachnick, Fidell, & Osterlind, 2001). Nevertheless, we decided to proceed on an exploratory basis and to take special care in interpreting significant findings. Four multiple regression analyses were computed for study 2, using the same stepwise procedure as that outlined above. Results are summarised in Tables 5 to 8. The reader is advised to keep in mind that substantial uncontrolled error variance may be contained in the following results.

Static-99 scores did not predict average yearly sexual offence convictions for the sexual recidivists. As Table 5 shows, the only significant univariate predictor of sexual offence convictions was self-reported age at first sexual contact with a child, t = - 2.28, p = .03. Specifically, the earlier the initial sexual contact with a child, the more sexual offence convictions over time.

The regression on average yearly nonsexual offence convictions is summarised in Table 6. Static-99 scores accounted for 13% of the variance in nonsexual offence convictions, F (1,38) = 5.54, p = .02. Criminological predictors markedly improved the prediction, with 35% of variance accounted for by the combined model. Age at first conviction for any offence was the only significant univariate predictor, t = - 2.39, p = .02.

Table 5. Summary of Results of an Hierarchical Multiple Regression of Static-99 Scores, Sexual Deviance and Criminological Predictors, on Average Yearly Number of Sexual Offence Convictions for Sexual Recidivists (n = 40)

Predictors	R^2	F	F (change)	Beta	t
Static-99	.00	0.01		-.052	-0.31
Sexual deviance predictors					
Early onset				-.415	-2.28*
Paraphilic interests	.20	2.95*	4.41*	-.185	-1.13
Criminological predictors					
Age at first conviction				.037	0.22
First conviction nonsexual	.24	2.13	0.92	-.199	-1.28

* p < .05; ** p < .01; *** p < .001

Table 6. Summary of Results of an Hierarchical Multiple Regression of Static-99 Scores, Sexual Deviance and Criminological Predictors, on Average Yearly Number of Nonsexual Offence Convictions for Sexual Recidivists (n = 40)

Predictors	R^2	F	F (change)	Beta	t
Static-99	.13	5.54*		.194	1.23
Sexual deviance predictors					
Early onset				-.007	-0.04
Paraphilic interests	.19	2.78	1.35	.240	1.58
Criminological predictors					
Age at first conviction				-.379	-2.39*
First conviction nonsexual	.35	3.58**	4.07*	.157	1.09

* p < .05; ** p < .01; *** p < .001

Table 7. Summary of Results of an Hierarchical Multiple Regression of Static-99 Scores, Sexual Deviance and Criminological Predictors, on Average Yearly Number of Sexual Offence Victims for Sexual Recidivists (n = 40)

Predictors	R^2	F	F (change)	Beta	t
Static-99	.12	5.16*		.168	1.07
Sexual deviance predictors					
Early onset				-.602	-3.68**
Paraphilic interests	.40	7.71***	8.01**	-.073	0.49
Criminological predictors					
Age at first conviction				.074	0.48
First conviction nonsexual	.40	4.45*	0.13	.037	0.27

* p < .05; ** p < .01; *** p < .001

Table 8. Summary of Results of an Hierarchical Multiple Regression of Static-99 Scores, Sexual Deviance and Criminological Predictors, on Total Period of Sexual Offending for Sexual Recidivists (n = 40)

Predictors	R^2	F	F (change)	Beta	t
Static-99	.08	3.10		.031	0.23
Sexual deviance predictors					
Early onset				-.684	-4.88***
Paraphilic interests	.37	7.05**	8.41**	.218	1.73
Criminological predictors					
Age at first conviction				.440	3.35**
First conviction nonsexual	.55	8.28***	6.75**	-.103	-0.86

* p < .05; ** p < .01; *** p < .001

Although the Static-99 scores did not predict official sexual offending outcomes, they did predict 12% of the variance in self-reported number of sexual offence victims, F (1,37) = 5.16, p = .03 (see Table 7). The prediction was strengthened considerably, however, with the addition of the two sexual deviance predictors, F (2.35) = 8.01, p = .001. Once again, self-reported age at first sexual contact with a child was the only significant univariate predictor, t = -3.68, p = .001, rendering the Static-99 scores effectively redundant.

Finally, Static-99 scores did not predict the self-reported total period of sexual offending. In this case, both the sexual deviance and the criminological predictors improved the regression model. In all, 55% of the variance was explained by the combined model. Age at first sexual contact with a child, t = - 4.88, p < .001, and age at first conviction for any offence, t = 3.35, p = .006, were significant univariate predictors. Once again, the older the offender when they were first convicted for any offence, the longer the total period of sexual offending.

Discussion

The purpose of this study was to examine criterion and predictive validity of the Static-99 in adult males convicted of sexual offences against children. Using both official and self-report data, we aimed to examine whether the Static-99 would predict four offence-related outcomes and whether prediction models would be improved with the addition of theoretically-derived sexual deviance and criminological predictors not included in the Static-99. Given the increasing use of actuarial risk prediction instruments in applied forensic settings, we set out to consider these research questions from an applied perspective.

Taken together, our results provide partial support for criterion and predictive validity of the Static-99. For the larger sample, which included sexual recidivists as well as men serving sentences for their first sexual offence convictions (n = 172), Static-99 scores predicted average yearly sexual offence convictions, average yearly nonsexual offence convictions, self-reported average yearly number of sexual offence victims, and self-reported total period of sexual offending. In each case the addition of other sexual deviance and criminological predictors improved prediction models. By and large, our expectations that the additional sexual deviance and criminological predictors would improve models for predicting sexual and nonsexual offending criteria respectively were supported.

Hanson and Bussiere (1998) provided evidence that different factors are associated with sexual and nonsexual offending in sexual offenders, and suggested that practitioners should consider the risk of sexual and nonsexual recidivism separately when undertaking sexual offender risk assessments. While we acknowledge the importance of considering both sexual and nonsexual offending among sexual offenders, our findings were less clear-cut. We found, for example, that multiple paraphilic interests (a traditional sexual deviance construct) were associated with both sexual and nonsexual offending outcomes. The present results underscore the need suggested elsewhere (Smallbone & Wortley, 2004) for theoretical accounts of sexual offending to give more explicit attention to general criminality among sexual offenders.

The number of known sexual recidivists in our sample was unfortunately too small to be confident in the interpretation of the second series of regression analyses. Nevertheless, the preliminary indications are that the Static-99 does not do so well when applied at the time of the first sexual offence conviction. Specifically, for these known sexual recidivists, Static-99 scores applicable at the time of their first sexual offence conviction predicted average yearly number of nonsexual offence convictions and average yearly number of sexual offence victims, but did not predict

official sexual offence convictions or self-reported total period of sexual offending. Even when the Static-99 by itself predicted offence-related outcomes, the shared variance with other predictors effectively rendered the Static-99 redundant with respect to all four outcomes. The most important predictor for all three sexual offence outcomes was the age at which offenders first had sexual contact with a child. Notwithstanding the problem of obtaining reliable self-report data in applied forensic settings, this item of information may therefore be of considerable value in such settings.

The most important predictor of nonsexual offending outcomes for the sexual recidivists was the age at first conviction for any offence. However, the circumstances of the first official conviction differed in terms of sexual and nonsexual offending outcomes. A conviction at a relatively early stage appears to be predictive of nonsexual recidivism (and by extension, criminal versatility), whereas being first convicted at a later age was associated with longer periods of sexual offending activity. The finding with respect to early first convictions is consistent with established knowledge that involvement in general crime tends to peak in adolescence and young adulthood and to decline steadily thereafter (Elliot, 1994), and is therefore uncontroversial - the risk of becoming involved in the criminal justice system increases universally during adolescence and early adulthood.

But why would later first convictions be associated with longer periods of sexual offending? One possibility is that late convictions represent a deterrence failure. Sexual offenders who offend for years before being officially brought to account may become more confident over time that their offending will go undetected. Interestingly, however, late first convictions were not associated with the number of self-reported victims, suggesting that the 'failed deterrence' hypothesis may apply more to intermittent than to chronic offenders. An alternative (though not incompatible) explanation may be that those convicted relatively late are those less likely to involve themselves in general crime, and so are at much less risk of becoming involved in the criminal justice system. In any case, replication of these findings with a larger sample of sexual recidivists would be required before confidence could be placed in these interpretations.

There are a number of potential implications of the present findings for conducting applied risk assessments of men convicted of sexual offences against children. First, our results suggest that the Static-99 may be a useful indicator of the real extent of sexual and nonsexual offending activity. While the Static-99 does not account directly for the full extent of previous offending, our results show that the combination of factors included in the Static-99 relates to continuous measures of both sexual and nonsexual offending, including unofficial accounts. This supports the criterion validity of the Static-99. Second, obtaining official data not required by the Static-99, namely the age of the offender at the time of their first conviction for any offence, and whether that first conviction was for a sexual or nonsexual offence, may improve risk assessment. The present results may provide some tentative basis to proceed toward formally incorporating these data in applied risk assessments. Third, obtaining self-report data, and particularly the age at first sexual contact with a child, may be especially informative, especially with respect to the risk of sexual recidivism.

Finally, and unfortunately, our results suggest that the Static-99 may not by itself be particularly useful for conducting risk assessments at the point of the first sexual offence conviction. Some Static-99 items (e.g., any male or stranger victims; any noncontact offences) may of course be applicable at the point of the first sexual offence conviction - such characteristics have in any case long been known to increase recidivism risk (see e.g., Marshall & Barbaree, 1990). Over-reliance on historical data, though, is a potential weakness for all risk prediction instruments, since their use for 'first-time' offenders will necessarily be limited. All chronic offenders were once 'first-time' offenders. One of the continuing challenges, then, will be to develop risk instruments suitable for use at the point of the first sexual offence conviction.

References

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders (4th edition).* Washington DC: American Psychiatric Association.

Barbaree, H. E., Seto, M. C., Langton, C. M., & Peacock, E. J. (2001). Evaluating the predictive accuracy of six risk instruments for adult sex offenders. *Criminal Justice and Behavior, 28,* 490-521.

Epperson, D. L., Kaul, J. D., & Hesselton, D. (1998). *Final report on the development of the Minnesota Sex Offender Screening Tool – Revised.* Paper presented to the 19th Annual Conference of the Association for the Treatment of Sexual Abusers, Vancouver, Canada.

Elliot, D. S. (1994). Serious violent offenders: Onset, developmental course, and termination – The American Society of Criminology 1993 presidential address. *Criminology, 32,* 1-21.

Hanson, R. K. & Bussiere, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*, 348-362.

Hanson, R. K., & Thornton, D. (1999). *Static 99: Improving actuarial risk assessments for sex offenders.* Report 1999-02. Ottawa: Department of the Solicitor General of Canada.

Hanson, R. K., & Thornton, D. (2000). Improving risk assessments for sex offenders: A comparison of three actuarial scales. *Law and Human Behavior, 24,* 119-136.

Hare, R. D. (1991). *Manual for the revised Psychopathy Checklist.* Toronto, Canada: Multi-Health Systems.

Marshall, W. L., & Barbaree, H. E. (1990). Outcome of comprehensive cognitive-behavioral treatment programs. In W.L. Marshall, D.R. Laws, & H.E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender* (pp. 257-275). New York: Plenum.

Smallbone, S. W., & Wortley, R. K. (2004). Criminal diversity and paraphilic interests among adult males convicted of sexual offenses against children. *International Journal of Offender Therapy and Comparative Criminology, 48*, 175-188.

Tabachnick, B. G., & Fidell, L. S., & Osterlind, S. J. (2001). *Using Multivariate Statistics.* London: Allyn & Bacon.

Sexual Abuse in Australia and New Zealand, July 2008; 1(1): 38-43

Phallometric Assessment of Sexual Arousal: A Review of Validity and Diagnostic Issues

Hannah L. Merdian
The University of Waikato, New Zealand

David T. Jones
Te Piriti Special Treatment Unit, New Zealand Department of Corrections

Nicola A.C. Morphett
University of South Australia, Australia

Douglas P. Boer
The University of Waikato, New Zealand

Abstract

While phallometric assessment of sexual offenders logically follows from sexual deviance theories of offending, we conclude that the evidence for this assessment process is inconsistent. A wide variety of methodologies, poorly specified and poorly chosen, or the absence of control groups has resulted in a fragmented literature in this area. Nonetheless, recent meta-analyses continue to portray sexual deviance (usually phallometrically determined) as the best predictor of future sexual violence. Recent studies have suggested that proxy measures of such deviance may provide sufficient evidence of deviance. We suggest that only by the use of research protocols with very rigorous methodology will the validity of phallometry be determined.

Introduction

According to the sexual preference hypothesis of sexual offending (Barbaree, 1990), offenders experience greater arousal from deviant sexual behaviours than from socially acceptable behaviours and this deviant arousal is the basis for choosing to offend sexually. The easiest way to assess male sexual arousal is to interview offenders about their sexual preferences, but this method is considered unreliable due to the denial of problems by offenders, or the consequences of admitting to deviant arousal in a correctional setting (e.g., being considered to be of elevated risk). Such considerations have led to extensive research in ways to measure arousal and sexual preference which do not rely on self report.

Penile plethysmography (PPG) is the oldest and most common of these, and has arguably the greatest face validity, since it consists of nothing more than recording the amount of penile tumescence shown by a subject in response to a variety of potentially arousing sexual stimuli. While simple, this assessment method consistently enjoys empirical support, and appears to be a strong predictor of risk for future sexual offending. For these reasons, it continues to be used at two Special Treatment Units for child sex offenders operated by the New Zealand Department of Corrections. However, there has always been controversy regarding the reliability and validity of this procedure. This review is intended to briefly discuss the current status of phallometry, with particular reference to its use in New Zealand settings.

Standardisation

The measurement of erectile response is ultimately dependent on the nature and quality of the stimuli used to elicit that response. A commonly cited problem in phallometric research has been the lack of standardisation in stimulus materials (e.g., Marshall & Fernandez, 2003; Kalmus & Beech, 2005). Stimulus sets reported in the literature have included video, still photographs, audio descriptions, written text and instructions to fantasise (Kalmus & Beech, 2005). Additionally, there are substantial variations regarding content and set-up within each stimulus category. Early research found that viewing sexually explicit motion pictures generated the strongest responses (Abel, Blanchard & Barlow, 1981). These are rarely used clinically, as they tend to produce a ceiling effect by provoking maximum responding across a range of categories, and significant legal and ethical issues are created by the use of either still or motion video

Correspondence: Douglas P. Boer, Department of Psychology, University of Waikato, Private Bag 3105, Hamilton, New Zealand. Email: drdoug@waikato.ac.nz

ISSN 0833-8488

material of illegal sexual acts (Marshall & Fernandez, 2000). Nevertheless, child sex offenders and incest offenders appear to respond more strongly to projective audiotapes (e.g., Letourneau, 2000; Murphy, Haynes, Stalgatis & Flanagan, 1986; Nunes, Firestone, Bradford, Greenberg, Smith & Serran,1999). It has been suggested that this is due to some of these offenders having arousal to individual victims only, fantasies of which may be triggered by audio scenarios containing similar elements to their offending (Murphy & Barbaree, 1994). Chaplin, Rice and Harris (1995) suggested using a combination of visual and audio stimuli in order to obtain the best response pattern. This is supported by a more recent study by Golde, Strassberg, and Turner (2000) who compared audio-only and audiovisual material in a sample of 53 non-offenders. An interesting advantage of the combination is that it allows for the measurement of different aspects of sexual arousal: visual stimuli for assessment of age and gender preference, and audio material to identify activity preferences (Laws, Hanson, Osborn, & Greenbaum, 2000). The use of computer-generated digital images stimulus sets allays, to some degree, the ethical concerns associated with photographs of children, and such sets are now commercially available.
Presentation length is another important factor of the stimuli used. Murphy and Barbaree (1994) reported that most labs using circumferential measures present stimuli for two to four minutes, while volumetric assessments are usually completed in less than 30 seconds. Avery-Clark and Laws (1994) found that maximal arousal was not reached until three minutes of audio presentation.

Finally, phallometric assessments also differ regarding the types of PPG systems used, data analyses and presentation, and instructions given to subjects (Adler, 1994; Byrne, 2000; Marshall & Fernandez, 2003).

Reliability

There are two ways of assessing phallometric assessment reliability: internal consistency and test-retest reliability. Internal consistency assesses how reliably a subject responds to the members of a stimulus category, for example, child versus adult (age groups), consenting sex versus coercive sex (types of sexual activities), and male versus female (gender) (Marshall & Fernandez, 2003). The internal consistency of phallometric assessments is difficult to measure, as most assessments include only one example of each stimulus variation. As a result, most measures of internal consistency have been obtained by collapsing data across stimulus categories (Marshall & Fernandez, 2003). Fernandez and Marshall (2002b, cited in Marshall & Fernandez, 2003) assessed internal consistency (α) separately for each category in both audio and visual stimuli and estimated α to be between .87 and .95 for incest offenders and .72 to .83 for extrafamilial offenders.

With regard to test-retest reliability, most studies have been conducted over short intervals, and do not address the reliability of such assessments over the time period for which treatment is conducted. Fernandez and Marshall (2002c, cited in Marshall & Fernandez, 2003) assessed reliability over six months using 40 child molesters who received no treatment in the interval. While adequate reliability was found for adult female (r= .75) and adult male (r=.74) stimuli, reliability estimates reduced with the age of the stimulus to r = .42 and r = .49 for female and male pubescent children respectively and r = .18 and r = .47 for female and male prepubescent children. There is evidence that repeated exposure to phallometric stimuli produces habituation effects (e.g. Eccles, Marshall & Barbaree, 1988). Golde et al. (2000) found that responses to audio stimuli declined over repeated exposure, while responses to video stimuli remained stable, but these results were based on consenting adult sexual material. Eccles et al. (1988) noted that this habituation effect is primarily on maximum arousal, and that relative ratio indices appear to be more reliable.

In summary, it is difficult to draw any conclusions due to the lack of standardisation in phallometric assessment procedures and studies, the limited research available, and the conclusion that current research failed so far to provide adequate levels of reliability (Marshall & Fernandez, 2003). Nonetheless, it seems that measures of internal consistency are at least satisfactory whilst test-retest reliability has yet to be demonstrated adequately.

Validity

Two main threats to the validity of phallometric assessment have been raised; first, that sexual arousal can occur without an erectile response, and second that sexual arousal is strongly dependent on environmental cues. Hence, arousal which could occur in a natural setting may not be detectable in the laboratory (Marshall & Fernandez, 2003). There has also been some attempt to use phallometric assessment in the natural environment by requiring subjects to wear portable plethysmographs while walking about. This is obviously difficult and intrusive, and only four subjects were used. Three subjects appeared to have similar arousal patterns to those shown in laboratory settings, while one was substantially higher in the natural environment (Rea, DeBriere, Butler, & Saunders, 1998).

The main test for validity in PPG assessments is that the results should correlate with the subject's known offending patterns. This has been tested empirically through using phallometric assessments to classify offenders from non-offenders, between offender types (discriminant validity), and through postdiction, the ability to predict past offending through phallometric results (criterion validity).

Classification Studies

The assumption underlying discriminant validity is that sexual arousal profiles obtained during phallometric testing can differentiate between people with deviant sexual preferences and people without deviant preferences, and between people with different sorts of deviant preferences. Generally, phallometric results appear to distinguish offenders from non-offenders, but the results have not been entirely clear (Marshall & Fernandez, 2000). Numerous studies have found group differences between extrafamilial offenders and non-offenders, but there is substantial variation within offender types. The majority of studies have found that incestuous offenders tend to appear normal (i.e., have arousal patterns similar to non-offenders) when assessed with visual material and more deviant when assessed with audio stimuli (Marshall & Fernandez, 2000). This may be due to Murphy and Barbaree's (1994) suggestion that some child molesters offend out of a genuine sexual interest in minors while others normally prefer adult partners and use a child victim only as a substitute in unusual circumstances. Hence, auditory stimuli would allow the latter group to fantasise about their own victim without being inhibited by photographs of other children.

Postdiction

There appears to be some evidence that an offender's profile of phallometric responses correlates with his offending characteristics. Several studies have found that adult sexual offenders who offend more aggressively show higher arousal to violent stimuli (Marshall & Fernandez, 2003). This appears to be true of child sex offenders as well. Further, homicidal child offenders display higher pedophile aggression indices than do non-homicidal child offenders (Firestone, Bradford, Greenberg, & Nunes, 2000) and child sex offenders with a more deviant profile have been shown to have had more victims and to have used more force in their offenses (Barbaree & Marshall, 1989). These results would suggest that phallometric profiles have some relationship with offending patterns, but this ultimately does little more than provide support for information which is already known from other sources.

In summary, data are less than satisfactory regarding the criterion validity of phallometric assessment measures. If most sexual offenders appear to display a non-distinct arousal profile in comparison to non-offenders or non-sexual offenders, then the value of phallometric assessments might be highly questionable (Marshall & Fernandez, 2003).

Limitations

The quality of validity studies is limited by the lack of standardisation. Available studies show considerable variability in subject populations, stimulus material, modality, and presentation (Marshall & Fernandez, 2003). In addition, subject characteristics such as age, IQ, and diurnal hormonal fluctuations affect the erectile arousal profile of sexual offenders (e.g. Blanchard & Barbaree, 2005; Murphy, Haynes, Coleman, & Flanagan, 1985; Rowland, Greenleaf, Dorfman, & Davidson, 1993). Further, many studies classify large percentages of examinees as "non-responders" who showed either no arousal or arousal below a set significance threshold (Marshall & Fernandez, 2003). There is also ongoing debate in the literature about the magnitude of response required before it is considered to be significant rather than random. Some authors exclude subjects who obtain arousal of less than 20% FE (Laws & Osborn, 1983). Barbaree and Marshall use a 10% FE criterion (Marshall & Fernandez, 2003), while Quinsey's laboratory includes all subjects regardless of arousal (Harris, Rice, Quinsey, Chaplin, & Earls, 1992). Rejection levels due to lack of significant arousal changes are high, from 1% to 40% of subjects according to a survey by Howes (1995). The two New Zealand sites appear to classify approximately 34% of offenders as non-responders using their significance criteria (Jones, 2004). Such high rejection ratios may introduce selection biases into the resulting research findings.

Another important issue is that many clients – at least in a correctional setting – attempt to suppress deviant arousal or fake appropriate erectile responses (e.g., Looman & Marshall, 2005). It appears from the literature that most men can inhibit or generate an arousal response to a large degree. Not surprisingly, subjects tend to generate arousal to adult appropriate stimuli, either by fantasising or mechanical movements; however, the most commonly used technique, "pumping" (attempting to force arousal), produces a visible signature on the phallometric trace (Freund, Watson & Rienzo, 1988). To control for such behaviour, other physical functions such as Galvanic Skin Response, can be monitored (Kalmus & Beech, 2005). Suppression is another concern, and several studies have shown that both normal and offender subjects are able to inhibit arousal using mental distraction techniques (Marshall & Fernandez, 2000). The use of cognitive procedures such as signal detection or secondary tracking tasks appear to reduce

this somewhat, but the problem remains. Marshall and Fernandez (2003) commented on an unpublished study by Haynes, Yates, Nicholaichuk, Gu, and Bolton (2000), which suggested that instructing subjects to suppress arousal increased the predictive ability of their assessments. It appears that those subjects at highest risk of reoffending are those who cannot suppress their arousal, which makes intuitive sense.

Despite all the aforementioned limitations, it still appears that phallometric assessment might be useful as a means for obtaining information to guide treatment targets - but this information is generally already known. Given that phallometric assessment is expensive, time consuming and generally unpopular with clinicians in New Zealand, the continued use of these assessments may rest on whether or not the PPG provides useful information for risk assessment estimates.

Risk Assessment

Sexual deviance, whether determined by the PPG, self-report or criminal history, has long been identified as a predictor of sexual recidivism (e.g., Boer, Hart, Kropp, & Webster, 1997). In a small early study of child molesters, Quinsey, Chaplin, and Carrigan (1980) found a significant relationship between sexual recidivism and deviant sexual arousal to children at post-treatment. In a later study, Rice, Quinsey, and Harris (1991) reported a significant, albeit weak, association between sexual recidivism among child molesters and an initial assessment of sexual deviance reflecting a sexual preference for children. However, not all studies have found support for the predictive validity of phallometrically assessed sexual deviance. For instance, Serin, Mailloux, and Malcolm (2001) found no significant relationship between sexual recidivism and deviant sexual arousal in rapists and child molesters. Still, when these studies are amalgamated using meta-analysis (Hanson & Bussière, 1998; Hanson and Morton-Bourgon, 2004), phallometrically assessed sexual preferences for children were consistently found to be the strongest predictor of sexual recidivism among child sexual offenders. This was not true of rapists, and phallometrically assessed sexual preferences for rape were not found to have any predictive value. A possible explanation for this is that a sexual preference for children is deviant by definition, while sexual offenses against adults may be motivated by an 'aggravated type' of appropriate interest in adult sexual partners and hence does not substantially differ from non-offenders' interests (J. Looman, personal communication, June 27, 2007).

Recently, there has been some evidence to support a relationship between non-physiological measures of sexual deviance and sexual recidivism. For instance, Hildebrand, de Ruiter, and de Vogel (2004) reported a significant relationship between the presence of sexual deviance in rapists, as assessed by the Sexual Violence Risk-20 (SVR-20; Boer et al., 1997), and an increased risk of sexual recidivism. However, while such proxy measures of deviance appear to be of predictive value, Hildebrand et al. (2004) noted that phallometric assessment measures are usually considered preferable to non-physiological measures (e.g., interviews, file reviews of offence behaviour), given that large numbers of sexual offenders tend to minimise or deny their deviant arousal (e.g. Byrne, 2000). Similarly, victim impact statements and police reports may not adequately represent the motivations or cognitions of the offender, although the nature of sexual violence certainly would seem logically related to deviant sexual interests. Thus, it is thought that phallometric assessment may be a more objective measure of deviant sexual interest, unaffected by cognitive processes present in many sexual offenders (Hildebrand et al., 2004).

At present, the evidence suggests that phallometric assessment measures are of value in the prediction of sexual recidivism, although this seems to be more applicable for child molesters than rapists. However, due to the inherent limitations, risk assessment with the PPG should occur as one part of a comprehensive 'prediction package' (Marshall, 2006).

Where to from here?

Summing up the evidence, it appears that phallometric assessments have problematic validity and reliability issues, poor standardisation, and significant ethical concerns regarding the use of stimuli involving real children. Still, phallometry appears to be the only relatively validated way of assessing deviant sexual arousal without reference to self-report, victim/police reports, or possibly outdated behavioural history. Alternative measures, such as Viewing Time (Letourneu, 2002) or the Emotional Stroop Test (Smith & Waterman, 2004) have shown early promise, but cannot yet be said to be validated measures in terms of detecting sexual deviance. Based on the limitations and advantages of phallometric assessments, we agree with several authors (e.g., Harris & Rice, 1996; Launay, 1999; Marshall & Fernandez, 2000) who note that phallometric assessment procedures should be used cautiously and in conjunction with other measures – especially when it comes to risk assessment. In the end, it may be worth taking a step back and looking at phallometric assessment for what it really is and what it can actually measure. Many authors have called for standardised assessments with tabulated norms, but we doubt that this is really possible. There are so many possible confounding variables that one could argue that complete standardisation is an impossible goal. It is highly unlikely that one stimulus set would ever appeal

equally to every subject, and equally unlikely that every subject would respond in comparable ways. As a result, it may be that the best use of phallometry is as an aid to treatment, with assessments customised to the individual. After all, few other assessments are standardised to that extent, and most rest on the ability of a skilled examiner to conduct the assessment and interpret the results.

To compare research studies on the PPG and to draw conclusions based on a firm basis would require commitment to a rigidly standardised research protocol. Only then could the true value of phallometry be assessed and justify a substantial role for the PPG in clinical practice and risk assessment. Nonetheless, we suspect that there will never be a standardised phallometric assessment with demonstrable psychometric properties. Thus, it is likely that phallometry will continue to be a useful tool in the clinicians' arsenal for both risk assessment and treatment, but not in a standardised form.

References

Abel, G. G., Blanchard, E. B., & Barlow, D. H. (1981). Measurement of sexual arousal in several paraphilias: The effects of stimulus modality, instructional set and stimulus content on the objective. *Behaviour Research and Therapy, 19*, 25-33.

Adler, J. M. (1994). *The effect technician gender has on sexual arousal responses of male sexual offenders*. Unpublished doctoral dissertation, The University of Tennessee, Knoxville.

Barbaree, H. E. (1990). Stimulus control of sexual arousal. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds), *Handbook of sexual assault: Issues, theories, and treatment of the offender* (pp. 115-142). New York: Plenum Press.

Barbaree, H. E. & Marshall, W. L. (1989). Erectile responses amongst heterosexual child molesters, father-daughter incest offenders, and matched non-offenders: Five distinct age preference profiles. *Canadian Journal of Behavioural Science, 21*, 70-82.

Blanchard, R. & Barbaree, H. E. (2005). The strength of sexual arousal as a function of the age of the sex offender: Comparisons among pedophiles, hebephiles, and teleiophiles. *Sexual Abuse: A Journal of Research and Treatment, 17*(4), 441-456.

Boer, D. P., Hart, S. D., Kropp, P. R., & Webster, C. D. (1997). *Manual for the sexual violence risk – 20: Professional guidelines for assessing risk of sexual violence*. Vancouver, BC: Institute Against Family Violence.

Byrne, P. M. (2000). *The reliability and validity of less explicit audio and "clothed" visual PPG stimuli with child molesters and nonoffenders*. Unpublished doctoral dissertation. The University of Utah, Salt Lake City.

Chaplin, T. C., Rice, M. E., & Harris, G. T. (1995). Salient victim suffering and the sexual responses of child molesters. *Journal of Consulting and Clinical Psychology, 163*, 249-255.

Eccles, A., Marshall, W. L., & Barbaree, H. E. (1994). Differentiating rapists and non-offenders using the rape index. *Behaviour Research and Therapy, 32*(5), 359-546.

Firestone, P., Bradford, J. M., Greenberg, D. M., & Nunes, K. L. (2000). Differentiation of homicidal child molesters, nonhomicidal child molesters, and nonoffenders by phallometry. *American Journal of Psychiatry, 157*(11), 1847-1850.

Freund, K., Watson, R., & Rienzo, D. (1988). Signs of feigning in the phallometric test. *Behaviour Research and Therapy, 26*(2), 105-112.

Golde, J. A., Strassberg, D. S., & Turner, C. M. (2000). Psychophysiologic assessment of erectile responses and its suppression as a function of stimulus media and previous experience with plethysmography. *The Journal of Sex Research, 37*(1), 53-59.

Hanson, R. K. & Bussière, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology*, *66*(2), 348-362.

Hanson, R. K. & Morten-Bourgon, K. (2004). *Predictors of sexual recidivism: An updated meta-analysis*. Public Works and Government Services Canada.

Harris, G. T. & Rice, M. E. (1996). The science in phallometric measurement of male sexual interest. *Current Directions in Psychological Science*, *5*(5), 156-160.

Harris, G. T., Rice, M. E., Quinsey, V. L., Chaplin, T. C., & Earls, C. (1992). Maximizing the discriminant validity of phallometric assessment data. *Psychological Assessment, 4*, 502-511.

Hildebrand, M., de Ruiter, C., & de Vogel, V. (2004). Psychopathy and sexual deviance in treated rapists: association with sexual and nonsexual recidivism. *Sexual Abuse: A Journal of Research and Treatment*, *16*(1), 1-24.

Howes, R. J. (1995). A survey of plethysmographic assessment in North America. *Behavioral Science, 7*(1), 9-24.

Jones, D. T. (2004). *The phallometric evaluation of child sex offenders at Te Piriti Special Treatment Unit*. Presentation to the New Zealand Department of Corrections Northern Regional Forum. Napier, NZ.

Kalmus, E. & Beech, A. R. (2005). Forensic assessment of sexual interest: A review. *Aggression and Violent Behavior, 10*, 193-217.

Launay, G. (1999). The phallometric assessment of sex offenders: An update. *Criminal Behaviour and Mental Health*, *9*, 254-274.

Laws, D. R., Hanson, R. K., Osborn, C. A., & Greenbaum, P. E. (2000). Classification of child molesters by plethysmographic assessment of sexual arousal and a self-report measure of sexual preference. *Journal of Interpersonal Violence, 15*(12), 1297-1312.

Laws, D. R., and Osborn, C. A. (1983). How to build and operate a behavioral laboratory to. evaluate and treat sexual deviance. In J. G. Greer, and I. R. Stuart (Eds.): *The Sexual Aggressor* (pp. 293-335). New York: Van Nostrand.

Looman, J. & Marshall, W. L. (2005). Sexual arousal in rapists. *Criminal Justice and Behavior*, *32*(4), 367-389.

Marshall, W. L. (2006). Clinical and research limitations in the use of phallometric testing with sexual offenders. *Sexual Offender Treatment, 1*(1), 1-18.

Marshall, W. L. & Fernandez, Y. M. (2000). Phallometric testing with sexual offenders: Limits to its value. *Clinical Psychology Review*, *20*(7), 807-822.

Marshall, W. L. & Fernandez, Y. M. (2003). *Phallometric testing with sexual offenders.* Brandon: Safer Society Press.

Murphy, W. D. & Barbaree, H. E. (1994). *Assessments of sex offenders by measures of erectile response: Psychometric properties and decision making*. Brandon, VT: The Safer Society Press.

Murphy, W. D., Haynes, M. R., Coleman, E. M., & Flanagan, B. (1985). Sexual responding of "nonrapists" to aggressive sexual themes: Normative data. *Journal of Psychopathology and Behavioral Assessment, 7*, 37-47.

Murphy, W. D., Haynes, M. R., Stalgaitis, S. J., & Flanagan, B. (1986). Differential sexual responding among four groups of sexual offenders against children. *Journal of Psychopathology and Behavioral Assessment, 8*, 339-353.

Nunes, K., Firestone, P., Bradford, J. M., Greenberg, D., Smith, D., & Serran, G. (1999, September). *The relative accuracy of auditory and visual stimuli in phallometric assessment to identify extrafamilial child molesters*. Poster Presentation for the 18th Annual Research and Treatment Conference for the Association for the Treatment of Sexual Abusers, Orlando, FL.

Quinsey, V. L., Chaplin, T. C., & Carrigan, W. F. (1980). Biofeedback and signaled punishment in the modification of inappropriate sexual age preferences. *Behavior Therapy*, *11*, 567-576.

Rea, J. A., DeBriere, T., Butler, K., & Saunders, K. J. (1998). An analysis of four sexual offenders' arousal in the natural environment through the use of a portable penile plethysmograph. *Sexual Abuse: A Journal of Research and Treatment, 10*(3), 239-255.

Rice, M. E., Quinsey, V. L., & Harris, G. T. (1991). Sexual recidivism among child molesters released from a maximum security psychiatric institution. *Journal of Consulting and Clinical Psychology*, *59*(3), 381-386.

Rowland, D. L., Greenleaf, W. J., Dorfman, L. J., & Davidson, J. M. (1993). Aging and sexual function in men. *Archives of Sexual Behaviour, 22*(6), 545-557.

Serin, R. C., Mailloux, D. L., & Malcolm, P. B. (2001). Psychopathy, deviant sexual arousal, and recidivism among sexual offenders. *Journal of Interpersonal Violence*, *16*(3), 234-246.

Smith, P. & Waterman, M. (2004). Processing bias for sexual material: The emotional stroop and sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 16*(2), 163-171.

Sexual Abuse in Australia and New Zealand, July 2008; 1(1): 44-52

Short Term Reoffending by Child Victim Sex Offenders in New Zealand: A Comparison of Those With and Without Extended Supervision

Teresa Watson
Victoria University of Wellington, New Zealand

Jim Vess
Victoria University of Wellington, New Zealand

Abstract

Sexual offenders with child victims in New Zealand who are considered at high risk for reoffending are subject to an Extended Supervision Order. This allows for a period of supervision of up to ten years following release to the community. The present study examined 89 offenders given Extended Supervision Orders over the 33 month period since the legislation was enacted. All types of reoffending resulting in criminal convictions by this group were included. A matched sample of sexual offenders with child victims released prior to this legislation and a sample of offenders judged to be lower risk were compared to those under extended supervision. Offenders under extended supervision reoffended faster and at a higher rate for both sexual and general offences than those deemed lower risk, but at a lower rate than pre-extended supervision high risk offenders. The relationship between specialist treatment programme attendance and completion, actuarial risk level, and recidivism in the extended supervision sample were also investigated. These variables were found not to be significant predictors of sexual recidivism.

Introduction

There has been a proliferation of legislative initiatives in recent years aimed at protecting the public from high risk sex offenders, especially those with child victims. In 2004 seventy-three percent of all contact sexual offence convictions in New Zealand involved a victim under the age of 16-years. There were 1,219 convictions that year for contact sexual offences against a child victim (Lash, 2006). It is possible that this high percentage of offences against children corresponds to a lower rate of reporting such incidents against adult victims, but an unknown number of unreported sexual offences against child victims is also acknowledged. Low arrest and conviction rates for sexual offences have been reported internationally and in New Zealand, so that official reconviction rates are not likely to reflect the actual prevalence of sexual offending (Bass & David, 1988; Briere, 1992; McLean & Rush, 1990). However, the ongoing consequences for childhood victims of sexual offending are well documented, from increased incidence of adult depression, substance abuse and isolation from peers, to anxiety and problematic sexual behaviours (Fergusson, Lynskey, & Horwood, 1996). Linehan (1993) refers to childhood sexual abuse as "one of the most traumatic invalidating experiences" a human being can undergo (p 4). Understanding the risk factors for sexual reoffending has important implications for judicial decision making with high risk sexual offenders.

The use of actuarial measures and assessment tools designed to predict risk based on dynamic variables is not without controversy. There is an ongoing debate in the literature about the optimal use of static actuarial indices of recidivism compared to structured clinical judgement (Berlin, Galbreath, Geary, & McGlone, 2003; Dvoskin & Heilbrun, 2001; Harris & Rice, 2003). Actuarial measures have been presented by some as the only legally defensible method for sexual risk prediction (e.g. Heilbrun, Dvoskin, Hart & McNiel, 1999). It has been argued that when diluted by clinical judgement, actuarial measures are open to systematic error that places society, potential victims and the rights of the offender at risk (e.g. Campbell, 2000; Harris, 2003).

However, the exclusive use of static actuarial measures does not allow for an etiological understanding of an individual's risk for reoffending. Static historical variables have been shown in many studies to be successful in predicting risk (Stadtland et al., 2005), but used in isolation they are most useful if the outcome measure is a simple dichotomy of recidivism or no recidivism. When using purely actuarial measures of risk, the specific contingencies leading to recidivism are not identified.

Decision making about release from prison, and the level of risk posed by sexual offenders after release, has moved towards consideration of various interventions for managing risk while an offender is in the community, as opposed to simple prediction of further offences occurring or not (Abracen, et al., 2004; Simourd, 2004). Risk prediction using actuarial measures that have been shown to be reliable and valid,

Correspondence: Jim Vess, School of Psychology, PO Box 600, Victoria University of Wellington, Wellington, New Zealand. Email: jim.vess@vuw.ac.nz

ISSN 0833-8488

in combination with clinical judgement assessing dynamic risk factors applicable to individual offenders, is seen by some as the best way of informing judicial and offender management decisions (Dvoskin & Heilbrun, 2001; Roberts, Doren, & Thornton, 2002; Watson & Vess, 2007).

Using a combination model of actuarial risk and structured clinical judgment allows for greater clarity not only for the clinician, but also for judicial decision makers (Webster, Hucker and Bloom, 2002). When important decisions are made about the release of sexual offenders, or imposition of any special conditions upon release, it is no longer considered sufficient to base assessments of risk on this large, heterogeneous population. Specific information about the likelihood of reoffending for distinct subgroups of offenders is now available. Increasingly, more refined risk analysis and a more complete picture of offenders is being requested by criminal justice professionals and decision makers (Monahan, 2004).

Concern about sexual recidivism by offenders with child victims has led to the development of new legislation specifically targeted to this population in various jurisdictions in North America, the UK, and Australia (Roberts, Doren, & Thornton, 2002; Sample & Bray, 2006; Stalans, 2004; Vess, 2005). New Zealand recently introduced the Parole (Extended Supervision) Amendment Act 2004 (www.legisation.govt.nz), which allows for the supervision in the community of high risk sexual offenders with child victims for up to ten years after release from prison. When making determinations regarding extended supervision, the rights of the offender must be weighed against the rights of potential victims and potential harm to society. Some have argued that supervision of an offender after their release from prison is punishment for possible future wrongdoings. On one hand, there is currently no method of precisely predicting the future behaviour of any offender; this is seen as an ethical dilemma that society is yet to resolve (Pratt, 2001). However, assessing risk is one of the most important tasks in the criminal justice system, one which is unavoidable in judicial decision making. Actuarial risk assessment methods have consistently shown a useful level of predictive accuracy for sexual reoffending. The emerging consensus in the field seems to be that it is no longer an issue of whether risk can be predicted, but rather an issue of identifying and validating the best available methods to do so (Abracen et al., 2004; Borum, 1996; Miller, Amenta, & Conroy, 2005).

Under the Parole (Extended Supervision) Amendment Act 2004, any offender considered eligible for an Extended Supervision Order must be assessed by a clinician experienced in the field of forensic risk assessment. The clinician must provide the Court with a report that specifies an offender's risk of sexually reoffending against children under the age of 16-years once they are released from prison. The report must stipulate "the nature of any likely future sexual offending by the offender, including the age and sex of likely victims, the offender's ability to control his or her sexual impulses, the offender's predilection and proclivity for sexual offending, the offender's acceptance of responsibility and remorse for past offending, and any other relevant factors" (Parole (Extended Supervision) Amendment Act, 2004, section 107 (F) (2)). The writing of this report is informed by the use of an actuarial measure, the Automated Sexual Recidivism Scale (ASRS). The ASRS was developed by the New Zealand Department of Corrections and normed on large samples of sexual offenders released to the community for periods of up to 15 years. It has shown levels of predictive validity similar to other internationally recognized actuarial measures (Skelton, Wales, Riley, & Vess, 2006). The risk assessments for extended supervision also routinely include a measure of dynamic risk factors, the Sex Offender Need Assessment Rating, or SONAR (Hanson & Harris, 2000, 2004).

An issue in many risk assessments is whether the offender has received treatment focusing on sexual offending against children. Yet, the impact of specialist treatment programmes for sexual offenders with child victims on offenders' reoffending remains uncertain. Some research, including longitudinal studies, has concluded that treatment programmes for sexual offenders with child victims had no significant effect on reoffending rates (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005; Rice, Harris, & Quinsey, 1993); while other studies have reported that specialist focused treatment has been shown to reduce predicted future sexual reoffending of programme participants (Looman, Abracen, & Nichloaichuk, 2000; Marshall & Serran, 2000; Rice & Harris, 2003).

Two dedicated treatment units for sexual offenders with child victims operate within New Zealand prisons; Te Piriti at Auckland Prison and Kia Marama at Rolleston Prison. The treatment programmes are designed for male offenders who have one or more convictions for sexual offending against a victim under the age of 16-years. A review of the Kia Marama specialist treatment programme for sexual offenders with child victims was undertaken by Bakker, Hudson, Wales and Riley (1999). The authors found that the sexual recidivism rate of programme graduates was half that of a comparable control of sexual offenders with child victims who had never attended a specialist treatment programme (ten percent vs. 21 percent). The Te Piriti specialist treatment programme for sexual offenders with child victims adopts a bi-cultural approach and has been shown to have a significant

effect in reducing sexual reoffending for all participants regardless of their reported ethnicity (Nathan, Wilson and Hillman, 2002). In their evaluation of the programme, Nathan et. al., (2002) reported graduates had a 5.5 percent sexual recidivism rate, compared to 21 percent for a control group.

Hanson and Bussiere (1998), in their meta-analysis of sexual offending found that successful completion of treatment was linked to lower recidivism. A study of drop out rates at an adolescent residential sexual offender treatment programme showed that drop outs were more likely to reoffend both violently and sexually (Edwards et al., 2005). Research on reoffending by adult sexual offenders with child victims in specialist treatment has yielded similar results, with offenders who do not complete the programmes reoffending over a shorter time-span and with more serious offences (Stadtland, et al., 2005). The results of recent treatment outcome studies suggest that offenders who drop out of treatment reoffend, both in terms of general recidivism and sexual recidivism, at a faster rate upon release from prison compared to those who completed specialist treatment programmes (Langton, Barbaree, Harkins & Peacock, 2006).

The current study is an exploration of reoffending over a thirty-three month period by a high risk sample of sexual offenders against children. The study was undertaken to identify commonalities, and differences, that may be used to further refine risk judgements made about sexual offenders with child victims. Three groups of sexual offenders with child victims were included. The first sample consisted of all offenders released into the community with active Extended Supervision Orders, the second sample consisted of all offenders where an Extended Supervision Order was considered, but a decision was made not to proceed because the offender's risk was not considered high enough, and the third sample was a cohort of sexual offenders with child victims released into the community prior to the passing of the Parole (Extended Supervision) Amendment Act 2004. Rates and types of reoffending were compared, and variables that distinguish those who reoffend from those who did not were examined.

Method

Participants

All samples consisted of male offenders. The three samples of offenders were as follows.

Extended Supervision Order (ESO) offenders This sample of offenders were those on whom an Extended Supervision Order had been imposed from July 2004 (when the legislation was passed) to 31 October 2006 and who had been released from prison. The study followed these offenders from release until 31 December 2006, for a maximum follow up time of thirty-three months at large in the community under extended supervision. Nationally (as at 31 October 2006), there were 99 offenders on whom an Extended Supervision Order had been imposed by the Court. Ten cases were excluded from final statistical analyses due to offenders having an Order imposed prior to release from prison and incomplete data being available. This left 89 offenders available for analysis.

The ethnic composition of the ESO sample was 60 percent New Zealand European (54 offenders), 33 percent Maori (29 offenders) and seven percent Pacific Island Nations (6 offenders). The mean age of these offenders at the time the Order was imposed was 37.8-years, with the age range from 20-years to 65-years. The median follow-up time for this sample was thirteen months. The mean total number of convictions imposed prior to the Extended Supervision Order relevant offence was 33, with the range of convictions for individual offenders from two to 108.

No Extended Supervision Order (No-ESO) offenders This sample consisted of sexual offenders with child victims who were considered for an Extended Supervision Order, but were concluded to present a level of risk too low for such an order based on available assessment information. A total of 54 offenders were included in this sample. Fifty-three percent of this sample were New Zealand European (28 offenders), 31 percent Maori (17 offenders), 15 percent Pacific Island Nations (8 offenders) and one percent identified as Other. The mean age of this sample of offenders at the time of release from prison was 37–years, with a range from 18-years to 70-years. The median follow-up time for this sample was eighteen months. The mean number of convictions prior to release in this sample was 24.7, with a range from one to 79 convictions.

1992-1993 released offenders control sample A Control sample of offenders released from prison in 1992-1993, after serving a sentence for sexual offending against a child was included. The general eligibility criterion for consideration for an Extended Supervision Order is an ASRS score in the risk category of medium-high or high. File information for offenders released in 1992-1993 were accessed and those with an ASRS score of medium-high or above were selected as the Control sample. The release years of 1992-1993 were chosen because information on the ASRS score and demographic data for these offenders were accessible through the Department of Corrections computerised files.

A total of 56 offenders were released from prison in 1992-1993 with an index sexual offence against a child

victim and an ASRS score in the medium-high to high range. After removing offenders for whom complete data were not accessible, 34 offenders were available for analysis. Seventy-nine percent of this sample were New Zealand European (27 offenders) and 21 percent Maori (seven offenders). No offenders identified as Pacific Island Nations. The mean age of offenders at time of release from prison in 1992-1993 was 41.1-years, with the age range from 21-years to 60-years. The mean number of total convictions imposed prior to release in this sample was 24.5, with the range of convictions for individual offenders from four to 82.

Procedure

For the purpose of this study recidivism or reoffending was considered to be any offence (sexual or non-sexual) recorded on an offender's Criminal and Traffic Conviction History, which is an official record of convictions used by the Police, Department for Courts and Department of Corrections. The recording of an offence on an offender's conviction history indicates they have been convicted of the named offence in Court. From this data the date of the offending was also obtained. This data was accessed for each offender, along with a record of attendance at one of the two specialist child sexual offending treatment programmes in New Zealand prisons (if attended) and whether or not the programme had been completed. In addition, ASRS scores and (where available) SONAR scores for each offender were gathered from the risk assessment reports provided for each offender. Data was anonymous with numerical identification used for each offender during data collection and analysis.

Recidivism data was collected for each offender in the three samples. For those offenders who reoffended, the type of offence was examined and placed into one of eight offence categories specified for convictions by the Ministry of Justice (Lash, 2006). These categories are; violent offences (including sexual offences), other offences against persons, property offences, drug offences, offences against justice, offences against good order, traffic offences, and miscellaneous offences.

Data Analysis

All reoffence convictions were statistically analysed for the Extended Supervision Order (ESO) sample and the Control sample. Within-group data for the group not given Extended Supervision (No-ESO group) were not conducted because only two members of this group reoffended. Data from these offenders was used in between-group comparisons of the ESO sample and the Control sample.

Chi-square analyses were performed on ASRS and reoffending data to investigate any significant differences for reoffenders in each sample. Kaplan-Meier survival analyses were conducted to look at the survival time (time from release from prison to reoffending). Logistic regression was also performed to investigate any variables predictive of the categories of general and sexual recidivism. Attendance at specialist child sexual offending treatment programmes, completion of treatment programme, SONAR scores (where available) and ASRS score were used as predictor variables.

Results

Time at large in the community for the Control sample was substantially longer (up to 160 months). To control for this, thereby allowing meaningful comparison, recidivism data was analysed for the 33-month period from the date of release of the first offender in the sample from the index sexual offence with a child victim. This recidivism data is presented in Table 1. Offenders in the No-ESO sample reoffended generally at a significantly lower rate than those in the ESO sample, 23.6 percent compared to 3.7 percent (Fisher's exact test, $p < .001$). The majority of offences committed were in the 'Against justice' category. A conviction in this offence category means that an offender has breached the conditions of their supervision, failed to answer District or High Court bail, breached a protection order, or breached conditions of release from prison. Convictions in this category may be a direct result of being in the community under the conditions of an Extended Supervision Order, given that 'Against justice' offences specifically include Breach conditions of supervision. There was no significant difference in sexual recidivism rate, with the ESO sample showing a rate of 4.5 percent compared to the No-ESO sample sexual recidivism rate of 1.9 percent (Fisher exact test, $p = .64$).

The results in Table 1 also show that the Control sample had significantly higher rates of sexual recidivism (Chi-square = 17.83, $p < .001$), particularly against child victims. Two of the sexual offenders in the ESO sample had reoffended sexually against a child victim and two had reoffended sexually against an adult victim. The data for offenders from the ESO sample who reoffended sexually was looked at in more depth. These data are presented in Table 2. Several variables were investigated that the literature suggests are associated with reoffending sexually against child victims. The two offenders who sexually reoffended against child victims (<16-years) both had prior unrelated female victims. The most rapid reoffending was against child victims, with sexual reoffending by the two offenders with adult victims (>16-years)

Table 1. Recidivism data for all samples over 33-month follow-up period

	Extended Supervision (n = 89)	Control (n = 34)	No Extended Supervision (n = 54)
General recidivism	23.6 % (21)	38.2% (13)	3.7% (2)
Most offence type*	Against justice	Against justice	Against justice
Total Sexual recidivism	4.5% (4)	17.6% (6)	1.9% (1)
Sexual child victim	2.2% (2)	14.7% (5)	0%
Sexual adult victim	2.2% (2)	2.9% (1)	1.9% (1)
Days to first offence	1	3	528
Length of follow-up	33 months	33 months	33 months

* Offence category as defined by Ministry of Justice (Lash, 2006).
The numbers noted in parentheses are the number of offenders, not number of convictions

occurring a substantially longer time after release from prison (46 days and 10 days compared with 604 and 731 days). The offender from the No-ESO sample who reoffended sexually was 27 years of age. He offended 568 days after release from prison against an adult victim. The offender had an ASRS score in the high risk category and had previous female and male child victims.

Table 2. Sexual recidivists from the Extended Supervision Order sample

	Offender 1	Offender 2	Offender 3	Offender 4
Age at reoffending	63 years	32 years	39 years	23 years
ASRS risk category	High	Medium-High	High	High
Days to sexual reoffence	46	10	604	731
Male victims	Yes	No	No	Yes
Female victims	Yes	Yes	Yes	Yes
Unrelated victims	Yes	Yes	Yes	Yes
Related victims	Yes	No	Yes	No
Reoffence victim	Child	Child	Adult	Adult

Survival Analysis

Survival analysis allows for the comparison of recidivism rates while controlling for any differences in the time that offenders are at risk in the community. In this study survival analysis was used to compare the recidivism rates of offenders in different ASRS categories from the ESO sample. Kaplan-Meier Product-Limited survival analysis was used because this method allows for giving equal weighting to each offender regardless of the amount of time in the community. The cumulative survival function signifies the proportion of offenders who have not reoffended. Data was collected from the date each offender was released from prison until date of reoffending or the study cut-off date 31 December 2006 with a maximum at risk period of 33 months.

Figure 1 shows the survival curve for the ESO sample for time to reoffending by ASRS category. The results show a significant difference between ASRS risk categories. The paths diverge almost immediately indicating that offenders in the high ASRS category reoffended at a faster rate upon release from prison. The inclusion criteria for recommendation for an Extended Supervision Order includes offenders in the medium-low ASRS category who are judged to have sufficiently high dynamic risk to qualify as an 'override' of the relatively lower static risk. These offenders are included in Figure1. This is a small group totalling three offenders, and the rate of reoffending

therefore looks more dramatic on the survival curve analysis. The rate of reoffending by this 'override' group suggests that the assessed risk of these offenders was comparable to others included in the ESO sample.

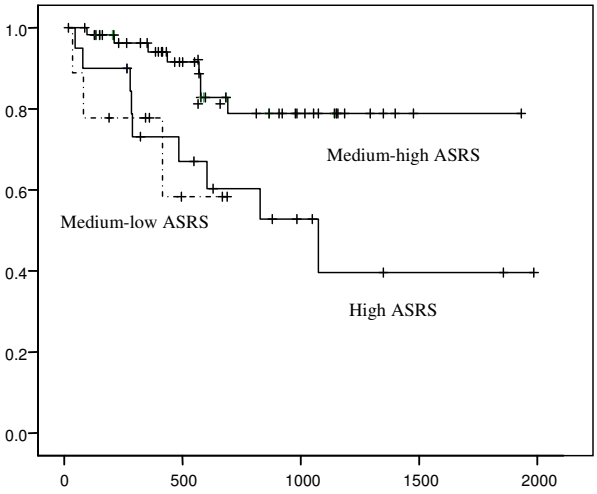

Figure 1: Survival curve for Extended Supervision Order sample

A log-rank test of equality was used to compare whether or not the survival curves for each group were proportional (i.e., the survival functions were approximately parallel). The Mantel-Cox Log Rank test for time to re-conviction was significant (χ^2 [2] = 8.7, p<.05), indicating that the survival curves were significantly different between the ASRS risk categories. This shows that those offenders in the high ASRS category were re-convicted at a higher frequency and took less time to reoffend than those in other risk categories. This result supports the findings that offenders in the ASRS high risk category were at a higher risk of reoffending upon release from prison.

Logistical Regression Analysis

To determine the influence of independent predictor variables on recidivism the data was analysed using logistic regression. Regression analyses allowed an examination of the predictive validity of various independent variables and allowed for testing of different combinations of predictor variables. The logistic regression procedure is based on the dichotomous criterion event of reoffending. It was considered valid and efficient to use the ASRS risk category as a predictor variable as this data includes number of prior sexual convictions, number of prior sentencing dates, any convictions for non-contact sexual offences, index offence containing non-sexual violence, prior non-sexual violence charges, and any male victims for each offender. Also included as predictor variables were attendance at one of the two specialist treatment programmes for sexual offenders with child victims and, if attended, programme completion. Forward stepwise logistic regression was used to determine the variables included in the predictive model. The results are presented in Table 3. These results show that ASRS risk category approached significance (*Exp(B)*=.40, p=.058). Attendance at a specialist treatment programme for sexual offending against child victims was not significant (*Exp(B)*=21.9, p=.09). Completion of a specialist treatment programme approached significance (*Exp(B)*=6.7, p=.055).

Table 3. Summary of logistic regression analysis for prediction of supervision

			95% CI for exp *b*		
	Wald's	*B(SE)*	Lower	exp *b*	Upper
Included					
Constant		3.9		0.00	
ASRS risk category	3.59	0.48	0.16	0.40	1.03
Programme attendance	2.78	1.90	0.58	21.96	832.41
Programme completion	3.68	0.99	0.90	6.75	47.46

Discussion

Extended Supervision Orders are used as a means to closely manage sexual offenders against children who have been judged to be at the highest risk of sexually reoffending against child victims. The results of the study showed that offenders subject to an Extended Supervision Order reoffended at a higher rate, both in terms of general recidivism and sexual recidivism, compared to those offenders who were considered for but not subjected to extended supervision. Only two offenders in the latter sample reoffended (one sexually), suggesting that the decision to base extended supervision eligibility on risk of reoffending was valid. In comparison to the two recidivists in this group, 21 offenders in the Extended Supervision Order group reoffended (four sexually).

Of the four in the Extended Supervision Order group who reoffended sexually, two were against child victims (<16-years) and two against adult victims (>16-years). For offenders with previous child sexual

offending convictions to reoffended sexually against adult victims is an unusual finding in the research literature on sexual offenders with child victims, but not unprecedented (Hanson & Morton-Bourgon, 2004). Contrary to the assumption that sexual offenders against children tend to specialize in this type of offending, several studies have found that sexual offenders with child victims tend not to specialise when reoffending compared to other types of offenders, such as violent offenders (e.g. Sample & Bray, 2006; Stadtland, et al., 2005; Parkinson et al., 2004). These studies have found that arrest for sexual offending against a child, in and of itself, is not predictive solely of further sexual offending with child victims. Many offenders continue to offend against property, public order and some sexually offend against adult victims (Miethe, Olson & Mitchell, 2006).

Perhaps the most relevant finding of the current study is the differences in rate and type of reoffending between those in the Extended Supervision sample and those in the Control sample. In the 33-month period under examination, the Control sample reoffended both generally and sexually at a higher rate than those on extended supervision. There was also a striking difference in the types of offences committed, with most of the Extended Supervision sample committing offences that reflect breaches of their supervision conditions, compared to less than 20 percent of the Control sample. This appears to be a result of the increased scrutiny that extended supervision places on offenders. In some cases, the breached conditions clearly represented behaviours that were considered precursors to the offender's pattern of previous sexual offences. There is no certainty that these offenders would have progressed to new sexual offences. However, the primary function of extended supervision is public protection. In these cases, it can be argued that this purpose was being served.

Analyses of reoffending using ASRS risk categories, attendance at specialist treatment programmes for sexual offenders with child victims, or completion of these programmes as predictor variables showed that ASRS risk category and completion of treatment approached, but failed to reach statistical significance. Lack of statistical significance is likely to be a function of the relatively small cell sizes, the limited follow-up period currently available, and the truncated distribution of scores with the consequent reduction in sample variance. In practical terms the offenders' ASRS risk category is considered a good prediction of risk of reoffending based on earlier findings with larger, more diverse samples and longer time at risk in the community. A substantial constraint in the current study is the limited follow-up time. Reoffence rates increase over time, as offenders have more opportunity to reoffend in the community. Further investigation of the current sample over a longer follow-up period is planned, and should provide a more complete picture of the factors associated with sexual reoffending.

Attendance alone at a specialist treatment programme for sexual offenders with child victims did not have an effect on whether or not an offender was likely to reoffend. Completion of the programme approached significance, but this comparison was also hampered by the same limitations cited for ASRS risk scores. Larger samples and longer follow-up are required to more adequately address the issue of treatment effectiveness in reducing sexual recidivism as a function of a priori risk.

Prediction of risk is primarily concerned about the accuracy of a measure or method used by the clinician to place the offender in a category that defines the probability of reoffending. Taking a purely individualised or idiographic approach to risk estimation is poor practice. Clearly defining risk categories can guide an offender's management while incarcerated; such as placement in particular institutions, employment options and access to treatment programmes. Assessed level of risk can also inform decisions regarding release, including levels of supervision required. Only the highest risk offenders should be subjected to unusual limitations of their freedom, and public safety is best served by placing the highest risk offenders under the closest supervision. Risk assessments with sexual offenders should be both transparent in their reasoning and verifiable by peer-reviewed research. Structured clinical judgement, using a combination of properly validated actuarial measures and empirically grounded dynamic risk factors, currently presents the best available approach to assisting judicial decision-making with high risk offenders. The effectiveness of initiatives such as extended supervision for enhancing public safety will remain the focus of ongoing empirical investigation.

References

Abracen, J., Mailloux, D.L., Serin, R.C., Cousineau, C., Malcolm, P.B., & Looman, J. (2004). A model or the assessment of static and dynamic factors in sexual offenders. *Journal of Sex Research, 41* (4), 321-329.

Bakker, L., Hudson, S., Wales, D., & Riley, D. (1999). *And then there was light: Evaluating the Kia Marama treatment programme for New Zealand sex offenders against children*. Christchurch, New Zealand: Department of Corrections Psychological Service.

Bass, E., & Davis, L. (1988). *The courage to heal: A guide for women survivors of child sexual abuse.* Harper & Row: New York.

Berlin, F.S., Galbreath, N.W., Geary, B., & McGlone, G. (2003). The use of actuarials at civil commitment hearings to predict the likelihood of future sexual

violence. *Sexual Abuse: A Journal of Research and Treatment, 15* (4), 377-382.

Borum, R. (1996). Improving the clinical practice of violence risk assessment: Technology, guidelines, and training. *American Psychologist, 51* (9), 945-956.

Briere, J.N. (1992). *Child abuse trauma: Theory and treatment of the lasting effects.* Sage: London.

Campbell, T.W. (2000). Sexual predator evaluations and phrenology: Considering issues of evidentiary reliability. *Behavioral Sciences and the Law, 118*, 111-130.

Dvoskin, J.A., & Heilbrun, K. (2001). Risk assessment and release decision-making: Toward resolving the great debate. *The Journal of American Academy of Psychiatry and the Law, 29,* 6-10.

Edwards, R., Beech, A., Bishop, D., Erikson, M., Friendship, C., & Charlesworth, L. (2005). Predicting dropout from a residential programme for adolescent sexual abusers using pre-treatment variables and implications for recidivism. *Journal of Sexual Aggression 11(2)*, 139-155.

Fergusson, D.M., Lynskey, M.T., & Horwood, L.J. (1996). Child abuse and psychiatric disorder in young adulthood: II. Psychiatric outcomes of childhood sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*, 1364-1374.

Hanson, R.K. (1998). What do we know about sex offender risk assessment? *Psychology, Public Policy, and Law, 4*, 50-72.

Hanson, R.K., & Bussiere, M.T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*, 348-362.

Hanson, R.K., & Harris, A. (2000). *The sex offender need assessment rating (SONAR): A method for measuring change in risk levels 2000-1*, Ottawa: Department of the Solicitor General of Canada.

Hanson, R.K. & Harris, A. (2004). A structured approach to evaluating change among sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 13(2)*, 105-122.

Hanson, R.K., & Morton-Bourgon, K. (2004). *Predictors of sexual recidivism: An updated meta-analysis 2004-02*. Ottawa: Department of the Solicitor General of Canada.

Harris, G. (2003). Men in his category have a 50% likelihood, but which half is he in? Comments on Berlin, Galbreath, Geary, and McGlone. *Sexual Abuse: A Journal of Research and Treatment, 15(4)*, 389-392.

Harris, G.T., & Rice, M.E. (2003). Actuarial assessment of risk among sex offenders. *Annals New York Academy of Sciences, 989,* 198-210.

Heilbrun, K., Dvoskin, J., Hart, S., & McNiel, D. (1999). Violence risk communication: Implications for research, policy, and practice. *Health, Risk and Society, 1,* 91-106.

Langton, C.M., Barbaree, H.E., Harkins, L., & Peacock, E.J. (2006). Sex offenders' response to treatment and its association with recidivism as a function of psychopathy. *Sexual Abuse, 18(1)*, 99-120.

Lash, B. (2006). *Conviction and sentencing of offenders in New Zealand 1995 to 2004*. Wellington, New Zealand: Ministry of Justice Research, Evaluation and Modelling Unit.

Linehan, M.M. (1993). *Skills Training Manual for Treating Borderline Personality Disorder.* The Guilford Press: New York.

Looman, J., Abracen, J., & Nicholaichuk, T.P. (2000). Recidivism among treated sexual offenders and matched controls: Data from the regional treatment centre (Ontario). *Journal of Interpersonal Violence, 15(3)*, 279-290.

Marques, J.K., Wiederanders, M., Day, D.M., Nelson, C., & van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's sex offender treatment and evaluation project (SOTEP). *Sexual Abuse: A Journal of Research and Treatment 17(1)*, 79-107.

Marshall, W.L., & Serran, G.A. (2000). Improving the effectiveness of sexual offender treatment. *Trauma, violence and abuse, 1(3)*, 203-222.

McLean, A., & Rush, C. (1990). *Base rates and characteristics of convicted sexual offenders: A New Zealand study*. Unpublished manuscript. Wellington, New Zealand: Department of Justice.

McMaster, K., & Wells, A. (2006). From uncertainty to certainty – is it possible? In McMaster, K. and Bakker, L. (Eds.), *Will they do it again?* (pp 7-23). Hall, McMaster and Associates: Lyttleton.

Miethe, T.D, Olson, J, & Mitchell, O. (2006). Specialization and persistence in the arrest histories of sex offenders. *Journal of Research in Crime and Delinquency, 43(3)*, 204-229.

Miller, H., Amenta, A.E., & Conroy, M.A. (2005). Sexually violent predator evaluations: Empirical evidence, strategies for professionals, and research directions. *Law and Human Behavior, 29(1)*, 29-54.

Monahan, J. (2004). Forecasting harm: The law and science of risk assessment among prisoners, predators, and patients. *ExpressO Preprint Series*. Working Paper 410. Retrieved from http://law.bepress.com/expresso/eps/410.

Nathan, L., Wilson, N.J., & Hillman, D. (2002). *Whakakotahitanga: An evaluation of the Te Piriti Special Treatment Programme for child sex offenders in New Zealand*, Psychological Service, Department of Corrections, New Zealand.

Parkinson, P.N., Shrimpton, S., Oates, R.K., Swanston, H.Y., & O'Toole, B.I. (2004). Nonsex offences committed by child molesters: Findings from a longitudinal study. *International Journal of Offender Therapy and Comparative Criminology 48(1)*, 28-39.

Parole (Extended Supervision) Amendment Act 2004, number 67, 7 July 2004. Accessed through www.legisation.govt.nz, 12 January 2005.

Pratt, J. (2001). Dangerousness and modern society. In M. Brown & J. Pratt (Eds.), *Dangerous Offenders. Punishment and Social Order* (pp. 35-47). New York: Routledge.

Quinsey, V.L., Rice, M.E., & Harris, G.T. (1995). Actuarial prediction of sexual recidivism. *Journal of Interpersonal Violence 10(1)*, 85-105.

Rice, M. E., Harris, G.T., & Quinsey, V.L. (1993). Evaluating treatment programs for child molesters. In J. Hudson & I.V. Roberts (Eds.). *Evaluation research in Canadian Justice Programs*. Calgary: University of Calgary Press.

Rice, M.E., & Harris, G.T. (2003). The size and sign of treatment effects in sex offender therapy. *Ann. N.Y. Acad. Sci. 989*, 428-440.

Roberts, C.F., Doren, D.M., & Thornton, D. (2002). Dimensions associated with assessments of sex offender recidivism risk. *Criminal Justice and Behavior, 29(5)*, 569-589.

Sample, L.L., & Bray, T.M. (2006). Are sex offenders different? An examination of rearrest patterns. *Criminal Justice Policy Review, 17(1)*, 83-102.

Simourd, D.J. (2004). Use of dynamic risk/need assessment instruments among long-term incarcerated offenders. *Criminal Justice and Behavior, 31(3)*, 306-323.

Skelton, A., Riley, D, Wales, D., & Vess, J. (2006). Assessing risk for sexual offenders in New Zealand: Development and validation of a computer-scored risk measure. *Journal of Sexual Aggression, 12(3)*, 277-286.

Stadtland, C., Hollweg, M., Kleindienst, N., Dietl, J., Reich, U., & Nedopil, N. (2005). Risk assessment and prediction of violent and sexual recidivism in sex offenders: Long-term predictive validity of four risk assessment instruments *The Journal of Forensic Psychiatry & Psychology, 16(1)*, 92-108.

Stalans, L.J. (2004). Adult sex offenders on community supervision: A review of recent assessment strategies and treatment. *Criminal Justice and Behaviour, 31*, 564-608.

Vess, J. (2005). Preventive detention versus civil commitment: alternative policies for public protection in New Zealand and California. *Psychiatry, Psychology and Law 12(2)*, 357-367.

Watson,T., & Vess, J. (2007). Risk assessment of child-victim sex offenders for extended supervision in New Zealand. *Journal of Forensic Psychiatry and Psychology* (In press).

Webster, C.D., Hucker, S.J., & Bloom, H. (2002). Transcending the actuarial versus clinical polemic in assessing risk for violence. *Criminal Justice and Behavior, 29(5)*, 659-665.

Sexual Abuse in Australia and New Zealand, July 2008; 1(1): 53-55

A Review of "Violence Risk: Assessment and Management"

By Christopher D. Webster and Stephen J. Hucker
West Sussex, England: John Wiley & Sons, Ltd., 2007, 202 pages

Douglas P. Boer
Department of Psychology, The University of Waikato, Hamilton, New Zealand

It is a bit disconcerting to write a review of a book that John Monahan has already prefaced as a resource that "will serve handsomely as a guide to evidence-based clinical practice in dealing with individuals who would harm others". However, this book intrigued me from the outset with its quirky use of free-style poetry, historical allusions, and quotations from the mainstream literature as means to set the tone for each chapter. The chapters are brief, to the point, and perhaps most interestingly allow a reader to come away knowing a synopsis of an issue and its more critical features.

This book is a relatively easy read of a difficult subject which makes it a desirable purchase for the busy clinician and perhaps for a graduate course in forensic correctional psychology. Although it should be trite to say, the chapters are laid out in a sequence that makes sense – first by developing a framework by laying out a legal structure, then discussing: background philosophies, predictions/errors, disorders, review of some studies, some statistical issues, debates in the literature and some invited chapters by experts from other areas, and then several chapters that deal with advice to the treating professionals in terms of the importance of team meetings and how to communicate risk messages effectively. The concluding chapter is not without controversy and illustrates the authors' commendable hopes that the field will unify and provide responsible risk assessments to help with treatment planning.

One of the strongest points the book makes includes the warning that "a risk assessment conducted for some specific purpose under one set of laws may yield information of little or no relevance in another legal context" (p. 5) in chapter 1. This is germane not only to the Canadian setting, but also the American and other jurisdictional settings. An assessment undertaken to inform treatment may have little apparent consequence say for a sexual violent predator (SVP) assessment, but if the offender lives in a SVP state in the USA, then it could resurface at a later date. One cannot afford to produce an assessment that is based on less than best practice in such situations (not that one should aspire to less).

I was interested in the "philosophies" chapter (2) as it would seem logical that assessment practices would be operating under the same sorts of theoretical assumptions that intervention operates under (e.g., relapse prevention theory). Clearly the authors feel that this is an issue that needs some work, but some reference to Ward, Polaschek and Beech (2006) could have been made in this regard. The book by Ward and colleagues is an excellent example of bringing theory to life in terms of the offending process – and it would make sense that the next steps for these authors would be an elucidation of the assessment and intervention process using the same theoretical process.

The "predictions" chapter (3) is excellent and all too brief. It highlighted the four activities of risk assessment (attribution, prediction, assessment and management). Not all authors like to think of their assessment instruments as bridging all four activities, but the fact is – this is what risk assessment does – and the chapter illustrates how this is the case. The "errors" chapter (4) is thankfully brief – although necessary. I was particularly happy *not* to see the 2X2 table once again, and the explanation was good in its stead.

The "disorders" chapter (5) makes the point that "diagnoses … tend not to have much statistical power when it comes to violence prediction … (but) are helpful to the extent that they can be used to summarize a great deal of information, aid in problem conceptualization, and assist in communication" (p. 26). It would have been useful to systematically provide the relationship between disorders and risk – this was done with some disorders, but not all, and not done or described in a relative sense. Perhaps this was beyond the scope of the chapter. The "psychopaths" chapter (6) is brief but poignant; it pays due credit to Robert Hare's work, but perhaps less credit than due to the serendipitous power the Psychopathy Checklist – Revised (2003) has shown in relation to risk assessment.

The "studies" chapter (7) provides two main things for the reader: a review of the outstanding research by outstanding authors, and to a lesser degree an integration of these findings. The ever ground-breaking work of the MacArthur Violence Risk Assessment Study is highlighted as well as the idea of complex interactions of risk factors as important in comparison with the inadequacy of simple additive models currently

Correspondence: Douglas P. Boer, Department of Psychology, The University of Waikato, Hamilton, New Zealand. Email: drdoug@waikato.ac.nz

ISSN 0833-8488

in use in actuarial practice. The "baserates" chapter (8) is too brief. It might have been nice to have provided some guidelines as to how to use (and how not to use) base rates in risk assessments. Clinicians sometimes refer to base rates as evidence of risk for an individual as opposed to the former being simply the observed frequency of some disorder or behavior in a population. While it makes logical sense that an offender who has committed violent crime X would be at a higher risk to repeat this sort of crime than someone who has not been convicted of such a crime, it is not possible to state that in all cases previously convicted offenders are necessarily riskier than individuals who have yet to be apprehended for that same sort of crime, especially given the rate of undetected crime. We simply know the frequency of detected crime and that the base rates for violent crime give some sort of salutary notion of relative risk. That being said, relative risk is generally unknown in most jurisdictions given that most base rate information is either unobtainable or unreliable.

Chapter 9 (factors) is again too brief given the importance of the subject. However, there are still nuggets of advice that are valuable. The references to Monahan's early and recent work are excellent and how the study of risk factors has evolved is instructive.

In chapter 10 (debates) the authors discuss the "clinical versus actuarial" debate and suggest that this debate "pits the relative importance of 'static', more or less unchanging variables, against the more fluid 'dynamic' ones often encountered in daily clinical practice". If the authors mean that 'actuarial' measures depend mostly on 'static' items and 'clinical' on 'dynamic' items (or the reverse for that matter), they are incorrect. Many of the newer actuarial scales by Hanson and colleagues are comprised entirely of dynamic items and many of the structured professional judgement (SPJ) clinical guideline scales have items that are static. Nonetheless, the advice that both static and dynamic variables interact in unique ways is excellent – advice that emanates from Monahan and colleagues again.

Chapter 11 (guides) is a review of existing SPJ schemes. There is a very nice 10 page example of a real offender (R.S.) on the HCR-20 – this really is an excellent addition to the chapter as it made the chapter come alive. The example is one worth sharing in training HCR-20 and PCL-R users as it is personal and revealing. We owe R.S. an ongoing note of thanks for his willingness to help others through his experience.

The "competitions" chapter (12) shows some of the various sorts of risk assessment research that is going on. The chapter is weak in the sense that there is an absolutely huge amount of research going on that is not mentioned, much of it in the sex offender area, which is not even given cursory mention. Certainly the debates are similar to those going on in the violent offender field. The next chapter on "assessing sex offenders" by Karl Hanson (13) addresses the issue of sex offender risk assessment, but in quite a different manner, and the debates noted in chapter 12 are given only notional acknowledgment. Arguably more comprehensive from a research point of view, the chapter is weak in terms of application. I suppose the not said reality here is that clinicians (i.e., those who do the work) actually do "value understanding their cases" and as a result "pure prediction scales are unsatisfying", if not sometimes useless in the individual case. The chapter by Randy Kropp on "spousal assaulters" (14) is different again. This chapter provides some solid advice via five "principles of spousal assault risk assessment" that should seem familiar to most SPJ users but which are embedded in some good research. The tenets of this latter chapter could have been more broadly proposed as applicable to any SPJ assessment process rather than just spousal assaulters, but that is an easy extension for the reader.

Chapter 15 (interventions) is admittedly "highly selective" but instructive. It was perhaps an unintentional oversight not to mention the usual principles of effective correctional treatment, but risk-based intervention should assume the former. There is also a portrayal of contrasting research findings regarding the importance of support to risk reduction – one study indicating no relationship and the other the opposite. The authors note that the absence of a finding, even within a study, doesn't mean the relationship isn't there – the authors just didn't find it. This would hold true for other sorts of studies as well and the lesson is a good one.

Chapter 16 (transitions) is done by another guest author, Mary-Lou Martin. The writing style is quite different, but the Transitional Discharge Model (TDM) is a good one to review and probably has broader application than proposed. It would seem a good model to formulating risk management planning for offenders coming out of jail. However, I would note that most readers of this book would not be familiar with the TDM and it would have been helpful to have spelled it out in a little more depth as was done with the "integrated care pathways" (ICP) model in the "teams" chapter (17).

The next three chapters illustrate the pro's and con's of mental health teams (17), effective risk communications (18), and folks who do expert witness work (19). All three chapters are very short (total of 10 pages for the 3 chapters), but there is still some good advice despite the brevity.

The "conclusions" chapter (20) is full of good advice and information for the clinician. It provides a brief description of the actuarial polemic regarding SPJ approaches and while not saying it, shows the silliness of the debate. Perhaps worse and unmentioned, the

debate is inhibiting good work that could come from using a convergent approach to risk assessment as suggested by Monahan in the past and others since. The chapter ends with some sage advice and some mention of issues to be discussed – some of it from elsewhere, but certainly conceptualized clearly in the last few pages. Finally, the "questions" chapter (21) is a good post-test for the reader. I found only one wrong answer – well, if you replaced "all" with "most" that is (#79)!

Did I note that the "NOTES" at the end of each chapter sometimes contain the most important bits of information? In many books this section is academic snoozage, but not here. *Read the notes* or you will miss absolutely critical snippets of information.

In sum, this is a good book that serves up entrée after entrée on complex subjects. The reader's interest should be whetted and invigorated by reading it. I doubt the authors felt they were producing a comprehensive text book, but I think it could serve very well as a graduate level text. It is easily read, but brings up topic after topic that would serve as topics for theses or seminars – I highly recommend it.

References

Hare, R. D. (2003). *The Psychopathy Checklist – revised (2nd ed.)*. Toronto, Ontario: Multi-Health Systems.

Ward, T., Polaschek, D.L.L., & Beech, A.R. (2006). *Theories of Sexual Offending*. West Sussex, England: John Wiley & Sons, Ltd.