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Assessment and Case Conceptualization in Sex Offender Treatment

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Abstract

The assessment of sexual offenders consists of the systematic collection of clinically relevant information in order to detect clinical phenomena or problems and to provide clear treatment targets. The result of this process is a conceptual model, or case formulation, representing the client's various problems, the hypothesized underlying mechanisms, and their interrelationships. The focus of this article is on the importance of psychological assessment and case formulation in the rehabilitation and management of individuals convicted of sexual offences. First, we make a number of general points about the importance of evidence based assessment and clinical reasoning in case formulation. Second, we review key elements of contemporary sexual offender theory that highlights the heterogeneity evident among sex offenders and the implications for case formulation and treatment planning. Third, we discuss the role of case formulation for risk assessment and management. Finally, we illustrate our major points with a brief case study and conclude with a brief consideration of the value of case formulations.
Keywords*:* assessment, clinical reasoning, case conceptualization, sex offenders.

Introduction

Sexual offending is a socially significant and complex problem that is the focus of intensive research and treatment efforts. Over the last twenty to thirty years considerable progress has been made toward understanding the various causes of sexual offending and how treatment can reduce reoffending (Ward, Polaschek, & Beech, 2006). More specifically, a range of theories have been developed that identify critical distal and proximal risk factors for sexual offending and the psychological mechanisms that are hypothesized to cause an offence (see Ward, et al., 2006). Extensive treatment outcome research has shown that our best programs can reduce offenders' risk of further sexual crimes (see Hanson et al., 2002), although there is still considerable room for improvement (e.g., Hanson et al., 2002; Marques, Wiederanders, Day, Nelson, & van Ommeren 2005; Ward, Yates, & Long, 2006). In addition, the frameworks and methods developed to analyze the risk posed by offenders for future sexual offences have become more sophisticated and empirically based (see Doren, 2006). As a result of these cumulative efforts, practitioners who work with sex offenders now have a relatively large body of conceptual, empirical, and professional knowledge to help guide their rehabilitative efforts with individuals convicted of sexual offences.

Applying knowledge of the causes of sexual offending and what works to reduce offending, however, hinges on practitioners' ability to appropriately and accurately *assess* individuals who commit sexual offences. Assessment involves the systematic collection of clinically relevant information in order to detect clinical phenomena or problems and to provide clear treatment targets. Assessment is in fact the starting point of effective rehabilitation and management because without accurate assessment it is impossible to determine the suitability and focus of treatment, nor whether treatment has had any positive impact. In conducting assessments practitioners must bring evidence based knowledge of sexual offenders as a population together with knowledge about a particular offender. The result of this process is a conceptual model representing the client's various problems, the hypothesized underlying mechanisms, and their interrelationships that is clearly linked to contemporary theory and research. In essence, this clinical theory specifies how the symptoms or problems are generated by psychological mechanisms, for example, dysfunctional core beliefs or behavioral deficits. A case conceptualization then provides a rational basis for determining treatment needs that can be used to tailor interventions with offenders in the aim of achieving optimal outcomes.

In some instances, offender assessment is equated with offender classification (Blanchette & Brown, 2006). Offenders may be categorized into distinct groups on the basis of specific criteria, such as high, medium, or low risk of recidivism. Although classification is a legitimate purpose of assessment and often an important component of case formulation and treatment planning, in keeping with clinical psychology we view assessment more broadly. For us, clinical assessment is concerned with the *identification* and *explanation* of an individual's difficulties (clinical phenomena), the future implications of these difficulties, and the options for eliminating or moderating these difficulties (Ward & Haig, 1997).

The focus of this article is on the importance of psychological assessment and case formulation in the rehabilitation and management of individuals convicted of sexual offences. First, we make a number of general points about the importance of evidence based assessment and clinical reasoning in case formulation. Second, we review key elements of contemporary sexual offender theory that highlights the heterogeneity evident among sex offenders and the implications for case formulation and treatment planning. Third, we discuss the role of case formulation for risk assessment and management. Finally, we illustrate our major points with a brief case study and conclude with a brief consideration of the value of case formulations.

Evidence Based Assessment and Clinical Reasoning: The Heart of Case Formulation

Psychological assessment involves a systematic process of collecting, evaluating, and integrating relevant information about clients' phenomena (or problems) of concern to arrive at conclusions about their nature, etiology, and implications (Ward & Haig, 1997; Ward, Virtue, & Haig, 1999). An assessment is said to be complete when the assessor arrives at a clear formulation of the client's difficulties which enables the relevant referral questions to be answered, at least provisionally. Relevant questions include: What are the main presenting problems or issues? How are these problems inter-related and what etiological explanations account for their occurrence? What options for modifying these difficulties are most likely to be efficacious for this person? Assessment is also an integral part of treatment in that practitioners must monitor and evaluate the effectiveness of their work with clients. Questions here might be: Are the interventions working as anticipated? Is there improvement in the targeted areas? Are modifications to the initial treatment plan necessary to achieve better outcomes for this individual?

For sex offenders, assessments are typically focused on detecting and explaining the offender's pattern of sexual (and serious non-sexual) offences and using this understanding to assist determinations of the offender's: (i) risk of future offending, (ii) rehabilitation needs, amenability for treatment, and other issues related to risk management, and (iii) treatment progress and current risk status (Thakker, Collie, Gannon, & Ward, in press). Increasingly, assessments are also conducted to assist Courts or paralegal bodies (e.g., parole authorities) to determine whether an offender meets criteria for application of specific civil commitment or criminal sentences. A clear formulation of the nature and causes of an individual's offending is often helpful in reaching final conclusions about ongoing risk and the necessity to use various interventions such as detention or incarceration to manage that risk (Dvorskin & Heilbrun, 2001).

Assessment is substantially more than the collection of information about a client. What is critical is that information is *evaluated* and *integrated* into a clear understanding of the nature of the clients' difficulties and the probable causes of these difficulties. From the outset this requires that the assessment is appropriately focused and that the specific methods and procedures selected to gather information are psychometrically sound. Adopting evidence-based assessment practice involves using assessment data from measures with established reliability and validity to evaluate the conditions for which treatment is sought and in the evaluation of the outcome of that treatment (e.g., Chambless & Hollon, 1998; Kazdin, Kratochwill, & VandenBos, 1986; Ollendick, 2003). Ideally, research and theory should also be used as the basis for selecting the primary assessment targets and to inform the process of assessment itself (Hunsley & Mash, 2005a). Recent moves to develop guidelines for evidence based assessment of common adult disorders have been undertaken to help provide

practitioners and programme designers information about which assessment measures are more capable of producing reliable and valid information (see Hunsley & Mash, 2005b). Although sexual offending assessment has not yet been the subject of an evidence based assessment guideline, several publications include systematic reviews of assessment measures and their psychometric properties which provide some guidance about the appropriate selection of measures from those currently available (for example, see Craig, Browne, Stringer, & Beech, 2005; Kalmus & Beech, 2005; Laws & O'Donohue, in press; Seto, 2007).

One of the more vexing issues involved in conducting sexual offender assessments is obtaining accurate or truthful disclosures from offenders, who for various reasons may be highly motivated to distort or deny the full extent of their criminal behavior. Some authors have specifically commented on interviewing styles that may encourage more honest disclosure and instruments that can assess the extent of impression management or malingering (for example see Thakker, et al., in press), but as yet this area is still underdeveloped empirically with sexual offenders. The two main approaches to tackling this problem that have been empirically investigated are the use of polygraphy to facilitate truthfulness (for a review see Gannon, Beech, & Ward, in press) and the use of objective measures of sexual preferences, such as plethysmography and attentional paradigms, to bypass offender self-report all together (for a review see Kalmus & Beech, 2005). For example, research has found that sexual offenders subject to polygraph testing disclose a greater number and variety of past victims (Ahlmeyer, Heil, McKee, & English, 2000; Heil, Ahlmeyer, & English, 1998; Hindman & Peters, 2001), disclose an earlier age of onset of sexual offending (Hindman & Peters, 2001; Wilcox, Foss, & Donathy, 2005), report less personal history of victimization (Hindman & Peters, 2001; Wilcox et al., 2005), and admit to a greater level of engagement in high risk situations during community supervision (English, Jones, Patrick, & Pasini-Hill, 2003; Grubin, Madsen, Parsons, Sosnowski, & Warberg, 2004). Research into the validity of plethysmographic assessment also provides some support for its potential to identify deviant sexual preferences in child molesters (e.g., Barbaree & Marshall, 1989; Quinsey & Chaplin, 1988; Travin, Cullen, & Melella, 1988), although several authors have raised a number of critical concerns regarding ecological validity, procedural standardization, and test reliability (e.g., Kalmus & Beech, 2005; Marshall & Fernandez, 2003). In addition, plethysmograph assessment does not appear to consistently discriminate deviant sexual preferences in rapists (e.g., Barbaree, Marshall, & Lanthier, 1979; Baxter, Barbaree, & Marshall, 1986; Hall, Proctor, & Nelson, 1988; Wormith, Bradford, Pawlak, Borzecki, & Zohar, 1988).

Although there are obvious merits to using procedures that enhance the accuracy of assessment, the problem of false negatives and measurement error mean that no method can promise perfectly accurate information. Thus, the decision to include use of strategies to enhance truthfulness or bypass self-report of sexual preferences relies on careful consideration of the empirical merits and limitations of these methods with the specific offenders and questions being answered. Ethical issues and overall alignment of methods with the rehabilitative values and aims being promoted by a programme are also important considerations (Gannon et al., in press). As with all aspects of assessment, the information or data obtained needs to be critically appraised and evaluated for reliability, validity, and meaning. As a general guideline multi-method assessments are preferable as these seek to address the limitations associated with specific methods or instruments. However, as stated above, a crucial component of assessment is the *evaluation* and *integration* of information from multiple sources into a clear formulation of client's difficulties and the probable causes of these difficulties.

Although treatment planning is strongly influenced by clients' presenting difficulties, understanding a client's vulnerability and protective factors and how these manifest in the problems leading to treatment is also invaluable (Ward et al., 1999). Clinical practice implicitly assumes the existence of various causal relationships between clients' biological, psychological, and social factors and their problems of concern. Standardized treatments reflect assumptions that there is a limited array of causal variables or mechanisms for a particular problem (Haynes, 1992), while individualized treatments across clients with the same problem reflect the notion that different mechanisms can give rise to the same phenomena or that it is of benefit to take into account other individual differences that

can affect treatment (Haynes, Leisen, & Blaine, 1997). In addition, many problem behaviors present in the same client can arise from a smaller set of causal factors (Haynes, 1993). For example, negative self-schema may give rise to low self-esteem, discomfort and avoidance in adult relationships, and emotional congruence with children. Alternatively, the hedonistic, callous, and impulsive traits of psychopathic personality can lead to a wide range of antisocial and criminal acts including sexual offending (Hare, 1991). Identifying the underlying causal factors in addition to the clinical phenomena linked with sexual offending helps guide treatment planning and informs an appreciation of what factors continue to create vulnerability for sexually offending.

In essence, case formulation involves developing an individualised theory about a client's problems, their interrelationships, and their primary causes. This theory then becomes the rational basis for determining treatment targets, considering the likelihood of treatment obstacles or treatment interfering behaviors (as well as strengths), and ultimately gaining a deeper understanding of the client that facilitates development of an empathic and constructive therapeutic alliance. Case formulation is a challenging task that involves a complex chain of clinical inferences, judgments, and decisions, otherwise known collectively as *clinical reasoning* (Ward & Haig, 1997). Using empirically based assessment methods brings standardization to the collection and interpretation of client information which can help achieve greater certainty in case formulations, yet the process of assessment and case formulation remains an inherently a clinical reasoning task involving an iterative practice of hypothesis development and evaluation (Hunsley & Mash, 2005a; Ward & Haig, 1997).

The accuracy of clinical judgment and decision-making has been the subject of considerable research within psychological science as well as other health related disciplines. Much of this research has underscored the potential for practitioners to make erroneous judgments and conclusions about their clients (for reviews see Garb, 1998, 2005; Hunsley, Lee & Wood, 2003; Wedding & Faust, 1989; Wood et al., 2002). For example, unstructured or routine clinical diagnoses typically underdiagnose some conditions compared to structured clinical interviews (e.g., Basco et al., 2000; Kranzler et al., 1995; White, Nichols, Cook, & Spengler, 1995). Others have also found that over-pathologizing clients can arise when practitioners use assessment instruments with poor validity, or inappropriately apply psychometrically sound instruments to areas for which there is no psychometric data (Garb, 1998; Hunsley, Lee & Wood, 2003). In the sex offender area, research about the accuracy of practitioner judgement has focused predominantly on the methods used to arrive at predictions of sexual recidivism. Actuarial (or mechanical) assessments which combine information in a prescribed way have typically been compared to unstructured clinical judgements and shown to provide a more reliable and valid evaluation of recidivism over a medium to longer timeframe (e.g., Hanson & Bussiere, 1998; Grove, Zald, Lebow, Snitz, & Nelson, 2000). However, although research studies have tended to present the choice of risk assessment method as a dichotomy, in practice risk assessment method can be conceptualised as existing along a continuum with pure actuarial measures and pure unstructured clinical judgements anchoring each end (Doren, 2006; Dvorskin & Heilbrun, 2001). In between these purist forms are intermediate options that combine the structure of actuarial methods alongside the flexibility of some clinical judgement. Adjusted actuarial methods initially ground risk assessment using an actuarial instrument but judiciously adjust that assessment following consideration of other relevant factors. Whereas, structured professional judgement involves conducting risk assessment according to structured guidelines based on theory and research but with the ultimate decision about risk level remaining a clinical summation or judgement. Clearly the degree of flexibility and therefore potential influence of clinician introduced 'error' is least with pure actuarial methods and most with unstructured clinical judgement. The adjusted actuarial and structured professional judgement methods are designed to capitalise on the benefits of both methods while incorporating safeguards against error.

A challenge for practitioners', like all humans, is that reasoning is subject to a range of information processing limitations including cognitive heuristics and biases (see Garb, 1998, 2005; Schwarz, 1994). Use of evidence based assessment methods and protocols are advocated as a means to obtain reliable and valid assessment data and guard against common errors in decision making (Hunsley & Mash, 2005a). In turn, use of formal models of case formulation is advocated as a means

to accurately translate assessment data into treatment recommendations (Nezu, et al., 2003; Ward et al., 1999). Several models of case formulation have been developed, most embedded within a particular branch of psychotherapy prefacing particular causal factors (e.g., Haynes, Leisen, & Blaine, 1997; Nezu & Nezu, 1989). However, the process of clinical assessment and case formulation is usefully depicted in *phases* (Hunsley & Mash, 2005, Ward et al., 1999). The first major task involves *phenomena detection*; that is identifying and describing the client's primary complaints or clinical problems, such as pattern of sexual offending. Once these descriptive hypotheses have been developed, the next task involves *inferring causal psychological mechanisms* that account for the clinical phenomena. The causal mechanisms or explanatory hypotheses can be construed as the client's psychological vulnerability which interacts with situational factors to produce the client's presenting problems. The choice of potential explanatory hypotheses ought to be guided by relevant research literature and reasoning about how this nomothetic information can be idiographically applied to this particular client (Nezu et al., 2003; Ward et al., 1999). A useful resource to help guide this level of reasoning was developed by Beech and Ward (2004; Ward & Beech, 2004) who integrated key empirical findings on sexual offender risk assessment with theoretical work and clinical experience to produce a schematic of a case formulation. The case formulation considers *developmental factors*, *vulnerability factors* (i.e., historical risk markers and stable-dynamic risk factors), *triggering risk factors*, and *acute-dynamic risk factors*. Using this model, Beech and Ward Beech make a distinction between psychological dispositions or *vulnerabilities* that cause sexual offending (e.g., sexual interests, offense-supportive beliefs, socio-affective functioning, and self-regulation) and variables they believe act as markers or signals for these underlying causal variables (usually labeled *historical* or *static* variables). The vulnerabilities that cause sexual offending are typically described as *stable dynamic* factors in the risk assessment area.

The next step in clinical formulation ideally involves fleshing out the proposed explanatory mechanisms to produce an *integrated clinical theory* representing the interrelationships between the clinical conditions, their causal mechanisms, and the various contributing distal and proximal factors. The benefits of developing an integrated causal model include being able to identify or prioritise the most appropriate target for treatment. One or two causal mechanisms may be at the core of the client's difficulties and therefore exhibit a strong relationship to other causal mechanisms and many clinical phenomena. For example, deviant sexual interests may be at the core of associated problems with offence-supportive beliefs and poor socio-affective functioning in adult intimate relationships. The integration of causal mechanisms depends on the practitioners' understanding of relevant psychological theories and clinical experience, particularly regarding the combinations of causal mechanisms that are implicated in clusters of clinical phenomena.

The final stage of clinical reasoning involves the *careful evaluation* of the case formulation according to its empirical adequacy alongside other important criteria, such as explanatory power, simplicity, and clinical utility. The importance of adequate evaluation cannot be overstated. Knowledge of the potential for error in human decision making should alert practitioners to the temptation to simply accept a case formulation as a clinical reality. In any clinical situation, there may be a number of plausible conceptualisations of the key issues and ways to refine the assessment (Ward et al., 1999). Careful attention to the quality of assessment information or data, a thorough understanding of contemporary sex offender theory and research, and use of a local scientist-practitioner model and attitude are all valuable attributes for construction and refinement of case formulations. At a practical level, clinical supervision and peer review of preliminary formulations, and systematic review and revision of case formulation during treatment are processes that can support the quality of clinical reasoning and formulation.

In summary, clinical case conceptualization involves multiple judgments about clients' behaviour problems and their causes. It is an integrated array of treatment relevant clinical reasoning that links clinical assessment data to the design of individually tailored treatment programs. Use of formal and systematic models of case formulation that draw on client information obtained using evidence based assessment practice provide the best means of minimizing clinician error and enhancing the benefits that case formulation offers.

Sexual offender theory

A good understanding of relevant theory ensures clinicians' assessments reflect contemporary knowledge of the causes of sexually aggressive behaviour and associated phenomenology. Although theories don't replace the need for evidence based assessment methods or clinical reasoning, assessment practices that are tightly linked to relevant theory helps guard against idiosyncratic assessment and conjecture about the causes and treatment needs of individuals who have offended (Collie & Ward, 2007; Hunsley & Mash, 2005). In this next section we discuss some key elements of contemporary sexual offender etiological and rehabilitation theories and highlight some of the implications for assessment and case formulation. Our objective is to show the heterogeneity evident among sex offenders, in order to argue for the utility of tailored or individualized formulations, rather than to critically review this large area.

Etiological theories

A number of single and multifactoral etiological theories have been proposed to account, primarily, for child molestation and rape (see Ward et al., 2006). Although the various theories emphasise different aspects of the phenomenon of sexual offending, together they suggest a core set of problem areas are evident in sexual offenders (Beech & Ward, 2004). These core areas can be summarised as (i) deviant sexual arousal, preferences or scripts (e.g., sexual arousal to children, arousal to rape stimuli), (ii) offence supportive cognition (e.g., cognitive distortions, child molestation and rape supportive beliefs, negative socio-cultural attitudes, hostility toward women), (iii) deficits in socio-affective functioning (e.g., intimacy deficits, social skills deficits), and (iv) self-regulation deficits (e.g., impulsivity, poor emotional regulation). Empathy deficits are common in sexual offenders but are hypothesized to arise from core problems in cognition and emotion regulation (Ward & Beech, 2006).

Although a core range of problems are indicated in sexual offending, theoretical accounts, research, and clinical experience tells us that the extent to which each problem area drives sexual offending varies from individual to individual (e.g., Hall & Hirschman, 1991; Hanson & Harris, 2000; Ward & Siegert, 2002). Some risk factors appear to play a stronger casual role than others. Hall and Hirschman's (1991) account of sexual offending, for example, proposed that one risk factor may be primary and intensify or elicit other risk factors (e.g., antisocial and distorted cognition may be the primary problem that elicits use of coercion during sex). Similarly extensive empirical work with rapists indicates that the primary motivation to offend may be classified taxonomically (Knight & Prentky, 1990). It is therefore important in the assessment and clinical reasoning process that practitioners identify the presence and manifestation of the various dysfunctional mechanisms that lead to sexual offending and the causal significance of each problem area. To illustrate, although deviant sexual arousal are arguably present in all coercive sexual offences it is a mistake to conclude that all sex offenders are *primarily* motivated by deviant sexual arousal (Lackie & de Man, 1997; Marshall, 2006). For some offenders, antisocial attitudes can lead to a sense of entitlement to sex and lack of concern about the harm caused through use of force or coercion to achieve this goal, while for others intimacy deficits may be the primary problem with deviant sexual arousal evolving from inappropriate sexualization of attachment to a child. The important point is that an individualised case formulation that is informed by contemporary theory and research provides a sound rationale for tailored treatment planning. If a client who sexually offends has otherwise normal sexual preferences and scripts, then extensive treatment to rectify deviant sexual preferences is misguided. Instead such a client primarily requires therapy to modify his (or her) entrenched maladaptive interpersonal strategies and beliefs about themselves and other people.

Rehabilitation and Treatment Theories

The *Relapse Prevention (RP)* model has been the dominant approach to understanding the sexual recidivism and offence processes of sex offenders over the last twenty years and in many

instances was used as the organizing therapeutic framework for sexual offender programmes (Laws, 2003, Laws, Hudson, & Ward, 2000; Ward, 2000; Ward & Hudson, 1996). Offence process theories describe the temporal sequence of psychological and situational factors that occur in offending (behavior chain analysis). They provide a clear account of *how* an individual offends and constitute the conceptual basis that underpins the self-management focus of cognitive-behavioral interventions with sex offenders (Hudson & Ward, 2000). According to the RP model, sexual offending follows a predictable pattern that (1) unfolds over time, (2) may be explained by a number of important concepts and principles (such as high risk situations, problems of immediate gratification), and (3) involves a self-regulation failure. In essence the RP model conceptualises sexual offenders' relapse process as a failure to control impulses sufficiently to avoid further offending.

Despite the clinical appeal and wide adoption of the RP sexual offence relapse model, the model and its application with sexual offenders has been criticised on a number of counts (see Laws et al., 2000; Ward & Hudson, 1998). Perhaps most significantly, research shows that sexual recidivism does not occur only through the traditional RP pathway but via multiple pathways. For some individuals the core problems are not self-regulatory failure but instead conscious and purposeful decision-making enacted in the pursuit of pro-offending goals (Laws et al., 2000; Ward, Louden, Hudson, & Marshall, 1995; Ward, Yates, & Long, 2006; Webster 2005).

Ward and Hudson (1998, 2000) developed the *Self-Regulation Model (SRM)* to better account for this heterogeneity in offenders' sexual goals and self-regulation style. The SRM contains four offence pathways that represent various combinations of avoidance and approach offence goals and self-regulation styles. Two avoidance pathways characterise individuals who wish to abstain from sexual offending. The *avoidance-passive* pathway describes individuals who lack sufficient coping skills and self-awareness to achieve their offence avoidance goal. The *avoidant-active* pathway describes individuals who use ineffective or counter-productive strategies that are ultimately unsuccessful (i.e., they have a misregulation style). In contrast, two approach pathways characterise individuals who wish to offend. The *approach-automatic* pathway describes individuals who have impulsive and poorly planned behaviour (i.e., they have an under-regulation style) and thus their offending happens in a somewhat automated, unconscious manner. The *approach-explicit* pathway describes individuals who use effective self-regulation (e.g., careful planning, emotional regulation, and problem solving) to create and exploit opportunities to sexually offend.

Compared to the traditional relapse prevention model, the SRM allows a more sophisticated evaluation of offenders' motivations, goals, and skills. Successful validation studies conducted with child molesters (Bickley & Beech, 2002; Proulx, Perreault, & Ouimet, 1999), rapists (Yates, Kingston, & Hall, 2003), and sexual offenders as a general group (Keeling, Rose, & Beech, 2006; Webster, 2005) indicate that most sexual offenders are quite easily classified to one of the four pathways. In addition, in stark contrast to the RP model's predictions, the most commonly identified pathway to sexual offending appears to involve approach goals. In terms of assessment the SRM facilitates the development of a more accurate and individualized picture of offending which moves away from a 'one size fits all' approach to treatment and risk management. In the avoidant-passive pathway, for example, the primary problems manifesting in sexual recidivism are inadequate coping skills and lack of offence process awareness. Thus treatment planning should include significant focus on increasing awareness of the steps in the offending chain and developing a range of skills to more appropriately deal with problems (Ward et al., 2006). In contrast, in the approach-automatic pathway a core problem resides in the offenders' positive beliefs about sexually abusive behavior. Although approach-automatic individuals also show self-regulation failures, enhancing these skills should only occur *after* achieving some fundamental shift in motivation to offend. Improving self-regulation ability in the absence of changing positive beliefs about sexual offending runs the very serious risk of increasing offenders' ability to achieve their pro-offence goals (i.e., facilitating their learning an approach-explicit pathway). Of the few studies investigating the pathways to recidivism of previously treated sexual offenders, also suggests that approach goal offenders present higher risk of repeat sexual offending and thus this information is valuable for community monitoring and supervision (Webster, 2005).

Attention to the nature of offenders' goals is also emphasized in the Good Lives Model (GLM) of offender rehabilitation (Ward, 2002; Ward & Gannon, 2006; Ward & Marshall, 2004; Ward & Stewart, 2003). The GLM is based on the notion that humans are active, goal-seeking beings whose actions reflect attempts to meet inherent human needs or *primary human goods* (Emmons, 1999; Ward, 2002). Primary human goods are actions, states of affairs, or experiences that are inherently beneficial and sought for their own sake (Arnhart, 1998; Deci & Ryan, 2000; Emmons, 1999; Schmuck & Sheldon, 2001). In other words, primary human goods are linked to psychological wellbeing, and as well a sense of meaning and purpose in life. Examples of primary human goods include autonomy, competence, and relatedness (Deci & Ryan, 2000). According to the GLM, individuals achieve primary human goods through engagement in secondary or instrumental goods. For example, intimacy (a subclass of the good of relatedness) may be met via romantic relationships or close friendships. In the case of sexual offenders, sexual crimes can result either through the direct pursuit of primary human goods by sexual abuse of a child or adult, or as an indirect effect of problems pursuing goods in a normally socially acceptable way. In the direct route, for example, sexual offending may be an offender's main means of obtaining intimacy, mastery, competence, or sexual satisfaction. In the indirect route, an intimate relationship may be the main means of obtaining sexual satisfaction but when blocked or frustrated sexual offending may arise. For example, some individuals sexually offend only in the context of significant life stressors, such as relationship dissolution, and when their coping skills are inadequate. The major point is that for some individuals offending constitutes their main source of essential human goods whereas for other individuals offending represents a deviation from an otherwise non-offending lifestyle.

Although this is a cursory review of the GLM, it is apparent that the GLM expands on the conceptualization of offence goals proposed in the SRM. Rather than limiting the focus to whether the offender attempts to avoid or seek out sexual offence opportunities, the GLM asks what human goods sexual offending provides or meets for the offender? The implications for assessment and case formulation include a need to determine what goods are being sought via offending and what problematic conditions give rise to offending. Treatment planning must then give consideration to the internal conditions (e.g., competencies, beliefs) and external conditions (e.g., opportunities, social environment) required to enable the client to achieve his primary goods in a personally satisfying and socially acceptable manner (see Ward, Mann, & Gannon, 2007, for a detailed discussion). At this stage empirical investigation of the GLM is only beginning to be undertaken (e.g., Whitehead, Ward, & Collie, in press), however, the approach is more generally based on large bodies of research relating to general human functioning and strengths based treatment.

In summary, theory and research with sexual offenders has developed sufficiently to arrive at a number of important understandings about several common core problems and pathways that are associated with recidivism. Equally theory and research highlights that the presence and manifestation of these factors varies between offenders. In addition, unique factors can always play a part or come to bare on the causes of sexual offending and clients' treatment needs. Individualized case formulations provide a means to recognise, understand, and address this heterogeneity in treatment.

Risk Assessment

Risk assessment is an important consideration in sex offender treatment. Risk level provides valuable information about the intensity of treatment that is appropriate, as well as the suitability of different treatment contexts (e.g., community, residential, and custodial settings). Furthermore, the overarching aim of treatment is to reduce the risk of harm to future victims through the provision of treatment and ongoing support and monitoring. In this regard, risk management is an important outcome of treatment.

There is currently a consensus in the assessment field that risk of sexual recidivism can be predicted with a useful level of accuracy, and that there is a need to empirically identify the best measures and methods to use (Abracen et al., 2004; Borum, 1996; Miller, Amenta, & Conroy, 2005).

Although there is continuing debate over the optimal utilization of static and dynamic risk factors in risk assessment (see e.g. Quinsey, Harris, Rice & Cormier, 1998, vs Hanson & Harris, 2001; Craig, Browne & Stringer, 2004), actuarial measures have demonstrated a statistically significant level of predictive accuracy regarding the risk of sexual reoffending, and consistently outperform clinical judgment (Hanson, 1998; Hanson & Thornton, 1999, 2000). Actuarial measures function by placing individual offenders into groups with known reconviction rates, so that individual risk estimates are based on observed group outcomes. Examples of such measures with research evidence of predictive validity include the Violence Risk Appraisal Guide (VRAG) (Harris, Rice & Quinsey, 1993), the Sex Offender Risk Appraisal Guide (SORAG) (Quinsey, Harris, Rice, & Cormier, 1998), the Rapid Risk Assessment of Sexual Offense Recidivism (RRASOR) (Hanson, 1997), and the Static-99 (Hanson & Thornton, 1999). With regard to the Static-99, for example, Doren (2004) notes that there have been at least 22 studies of the Static-99's predictive validity beyond the Hanson and Thornton (2000) developmental study, where they originally reported a correlation with sexual recidivism of .33 and a receiver operating characteristic (ROC) area under the curve (AUC) of .71.

Actuarial measures such as these form the foundation of the best-validated risk assessment procedures currently available. One of their characteristics, however, is their almost exclusive reliance on static (unchangeable) risk factors. Thus it is now standard practice in sexual offender recidivism risk assessment to also include consideration of dynamic factors, that is, those factors that can change over time and influence the degree of risk for reoffending. One of the most common measures for dynamic variables currently in use is the Sex Offender Need Assessment Rating (SONAR) an actuarially based measure of dynamic risk factors empirically related to rates of sexual recidivism (Hanson & Harris, 2000a, 2000b). The SONAR scores variables across two domains – stable dynamic and acute dynamic. Stable dynamic factors are those present for a month or more that affect an offender's functioning (namely, intimacy deficits, negative social influences, attitudes tolerant of sex offending, sexual self-regulation, general self-regulation). Acute dynamic factors are those that may be present for only a short time prior to an offence and have a precipitating affect on the offending (namely, substance abuse, negative mood, anger, victim access).

Recent research on sex offenders has supported the inclusion of dynamic variables into risk assessment to give a fuller picture of individualized risk (Craig, Browne, & Stringer, 2004; Craissati & Beech, 2005). Studies have shown that including an assessment of dynamic factors can strengthen the predictive ability of static actuarial measures designed to measure sexual recidivism (Beech, Friendship, Erikson, & Hanson, 2002; Thornton, 2002). A recent review of the effectiveness of sexual recidivism risk assessments found that structured clinical judgment, where a clinician makes a prediction of risk guided by an appropriate actuarial measure, combined with dynamic variables individual to an offender, showed good predictive accuracy (Hanson & Morton-Bourgon, 2005).

In summary, there is now a substantial body of research literature to guide the practice of risk assessment with sexual offenders. Well validated actuarial measures are available that can help distinguish between higher and lower risk offenders. Research findings are beginning to emerge that more clearly address the risk presented by specific subgroups of offenders such as child molesters. Findings based on static actuarial measures, which by definition cannot detect changes in risk status over time, are now being augmented by standardized approaches to assessing dynamic or changeable risk factors. These dynamic risk measures are themselves currently undergoing a process of empirical validation through research studies. What we believe is needed is an individualized risk assessment which provides an *etiological* understanding of the factors contributing to sexual offending in a given case, but that is primarily grounded in the relative risk of reoffending based on a recognized actuarial measure such as the Static-99. Such an approach will also incorporate other factors known to be associated with risk of sexual reoffending.

An advantage to thinking about risk variables in etiological terms is that it encourages clinicians to consider a wider range of vulnerability factors that correspond to different types of risk markers (Beech & Ward, 2004). This enables practitioners to develop case formulations more clearly linked to the different risk domains. In a sense, it could improve the quality of risk assessment and

help to tailor risk assessment procedures to the unique set of causes relevant to individual offenders. This approach also suggests, perhaps, a novel approach to risk assessment. Rather than taking a clinically adjusted actuarial approach, it might be better to start with a dynamic risk assessment and then adjust the level of risk based on the levels of historic risk based on actuarial risk instruments.

Case Study

Thus far we have attempted to overview the important conceptual elements of assessment and case formulation, and draw on current knowledge of the causes of sexual offending to construct an argument for the need and value of individualized case formulation in sexual offender rehabilitation and management. We include a short case vignette and discussion in this section to provide a more concrete illustration of the goals, skills, and underlying vulnerabilities that appeared relevant to an individual's pattern of offending and formulation of his case. The client was extensively interviewed and collateral information reviewed by one of the authors (RC) as part of a research study investigating the role of personality variables on offence processes. The client was just entering a prison based sexual offender treatment programme that provided standardised modules to all participants. The outcome of his treatment is not known unfortunately.

Client A

Client A is a twenty-four year old man who was convicted of sexual offences against two boy victims aged between 10 and 14 years of age. He offended against the boys independently. Client A's pattern of offending involved fondling the victims and progressed quickly to masturbation, oral sex, and anal intercourse. He met the boys locally, identifying them as lonely kids due to the absence of their fathers and having no siblings of a similar age. He gained the trust of their mothers over time and subsequently orchestrated opportunities for each boy to visit at his house or for him to visit when their mothers were out. Client A groomed the boys via friendship, providing items that their mothers could not such as pocket money and access to computer games, and by giving them access to pornographic magazines. He reported enjoying the boys company and their sexual "relationship". Client A regarded the abuse as consensual as it included him performing sexual acts on the boys and did not involve physical violence. He claims he would have stopped had the boys protested. He discouraged the boys disclosing their abuse by saying they would all get into very serious trouble and he would be sent to jail.

Client A has a prior conviction for sexual offending at nineteen years of age against his 11 year old male cousin. However, he disclosed that the offending began when his cousin was 8. He said it occurred mostly when he was babysitting the victim. Again he believed the abuse was consensual and mutually beneficial. Client A also disclosed a history of personal sexual abuse by an uncle between 9 and 17 years of age, which he came to believe represented a consensual relationship. He also has a history of sexually activity with same aged male peers, and on occasion female peers, from 12 years of age. On at least one occasion this involved Client A being raped. Client A reported seeking out opportunities for sex as this represented one of the few positive and pleasurable things in his life.

Some of the prominent features of Client A's case formulation are that he follows an approach-explicit sexual recidivism pathway as he desired to sexually offend and uses explicit planning to achieve this goal. In keeping with his pro-offence orientation and active use of goal attainment strategies, Client A has committed a large number of offences against at least three victims. He takes advantage of opportunities within his family and community to befriend children and manipulate adults to have access to children for his own sexual gratification. Core problems for Client A are his deviant sexual preference for pre-pubescent and pubescent boys, as indicated by his offence pattern and self-report. Such a preference is likely to have its origins in his own experience of sexual abuse as a child and adolescence, which appears to have been reinforced by early sexual experiences with his peers. Client A also evidences entrenched beliefs about the appropriateness of sexual relations between adults and children, and children's ability to consent to and benefit from sex.

These attitudes appear to have been developed and reinforced since an early age. As a result Client A does not regard his offending as problematic or harmful. Rather, he explicitly approaches offending to directly seek certain goals via the sexual abuse of boys (e.g., pleasure, relatedness) and he believes that his actions provide benefits to his victims.

Client A has a number of identified risk factors for sexual recidivism. Static risk factors include that he is single, young, has prior charges/convictions for sexual offences, and that he has offended against victims who are male and unrelated. Assessment with an actuarial measure designed to assess the risk of sexual and violent recidivism in offenders already convicted of a sexual offence, namely the Static-99 (Hanson & Thornton, 1999), indicate that he is at medium-high risk of sexual recidivism over a five or more year period. Dynamic risk factors based on case-specific factors assessed using the Stable 2000 (Hanson & Harris, 2000) include his intimacy deficits, lack of positive social influences, attitudes supportive of sexual offending, and sexual regulation problems. In addition, Client A appears to have emotional congruence with children.

In this case, a formulation that identifies A's offence pathway, his prominent causal factors (dynamic risk variables), and overall level of risk was arrived at utilizing psychometric, interview and psychological measures. This formulation, albeit brief and incomplete, points to a number of treatment issues. Given Client A's relatively high risk of sexual recidivism (due to his actuarial assessment and the presence of a number of dynamic risk factors), he will require a high intensity treatment program with maintenance programming in the community. It is necessary to provide Client A with alternative means of securing the goods associated with his offending (which appear to include friendship, sexual satisfaction, and agency). This will involve providing him with the capabilities and opportunities to establish meaningful relationships with adults, including intimate relationships, to find other means of obtaining sexual satisfaction, and more generally sources of pleasure.

Conclusion

Case formulation requires systematic clinical reasoning about an offender's sexually abusive actions and their causal underpinnings. The result of such a clinical analysis is a (micro) clinical theory containing a set of interrelated descriptive and explanatory hypotheses about a particular individual. Ultimately, the value of constructing individual case formulations needs to be ascertained and their role in routine clinical work established. If researchers such as Garb and Wilson are right (Garb, 1998, 2005; Wilson, 1996), then the fact that human beings are poor decision makers will always exclude significant reliance on the judgment of individual clinicians in determining the structure of treatment. Professional discretion may be exercised in exceptional circumstances, but this will be a rare occurrence. According to this perspective, the way of the future will be more flexible and refined manual based treatment programs with patients' needs determining what interventions they receive. These will be identified using reliable and valid measures, and arguably, clinical algorithms.

We disagree with this position and believe that disciplined clinical judgment is an irreducible element of sound practice, although the reasoning processes resulting in clinical decisions should be arrived at through the application of a systematic and articulated method. It will simply not do to rely on unchecked intuition or vague generalizations concerning underlying causes. Every link in the chain of reasoning should be defensible and rooted in established theory and data. Furthermore, the model of case formulation used needs to be clearly identified and its efficacy researched. Ethical and scientific values dictate that the best model should be used, and if this has not been settled empirically, then a case should be made on conceptual and pragmatic grounds. Either way, a defense should be mounted that constructing an individual case formulation can help clinicians tailor treatment to individual offenders and result in more appropriate therapy. In brief, our natural tendency to theorize about the world, if sufficiently disciplined by an explicit attention to method, can be a benefit rather than a burden.

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