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

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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

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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.

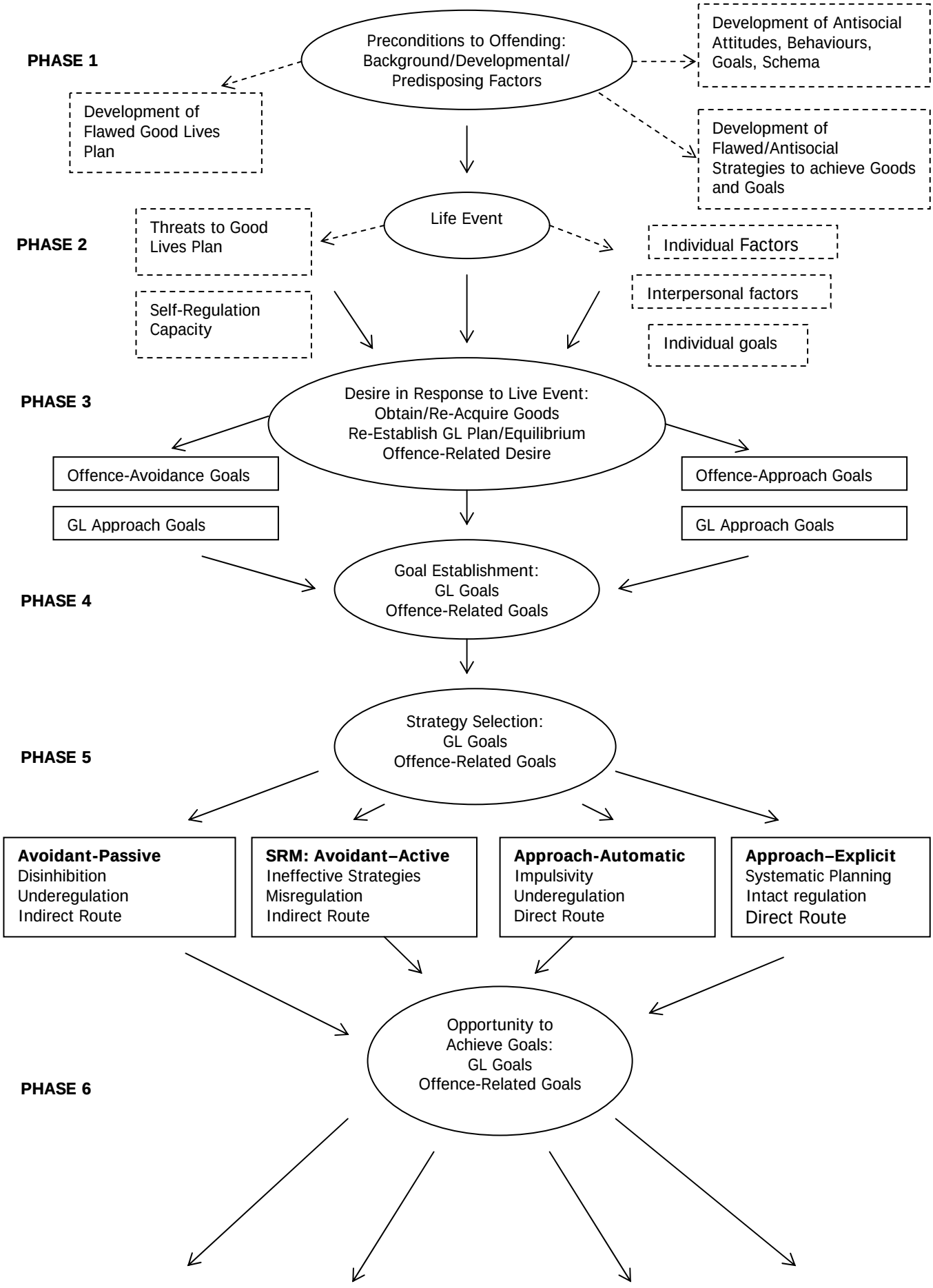
Reconstruction of the Self-Regulation Model

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.



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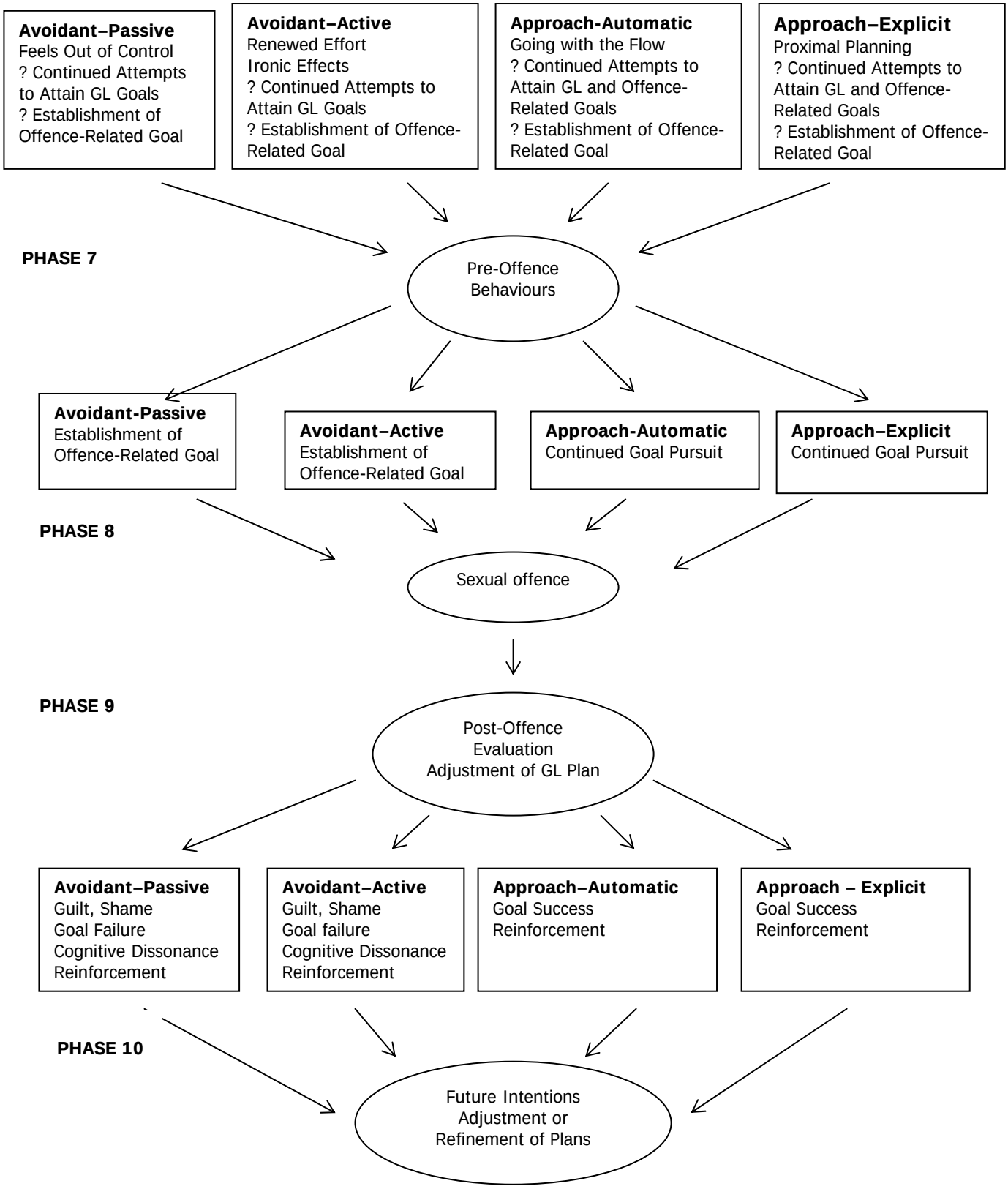

Figure 1: Revised Self-Regulation Model of the Sexual Offence

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.