

**Taking the Leap:
Abandoning Relapse Prevention and Applying the Self-Regulation Model to the
Treatment of Sexual Offenders**

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Introduction

In 1998, Tony Ward and Stephen Hudson proposed the self-regulation model as an alternative to the relapse prevention approach to the treatment of sexual offenders. Since that time, this model has been implemented in several correctional services worldwide (Yates, 2005), including Canada, the United Kingdom, Australia, and at least one US state, has been subjected to a number of empirical evaluations (see Ward, et al., 2004; Ward, Yates, & Long, 2006; Yates & Kingston, 2005; Yates & Ward, in press), and has been embedded within the Good Lives Model of rehabilitation (Ward & Gannon, 2006; Ward & Stewart, 2003, Yates & Ward, in press; Ward, et al., 2006). While many individuals report that the self-regulation model and theory seem sensible and, perhaps, superior to relapse prevention, numerous questions have been raised by practitioners in the field about the application of the model to the treatment of sexual offenders. Understandably, clinicians are reluctant to abandon established practice in order to adopt a treatment model that is perceived to be relatively untested. Others report that they have been, in fact, implementing approximations of the self-regulation model under the auspices of their current relapse prevention programs. Those who are interested in, but tentative about, the model highlight its predominantly theoretical nature at present and the lack of information available on translating the model into actual practice with sexual offenders.

The present chapter is designed to address such questions and to provide information on the practical application of the model to interventions with sexual offenders. Necessarily, a complete exploration of this application is beyond the scope of this chapter. The aim, therefore, is twofold: (1) to demonstrate the superiority of the self-regulation model over the traditional relapse prevention model and its adaptation to sexual offenders; and (2) to provide clinicians and others involved in the treatment and supervision of sexual offenders with examples of how the model can be applied in practice, in keeping with sound therapeutic practices and established principles of effective intervention and risk management. The two models are compared and contrasted, research is reviewed, and the examples of the application of the self-management model to clinical practice are provided.

What, Exactly, is the Relapse Prevention Model?

Relapse prevention was originally designed as maintenance strategy for alcoholic patients following treatment for addiction (Marlatt, 1982; Marlatt & Gordon, 1985). The aim was to assist recovering patients to gain self-control and to maintain change that had occurred during treatment. The model was developed as a result of observations that these patients, although motivated to refrain from substance use, experienced difficulty maintaining abstinence following successful completion of treatment (Marlatt, 1982), and demonstrated very high rates of relapse (Hunt, Barnett, & Branch, 1971). Briefly, the model proposed that relapse occurred when individuals encountered high risk situations via a series of *seemingly irrelevant decisions* – apparently innocuous decisions that, in

reality, were subconsciously purposive and led the individual to embark on a course of action that placed him or her at risk for substance use. When individuals encountered these situations, they experienced a loss of control and the *problem of immediate gratification* – the inability to resist substance use as a result of loss of control and anticipation of the positive consequences of use. This inability to delay gratification led to a *lapse* (a temporary return to substance use), after which individuals then experienced an *abstinence violation effect* – the confluence of negative emotions, cognitive distortions, and decreased self-efficacy resulting from failure to successfully abstain from substance use. This process increased individuals' expectations of failure, exacerbated loss of control, and caused them to abandon their abstinence goal, resulting in *relapse* (a complete return to substance abuse).

In treatment, the focus of the traditional relapse prevention approach is to assist individuals to identify and anticipate problems that can lead to lapse and, ultimately, relapse (Laws & Ward, 2006; Marques, Day, & Nelson, 1992; Pithers, 1990; 1991). Using a risk management approach, treatment within this model assists individuals to develop skills with which to cope with internal conditions and external circumstances that can lead to lapse and relapse, to avoid high risk situations, and to increase self-efficacy and outcome expectancies in order to instill confidence that behavioral change can be maintained in the face of problems. The individual is taught a variety of skills in order to overcome deficits in coping ability, to regain self-control, and to implement adaptive responses at various points in the sequence, which would function to further increase self-efficacy and positive outcome expectancies and the re-establishment and maintenance of abstinence.

Relapse prevention as applied to sexual offenders varies little from its original framework (Marlatt 1982; Marlatt & Gordon, 1985), although some minor revisions were made, such as redefining the concept of lapse to include pre-offence behaviors (e.g., engaging in sexually deviant fantasies) rather than a temporary return to sexual offending (Laws, 1989; 2000; Laws & Ward, 2006; Marques, et al., 1992; Pithers, 1990; Pithers, Kashima, Cumming, & Beal, 1988; Pithers, Marques, Gibat, & Marlatt, 1983). Since these adaptations, virtually all cognitive-behavioral sex offender treatment programs have adopted the relapse prevention approach as "the treatment of choice" (Laws, Hudson, & Ward, 2000, p. 5).

As applied to sexual offenders, treatment goals remain similar to those of the traditional relapse prevention model. These include assisting individuals to identify and anticipate internal states and external situations that can lead to lapse and relapse, and teaching a variety of cognitive and behavioral skills to cope with these problems should these arise (Laws & Ward, 2006; Marques et al., 1992; Pithers, 1990; 1991; Yates, 2002; 2003; Yates & Ward, in press). Sexual offending and associated behaviors are viewed as a cycle or sequence of events that can avoided or, if unavoidable, can be interrupted by individuals to prevent re-offending by increasing their awareness of this cycle and developing their capacity to intervene in the sequence via the use of effective coping skills. As in the original model, treatment takes a risk management approach by assisting the offender to identify and avoid high risk situations, to prevent lapse and relapse, to develop coping skills, to increase self-control, and to increase self-efficacy and outcome expectancies.

What is Wrong with the Traditional Relapse Prevention Model?

This is a commonly posed question for which a comprehensive response is complex. There are problems with the theoretical structure of the original relapse prevention model and some of its constructs that are beyond the scope of this chapter, but that are that are well described elsewhere (Laws, et al., 2000; Ward, et al., 2006; Laws & Ward, 2006; Ward, Polaschek, & Beech, 2006; Yates, 2005; Yates, et al., 2000; Yates & Kingston, 2005; Yates & Ward, in press). Briefly, problems with the theoretical model include a lack of coherence, as evidenced by multiple conflicting mechanisms within the model, unnecessary complexity, for example, multiple proposed mechanisms for such processes as the transition between lapse and relapse, and a lack of scope, for example, the model's failure to account for those circumstances during which individuals fail to implement coping strategies that are clearly evident in their repertoire. In addition, there is an absence of research supporting the effectiveness of the model with sexual offenders (see below). Perhaps most significant for practitioners are the considerable problems associated with the application and adaptation of relapse prevention to sexual offenders that impact significantly on its applicability to treatment with this group. These are reviewed below.

Lack of Consideration of Heterogeneity Among Sexual Offenders

The traditional relapse prevention model fails to account for the heterogeneity evident among sexual offenders and the diversity in offending behavior and motivation for offending. This problem is, in part, due to the model's reliance on a single pathway to offending that does not take into account the variability in self-regulatory capacity among individual offenders (Ward & Hudson, 2000; Ward, et al., 2006; Yates, 2003; 2005; Yates & Kingston, 2005; Yates & Ward, in press). It is well-established that sexual offenders vary in the risk they pose to re-offend, dynamic risk factors associated with offending, and recidivism rates (Hanson, et al., 2002; Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2004; Nicholaichuk, Gordon, Gu, & Wong, 2000; Nicholaichuk & Yates, 2002; Polascheck, 2003; Yates & Kingston, in press; Yates, Kingston, & Hall, 2003). However, the relapse prevention model posits only a single pathway to offending, characterized predominantly by self-regulatory deficits. It is questionable whether this single pathway applies at all to sexual offenders, given that it was not developed and validated with this group, and it is certain that this pathway does not apply to offenders with intact self-regulation. Specifically, some sexual offenders seek out opportunities to offend, while others demonstrate problems with their ability to regulate their behavior and cognitive and emotional states. While the traditional relapse prevention model may, to some extent, explain behavior among offenders demonstrating self-regulatory deficits and can incorporate treatment strategies for this group, the single relapse pathway does not adequately account for behavior of offenders with intact self-regulation, nor can it accommodate treatment and management strategies for this group. As such, the traditional relapse prevention model is of questionable utility with many sexual offenders.

Lack of Applicability of Constructs to Sexual Offending Behavior

Several important constructs contained in the traditional relapse prevention model are problematic in their application to sexual offenders. The construct of *abstinence* is

particularly problematic, since there is no evidence to suggest that sexual offending is an addictive behavior that is similar to substance abuse, nor that it follows the same processes of development, maintenance, and recurrence as does substance abuse behavior. Furthermore, the ultimate outcome of sex offender treatment is not to ensure abstinence from sexual behavior, but to ensure cessation of sexually *offensive* behavior. It can be argued that the basis of the model with respect to its ultimate objective, abstinence, is not applicable to sexual offenders. In addition, in practice, the construct of abstinence has, regrettably, been applied in such a manner as to actually prohibit sexual offenders from achieving appropriate sexual behavior. For example, as part of treatment and risk management, sexual offenders have sometimes been required to abstain from all sexual relationships, whether or not these pose a risk for re-offending, and without consideration for the importance of sexual activity in individuals' lives and the negative impact of such abstinence on their lives, psychological well-being, and risk for re-offending.

The traditional relapse prevention constructs of *seemingly irrelevant decisions*, the *problem of immediate gratification*, and the *abstinence violation effect*, are also problematic in that there is no theoretical or practical basis for these constructs within theories of sexual offending behavior. That is, there is no evidence that suggests that sexual offenders experience these events during offending. In addition, these constructs do not sufficiently account for the variation in the degree of planning evident in sexual offending. They are of particularly questionable utility with those offenders who actively implement strategies to prevent offending, those who demonstrate the ability to direct and control their behavior, to delay gratification, and to refrain from offending on certain occasions, and to those who do not experience cognitive dissonance when their behavior (offending) is congruent with their pro-offending attitudes and offence goals. In addition, in practice, the traditional relapse prevention model is unable to distinguish between those circumstances in which gratification of desires is appropriate and acceptable and those in which they are not.

Overemphasis on Negative Affect

In addition to its focus on self-regulation deficits, the single pathway in the traditional relapse prevention model is characterized predominantly by negative emotional states associated with offending. Negative affect can precede high risk situations, or can be triggered by these situations, their appraisal, and other internal events. Offending is viewed as resulting from a breakdown in ability to cope with these states or to the relieve negative affect. In addition, individuals are also presumed to experience predominantly negative affect, such as shame and guilt, following offending. This leads to decreased self-efficacy and outcome expectancies, creating a cycle of behavior from which the individual cannot escape, and leading to increased risk for future offending. Although the influence of positive affect is minimally acknowledged in the traditional relapse prevention model, its role is underemphasized and the focus remains, in practice, on negative affect and the development of skills to cope with these states.

However, while some sexual offenders do experience negative affect both prior to and following offending, others experience predominantly positive emotional states, such as anticipation, sexual gratification, achievement of intimacy, and increased feelings of self-worth, and actively seek out offending in order to achieve these states (Hudson,

Ward, & McCormack, 1999; Laws, et al., 2000; Ward, Louden, Hudson, & Marshall, 1995). The traditional relapse prevention model, therefore, fails to account for those offenders who are not motivated to offend by negative affect or those who experience solely or predominantly positive affect associated with offending behavior. Treatment provided within this framework neglects to assist individuals to cope with positive states associated with offending or to achieve these states via alternative, non-offending means. As such, while negative affect can be instrumental in the commission of sexual offences by some offenders, it is not always present or predominant among sexual offenders. This focus of the traditional relapse prevention model renders treatment using this approach irrelevant to the latter group, and runs the risk of ignoring important offence dynamics during treatment and in the management of risk to re-offend.

Overemphasis on Avoidance Strategies

Treatment based on the traditional relapse prevention model advocates avoidance of high risk situations and states as the predominant strategy in preventing a return to problematic behavior. Treatment focuses on assisting individuals to identify situations that place them at risk to offend and on the development of strategies to avoid these situations and the seemingly irrelevant decisions that lead to placing themselves at risk. As such, offenders are taught to avoid engaging in deviant sexual fantasies, to avoid potential victims, and to avoid experiencing negative emotional states that have, in the past, lead to sexual offending. Treatment also includes the development of strategies to cope with these situations should the individual have been unsuccessful in avoiding them, with the predominant strategy being to escape from the situation. Although there is a role for avoidance strategies in risk management, there is an over-reliance on avoidance and escape strategies in the traditional relapse prevention model. In practice, this also results in the overgeneralization of avoidance strategies to situations that may not place the individual at risk to re-offend. For example, individuals who have offended against adults are admonished to avoid contact with children, against whom they have never offended and toward whom they do not pose a risk. It is argued here that additional strategies are necessary for adequate risk management and to increase both the individual's ability to successfully cope with such situations and to ultimately reduce the need to avoid these situations (see below).

Lack of Consideration of Goods Sought Via Offending

Perhaps one of the most significant practical problems with the relapse prevention model is its failure to take into account the offenders' goals with respect to offending – that is, that which they seek to achieve or obtain via sexual offending. Within the Good Lives Model, behavior is regarded as purposeful and the individual's goals are viewed as essential human goods that the sexual offender obtains via unacceptable means (Ward & Gannon, 2006; Ward & Stewart, 2003; Ward, Vess, Collie, & Gannon, in press; Ward, et al., 2006; Yates & Ward, in press). Goals function to guide behavior with respect to planning, implementation, and evaluation, and are related to the individual's needs, affect, motivation, and psychological well-being (Ward, et al., in press). Goals include *approach goals*, which are concerned with the acquisition of desired states or goods, and *avoidance goals*, which are concerned with the prevention of an undesirable situation or state (Ward, et al., in press). Both types of goals are active in both sexual offending and

in risk management. That is, individuals can either approach or avoid offending, as well as work toward achieving pro-social goals as part of reducing risk and managing their behavior. Approach goals function to motivate individuals to achieve desired states or outcomes, and are more easily attained than avoidance goals (Mann, 1998; Mann, Webster, Schofield, & Marshall, 2004; Ward, et al., in press). Furthermore, approach goals are associated with positive affect, reduced cognitive load, less deterioration in self-regulatory ability, and lower levels of psychological distress (Carver & Scheier, 1981; Ward, et al., in press). By contrast, avoidance goals are associated with negative affect, psychological distress, impairment in psychological functioning, impairment of self-regulatory capacity in situations of stress, and require considerable cognitive resources to attain and maintain (Austin & Vancouver, 1996; Emmons, 1996; Ward, et al., in press).

By focusing on avoidance goals, both as motivating offending and in risk management, the traditional relapse prevention model neglects to understand that which offenders seek to obtain via offending (i.e., their approach goals with respect to offensive behavior), or those goals toward which they can work in order to manage risk and to achieve desired (pro-social) ends. Without such an understanding, treatment runs the risk of being unable to assist offenders to achieve their goals via acceptable means, of being irrelevant to individuals' personal and social circumstances, and of being unable to assist them to ultimately lead an offence-free life that is satisfying to them. Treatment within this approach also results in the creation of risk management plans that are avoidance-focused, that reduce motivation, that demand considerable cognitive resources on the part of the individual, that do not provide the individual with objectives toward which he or she can strive, and that run the risk of failure and deterioration in self-regulation capacity during times of stress.

Misapplication of the Model to the Treatment of Sexual Offenders

Given its origins, the applicability of the traditional relapse prevention model to sexual offenders is, at best, questionable. As indicated above, treatment using this approach was specifically designed to assist alcoholic patients to maintain abstinence from substance use, and was developed for individuals who are motivated to abstain from problematic behavior. As clinicians can attest, sexual offenders possess varying levels of motivation to change their behavior and are not always motivated to change (Thornton, 1997). It can be argued that treatment based on the relapse prevention approach is simply inappropriate for individuals who are unmotivated to change at the start of treatment. However, exclusion of these individuals from treatment on this basis can have serious consequences – increased recidivism and future victims – and indicates that the field of sexual offender treatment is in need of a model that can successfully accommodate those who are not initially motivated to change their behavior.

The traditional relapse prevention model has also been misapplied both as a model and as a treatment method with sexual offenders (Laws, 2003; Laws & Ward, 2006; Ward & Gannon, 2006; Ward & Hudson, 1998; Ward & Stewart, 2003; Yates, 2002; 2005; Yates & Kingston, 2005; Yates & Ward, in press). Specifically, this model has been applied to sexual offenders as *treatment*, rather than as post-treatment maintenance, an application that is far beyond the original intention of the model (Laws & Ward, 2006; Yates, 2005; Yates et al., 2000). Furthermore, although maintenance programming following treatment represents accepted practice with sexual offenders

(Cumming & McGrath, 2000; Laws, et al., 2000; Wilson, Stewart, Stirpe, Barrett, & Cripps, 2000; Yates, et al., 2000), there is no theoretical or empirical rationale that suggests that the relapse prevention approach is the most appropriate method to achieve risk management following treatment.

Failure of the Model to Evolve

In addition to questions of applicability of the theoretical relapse prevention model to sexual offending behavior and treatment with this group, the model has evolved little in the field of treatment of sexual offenders. In the field of substance abuse, the model has been refined over the years to incorporate multiple influences on behavior, such as harm reduction and the inclusion of approach-motivated behavior (Buhringer, 2000; Donovan, 1996; Marlatt, 1996; Shiffman, 1989; Witkiewitz & Marlatt, 2004). However, it has remained essentially unchanged over the past 15 years as applied to the treatment of sexual offenders. Furthermore, in practice, the application of the traditional relapse prevention model has not systematically incorporated research on best practices with offenders in general or with sexual offenders in particular, such as the principles of risk, need, and responsivity, methods of treatment most effective for this group, or research on static and dynamic risk factors.

What, Exactly, is the Self-regulation Model?

Ward and colleagues' model is based on self-regulation theory (Baumeister & Heatherton, 1996; Karoly, 1993) and a detailed analysis of the offence and relapse process in sexual offenders (Hudson, et al., 1999; Ward, Hudson, & Keenan, 1998; Ward, Hudson, & Marshall, 1995). It posits a nine-stage model of sexual offending that takes into account variability in the manner in which individuals regulate their behavior. Offenders are viewed as goal-directed individuals who possess the capability to choose, monitor, modify, and evaluate their actions in seeking to achieve important goals or goods, and who are ultimately capable of living offence-free good lives (Ward & Hudson, 1998; 2000, Ward, et al., 2004; Ward & Gannon, 2006; Ward & Stewart, 2003; Ward et al., in press; Ward et al., 2006). Goals are defined as desired states that may include actively seeking to achieve a specific outcome (appetitive or approach goals) or avoiding an undesirable outcome or state (inhibitory or avoidance goals). For example, in the commission of their offences, some sexual offenders may be motivated to achieve the goal of intimacy or retaliation, while others may be motivated to avoid or cope with such states as loneliness or loss of personal power, with the former representing approach goals and the latter, avoidance goals.

In attempting to achieve their goals, individuals demonstrate differences in self-regulatory ability (Ward, et al., 2004; Ward & Hudson, 1998; 2000; Ward, et al., in press; Ward et al., 2006). Some individuals fail to control their behavior or emotional states (*disinhibition*). Others attempt to actively control their behavior using strategies that are ultimately counterproductive and ineffective, leading to *mis-regulation*. Finally, other individuals have intact self-regulatory abilities, but inappropriate goals, such as the explicit desire to harm others.

The self-regulation model takes into account both the individual's goals with respect to offending (inhibitory versus acquisitional) and the strategies used to achieve these goals (self-regulatory style). Offence strategies reflect the varying degrees of

awareness and planning associated with decision-making with respect to offending (i.e., passive, active, automatic, and explicit). The combination of goals and strategies reflect four distinct pathways to sexual offending, which are described briefly below. These goals and strategies are represented within a nine-stage model of offending containing four pathways (for a detailed description of this model and the pathways, see Ward & Hudson, 1988; 2000 and Ward, et al., 2004). Briefly, the four pathways are as follows.

Avoidant-Passive Pathway. Offenders following this pathway desire to refrain from sexual offending. However, they lack the requisite skills and awareness to effectively control their behavior. With the emergence of the desire to offend, they experience negative emotional states and subsequent disinhibition of behavior, loss of control, impulsivity, and anxiety. As such, this pathway is an *underregulation* pathway. Offences are planned covertly, rather than overtly, and individuals following this pathway are unaware that their behavior functions to bring them closer to offending. In attempting to cope with the desire to offend, they may simply deny its existence or attempt to distract themselves, which are obviously strategies that will ultimately be ineffective in preventing sexual offending. This pathway most closely resembles the traditional relapse process (Ward & Hudson, 1988; 2000).

Avoidant-Active Pathway. The avoidant-active pathway is a *misregulation* pathway. Similar to the avoidant-passive pathway, offenders following the avoidant-active pathway are characterized by having an avoidance goal (i.e., the desire to prevent offending). Unlike the avoidant-passive pathway, individuals following this pathway implement active or explicit strategies to cope with the desire to offend, such as using pornography instead of acting out sexually, rather than simply denying or ignoring this desire. However, the strategies they select to achieve this goal are ineffective and, in some instances, actually result in the ironic effect of increasing the likelihood of offending. This pathway also partially approximates the traditional relapse process in that, for example, the individual may demonstrate some deficits in coping skills, for example (Ward & Hudson, 1988; 2000).

Approach-Automatic Pathway. Offenders following an approach-automatic pathway have approach-motivated (acquisitional or appetitive) goals with respect to offending, and are characterized by *underregulation*. They do not desire to prevent offending and do not attempt to refrain from acting out sexually. Their behavior is relatively automatic, tends to be impulsive, and is based on well-entrenched cognitive and behavioral scripts that are activated by situational cues of which they may not be cognizant. Offence planning is rudimentary and unsophisticated, and offending is typically associated with positive emotional states, such as anticipation of sexual gratification or achieving revenge. Following the commission of an offence, these individuals view their behavior positively, as they have achieved their goals. They are unlikely to experience cognitive dissonance between their actions and their views of themselves and the world.

Approach-Explicit Pathway. Offenders following an approach-explicit pathway possess intact self-regulation. That is, they do not have deficits in their ability to regulate their behavior, nor do they experience a loss of control. Instead, their sexual offences are explicitly and overtly planned in order to achieve a desired end, and these individuals hold attitudes and core beliefs that sexual aggression is an appropriate means by which to achieve these goals. Thus, the problem typically resides in the nature of this group's

goals and their associated values and beliefs about others, themselves, and the world, and not in deficits in self-regulatory capacity.

Are the Self-Regulation and Traditional Relapse Prevention Models Really Different?

As can be seen from the above discussion, there are obvious dissimilarities between the two models that range from theoretical differences to differences in application to practice. The traditional relapse prevention model posits a single pathway to offending, while the self-regulation model proposes four distinct pathways. Relapse prevention posits that sexual offending results from failure to cope or a breakdown or deficits in skills to avoid offending (Pithers, 1990; Pithers, et al., 1983), whereas the self-regulation model posits that offending can occur as a result of deficits or when there are no deficits present. Following the commission of a sexual offence, the traditional relapse prevention model assumes that the individual negatively evaluates their behavior and experiences cognitive dissonance between their goals and behavior. Conversely, the multiple pathways contained within the self-regulation model allow for congruence between the individual's goals, beliefs, and actions. The self-regulation model also explicitly considers individuals' goals with respect to offending behavior and existing skills, and accommodates both positive and negative affect associated with offending, while the traditional relapse prevention model does not consider individuals' goals in offending and focuses predominantly on negative emotional states. The model places a strong emphasis on pro-social approach goals, toward which the individual actively works to achieve during treatment, while such goals are not included in the traditional relapse prevention model or its adaptation to sexual offenders. This focus is, in and of itself, motivating to offenders to change their behavior. Finally, with its consideration of individuals' personal circumstances, life contexts, and goals, the self-regulation model allows greater opportunity for treatment to include individuals with varying levels of motivation to change. These differences are summarized in Table 1.

Table 1 here

It can also be argued that the self-regulation model is also more amenable to the principles of effective correctional practice (Andrews & Bonta, 1998), in which intervention is matched to the risk posed by the offender (*risk principle*), targets criminogenic needs (*need principle*), and is tailored to individual learning styles and abilities of offenders and the contexts in which they live their lives (*responsivity principle*). The risk principle indicates that intervention is most effective with offenders when it varies in nature and intensity based on the level of risk to re-offend, with higher intensity interventions reserved for higher risk offenders (Andrews & Bonta, 1998). Effective treatment also entails targeting the criminogenic needs of offenders (*need principle*), and is most effective when it aims to eliminate or reduce the influence of dynamic, changeable risk factors associated with offending, both empirically and in an individual case (Andrews & Bonta, 1998; Gendreau & Goggin, 1996; 1997; Gendreau, Little, & Goggin, 1996; Nicholaichuk, 1996). Finally, effective intervention adheres to the *responsivity principle*, which indicates that treatment will be most effective when

delivery is tailored so as to be consistent with offenders' learning styles, abilities, and culture (Andrews & Bonta, 1998; Gendreau & Goggin, 1996; 1997; Gendreau et al., 1996). Since offenders differ in self-regulatory ability, risk to re-offend, dynamic risk factors, life context, personal circumstances and environments, and life goals, treatment using the more flexible self-regulation model has greater potential to adhere to these principles than does the traditional relapse prevention model. The self-regulation model is particularly better able to adapt to offender responsivity than is the relapse prevention model, since the former approaches treatment from the starting point of assessment of individual goals and life contexts, and subsequently incorporates this variation into treatment objectives and methods, whereas this process does not form part of intervention in the traditional relapse prevention model.

The self-regulation model also takes a positive orientation that is more amenable to the principles of effective therapy. Recently, the importance of therapeutic process in the treatment of sexual offenders has been acknowledged (Fernandez, 2006; Fernandez, Marshall, Serran, Anderson, & Marshall, 2002; Marshall Anderson, & Fernandez, 1999; Marshall, et al., 2003; Yates et al., 2000). In order to be maximally effective, there needs to be a strong therapeutic alliance between the client and therapist, and the therapist needs to use effective techniques in treatment in order to reinforce and maintain behavior change and skill development (Fernandez et al., 2002; Marshall, et al., 1999; Yates, 2003; Yates et al., 2000). Because the self-regulation model takes a more positive approach to treatment and places less emphasis on deficits, it has greater potential to incorporate these essential characteristics into treatment practice and to make treatment more effective. For example, the potential to use positive reinforcement to support, shape, and entrench pro-social goals, behavior, and attitudes is greater in treatment based on the self-regulation model than in the relapse prevention framework, since the former explicitly seeks to build on offenders' existing strengths and pro-social goals. In treatment using the self-regulation approach, clients are also more likely to engage with treatment, since they are working toward improving their lives and achieving their goals in collaboration with the therapist. Furthermore, it is suggested this focus on strengths and assisting offenders to achieve their goals is more likely to result in commitment to treatment, the development of a strong working alliance, and, ultimately, successful completion of treatment, than is the traditional relapse prevention approach with its focus on deficits, which is more likely to create resistance to treatment and to the therapist.

But What About the Research?

The traditional relapse prevention model has been widely accepted as a method of treatment for sexual offenders, despite a lack of empirical research attesting to its applicability, utility, validity, and efficacy with this population (Hanson, 1996; 2000; Laws, 2003; Laws & Ward, 2006; Marshall & Anderson, 1996; Yates, 2005; Yates & Kingston, 2005; Yates & Ward, in press). Because of its intuitive appeal, and likely as a result of a lack of alternatives for sexual offender treatment at the time, the model was unquestioningly embraced as *the* approach to the treatment of sexual offenders and the majority of treatment programs have included this model and its methods (Freeman-Longo, Bird, Stevenson, & Fiske, 1994; Laws, 2003; Laws, et al., 2000; Laws & Ward, 2006; Polaschek, 2003).

Although cognitive-behavioral treatment (which is *not* synonymous with relapse prevention) is the mode of treatment demonstrating the greatest reduction in recidivism among sexual offenders (Hanson et al., 2002; Losel & Schmucker, 2005), treatment based specifically on the relapse prevention model, however, has *not* been demonstrated to be effective in reducing re-offending among sexual offenders (Berliner, 2002; Hanson, 1996; Laws, 2003; Marques, Day, Nelson, & Miner, 1989; Marques, Nelson, Alarcon, & Day, 2000; Marques, Nelson, Wiederanders, & Day, 2002; Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005; Marshall & Anderson, 1996; Schweitzer & Dwyer, 2003). For example, the SOTEP study, a randomized trial of the effectiveness of relapse prevention, has repeatedly demonstrated no difference in rates of recidivism between randomly-assigned treated and untreated offenders. Although there are methodological problems with this study, the study authors acknowledge that the lack of treatment effect may have been due, in part, to the type of treatment provided – a highly structured relapse prevention program (Marques, et al., 1989; 2000; 2002; 2005).

Unlike the relapse prevention model, the self-regulation model was developed empirically on child molesters (Ward & Hudson, 1998) and then validated on adult rapists (Hudson, et al., 1999). Its key ideas have been empirically supported by numerous independent studies, whereas the key ideas of the traditional relapse prevention model have never been validated or empirically supported in their application to sexual offenders. Specifically, recent research provides some preliminary support for the validity of the self-regulation model, including the existence of multiple pathways to sexual offending (Bickley & Beech, 2002; 2003; Proulx, Perreault, & Ouimet, 1999; Ward, et al., 1995; Yates & Kingston, in press; Yates, et al., 2003), variability in pathways across different types of offenders and with variations in static and dynamic risk (Yates & Kingston, in press; Yates, et al., 2003), and association with recidivism (Webster, 2005). (For the interested reader, detailed reviews of this research can be found in Ward, et al., 2004; Ward et al., 2006; Yates and Kingston (2005) and Yates and Ward (in press).) It is evident that the self-regulation model has actually received greater empirical support than has the relapse prevention model.

It is true that the self-regulation model has been developed relatively recently and, thus, has had limited opportunity to be tested in practice. However, all models have, at some point, been relatively new and untested. Treatment for sexual offenders has taken various approaches throughout its history: traditional psychotherapy, neurosurgery, physical castration, pharmacological treatment, behavioral arousal reconditioning, and cognitive-behavioral treatment, each with varying degrees of effectiveness and acceptability (for a review, see Yates, 2002). The fact that psychotherapy, neurosurgery, and physical castration have been demonstrated to be ineffective in reducing re-offending did not prevent their widespread adoption at the time they were proposed, since they held the greatest promise for intervention given the state of the art at that time. Similarly, it is now widely accepted (and supported by research) that behavioral reconditioning and pharmacological treatment are most effective when applied as adjunctive interventions to cognitive-behavioral treatment, for those individuals who specifically demonstrate high levels of deviant sexual arousal or deviant sexual preference (Becker & Hunter, 1997; Bradford, 1990; Cooper, 1986; Fedoroff, Wisner-Carlson, Dean, & Berlin, 1992; Grossman, Martis, & Fichtner, 1999; Maletzky, 1980; 1991; Marshall, 1996; Marshall, Jones, Ward, Johnson, & Barbaree, 1991; Meyer, Cole, & Emory, 1992). However, at

one time, these were implemented as the sole method of treatment. The point here is that, as research, theory, and practice advance, new approaches to treatment are developed, while others are abandoned, replaced, or augmented with new methods.

In summary, although there is evidence that cognitive-behavioral treatment is effective in reducing recidivism among sexual offenders, this research is not directly applicable to, nor is effectiveness attributable to, the relapse prevention model. Second, although there is minimal research to date on the effectiveness of treatment using the self-regulation model, there is evidence that validates the theoretical model and its use in treatment, and there is more evidence supporting the self-regulation model than the relapse prevention approach. Finally, while there is no research supporting the link between relapse prevention and principles of effective intervention (i.e., risk, need, and responsivity), there is an emerging body of research supporting the link between these principles and the self-regulation model, as well as the link between sexual offence risk and the four pathways of the model (Yates, et al., 2003; Yates & Kingston, in press). Thus, while practitioners may have reasons to retain the relapse prevention model as the basis of treatment and to not adopt the self-regulation model, this rationale is not empirically-based and, therefore, not justified.

What About Avoiding High Risk Situations?

As described above, both the Good Lives and self-regulation models place a strong emphasis on the importance of approach goals in reducing recidivism and improving offenders' lives, a focus that has resulted in the criticism that the self-regulation model minimizes or ignores the importance of avoiding high risk situations that can place an individual at risk to re-offend. However, a close examination of the self-regulation model makes apparent its inclusion of avoidance goals. In fact, the self-regulation approach explicitly incorporates research that indicates that particular circumstances, such as access to potential victims, is a risk factor for sexual offending (Hanson & Harris, 1998; 2000). Such situations should, in fact, be avoided, at least during the initial stages of treatment and maintenance (Ward et al., 2006). What differs between the two models is the relative emphasis that is placed on these divergent goals, rather than the elimination of one in favor of the other. Specifically, the self-regulation model recognizes the importance of targeted avoidance strategies under specific conditions, but explicitly advocates for the superiority of approach over avoidance strategies. As such, the perception that the self-regulation approach ignores the need to avoid high risk situations is inaccurate, and likely arises from its strong focus on approach goals.

As indicated above, the relapse prevention model focuses solely on the risk management element of offender rehabilitation, resulting in an overemphasis on avoiding circumstances, cognitions, and emotional states that have, in the past, been associated with offending for an individual offender (Mann, 2000; Mann, et al., 2004; Yates & Ward, in press; Yates, 2005). Relapse prevention treatment and associated supervision methods have taken this to extremes, including such "management strategies" as lifetime bans on offenders frequenting places where potential victims may be present, such as schools and parks. Furthermore, it is assumed that avoidance strategies are essential and must be maintained throughout the individual's lifetime. Finally, in practice, such methods are frequently generalized to avoidance of all potential high risk situations,

regardless of their relevance to the particular offender, such as banning *all* sexual offenders from living near schools, regardless of whether they are at risk to offend against children or not.

Conversely, the self-regulation model proposes that avoidance strategies should be selective and relevant to the individual. The focus in treatment on approach goals rather than avoidance goals results in ensuring that the individual is able to gain access to pro-social influences and opportunities to achieve goals in non-offending ways (Yates & Ward, in press; Ward, et al., 2006). In fact, it is suggested that focusing on pro-social approach goals can function to reduce or eliminate criminogenic need factors associated with risk for re-offending, without the requirement for avoiding such situations (Ward, et al., in press; Ward, et al., 2006). Furthermore, it is suggested that the majority of individuals can eventually develop internal control over behavior such that avoidance strategies and external control mechanisms become redundant, and that such internal control is more likely to be sustainable over the long term (Yates, 2003). Finally, although strategies to avoid offending form part of intervention, it is important to note that these are associated only with the risk management element of offending, and not with the development of pro-social goals and offence-free lifestyles.

By contrast to traditional methods, the Good Lives model acknowledges the important relationship between goods promotion (approach goals) and risk management in the treatment of sexual offenders, and the self-regulation model explicitly links these in treatment (Ward, et al., 2006). As indicated above, it is proposed that promoting the acquisition of particular goods or goals is likely to eliminate or modify most dynamic risk factors, and that assisting offenders to achieve goods in non-offending ways can eliminate or reduce the need to offend (Ward, et al., in press). However, focusing *only* on the management of risk factors without assisting individuals to acquire that which is important to them (e.g., relationships, intimacy, autonomy), is unlikely to promote the conditions in the individual's life that are necessary for longer term desistance from offending. A focus on risk management can result in a reduction in risk, but neglecting to instill other methods to achieve the goals sought by offending is likely to result in the re-emergence or elevation of risk, since the individual continues to seek to obtain these goals or goods but has not developed alternative methods to achieve these.

It is also unrealistic to expect that individuals can predict and plan for all opportunities to offend and high risk situations that may arise. In addition, new circumstances may arise in future that did not arise in the past or that were not associated with offending previously but which can still pose a risk. For example, some offenders may experience the re-emergence of risk following a traumatic event, such as the death of a loved one. This could affect their ability to cope, particularly if the focus of intervention has been solely on risk management and not on instilling strengths to achieve a positive, pro-social, healthy life. As such, it is preferable in treatment to develop both specific and higher order skills that can ultimately serve to prevent offending over the longer term, and to assist the individual to seek out desired states (via non-offending behavior) rather than to simply avoid all problematic life events or potentially problematic situations. To illustrate, consider the focus of traditional treatment methods on altering cognitive distortions. In treatment, sexual offenders learn to identify and challenge specific cognitive distortions that support sexual offending which they have utilized in the past when offending. The aim of this exercise is to

increase the probability that they will prevent offending in the future via the development of new, non-offending thoughts that they can apply in specific future situations when the desire to offend has emerged. However, in order to successfully prevent offending over the long term, they must also learn the higher order skills of meta-cognition (Wells, 2000; Wells & Matthews, 1994; 1996) and self-monitoring (Heidt & Marx, 2003; Leahy, 2001), and to change their belief systems associated with offending. This enables them to better understand the manner in which they typically view and respond to the world, and to develop the ability to identify when their perception of the world is becoming problematic and to ultimately develop a positive belief system that can act as a protective factor (Yates et al., 2000; Yates & Ward, in press). Over time, with learning, rehearsal, and reinforcement of non-offending cognition and behavior, while simultaneously working toward and achieving desired states, the individual can better develop a belief system and conditioned responses that will be maintained, that will serve to prevent offending over the long term, and that will render continual challenging of cognitive distortions unnecessary, as these cease to occur.

Consider the example of smoking, which is frequently raised as an argument against the focus on approach goals in the self-regulation model. When an individual quits smoking, it is certainly advisable and sensible to avoid situations that are likely to present a risk for relapse. So, the individual initially avoids activities associated with smoking, such as consumption of alcohol and coffee and social activities with friends and acquaintances who smoke. Over time and with successful abstinence, however, the individual eventually develops internal controls that assist in maintaining abstinence, typically in the form of reinforcement for successfully resisting the urge to smoke, coping successfully with high risk situations, and improved self-efficacy and outcome expectancies. The benefits of not smoking also begin to reinforce both abstinence and the individual's commitment to his or her goal (to refrain from smoking). Through these processes, abstinence becomes reinforced and the individual becomes internally motivated to continue to abstain. Once this occurs, the person can then begin to engage in activities that previously posed a risk, such as socializing with others who smoke. Some individuals may need support when initially confronted with these situations, and so enlist the help of a non-smoking friend or partner to accompany them during social situations, for example. Eventually, the individual will be able to safely confront these situations alone, when the non-smoking behavior becomes entrenched in his or her behavioral repertoire, when change occurs in his or her attitude toward smoking, and when he or she is working toward other goals, such as improved health, increased physical exercise, protecting family members from exposure to second-hand smoke, and saving money that would have been spent on cigarettes. Approaching these important goals thus eliminates or reduces risk factors for smoking, making risk management via avoidance ultimately unnecessary for most individuals or required only in extraordinary circumstances.

Four things are immediately evident in this example. First, although the individual is avoiding high risk situations, he or she is also working toward (i.e., approaching) a goal, in this case, a life free from smoking, for reasons unique to that person. It is this approach goal that motivates the individual, while avoidance of high risk situations is a secondary concern that assists in managing the risk of lapse and relapse. Second, the importance of internal control over behavior is obvious, as it is

inevitable that the individual will encounter situations that place him or her at risk. When this occurs, it is these internal controls that assist the person to maintain the non-smoking goal and to successfully cope with these situations over the long-term. Third, avoidance will only be effective if high risk situations never present themselves. Thus, internal control strategies are required *in addition to* avoidance strategies. Finally, the development of internal control that maintains abstinence over time allows the individual to eventually engage in pleasurable activities that previously posed a risk. Otherwise, the person who quits smoking would never be able to socialize with colleagues who smoke, would need to terminate relationships with partners, friends, and family members who smoke, would never be able to go to restaurants or bars where smoking is permitted, would need to abstain from alcohol and coffee, and so forth, and would need to do so for the rest of his or her life. It is easy to imagine how such consequences would reduce or eliminate the individual's desire or commitment to quit smoking.

This example is easily applied to sexual offenders. Consider the individual who has offended against children as a result of attempting to meet intimacy needs that he has been unable to achieve with adult partners. Using the relapse prevention approach, treatment with this individual would require avoiding all contact with children and learning to cope with intimate and sexual desires in the knowledge that these can never be fulfilled. Initially, and until internal controls over behavior are developed, such strategies as avoiding children may be necessary for effective management of risk to re-offend, and would form a component of treatment within the self-regulation approach. However, what differs is that this approach also acknowledges and validates the essential needs of intimacy and sexual gratification, and treatment within this model assists the individual to seek out and achieve these goals with appropriate partners. Thus, the offender does not need to abandon these needs or to avoid situations involving intimacy, but learns to meet these needs in non-offending ways, *in addition to avoiding situations that place him or her at risk and managing deviant sexual thoughts and attraction*. Over time, as the individual both successfully copes with deviant desires and achieves intimacy in non-offending ways, internal controls over sexual offending are developed (risk management) and the individual is able to meet these needs appropriately (approach and good lives goals). As with the smoker, it is easy to envision a sexual offender abandoning treatment if he were told that he needed to avoid all situations in which he would achieve intimacy and sexual satisfaction, for the rest of his life.

It is possible that the controversy with respect to approach and avoidance goals has resulted from a misunderstanding that the self-regulation model advocates abandoning avoidance strategies in favor of approach strategies. As can be seen from the above discussion, this is not the case. Rather, the model proposes that both are required, but that approach goals are likely to be more successful in maintaining non-offending behavior over the long-term, are more likely to facilitate a life that is ultimately offence-free, and are likely to be more motivating to offenders to undertake the difficult process of change required during treatment. That is, if individuals understand that they can achieve important goals, they are more likely to be motivated to undertake the change process, to engage with treatment, and to work toward achieving goals in non-offending ways, as well as to be effective in managing their risk to re-offend.

But This is What I Do in Practice Anyway!

When clinicians are exposed to the self-regulation model, a common response is that this describes the approach they already use in their treatment programs. If this is, in fact, what clinicians do in practice with sexual offenders, then treatment is addressing the issues discussed above – it just is not relapse prevention! In fact, it has long been noted that “virtually any kind of posttreatment intervention has been called relapse prevention” (Laws, 1999, pp. 291), despite the fact that these programs do not adhere to this model. Furthermore, as the preceding discussion illustrates, relapse prevention as originally developed is the core intervention model for post-treatment maintenance based on medical theory and designed for use with motivated alcoholic patients once abstinence from addictive behavior has been instigated and treatment successfully completed. While it is true that this model has been revised and adapted both among substance abusers and with sexual offenders, it has been argued here that, despite these adaptations, the model remains problematic in its application to sexual offenders, lacks a rehabilitation framework that is specific to sexual offenders, does not address issues beyond risk management, and is insufficient as a treatment model to address the diversity evident in sexual offending behavior and among offenders. It is, therefore, suggested that both the traditional relapse prevention model and subsequent revisions and adaptations of this model, are not appropriate for use with sexual offenders, and that the self-regulation model holds greater promise for more effective intervention.

In addition, while it is possible that some elements of the self-regulation model have been incorporated into some existing programs, given the recent emergence of the self-regulation model, it is unlikely that the model as a whole has been fully integrated into practice with sexual offenders. Although some jurisdictions have explicitly abandoned relapse prevention and have implemented newly developed programs based on the self-regulation model (Yates, 2005), this author is not aware of treatment programs beyond these few jurisdictions that have adopted the model in full. In fact, a full treatment package based on the self-regulation model that incorporates elements of the Good Lives Model, has not yet been developed. As such, inclusion of elements of self-regulation theory in existing relapse prevention programs amounts to yet another *ad hoc* adjustment of the traditional relapse prevention approach, in the absence of an overarching theory, and these programs, while moving in this direction, cannot be said to implement the self-regulation model of treatment with sexual offenders.

A Self-Regulation Quiz for Your Treatment Program

For those interested in determining the fit of their programs with the self-regulation model, I would pose the following questions:

- Does my treatment program explicitly vary the level of intensity (i.e., length of treatment, number of sessions) to match the risk to re-offend posed by my clients (or do all clients receive intervention of the same duration and frequency of contact)?
- Do I assess individual clients’ dynamic risk factors prior to intervention, and then explicitly target these individual criminogenic needs?
- Do I assess individual pathways to offending for each client prior to intervention, and then deliver treatment according to the results of this assessment?
- Do I assess the goals and goods that individual clients seek to obtain via offending?

- Does my program explicitly assist clients to achieve these goals in non-offending ways?
- Do I know what my clients hope to get out of life?
- Do “relapse prevention plans” include strategies to acquire important goods or goals in life (or do these focus predominantly on avoiding or escaping high risk situations and coping with negative emotions)?
- Do the methods I use in treatment sessions vary depending on differences among participants with respect to their goals, pathways, personal circumstances, and responses and reactions during treatment?
- Are my clients engaged with treatment and feel that they are working toward something that is important to them (or is it a struggle for me to impart important learning points)?
- Are “homework” assignments tailored to clients’ individual circumstances, risk, abilities, and goals (or are these the same for everyone)?
- Do I assist my clients in developing personal plans to live offence-free lives that are congruent with their own life circumstances and values (or do I “teach” clients only what they need to change in their lives)?
- Do participants’ relapse prevention or self-regulation plans differ at the end of treatment (or is there a generic model or template into which their plans must fit?)

The answers to these and similar questions will help determine the approach you are using in your treatment program. If you answered “yes” to the above questions, you are using the self-regulation model; if you answered “no” to the questions (or “yes” to the parts of the questions in parentheses), you are using another approach, such as traditional or adapted relapse prevention. This exercise is not meant to imply that our programs are inappropriate or ineffective, but that they may not necessarily follow the self-regulation approach, even if we think they do. Furthermore, the intent of this type of examination is to determine whether we can improve what we do in the treatment and management of sexual offenders.

How Do I Apply the Self-regulation Model in Practice?

Applying the self-regulation model to the treatment and supervision of sexual offenders involves implementation of the objectives described above. A complete account of implementation is beyond the scope of the present chapter, however, some examples are provided here. An introduction to treatment using this model is found in Ward, et al. (2004) and a detailed application of the model to the different pathways to offending is available in Ward, et al. (2006).

Generally, in implementing treatment using the model, dynamic risk factors and goals with respect to offending are assessed prior to treatment, individuals’ pathways to offending are determined, and treatment objectives and methods are established based on these evaluations. The treatment plan includes elements of both risk management and good life goals, and is individualized based on the results of assessment and in accordance with the principles of effective intervention. Similarly, maintenance programming and supervision are also conducted in accordance with results of evaluation and principles of effective practice, as well as progress throughout treatment and

supervision, including both risk management and achievement of pro-social approach goals.

In treatment, the nine-stage model of offending (Ward & Hudson, 1998; 2000; Ward et al., 2004; Ward et al., 2006) can be used to identify life events that trigger the offence progression, individuals' interpretations of, and responses to, these life events, the precise nature of the offence-related desires and goals, individuals' goals with respect to offending (i.e., avoidance-based versus approach-based), strategies used to achieve these goals, the affective and control responses to offence-related desires and risk situations, and individuals' evaluation of their behavior and offending following the commission of offences. This model can assist in uncovering offenders' motivations for offending and their implicit theories with respect to offending (Polaschek & Gannon; 2004; Polaschek & Ward; 2002; Ward & Keenan, 1999). Specific interventions and supervision strategies are implemented depending upon the individual's offence progression and its elements and dynamics, and their self-regulatory style or pathway. At the conclusion of treatment, an individualized self-regulation plan that incorporates offenders' plans for living that possesses the essential elements of an offence-free life and effective strategies to both cope with problematic situations and to achieve this life, is developed. Although this plan may be subsequently revised depending upon specific circumstances, the aim is to ensure that individuals are working toward achieving desired goals and acquiring desired goods in non-offending ways, in addition to ensuring that risk management strategies are in place. It is also essential that progress toward achieving important goals is evaluated in addition to monitoring risk and offenders' capacity to manage risk.

To illustrate this process, consider examples of two offenders following very different pathways and with different self-regulation styles. Although simplified, these examples serve to illustrate both the differences in offence pathways and the manner in which the self-regulation model approaches treatment in these divergent cases.

Case Example One

Mr. A has committed several offences against male children. When he experiences sexual arousal to boys, he feels guilty and shameful, and does not understand the origin of this arousal or what he should do about it. He knows that this is wrong and decides not to act on his desires, as he genuinely does not want to harm children. To cope with this desire, he views pictures of child pornography on the internet, masturbating to images of partially clothed boys. He nevertheless feels guilty, but believes that he has not harmed anyone because he has not physically acted out on his desires. He would like to have a long-term relationship, but his attempts to establish this have failed because he is shy and awkward and does not know how to approach adult males for possible future relationships. He once placed an advertisement with an on-line gay dating service and went out with a few men, but these were not successful in the long-run. Each of his sexual offences against boys occurred when he felt dissatisfied as a result of these experiences.

This offender clearly follows an avoidant-active pathway to offending, based on his desire to refrain from offending (an avoidance goal) and his active implementation of strategies to cope with the desire to offend. Mr. A's strategies, however, are ineffective to either cope with sexual arousal (risk management) or to achieve intimacy (acquisition

of the good of relatedness and intimacy). In an ironic effect, one of his strategies, masturbating to images of boys on the internet, increased his risk to offend as a result of the pairing of deviant sexual arousal and sexual gratification, and the reinforcement obtained via masturbating to orgasm. His unsuccessful attempts at dating reinforced his sense of low self-worth in social relationships.

Similar to a traditional (i.e., relapse prevention) approach, treatment using the self-regulation model would utilize risk management strategies such as arousal reconditioning techniques to extinguish deviant sexual arousal to boys, but would additionally utilize these methods assist this man to develop or reinforce age-appropriate arousal (an approach goal). Since he also demonstrates age-appropriate sexual interests, the major aim of treatment in this area is to help him to access adult partners, such as establishing links with the gay community, in order that he may achieve the relationships he seeks. Unlike traditional interventions, access to internet pornography would not necessarily be banned, but would instead be restricted to viewing images of adult men in order to assist Mr. A to achieve the sexual satisfaction he seeks, via non-offending means.

Also similar to traditional interventions, treatment would assist him to cope with feelings of loneliness and lack of intimacy; however, this intervention would be secondary to assisting him to fulfill these needs in viable ways. The treatment target in this area is to assist him to achieve the goals that he presently seeks via offending (intimacy and sexual gratification). Coping with the absence of these states when they occur is a secondary goal, and these states are expected to occur less frequently as a result of meeting his needs appropriately in this area. In treatment using the traditional relapse prevention approach, the development of such coping skills would be a primary, rather than secondary, treatment target, and achievement of satisfying relationships may not be addressed at all. This offender demonstrates interest in adult men and the ability to seek out these relationships, but lacks some capacity to develop these relationships once they are initiated. As such, rather than focus on what is lacking for him in this area, treatment reinforces these efforts and focuses on how he can be more successful. Although initially in treatment he will need to avoid exposure to child pornography involving boys, he will not need to avoid exposure to sexual images of adult men, which may, in fact, be helpful. It is expected that such avoidance will ultimately be unnecessary once he has achieved intimacy and gratification in age-appropriate relationships.

Case Example Two

Mr. B committed rape against an adult woman, whom he met while in a bar. He bought her a few drinks and they danced, after which he invited her to his apartment, intending to engage in sexual intercourse. She declined, telling him she had a boyfriend, after which he became angry because he felt that she had “led him on”, an experience he had had on numerous previous occasions. He waited until she left the bar, followed her, attempted again to “convince” her to return to his apartment, and sexually assaulted her in the parking lot when she declined his advances a second time. He reports that he felt rage and had not intended to sexually assault her, but that it “just happened”.

In this example, Mr. B followed an approach-automatic pathway to offending. The commission of the sexual offence occurred in response to the activation of core beliefs and implicit theories (cognitive scripts) associated with rejection, both by the

victim of the offence and as a result of his history of rejection by women in general. While it appears that his goal in offending was sexual gratification, the primary goods that he actually sought via offending were personal power and emotional regulation, specifically, dealing with the emotional states associated with rejection by, and hostility toward, women. For him, because of his learning history and personal experiences, these are expressed via sexual aggression. When he followed the victim into the parking lot, his goal was to obtain sexual gratification, but upon being rejected, his goal became regaining control and retaliating against women. His behavior was impulsive and activated by situational cues (i.e., rejection).

Using traditional methods, treatment would focus on both seeking sexual gratification via offending (a secondary goal), and on confronting cognitive distortions that are symptomatic of the core beliefs or attitudes from which these are derived, but which do not, in and of themselves, represent the core beliefs. This amounts to changing specific ways of thinking rather than the manner in which the individual approaches the world, and is likely to be ineffective because the attitudes upon which these cognitive distortions are based remain unchanged. In addition, this does not target that which he seeks to achieve via offending – retaliation and emotional control. Conversely, treatment within the self-regulation model would first assist him to understand the origin of core beliefs and attitudes surrounding retaliation and hostility. He may need to explore and resolve long-standing issues and events associated with rejection by women and his hostility toward them, uncovering that which underlies these attitudes, and his ultimate goals with respect to relationships with women. In addition to attitude change, treatment within the self-regulation model would also assist him to understand the goods he seeks, and the manner in which his attitudes and behavior interfere with obtaining these goods. While treatment using the traditional relapse prevention approach would focus on altering cognitive scripts and developing skills to cope with rejection and sexual arousal, treatment using the self-regulation model would first assess that which he seeks to achieve via offending and that which he gains via achieving retaliation. Concurrently, treatment would assist this man to work toward achieving these goals without offending. Once attitude change has occurred and Mr. B is working toward meeting his personal power and emotional regulation needs, the need to challenge and to continually monitor cognitive distortions is reduced.

Is the Self-Regulation Model Applicable to Juvenile Sexual Offenders? What About Women Offenders, Offenders from Various Cultural Groups, and Intellectually Disabled Offenders?

The self-regulation model has been developed and validated on adult male sexual offenders and, therefore, has not been tested on different groups of offenders, such as juveniles, women, offenders with various cultural origins, and those with intellectual disabilities. However, it is expected that, given the model's flexibility, consideration of multiple pathways to offending, and attention to responsivity and individuals' life contexts and environments, it can be easily applied to a variety of specific offender groups, particularly when embedded within the Good Lives Model (Ward, et al., 2006; Yates & Ward, in press). Thus, the self-regulation model is better able to respond to the unique needs of offenders with respect to gender, age, culture, values, and abilities, and

to better incorporate this diversity in a meaningful way into assessment, treatment, and supervision. In fact, the self-regulation model is more likely than the relapse prevention model to be applicable to various offender groups as a result of this flexibility and attention to internal and external responsivity considerations.

With respect to juvenile sexual offenders specifically, the self-regulation and Good Lives models are consistent with multi-systemic therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), which represents current best practice with youthful offenders. MST involves the use of practical interventions that aim to increase pro-social and other responsible behavior on the part of the youth while decreasing antisocial behavior, by building both individuals' capabilities and those of their social, familial, educational, and personal systems and values (Henggeler et al., 1998). Such activities are consistent with the focus of the Good Lives Model on equipping individuals with the internal and external capabilities and conditions necessary to modify criminogenic needs and to attain a healthy, pro-social lifestyle (Ward, 2006). With its focus on variability in self-regulatory capacity, approach goals, and contextual factors, the self-regulation model appears remarkably consistent with this approach to juvenile sexual offenders.

Conclusions

This chapter represents an attempt to illustrate some of the differences between the relapse prevention and self-regulation approaches to the treatment of sexual offenders. The two models differ in their theoretical orientation, and utilize significantly different methods for intervention and treatment. While the traditional relapse prevention model and its adaptations to sexual offenders proposes a single pathway to offending focused on negative affect and avoidance strategies, the self-regulation model proposes multiple pathways to offending behavior, better incorporates multiple influences on offending behavior, and focuses on that which the individual gains via offending, as well as explicitly upon the manner in which the individual can achieve these same outcomes without offending. The brief review of the research pertaining to both models clearly demonstrates the superiority of the self-regulation model, and examples have been provided to illustrate the manner in which the model can be applied to treatment in a practical sense.

As indicated above, the objective of this chapter was to respond to common questions posed regarding this approach to treatment, and to provide opportunities to enhance, refine, and advance the treatment of sexual offenders in order to both reduce the likelihood of future victimization and to assist those individuals who have committed sexual offences to lead productive and satisfying offence-free lives. It is hoped that this goal has been met, and that this analysis can be used to improve practice in the treatment and management of sexual offenders.

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Table 1.

Comparison of traditional relapse prevention and self-regulation models of sexual offending.

<i>Conceptualization of Offending</i>	<i>Traditional Relapse Prevention Model</i>	<i>Self-Regulation/Good Lives Model</i>
<i>Pathways to offending</i>	One	Four
<i>Self-regulatory causes of offending</i>	Deficits in coping skills	Deficits in coping skills Intact self-regulation
<i>Offence-related goals</i>	Avoidance of undesired states, events, or circumstances	Avoidance of undesired states, events, or circumstances Active strategies to achieve desired goals and goods
<i>Affective states associated with offending behavior</i>	Predominantly negative	Negative or positive
<i>Post-offence evaluation of behavior</i>	Predominantly negative Cognitive dissonance	Negative or positive evaluation Cognitive dissonance Goal congruence
<i>Goals achieved via offending</i>	Not considered	Explicitly assessed and addressed in treatment
<i>Consideration of life context/individual circumstances</i>	Minimal	Explicit consideration and conceptualization in treatment planning and case management
<i>Achievement of offence-related goals via non-offending means</i>	Not considered	Comprise treatment and management targets
<i>Overall rehabilitation strategy and focus</i>	Avoidance-focused Risk management	Approach-focused Risk management Achievement of satisfying, offence-free life