Chapter 19

Treating Dangerous Offenders

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The effective treatment of dangerous offenders has important implications for society in general and the offenders themselves. By definition, dangerous offenders pose a risk of serious harm to other people. The rates of re-offending for violent offenders tend to be higher, particularly when compared to other non-violent offenders (Motuik & Belcourt, 1997). Canadian research published in 1999 showed approximately 40% of offenders incarcerated for violent offences returned to custody for a similar offence within two years (Dowden, Blanchette, & Serin, 1999). While, sexual recidivism rates are roughly in the range of 11% (Hanson & Morton-Bourgon, 2009) to 14% (Hanson & Morton-Bourgon, 2005), but it is acknowledged that this is likely an underestimate of the true rates of sexual reoffending (Ahlmeyer, Heil, McKee, & English, 2000).

Effective treatment hopefully means the prevention or reduction of future harm, but also that the offenders can move past their offending and on to more positive lives that are incompatible with offending. The aim of this chapter is briefly describe:

- The types of serious violent/sex offenders who can receive treatment;

- The types of treatment typically undertaken with these offenders;
- The evidence base for the effectiveness of such treatments
- And the factors that need to be considered when working with such dangerous offenders.

Types of Dangerous Offenders Typically Treated in Criminal Justice Settings

Violent Offenders

Individuals convicted of violent offences tend to make up a significant proportion of prison populations (around 50% in some jurisdictions; Australian Bureau of Statistics, 2007). From a psychological (treatment) perspective, violence has been described as the intentional and malevolent physical injury of another (Blackburn, 1993). Violence can take many forms and there is a great deal of variability between offenders in terms of what may have caused and maintained their violent behaviours. Violent offenders may include those who have: assaulted their partner or children; been involved in a serious fight or fights; committed violence within a gang context; committed violence in course of a robbery; as well those who have killed someone.

There is a relatively small group of violent offenders who can be characterised as persistent, or repeat, offenders. These offenders have been termed 'life-course-persistent offenders' (Moffit, 1993). These men tend to have more frequent, and more violent, offending than other offenders; as well as diverse and frequent non-violent offences (Polaschek, Collie, & Walkey, 2004). It is these serious violent offenders who are likely to commit further serious violent crimes unless appropriate treatment and management is provided. These offenders are most usually assessed on risk assessment measures as *high-risk* of violent re-offending. It is these offenders that we

attempt to target into the treatment irrespective of their offence type. We will now briefly describe different forms of violence.

Instrumental versus Expressive Violence.

Violence is often referred to as either *instrumental* or *expressive* (Berkowitz, 1993). Instrumental violence is usually characterized as goal oriented or purposeful, controlled, and unemotional. It is often used as a means to an end. For example, an individual may use violence in the course of a robbery, to ensure that he/she is successful. Expressive violence may also be labelled either: *reactive, angry, emotional,* or *impulsive* (McGuire, 2008). Expressive violence often occurs when an individual is attempting to decrease an unpleasant internal state - such as their anger or physiological arousal. For example, someone may commit a violent act purely because they were angry. However, aggressive acts commonly serve more than one function and may be planned; yet still involve high levels of anger (Daffern, Howells, & Ogloff, 2007).

Intimate Partner Violence

Intimate Partner Violence (IPV) or domestic violence (see Chapter 19 for a more in-depth discussion of IPV) involves the use of aggression between partners in intimate relationships. Terms such as *battering*, *spousal abuse*, and *marital violence* are often used interchangeably to describe it (Graham-Kevan, & Wigman, 2009). IPV is considered to include not only physical aggression, but extends to acts of verbal and emotional abuse (including yelling, swearing threats and name calling), sexual abuse, in addition to destruction of pets and property and other coercive behaviours.

Murder

Dearden and Jones (2008) reports that around 40% of murder victims are killed by a family member, and nearly 25% by an intimate partner. Contrary to popular opinion, convicted murderers are extremely unlikely to be convicted of a second homicide, even without treatment. Studies have found that only between 1-3% of murderers are re-arrested for another murder (Bjorkly & Waage, 2005). They are also comparatively unlikely to be convicted of a further offence of any kind. Langan and Levin (2002) followed up 272,111 released U.S. prisoners and found that murderers had the lowest re-arrest rates (40.7%) compared to other groups of violent offenders. Roberts, Zgoba, and Shahidullah (2007) found the rate of violent recidivism for murderers ranged from 2% (for those committed of an accidental murder) to 16% (for those who committed a murder resulting from an altercation).

Sexual Offenders

A sexual offence occurs when an individual forces another to engage in sexual behaviour, exposes their genitals or sexually touches someone against their will, or if they engage in sexual behaviour with someone who is not of a sufficient age or does not otherwise have the ability to consent. This includes exposing sexual material to others against their will, production of sexual material depicting individuals who are not old enough to consent to sexual activity, and possession of such images. It also includes observing unsuspecting people who are naked or engaged in sexual activity (i.e., voyeurism).

Child Sexual Offenders

Individuals who sexually abuse children are a wide-ranging group from those who are completely *paedophilic* (attracted to prepubescent children), to those who are attracted to pubescent children (*hebephilic*), through those who are aroused to both children (typically teenagers) and adults, to those who are aroused to adults but who abuse children for a variety of reasons to do with power, control, or sense of entitlement (i.e., incestuous offenders). It is common practice in both research and reviews (Bourget & Bradford, 2008; Laws & O'Donohue, 2008) to describe sexual offenders in relation to the type of offence they committed. The term child sexual abuse is used to describe sexual activity with a child, including both familial (incestuous) and extra-familial victims. The term *child abuser* is commonly used in the U.K. and the equivalent term *child molester* is commonly used in North America. These terms broadly cover all those who have committed offences against children (regardless of gender and relationship to victim). Individuals who abuse children are most commonly classified according to their relationship with the victim (i.e., related/unrelated), the gender of victim they target (male/female/both), and age group (pre/post pubescent).

Rapists

Rape is defined as a sexual assault upon an adult usually involving, or with the intent to commit penetrative sexual acts without the victim's permission. It has been noted that that offenders who commit rapes are typically not that different from other more general offenders (Howard, Barnett, & Mann, 2015), or for that matter from non-offenders (Marshall, 2000). Early research evidence for this can be found in work by Malamuth (1981) who found in a survey of U.S. college males that 35% of the sample reported that they would be willing to rape if they were assured of not being punished.

Rapist typologies exist which highlight the underlying motivations for rape. Generally, the overarching themes of rapist typologies focus on whether the rape was motivated by sexual or non-sexual needs (Beech, Oliver, Fisher & Beckett, 2005; Robertiello & Terry, 2007). See Box 1 for a classification of types of rapists as outlined by Knight and Prentky (1990).

Box 1: Classification of rapists (according to Knight & Prentky, 1990)

Here, rapists are grouped around three motivational types: sexual motivation, anger motivation and sadistic motivation. There are two types of *sexually motivated rapists* identified in the system:

- **The opportunistic rapist,** where the offender has a number of pro-offending attitudes, including the belief that there is nothing wrong with having coercive sex with women. The sexual assault committed by this type of rapist is an impulsive, predatory act, controlled more by situational circumstances than by explicit sexual fantasy or anger.
- **The non-sadistic sexual rapist,** where there will be a high level of sexual fantasy that precedes the offence(s). These fantasies will reflect sexual arousal and distorted attitudes about women and sex. Typically, there may be comparatively low levels of interpersonal aggression in this type of offender, with the offender using instrumental force to ensure compliance from the victim.

There are two types of *anger-motivated rapists* identified in the Knight and Prentky system:

- **The vindictive rapist.** Women are the central and exclusive focus of these men's anger. The sexual assault is marked by behaviours that are physically damaging and intended to degrade and humiliate their victim(s). There is no evidence that anger is eroticized or that they are preoccupied with sexual fantasies. The system notes that the violence of the vindictive rapist may be so severe that it results in murder.
- **The pervasively angry rapist.** This type of offender is motivated by undifferentiated anger in all aspects of his life. Such offenders are equally likely to express their unmanageable aggression towards men and women. These men will have long histories of anti-social behaviour where rape is another expression of their anger and hostility.

There is one further type referred to as the **sadistic sexual rapist** in this system, where there is a fusion of sex and aggression. Knight and Prentky note that here there is a frequent occurrence of erotic and destructive thoughts and fantasies, and that anger is eroticized.

Sexual murderers

Estimates would suggest that there are around 200 men within the prison system in the United Kingdom who have committed a murder with an apparent, or admitted, sexual motivation (A. Carter, Lifer Unit, HM Prison Service, personal communication, May 2003). For the most part, such individuals have, up until only recently, been managed within the prison system in the same way as other, nonsexual violent offenders because of their status as a murderer rather than a sex offender . It is only in the last 10-15 years that the sexual element of their crime has been formally recognized in terms of treatment provision, with men who have killed their victims (where it is suspected or known that there was a sexual component to the killing) now accounting for approximately 5% of all men going through sex offender treatment (Beech et al., 2005). See Box 2 for a classification of sexual murderers suggested by Beech, et al., 2005).

Box 2: Classification of sexual murderers

- **Sadistically motivated** Here, the offender is under extreme internal compulsion to kill. The murder arises because the offender carries out his deviant/sadistic fantasies related to sex murder. This type of sexual murderer could be seen as a more extreme version of the sadistic rapist described in Box 1.
- **Sexually motivated** Here, the murder is motivated by the offender's need to keep his victim quiet or to prevent detection during, or after, the commission of a sexual assault. The primary motivation in this type of offender is to sexually offend. In this way, the perpetrator either impulsively kills or has planned to kill his victim to avoid detection. Hence, this type of offender could be seen as either an extreme version of the sexually motivated opportunistic rapist (sexual assault plus impulsive murderer) or the non-sadistic sexual rapist (sexual assault plus planned murder) described above.
- **Grievance motivated** Here, the murder and associated sexual attack arise out of a strong build-up of violence. This tension arises from protracted conflict with another person(s) or circumstances usually unrelated to the murder victim. This type of sexual murderer could be seen as a more extreme version of the anger driven rapists (especially the vindictive types) described in Box 1.

Although sex offenders are generally discussed as falling into one of these categories, recent evidence suggests that there is crossover between sex offending and other types of offending, and even within sex offending somewhat (Howard, et al., 2015). In a sample of 14,408 offenders in the UK, only 24% were found to have been sanctioned for sexual offenses only, but sex offenders were found to be moderately specialized in one particular type of sex offending (Howard et al., 2015). Similarly, Soothill (2000) found that if sexual offenders committed a new sexual offense, it was most likely of the type they had previously committed.

Treatment Frameworks

Treatment Frameworks for Violent Offenders

Within their review of the rehabilitation efforts with violent offenders Polaschek and Collie (2004) usefully distinguished violent offender treatment on the basis of their

theoretical approaches. They classified treatment programmes as being based on *anger management, cognitive skills, interpersonal violence programmes,* or *multi-modal approaches.* Anger management and cognitive skills tend to be shorter and less intense treatment (typically less than 150 hours). They are both based on the assumption that one factor (anger or antisocial thinking) is the cause of violent behaviours. Multi-modal programs tend to be far more intensive (typically 300+ hours) and assume that many factors are involved in the causation and maintenance of violent behaviours, targeting a large number of psychological and behaviours factors (such as social skills, thinking, substance abuse, and so on). We will now briefly describe each of these approaches in more detail.

Anger Management

One of the most common types of programmes used with violent offenders is *Anger Management* (Novaco, 1975). Anger management programmes tend to be facilitated in groups and are brief in duration (i.e., 10-20 two-hour sessions). They typically focus on increasing the offender's awareness of anger and its triggers, and then providing a range of skills including social skills and relaxation training to assist the offender to decrease anger arousal and strengthen anger control.

This approach assumes that the violence was caused by, or as a consequence, of the individual's anger. Howells (2004), for example, notes that violent acts have been labelled as *angry behaviours* (p.190). However, there are studies (e.g., Mills and Kroner, 2003) that do not find support for a link between anger and violent criminal behaviours. Given that many proponents of Anger Management programmes also note that anger should be considered a contributing factor to violence "particularly when occurring with a number of other conditions" (Howells, 2004, p.189), or is not

even necessary for violence to occur (such as when violence was instrumental or even sadistic), then it seems necessary to also target the other conditions and hence the need for multi-faceted treatment (Novaco, 2013; Polaschek, 2006).

Cognitive Skills Programmes

Cognitive skills programmes have also been used explicitly in the treatment of violent offenders (Hollin, Palmer, & Hatcher, 2013). Examples of cognitive skills programmes include *Reasoning and Rehabilitation* (Antonowicz, 2005), *Think First* (McGuire, 2005), Enhanced Thinking Skills (Clark, 2000), and the *Cognitive Self-Change Model* (Bush, 1995).

These programmes are based on the notion that violent offending is caused by anti-social cognitions and are focused towards helping offenders recognise their thought patterns that are conducive to crime and to acquire new ways of thinking about and solving their problems. They are facilitated in groups and tend to brief although comparatively longer than anger management programmes. Robinson (1995) reported on a cognitive skills programme in Canada that consisted of 36 two-hour sessions. Henning and Frueh (1996) reported a mean length of 10 months attendance in a sample of 55 offenders completing cognitive skills programmes. Bush's (1995) Cognitive Self-Change Model, however, has been reported to last up to three years with two sessions per week.

Ward and Nee (2009) have argued that cognitive skills programmes are unlikely to meet the needs of serious high-risk violent offenders with their well-rehearsed and entrenched beliefs and attitudes about aggression and violence. They argue that these programmes are based upon a relatively narrow approach to changing cognitions that may not be adequate on their own for such violent offenders.

Intimate Partner Violence (IPV) Programmes

IPV programmes have historically been educational and developed around feminist theories of why IPV occurs (see Chapter 10 for more details of this). Consequently they tend to focus on issues such as power and control, abusive/coercive behaviours within intimate relationships, and communication and stress management techniques (Graham-Kevan & Wigman, 2009), and hence IPV programmes have developed quite separately from those for generally violent men (Polaschek, 2006). This has been the result of an assumption that men who physically assault their partners are different from generally violent men. However, although Hanson and Wallace-Capretta (2000) report that IPV offenders are more likely to possess attitudes tolerant of partner assault, including attitudes related to sex roles and relationships with women, they also found that IPV offenders also shared many characteristics of the generally violent offenders, such as high levels of antisocial attitudes.

More recently, many researchers/clinicians in the field of IPV research take a gender inclusive approach (i.e., women also perpetrate violence towards men), thus it has been argued (e.g., Dixon, Archer, & Graham-Kevan, 2012; Dutton, 2006) that feminist oriented approaches are not adequate to address violence perpetrated by women while Mederos (1999) has argued that the focus of IPV programmes is too narrow and that they do not currently take into account the heterogeneity of IPV offenders; and Norlander and Eckhardt (2005) notes that the relevance of alcohol abuse is often overlooked by IPV programmes.

Multi-modal Programmes

McGuire (2008) has noted that (on the basis of a review of effective aggression and violence treatment), 'it is almost certainly necessary to increase the duration and intensity of treatment ('dosage') above presently inadequate levels' (p. 2591). The more recently developed multi-modal treatment programmes for high-risk violent offenders tend to be of greater intensity and target a larger and broader range of issues than do anger management or cognitive skills programmes.

Multi-modal programmes such as the *New Zealand Violence Prevention Unit* (Polaschek et al., 2005) are typically are reserved for men with a history of serious violent behaviour who have been assessed as higher risk of recidivism. They are usually staffed by multi-disciplinary teams consisting of psychologists, custodial staff and other educational and programme staff. The duration of such programmes is usually at least 12-months, with treatment being delivered primarily in a group therapy setting with additional individual treatment as is necessary.

These programmes, at least in theory, allow for a greater level of individualisation of therapeutic targets within the treatment programme and longer period of time in which to achieve these. These programmes also operate on the assumption that violence may have been caused by multiple issues and therefore all of these issues need to be targeted in treatment (Polaschek, 2006). In this sense they are of far greater intensity than anger management or cognitive skills programmes and target a greater range of issues.

Treatment Content of Programmes for Violent Offenders

A longstanding question regarding the treatment of violent offenders is whether they require specialised treatment, or if they simply can attend and benefit from more general offending programmes (Polaschek & Collie, 2004). The ultimate question is

whether serious violent offenders have treatment needs that are different from that of non-violent offenders. This is complicated by the fact that non-violent high risk offenders tend to have histories of at least one violent offence (Bourgon & Armstrong, 2005), and that risk factors or criminogenic needs for violence appear to be better predictors of non-violent re-offending (see for example, Wong & Gordon, 2006).

When planning for treatment, the most important factor to consider is the heterogeneity among violent offenders. Specifically, it is critical that the function of the violence for the offender and the causative and maintaining factors are well understood (Howells & Day, 2002). Given the wide range of violent behaviours, it is entirely plausible that two individuals with what appear to be very similar violent crimes may have offended for very different reasons.

It is equally important when planning treatment to consider how to prepare and motivate the violent offender. Howells and Day (2002) discussed this in terms of the offender's readiness for treatment (see section below on this). Violent offenders are typically ambivalent at best regarding the need for, or simply not ready to benefit from, treatment. Violent offender treatment is further complicated by the difficulties therapists may face in working with violent offenders.

As described in Chapter 16, Andrews and Bonta (2006) initially coined the term *criminogenic needs* to describe the attributes of offenders that are directly linked to criminal behaviour and which should therefore be the focus of treatment. Polaschek (2006) reviewed the evidence base for criminogenic needs for violent offender treatment. She noted that there was 'a need for more research on serious violent offenders' as there were 'still too few studies that have investigated their criminogenic needs.' (p. 145). However, most multi-modal treatment violent offender programmes target a number of issues - many of which appear to have at least some

relationship to risk of recidivism, and therefore are likely to be criminogenic needs (Polaschek, 2006). As an example, negative/anti-social attitudes may reflect generally antisocial attitudes or they may reflect attitudes specifically condoning the use of violence.

Polaschek, Collie, and Walkey (2004) have demonstrated that both a general criminal attitude measure and a measure of violent attitudes, predicted recidivism risk. A number of studies have shown impulsivity to be higher in violent than non-violent offenders (e.g., Nussbaum et al., 2002). We have listed a number of criminogenic needs identified as being relevant to violent offenders in Box 3.

Box 3: Treatment needs of violent offenders

- Anger
- Negative/anti-social attitudes
- Hostility
- Substance abuse
- Impulsivity
- Active symptoms of major mental illness
- Interpersonal and problem solving skill deficits
- Anti-social personality
- Social information-processing deficits
- Relationship instability
- Empathy deficits
- Education/employment
- Antisocial companions

INSERT VIOLENCE CASE STUDY ABOUT HERE

Frameworks for Treating Sexual Offenders

Although sex offenders are commonly studied and discussed according to offence type, treatment for sexual offenders in general is primarily targeted to address the treatment needs of child molesters. Rapists are generally treated alongside child molesters, although there is little evidence to support this practice (Gannon, Collie,

Ward, & Thakker, 2008). It would also appear that of the men who attend treatment, only 15% of them are rapists, despite rapists making up roughly half of all of the incarcerated sexual offenders in the UK (Beech et al., 2005). We will now examine current treatment approaches for sexual offenders.

Cognitive-behavioural Treatment The most common method of treatment of sexual offenders is cognitive-behavioural therapy (CBT). The cognitive component addresses their pro-offending beliefs that individuals have, as well as cognitions that affect mood state and behaviours in ways that increase the likelihood of offending. Cognitive therapy therefore aims to encourage an individual to think differently about events, specifically, enabling insight into how cognitions influence their sexual behaviours, and trains them to identify their own thinking patterns related to sexual offending, and uses various tools to help individuals re-evaluate these thinking patterns.

The behavioural aspect of CBT addresses the overt and covert behaviour of an individual. Originally this was confined to the use of procedures to alter behaviour, based on the principles of learning theory (i.e., rewarding desired behaviours and punishing unwanted behaviours), but has since broadened out to include modelling (demonstrating a desired behaviour) and skills training (teaching specific skills through behavioural rehearsal). CBT, therefore, provides a comprehensive approach to treating sex offenders, which now has research evidence to support its efficacy (see the section on treatment efficacy below).

Relapse Prevention Approaches A significant addition to the CBT approach was the adaptation of the relapse prevention (RP) approach from the addictions field

(Marshall & Laws, 2003; Pithers, Marques, Gibat, & Marlatt, 1983). RP is a self-management approach designed to teach individuals who are trying to change their behaviour, how to anticipate and cope with the problem of relapse. As applied to sex offenders, a relapse is a return to sexually deviant fantasies or reoffence. RP is intended to help clients maintain control of their sexual deviance over time and across various high-risk situations they may encounter in the community. However, more recently issues regarding the overall usefulness of RP as a one-size fits all approach, has been questioned in that:

(a) It presumes that all offenders follow the same pathway to offending (Laws & Ward, 2006). However, evidence suggests that there are multiple potential pathways that sex offenders may take in the lead up to an offence (Bickley & Beech, 2002; Ward & Hudson, 1998; Ward & Siegert, 2002)

(b) RP also has a rather negative focus in treatment, in that it presumes offenders must avoid multiple situations to in minimise their risk of reoffending, which makes it less appealing to the offenders, than approaches that have a more positive focus. There is clearly evidence that using *approach* rather than *avoidance* goals in treatment results in greater engagement (Mann, Webster, Schofield, & Marshall, 2004).

However, in spite of the issues that have been raised with RP, it is still a component in many current CBT programmes.

Treatment Targeting Risk/Need/Responsivity The principles of risk, need, and responsvity (RNR) have been described in Chapter 16 as key element of effective rehabilitation of offenders. But to briefly summarise here, this means prioritising *high-risk* cases, treating their identified *psychological problems* (their *criminogenic*

needs) in a way that is appropriate to the person in question (*responsivity issues*). In relation to sex offenders in particular, risk level would most appropriately be determined using a specific sex offender risk assessment measure (see Chapter 16). Criminogenic need variables specific to sex offenders can be encompassed under four overarching domains proposed by Thornton (2002; 2013), that is their level of (1) [deviant] *sexual interests* (i.e., are they sexually aroused to children, or coercive sex with adult victims); (2) *distorted attitude* (do they have thoughts that give them permission to have sex with children or coercive sex with adults) ; (3) [low levels of] *socio-affective functioning* (i.e., intimacy or hostility issue towards others); and (4) [problems in] *self-management* (i.e., poor control of their behaviours/emotions).

Problems in these four key areas have been shown to be related to recidivism (e.g., Craig, Thornton, Beech, & Browne, 2007; Hanson, Harris, Scott, & Helmus, 2007; Thornton, 2002; Wakeling, Beech, & Freemantle, 2013). When assessments are made of criminogenic needs before and after treatment, typically they are seen to improve as a result of treatment (e.g., Marques, Wiederanders, Day, Nelson, van Ommeren, 2005; Olver, Wong, Nicholaichuk & Gordon, 2007). Therefore, crimonogenic needs are the most important variables to consider as treatment targets within sexual offender treatment (Mann, Hanson & Thornton, 2010; Thornton, 2013).

In terms of responsivity, some make the distinction between *internal* and *external responsivity* factors (Looman, Dickie, & Abracen, 2005). Internal responsivity factors include motivation. External responsivity factors are those that exist outside the individual but influence their ability to benefit from treatment, such as therapist characteristics and therapeutic climate (Looman et al., 2005). These will be discussed in more detail in the final section of this chapter.

In terms of evidence for the utility of the risk-need-responsivity principles, Hanson, Bourgon, Helmus and Hodgson (2009) identified 23 studies (*n*=6746) that met the basic criteria for quality of design. All studies were rated on the extent to which they adhered to the RNR principles. Hanson et al. found that the sexual recidivism rate in untreated samples was 19%, compared to 11% in treated samples. Studies that adhered to all three RNR principles were found to produce recidivism rates that were less than half of the recidivism rates of comparison groups. Studies that followed none of the RNR principles had little effect in reducing recidivism levels.

In spite of the evidence for the effectiveness of the RNR approach, a number of criticisms have been levelled at thus approach. In particular it has been argued that the focus on criminogenic need in treatment means that other problems the individual has are neglected; the person is not treated as a whole, but as a collection of criminogenic needs. It is noted that if the focus is only on targeting criminogenic need, without also illustrating how this will improve the person's life, this will likely hold little appeal to the client (Willis, Gannon,Yates, Collie, & Ward, 2010). As RNR is primarily focused on risk management, it does not maximise client engagement as much as approaches that considers the client's values and priorities in life.

The 'Good Lives' Model Newer approaches have been suggested which address the criticisms of the RNR framework. In particular, the movement towards more positively oriented (as opposed to just risk management oriented) theoretical frameworks of offender rehabilitation have been received very positively by practitioners. *The Good Lives Model* (Ward & Stewart, 2003) is such a framework that is increasingly being used with sex offenders. Such positive rehabilitation

theories recognise the utility of offering treatment in a manner that will likely hold more appeal to the individual and thus increase their likelihood of benefiting from treatment. According to this theory, all human beings, including sex offenders seek a set of primary 'goods' (Ward & Stewart, 2003; Ward, Vess, Collie, & Gannon, 2006; Willis, Yates, Gannon, & Ward, 2013). A set of 10 *primary goods* from Ward & Stewart (2003) are shown in Box 4.

Box 4: Ward's primary goods from the GLM model

- Life (including healthy living and functioning);
- Knowledge acquisition;
- Excellence in play and work (being good at something);
- Excellence in agency (being in control and the ability to be able to get things accomplished);
- Inner peace (freedom from emotional turmoil and stress);
- Friendship (having intimate, romantic, and family relationships);
- Community (being part of wider social networks);
- Spirituality (finding meaning and purpose in life)
- Happiness
- Creativity.

Sexual offending, according to this framework (e.g., Ward et al., 2006; Ward & Stewart, 2003; Willis et al., 2013) arises as a result of an attempt to obtain these goods in inappropriate ways. Treatment aims to instil in the individual the knowledge, skills, and competence in order to lead successful lives, incompatible with offending, in the context to which they will be released (Ward et al., 2006).

The main criticism of the GLM to date is the lack of empirical evidence for its effectiveness. However, evidence is beginning to accumulate to support the use of this approach being at least as effective as RP approaches (e.g., Barnett, Mandeville-Norden, & Rakestow, 2014; Harkins, Flak, & Beech, & Woodhams, 2012). In spite of the criticism of this framework, many are beginning to recognise the potential in combining the positive, motivational framework of the GLM approach with the empirically supported framework of RNR (Ward, Mann, & Gannon, 2007; Willis et al., 2010).

Integrated frameworks Modern theories of sexual offending integrate biological, social, and psychological causes (e.g., Marshall & Barbaree, 1999; Ward & Beech, 2005; Ward, Polachek & Beech, 2006). It could be argued that treatment frameworks have not yet quite caught up with this integrated approach, being mainly psychological, and focusing on issues such as offence-supportive attitudes, relationships, and self-regulation.

The majority of North American programmes described themselves as cognitive-behavioural in a recent survey (McGrath et al., 2010), with about half describing themselves as following the RP model (respondents were able to select more than one option to describe their theoretical approach). Less than one third of programmes described themselves as adhering to the RNR model, despite the superiority of the evidence backing this approach (e.g., see Andrews, 2011). Even fewer programmes described themselves as following a sexual trauma model, or as Multi-Systemic Therapy - an empirically supported approach for juvenile sexual offenders. Despite the evidence-base for augmenting psychological treatment with medical treatment for those offenders who suffer from sexual preoccupation or

compulsive sexual fantasies, less than 20% of North American programmes reported the availability of a physician to prescribe anti-libidinal medication or Selective Serotonin Reuptake Inhibitors (SSRIs).

Obviously, some lead-in time is required for programme content to catch up with changes in the evidence base, particularly for large or multi-site manualised programmes such as the prison and probation programmes in England and Wales. The process of changing the design of a programme can take several years, especially if the changes have to be approved by an external body, as is the case in jurisdictions that operate a system of programme accreditation (McGuire, Grubin, Lösel, & Raynor, 2010).

The first decade of this millennium has seen some important developments in our knowledge about the causes of sexual offending as well as in evidence about effective treatment components, but there are still numerous unanswered questions about sexual offending and how it should be treated. For example, as Hanson (2010) concluded, the causes of paedophilia are still not known. Although some (e.g., Caimilleri & Quinsey, 2008; Seto, 2008) have explicitly stated their support for neurodevelopmental explanations of paedophilia, this evidence base is still in early days, and the translation of this knowledge into a treatment paradigm is yet to come.

At present, the best integrated treatment frameworks would aim to strengthen biological, social and psychological resources, would operate in line with the RNR principles, and would recognise that programme goals must be viewed as attractive and achievable by treatment participants. There are arguments for and against manualised treatments (e.g. Mann, 2009a; Marshall, 2009), although most people would agree that some pre-defined structure for a programme is necessary to maintain treatment fidelity and to permit evaluation studies. Most treatment programmes are

group programmes, which are generally preferred not just for their efficiency but also because they offer the opportunity for participants to develop interpersonal skills in a way that would not occur in individual therapy, but there is no evidence to speak of that supports one modality over the other (Ware, Mann & Wakeling, 2009).

Treatment content of sex offender programmes

A survey of 1,379 sexual offender treatment programmes across North America (McGrath et al., 2010) revealed, somewhat surprisingly, that the majority of programmes focus on issues that have not been shown to have a strong relationship with recidivism, such as *taking responsibility for offending* and *victim empathy*. It is likely that the focus on these matters stems from influential earlier texts on sexual offender treatment (e.g., Salter, 1988), written before criminogenic need research became so well established. Mann, Hanson and Thornton (2010) and Thornton (2013) have attempted to encourage a change in treatment programme design by reviewing the risk factor literature to create lists of those risk factors (and hence those area that should be targeted in treatment) with the greatest empirical support. Box 5 summarises the outcome of this review - further description of each risk factor can be found in the source paper.

Box 5: Empirically-based risk factors for sexual recidivism

Empirically supported risk factors	**Promising risk factors**	**Unsupported but with interesting exceptions/Worth exploring**	**Not risk factors**
Sexual preoccupation	Hostility towards women	Denial	Depression
Sexual preference for children	Machiavellianism	View of self as inadequate	Poor victim empathy
Sexualised violence	Callousness	Major mental illness	Lack of motivation for treatment at

			treatment intake
Multiple paraphilias	Sexualised coping	Loneliness	Poor social skills
Offence supportive attitudes	Externalising	Adversarial sexual attitudes	
Emotional congruence with children		Fragile narcissism	
Lack of emotionally intimate relationships with adults		Sexual entitlement	
Lifestyle impulsivity			
Self-regulation problems			
Poor problem solving			
Resistance to rules			
Grievance thinking			
Negative social influences			

These empirically supported risk factors should be the main focus of treatment programmes. However, as McGrath et al. (2010) revealed, this is not always the case in practice. For example, deviant sexual interest is the risk factor with the strongest relationship with recidivism, yet only about two thirds of programmes in the US reported addressing this issue. McGrath et al. (2010) concluded that treatment targets of many sexual offending programmes "are often at odds with" the research into the factors that predict sexual recidivism.

The discrepancy between practice and the evidence base probably exists because it takes some time for treatment programmes to change - for instance, manuals may have to be rewritten, staff may have to be retrained, etc. In some cases, where research contradicts strongly held beliefs (such as the very widespread belief that offenders must take responsibility for their offending in order to reduce their risk), staff may actively resist change. Programme designers may therefore be likely

to wait some time after publication of research findings before introducing major changes to treatment programmes.

INSERT SEX OFFENDER CASE STUDY ABOUT HERE

The Evidence-Base for the Treatment of Dangerous Offenders

Violent Offenders

There is a surprising lack of empirical evidence from which to draw conclusions as to the effectiveness of violent offender treatment. This probably reflects the fact that most jurisdictions have focused their resources on the treatment of other offenders - most notably sexual offenders (Howells, Watt, Hall, & Baldwin, 1997; Polaschek, 2006). That said, most criminal justice systems recognise the importance of providing treatment to these serious violent offenders. Therefore, they either provide *general* criminogenic programmes (as outlined above), or have more recently developed specific intensive treatment programmes for this group (Serin, Gobeil, & Preston, 2008). This explains why there have been comparatively few attempts to thoroughly evaluate specific violent offender treatment programs.

In the first extensive review of violent offender treatment Polaschek and Collie (2004) summarised the outcomes of nine studies that they considered to be of sufficient methodological rigour to warrant inclusion. Two of these were cognitive skills programmes, three were anger management programmes, and the remaining three were classed as multi-modal programmes. Each of these studies reported promising outcomes. However, Polaschek and Collie (2004) considered all of these studies to have methodological weaknesses, or a lack of information, which prevented any firm conclusions as to the effectiveness of violent offender treatment being drawn. More recently, Jolliffe and Farrington (2007) systematically reviewed the

effectiveness of violent offender programmes and could find only 11 outcome studies that met their methodological criteria for the identification of good treatment programmes.

Since the initial Polaschek and Collie (2004) review, there have been a number of evaluations of multi-modal (intensive) violent offender programmes. These have also produced inconsistent results. Polaschek (2011) reported on the New Zealand prison based intensive Violence Prevention Unit programme. This is an intensive group-based programme that ran for four sessions per week over a 28-week period (approximately 330 hours). Polaschek (2011) matched 112 medium and high-risk violent offenders who completed the program with 112 untreated offenders over a period averaged 3.5 years. Polaschek found that 12% fewer offenders from the treated sample had re-offended and those treated offenders who did re-offend took twice as long to commit a further offence than the matched controls.

Cortoni, Nunes, and Latendresse (2006) compared 500 violent offenders who completed the 94-session prison-based *Violence Prevention Programme* (VPP) in Canada with 466 matched untreated controls. They found that offenders who completed the VPP had significantly fewer major institutional misconduct charges in the six-month, and one-year period following completion of the programme. More importantly, untreated offenders were more than twice as likely to be re-convicted for a violent offence over 12-month period.

Serin, Gobeil, and Preston (2009) evaluated the *Canadian Persistently Violent Offender* program with less positive results. They found that violent offenders who had completed this 144-hour programme were as likely to re-offend as offenders who completed an AM programme or no programme at all. Similarly there were little

differences between offenders with respect to institutional misconducts or measures of treatment change.

Results regarding the efficacy of anger management programmes have also produced mixed results. Dowden, Blanchette, and Serin (1999) reported an 86% reduction in violent re-offending for 110 anger management programme participants over a three-year follow up. Research has also demonstrated that anger management programmes can reduce; rule violations, re-arrest rates, angry patient behaviours as observed by staff, disciplinary incidents, physical assaults in hospitals, and verbal and physical aggression incidents (Novaco, 2013). In contrast, anger management programmes evaluated in Australia appear to have produced only small effects (Howells et al., 2002). Of note these programmes appear to have been shorter, and less intense, than those reported by Dowden et al. (1999).

Evaluations of cognitive skills programmes have also produced mixed results. In a meta-analysis of 16 studies across four countries, Tong and Farrington (2006) reported a significantly positive effect of cognitive skills programmes. In England and Wales, a large scale study of cognitive skills programs (e.g., Reasoning and Rehabilitation, Enhanced Thinking Skills) reported significant reductions in re-offending after a two year follow up period (Friendship et al., 2003). In a large scale Canadian study, Robinson (1995) reported reductions in recidivism of up to 36%. Offenders with a variety of convictions completed these 36-session prison-based Reasoning and Rehabilitation cognitive skills programmes; here, violent offenders were more likely to benefit from the programme compared to offenders convicted of theft offences. A similarly large evaluation in England and Wales (Falshaw et al., 2004) found no differences between the two-year recidivism rates of offenders who completed cognitive skills programmes and a matched control group.

Babcock, Green, and Robie (2004) conducted a large meta-analysis of IPV programmes based on 22 studies. They concluded that IPV programmes had, at best, a small positive impact on re-offending, but for the most part these programmes were not effective.

Treatment Effectiveness of Sex Offender Therapy

The effectiveness of sex offender treatment has been studied and reviewed extensively (Dennis et al., 2012; Gallagher, Wilson, Hirschfield, Coggeshall, & MacKenize, 1999; Hall, 1995; Hanson et al., 2002; Kenworthy, Adams, Bilby, Brooks-Gordon, & Fenton, 2004; Långström,et al., 2013;Rice & Harris, 2003). Numerous factors should be considered when determining the effectiveness of treatment (e.g., Harkins & Beech, 2007; Levenson & Prescott, 2014. These include the type of treatment (e.g., insight oriented, CBT), the study methodology (e.g., incidental cohort, Randomised Control Trial) and how effectiveness is measured (e.g., recidivism, change within treatment).

A useful method for evaluating various treatment approaches has been through the use of meta-analysis. This combines results from a number of studies to determine if there is an overall effect. It allows for small effect sizes to be detected in the large sample sizes that typically result from amalgamating studies.

Hanson et al. (2002) conducted a meta-analysis examining treatment evaluation studies identified prior to May 2000. The studies analysed all had a comparison group, including those who had received no treatment, as well as those who attended programs that were determined to be inadequate or inappropriate. This search yielded 43 studies (N = 9,534) from 23 published and 20 unpublished community and institutional treatment programs, with an average length of follow-up

time being 46 months. Hanson et al. reported a significant effect of treatment (12.3% for treated vs. 16.8% for untreated samples). Averaged across all types of treatment there was a significant effect of treatment. Breaking down treatment, by type of approach, Hanson et al. found that 'older treatment' options (i.e., non-behavioural/non-CBT) appeared to have little effect in reducing and CBT had a positive treatment effect.

Lösel and Schmucker (2005) reported similar results, analyzing 69 studies (*N* = 22,181) that were completed prior to June 2003. This meta-analysis also identified a positive effect of treatment with treated sexual offenders. They found that physical treatments (i.e., surgical castration and hormone treatments) had larger effects than psychosocial approaches. Both CBT and classical behaviour therapy were also shown to have a significant impact on sexual recidivism. In contrast, more psychotherapeutic approaches (i.e., insight oriented, therapeutic community, and other unclear psychosocial approaches) did not significantly influence recidivism.

Beech, Robertson and Freemantle (in preparation) examined 54 treatment studies (*N* = 14,694), which included a range of different designs all using a control group. Results indicated a positive effect of treatment for both sexual and general recidivism, with an advantage of systemic and CBT approaches, in reducing both sexual and general recidivism. Robertson et al. suggest that these results lend support for the efficacy of sexual offender treatment, particularly when the strongest treatment designs (i.e., randomised control trials and incident cohort combined) are used, with systemic therapy and CBT appearing to hold the most promise for effective interventions.Two recent systematic reviews have reached conclusions less supportive of the effectiveness of treatment. Långström and colleagues (2013) examined 167 treatment outcome studies with adult or adolescent offenders and child

victims. They included 8 of sufficient quality in their review. They concluded that the evidence is insufficient to determine if CBT with RP is effective for reducing sexual recidivism. In terms of adolescent offenders, there was evidence from one study (Borduin, Schaeffer, & Heiblum, 2009) suggesting that multisystemic therapy could be effective in preventing sexual reoffending but otherwise they concluded that there was no evidence to draw conclusions about the effectiveness of other treatment approaches. Dennis et al. (2013) reviewed 10 relevant studies (N=944 offenders) and concluded that further randomized control trials are needed because the current evidence does not support the position that treatment reduces risk of reoffending.

Although findings about the effectiveness of treatment are mixed, a number of important considerations have been noted in terms of their impact on outcome studies (Levenson & Prescott, 2014). Randomized Control Trials are heralded by some as the "gold standard" for evaluating effectiveness, but others argue that it is unethical to withhold treatment from willing participants who may be more likely to reoffend without treatment (see Marshall and Marshall (2007) for a discussion of the problems with using RCT with sex offenders and Seto et al., (2008) for a rebuttal). Other have noted the importance of considering prosocial treatment change instead (e.g.,Wakeling et al., 2013). The importance of considering process (as opposed to content) related variables (e.g., the therapeutic relationship instead of the specific material covered in treatment)to determine whether treatment has been effective, rather than a strict focus on recidivism as the only outcome of interest has also been noted (Levenson & Prescott, 2014).

Considerations in Working with Dangerous Offenders

There are number of considerations when working with dangerous offenders we will now briefly consider some of these.

The Psychopathic Offender

Psychopathy is a condition marked by: (1) self-serving interpersonal traits (e.g., grandiosity), pathological lying, manipulativeness; shallow affect (e.g., lack of emotional depth), lack of empathy, guilt or remorse; and (2) a set of broadly antisocial traits (e.g., impulsivity, persistent violation of social norms) (Hare, 2003). There are a number of studies and reviews discussing the commonly stated position that men who score high in psychopathy[1] tend to respond poorly, as a group, to traditional treatment programs (Hare, Clarke, Grann, & Thornton, 2000; Hare & Neumann, 2009; Hobson, Shine, & Roberts, 2000). Some studies have even seemed to indicate that treatment may make highly psychopathic men worse (i.e., more likely to recidivate; Hare, et al., 2000; Looman, Abracen, Serin, & Marquis, 2005; Rice, Harris, & Cormier, 1992; Seto & Barbaree, 1999). However, there are some problems with studies indicating negative treatment outcome for psychopaths and more current work suggests that psychopaths do not invariably have high recidivism rates (Abracen, Looman, Ferguson, Harkins, & Mailloux, 2010; Barbaree, 2005; Langton, Barbaree, Harkins, & Peacock, 2006).

Reviews of the available literature on the treatment of psychopaths have generally concluded that there is not enough evidence to support the view that men who score high on the PCL-R have a negative response to treatment (Abracen, Looman, & Langton, 2008; Doren & Yates, 2008; D'Silva, Duggan, & McCarthy, 2004;Loving, 2002; Olver & Wong, 2009; Polaschek, 2014; Thornton & Blud, 2007). It is possible that psychopathy presents an obstacle to therapy because psychopaths are more of a challenge to treat than non-psychopaths, but they may be treatable

[1] A score of 30 on the PCL-R is used as a cut-off to indicate psychopathy (Hare, 2003).

nonetheless. In particular, it is possible that psychopaths do not respond well to traditional treatment programs, but may be more responsive to programs designed specifically to meet their needs (Harkins, Beech, & Thornton, 2011; Polaschek, 2014; Thornton & Blud, 2007; Wong & Hare, 2005).

Treatment Readiness

Some suggest these responsivity issues should be considered under the broader term of 'treatment readiness' (Serin, 1998; Ward, Day, Howells, Birgden, 2004). This concept incorporates a variety of person (e.g., beliefs, emotions, skills) and context (e.g., treatment setting and availability, external supports, availability of qualified therapists) factors that promote engagement and enhance change (Ward et al., 2004). According to this theory a person will be ready to change based on the extent to which they possess certain internal qualities in the context of external factors that promote the changes the person is trying to make (Ward et al., 2004; Ward et al, 2006).

Ward et al. (2004) suggest that treatment outcome can be improved by addressing issues surrounding treatment readiness. Such issues might include learning difficulties, a lack of verbal skills and literacy deficits, cultural factors whereby the therapist is of a different culture, a genuine lack of motivation to change, denial of the violent offences have all been highlighted as important issues to address before an individual commences treatment (Howells et al., 1997; Serin & Preston, 2000). Any of all of these issues may result in an offender being "resistant" to therapeutic efforts. This is a critically important issue given that dangerous offenders who drop out of treatment are almost always found to have higher recidivism rates than offenders who did not receive any treatment (e.g., for violent offending , 40% v 17% respectively, Dowden & Serin, 2001).

Therapeutic Climate

The therapeutic climate of a group refers to the context in which treatment occurs. It encompasses factors such as therapist characteristics and the inter-relationships between individuals in a group. Therefore, in addition to characteristics of the offender being important, the characteristics of the therapist and the group itself should not be undervalued. From a review of the literature, Marshall, Fernandez, et al. (2003) suggest aggressively confrontational approaches should be avoided and a more empathic, respectful type of, supportive, but firmly challenging, style should be employed. Marshall and colleagues (Marshall, et al., 2002; Marshall, Serran, et al., 2003) found that a number of therapist features, including empathy, warmth, a rewarding style, and being directive were related to positive change within treatment. Harsh confrontation was adversely related to treatment change. This 'motivational' approach is also supported by a number of other researchers, for both sex offenders (e.g., Drapeau, 2005; Fernandez, 2006; Garland & Dougher, 1991; Kear-Colwell, & Pollock, 1997; Preston, 2000) and the general criminal population (e.g., Andrews & Bonta, 2003; Ginsberg, Mann, Rotgers, & Weekes, 2002; Mann, Ginsberg &Weekes, 2002). A motivational approach has also been related to positive group environment among sex offenders (Beech & Fordham, 1997).

In terms of the group environment, Beech and Fordham (1997) examined the characteristics of successful sex offender treatment groups, demonstrating that effective groups instil a sense of hope in members, are cohesive, well-organized, have desirable group norms, and are well-led. Beech and Hamilton-Giachritsis (2005) examined whether the therapeutic environment of sexual offender groups was related to changes in pro-offending attitudes within treatment (Beech & Hamilton-Giachritsis,

2005). They found that significant treatment change on measures of criminogenic need (i.e., victim empathy, cognitive distortions, and emotional identification with children,) was associated with level of cohesiveness in the group and the extent that group members felt able and encouraged to express themselves within the group.

Treatment Context

Treatment programmes are often seen as the main route by which risk can be reduced, but the truth is that even the best designed programme will only be effective if it is delivered in a context that reinforces the messages of treatment and where the treatment participant feels safe and supported. Treatment programmes in correctional settings therefore pose a considerable challenge, perhaps particularly for sexual offenders, who are viewed as 'the lowest of the low' by both their fellow offenders and many criminal justice personnel. As Glaser (2010) has pointed out, where programmes are required activities of a criminal justice system, they take on the features of punishment rather than rehabilitation: that is, they do not have the best interests of the participant as their first priority but rather they exist to support the social goal of public protection; they tend not to offer the same standards of confidentiality as non-forensic mental heath treatments; and attendance at treatment is often enforced by the courts and hence does not respect the offender's autonomy or right to choice. Treatment programmes in prison face additional challenges, in that prison rules and codes often respect different principles than those promoted by treatment programmes. For instance, treatment programmes, as we have seen, often place considerable store on taking responsibility for offending, whereas survival in prison often depends on the offender providing acceptable excuses for his sexual crimes.

Mann (2009b) has outlined some of the key contextual issues for prison programmes in particular. These include: the mistrust that prisoners often feel for prison staff, which extends to programme staff; the expectation of hostile reactions from others; and the fear of stigma. Mann suggested that some simple alterations to the way in which sex offenders are managed in prison could increase treatment take-up, including: taking more time to listen and understand the sex offender's experience of prison; taking more action to counter popular prison myths about treatment; communicating the strength-based aims of treatment; making referrals quickly and sensitively; educating non-treatment staff about the purpose, principles and effectiveness of treatment; and ensuring that prison leaders encourage pro-social modelling and a supportive environment.

While programmes for violent offenders, and programmes in community settings, are probably less vulnerable than sex offender programmes in prison, they also share the feature that 'treatment' is inextricably intertwined with punishment, and hence the context of treatment inevitably works against rather than with the personal aims and priorities of the offender.

Summary

- This chapter has highlighted the importance of providing effective treatment for dangerous offenders.
- In spite of criticisms for all treatment approaches, it would appear that the best approaches to treatment are those that take an integrated or multi-modal approach, use an overall RNR framework for delivering treatment, and have programme goals that are appealing and attainable by those attending treatment.

- The best current evidence suggests that some of the best treatment targets (i.e., criminogenic needs) for sexual offenders include sexual preoccupation, a sexual preference for children or sexualised violence, emotional congruence with children, lack of emotionally intimate relationships, and lifestyle impulsivity.
- Evidence from the various approaches to treating violent offenders is limited and inconsistent, but does suggest some of the approaches (Anger management, Cognitive skills, and multi-modal approaches) are promising.
- The most promising treatment targets for violent offenders include anger, hostility, impulsivity, substance abuse and relationship instability, amongst others.
- Meta-analyses provide support for the effectiveness of Risk-Needs-Responsivity, CBT, physical, behavioural and systemic approaches to treating sex offenders.
- For all treatment approaches aimed at dangerous offenders, it is useful to consider the potential influence of psychopathy and the offender's level of treatment readiness.
- It is also important to attend to the therapeutic climate of a group including the characteristics of the therapist and the context in which treatment is provided. Attention to these factors should take us some of the way towards preventing or reducing future harm, alongside improving the future prospects of individuals who have committed dangerous offences.

Essay/ Discussion Questions

Critically discuss treatment approaches for violent offenders.

What are important considerations in delivering effective sex offender treatment?

What is the evidence for the effectiveness of treatment approaches for dangerous offenders?

What is the evidence for the effectiveness of treatment approaches for sexual offenders?

What are the main considerations when working with dangerous offenders?

Case Study: Treating a violent offender

Ron was 28-years old when he was incarcerated for his third time. All of his prison sentences were for violent and drug related offences but he also has a long list of theft, fraud, and driving convictions. He has been unemployed for most of his life. His most recent violent offences all occurred on the same evening. The initial offence involved a serious assault on an unknown 18 year-old male which happened outside a busy pub. Police witnesses described it as a totally unprovoked attack. The second offence occurred within two hours of the first. It involved an assault on a 55-year old patrol station attendant during the commission of an armed robbery. Ron and two friends were armed with meat cleavers. Both the victims suffered injuries that required hospitalisation.

When asked about the offences during an assessment Ron described the night in question as "a little fun with me mates". He was not concerned over either victim's injuries and stated that the 18 year-old pushed him when he was buying a drink (insulting him) and that the robbery was simply a way of "getting more money for their drugs". He also stated that "everyone needs a little bashing now and again – it toughens you up". Ron reported consuming a large quantity of alcohol and drugs over a 24 hour period prior to being in the pub. He reported being "a little bit" angry at his girlfriend whilst at the pub and then also added that he thought that the victim was a "good looking little jerk". Later, Ron acknowledged that he had seen the victim talk to his girlfriend. Ron's description of the robbery indicated that it was not very well planned. Ron and his friends simply needed more money to pay for drugs and had previously discussed maybe "doing over" the petrol station.

Main treatment targets/ criminogenic needs:

- Offence supportive attitudes towards the use of violence (e.g., "It was a little fun and "everyone needs a bashing")
- Probable anti-social personality (three previous violent offences and other convictions)
- Antisocial companions (would he have committed these offences if not with his friends?)
- Substance abuse (noting that the violence appears to be used as a means to get money for alcohol and drugs)
- Anger (the treatment question was whether the important emotional state to target was anger or in fact jealousy/fear of rejection).
- Relationship instability
- Interpersonal and problem solving skill deficits
- Impulsivity (it is probable that he decided to assault the victim very quickly without necessarily planning to do so)
- Employment/education

Treatment approach:

Given the multiple treatment targets Ron is unlikely to benefit from only a cognitive skills or anger management programme. In fact he had completed an anger management program whilst incarcerated previously. In his case the violence appears to have been caused by multiple issues and therefore all of these should be targeted within a multi-modal treatment program (or through the use of a number of specific programs such as alcohol and drug programs, cognitive skills, programs).

A multi-modal treatment approach would involve the development of an overarching relapse prevention/self management plan which would determine the multiple situations in which Ron was likely to use violence and plan strategies to assist Ron to not have to resort to violence. Treatment would also need to target all of the criminogenic needs particularly given that Ron's use of violence was both reactive and instrumental.

Case Study: Treatment for a sexual offender

Joe is a 23-year old offender who has been convicted of sexual activity with a female child under 16. He has no previous offences. When asked about the offence during an assessment, Joe described having a 'relationship' with the victim, who was 12 at the time of the offence. He says this relationship lasted three weeks. He claims he was in love with the victim. He reported his belief that his sexual activity with the victim was not an offence because she enjoyed it. He describes it as "just a little fun". He also describes three other 'relationships' with age appropriate females, lasting several days at the longest.

Joe is very close to his parents and will move back in with them after his release. He worries that he will struggle to find a job because his previous experience has been working with young people and he's not allowed to do that now. He spends most of his spare time with people who were generally 13-21 years of age because he shares similar interests with them such as skateboarding and video games. He reports that he feels people his own age are intimidating. Joe has an older sister who is supportive of him. She has two children. Joe's sister believes that he is innocent and occasionally asks Joe to babysit her kids in a pinch.

Treatment targets/ criminogenic needs: Offence supportive attitudes (e.g., "It was not an offence because she enjoyed it"), Emotional congruence with children (e.g., having 'relationships' with kids, having interests similar to children, and finding adults intimidating), and Lack of emotionally intimate relationships with adults.

Relapse Prevention Approach: Treatment would involve developing a relapse prevention plan, which would include determining potential risky situations Joe might encounter and how to avoid these. For instance, Joe would likely identify that

socialising with children would put him at an increased risk of reoffending and therefore need to develop methods to avoid being in such social situations, such as perhaps leaving a gathering if someone underage joined them. He would also develop a number of potential responses for how to cope with the situation of his sister asking him to babysit for her, even if she is desperate for help.

Good Lives Approach: Treatment would involve identifying which 'goods' Joe was trying to meet through his offending. It is likely that Joe was attempting to meet the good of (intimate and romantic) friendship. A GLM approach would assist Joe to develop the skills needed to develop the confidence to pursue intimate relationships with age-appropriate partners.

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Annotated Reading List

Marshall, W.L., & Laws, D.R. (2003). A brief history of behavioural and cognitive approaches to sexual offenders: Part 2, the modern era. *Sexual Abuse: A Journal of Research and Treatment, 15*, 93-120. *This paper provides a historical perspective on the development and implementation of many treatment approaches that are currently in use with sex offenders.*

McGrath, R.J., Cumming, G. F., Burchard, B.L., Zeoli, S., & Ellerby, L. (2010). *Current practices and emerging trends in sexual abuser management: The Safer Society 2009 North American Survey*. Brandon, VT: Safer Society Press. *This paper outlines a number of the sex offender treatment approaches that are currently used and provides evidence for their use in practice in the US and Canada.*

McGuire, J. (2008). A review of effective interventions for reducing aggression and violence. *Philosophical Transactions of the Royal Society B, 363,* 2577-2597. *A useful review of the effectiveness of aggression and violence treatments.*

Polaschek, D.L.L., & Collie, R.M. (2004). Rehabilitating serious violent adult offenders: An empirical and theoretical stocktake. *Psychology, Crime and Law, 10*, 321-334. *This paper usefully distinguished violent offender treatment on the basis of their theoretical approaches and provides summaries of studies they deem to be of the highest methodological rigour.*

Ward, T., Polachek, D.L.L., & Beech, A.R. (2006). *Theories of sexual offending*. Chichester: Wiley. *The book outlines and critiques all the historical and current theories of relevance in treating sexual offenders.*

Glossary

Anger management programmes typically focus on increasing the offender's awareness of anger and its triggers, and then providing a range of skills including social skills and relaxation training to assist the offender to decrease anger arousal and strengthen anger control.

Cognitive Skills programmes are based on the notion that violent offending is caused by anti-social cognitions and are focused towards helping offenders recognise their thought patterns that are conducive to crime and to acquire new ways of thinking about and solving their problems.

Good Lives Model is a strengths-based rehabilitation framework that proposes that all individuals, including offenders are seeking a set of 'goods' (e.g., happiness and knowledge) which are sought for their inherent value. Sexual offending, according to this framework arises as a result of an attempt to obtain these goods in inappropriate ways. Treatment aims to instil in the individual the knowledge, skills, and competence in order to lead successful lives, incompatible with offending, in the context to which they'll be released.

Integrated frameworks recognise that theories of sexual offending combine biological, social, and psychological causes thus programmes would aim to strengthen biological, social and psychological resources, operate in line with the RNR principles, and would recognise that programme goals must be viewed as attractive and achievable by treatment participants.

Intimate Partner Violence (IPV) programmes have historically been educational and developed around feminist theories of why IPV occurs (see Chapter 10 for more details of this). Consequently they tend to focus on issues such as power and control, abusive/coercive behaviours within intimate relationships, and communication and

stress management techniques (Graham-Kevan & Wigman, 2009). More recently, many researchers/clinicians in the field of IPV research take a gender inclusive approach (i.e., women also perpetrate violence towards men), thus it has been argued (e.g., Dixon, Archer, & Graham-Kevan, 2012; Dutton, 2006) that feminist oriented approaches are not adequate to address violence perpetrated by women.

Multi-modal programmes assume that many factors are involved in the causation and maintenance of violent behaviours, targeting a large number of psychological and behaviours factors (such as social skills, thinking, substance abuse, etc.).

Relapse Prevention is a self-management approach designed to teach individuals who are trying to change their behaviour, how to anticipate and cope with the problem of relapse. As applied to sex offenders, a relapse is a return to sexually deviant fantasies or reoffence.