

RUNNING HEAD: Relapse Prevention

In G. McIvor and H. Kemshall (Eds.) Research highlights in social work – sex offenders: Managing the risk. San Francisco, CA: Jessica Kingsley.

Relapse Prevention: Theory and Practice.

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Introduction

Over the last 20 years, the utilisation of relapse prevention strategies has become a crucial component of therapy for reoccurring and somewhat intractable disorders. Following the reduction of the presenting clinical problem(s) it has become common to shift the focus of therapy from the process of creating change to that of maintaining treatment gains or preventing relapse. Hence, the presence of a relapse prevention component is considered pivotal to the ongoing success of achieving abstinence from ongoing psychological problems, for example, substance abuse or pathological gambling. Ideally, a relapse prevention module should be embedded within a treatment programme and also function as an overarching or umbrella concept capable of unifying the entire therapeutic program (Laws, in press).

Relatedly, in recent years a number of clinicians and researchers have argued that the treatment of sexual offenders ought to be based on an understanding of the process of relapse (e.g., Pithers, 1990). It has been suggested that there are clear patterns evident in the behaviour of sexual offenders which translate into distinct clusters of cognitive, affective, and behavioural offence variables (Ward, Loudon, Hudson, & Marshall, 1995). Models of the relapse process set out to provide a rich description of the cognitive, behavioural, motivational and contextual factors associated with a sexual offence (Ward & Hudson, 2000). Theory at this level typically includes an explicit temporal factor and focuses on proximal causes or the "how" of sexual offending.

In addition, the high recidivism rates of sexual offenders have led many theorists and researchers to view sexual deviance as analogous to addiction (Laws, 1989). In light of these observations, treatment strategies such as relapse prevention

have been taken from the addiction area and applied to sexual offenders (Ward & Hudson, 1996).

A Brief Historical Summary of Relapse Prevention

Relapse prevention's ancestry lies in the vast array of literature on substance abuse (Laws, in press; Ward & Hudson, 2000). Marlatt (1982; 1985) developed the original Relapse Prevention (RP) model for the treatment and management of addictive behaviours, in particular, alcoholism. Before briefly outlining the model, we should draw attention to one of Marlatt's most notable theoretical contributions, the construct of the relapse process. Rather than viewing relapse as a condition where a person moves directly from a state of abstinence to a state of relapse, Marlatt assumed that relapse occurred in discrete steps over time (Ward et al., 1996). This led to the critical distinction within the RP model between a lapse (a single event involving the recurrence of a prohibited behaviour) and a relapse (a return to an addictive pattern). Whether a lapse leads to a relapse depends on several individual and situational factors (Blackburn, 2000). In Marlatt's cognitive-behavioural model, a high risk situation occurs when person is placed in a situation where their commitment to abstinence is threatened-essentially because of a lack of effective coping skills. There are three different ways in which high-risk situations can be created. The first occurs when a person is unexpectedly placed in a situation he/she has difficulty managing (e.g. being offered a cigarette by a superior at work-Ward et al., 1996). A second pathway represents a direct route from lifestyle imbalances to high-risk situations. Here, the person experiences difficulty in coping with stressors and as a result of feeling overwhelmed, he/she relies on old methods of coping (i.e. the addictive behaviour). The high-risk situation here is likely to be an internal one, typically a

negative affective state. The third major, and covert pathway involves apparently irrelevant decisions¹; that is, seemingly trivial decisions that appear reasonable and unrelated to addiction but which collectively help set up high-risk situations. The individual may not be fully aware of the motives behind these decisions (i.e. to indulge in a prohibited behaviour), as apparently irrelevant decisions function to avoid self-criticism and social disapproval, and provide an excuse for lapsing.

Once in a high-risk situation, prior experiences with the drug in question may cause individuals to anticipate a number of pleasurable and positive effects and to discount any negative consequences (the problem of immediate gratification-PIG). The presence of the PIG can facilitate the chances of a lapse occurring. Failure to deal adaptively with the high-risk situation leads to decreased self-efficacy, lapse, and the abstinence violation effect (AVE), essentially, recognition that the commitment to abstinence has been violated (Blackburn, 2000; Laws, in press). Depending on how the AVE is managed, a relapse may or may not occur. According to Marlatt, the AVE consists of two major components, an attribution concerning the cause of the lapse and an affective reaction to this attribution (Marlatt & Gordon, 1985). For example, if a lapse is thought to be caused by external, unstable and specific factors (e.g. "I had to have the cigarette so as not to offend my boss") the effect should be minimal and the possibility of relapse unlikely (Ward et al., 1996). However, if a lapse is attributed to internal and unavoidable factors (e.g. "I am weak") then a negative emotional reaction will likely be felt and the chance of relapse increased (Laws, in press). The greater the intensity of the AVE, the more likely it is that an individual will relapse, that is return to his or her previous levels of addictive behaviour. From this perspective one

¹ Apparently Irrelevant Decisions (AIDs) have been also been referred to in the literature as Seemingly Irrelevant Choices (SICs) and Seemingly Unimportant Decisions (SUDs).

of the functions of addictive behaviour is to cope with emotional stressors, basically it represents a maladaptive coping strategy.

Pithers' Relapse Prevention Model

The sex offender variation of RP, based on Marlatt's (1985) model, was originally developed by Pithers, Marques, Gibat, and Marlatt (1983) and has remained relatively unchanged since its inception (Laws, in press).

Pithers (1990) outlined a RP program for child molesters and rapists based on the idea of a cognitive-behavioural chain, a similar construct to the relapse process. Cognitive-behavioural chains refer to the idea that sexual offences are not isolated events; rather, they are the final event in a lengthy sequence of thoughts and actions (Barbaree & Seto, 1997; Nelson & Jackson, 1989). Pithers et al. (1983) were the first to outline the sexual offence chain in relapse prevention terms and postulated that it consisted of four stages. First, there is a lifestyle, personality or situational event, which forms the background to the offence behaviour. Second, the offender becomes dysphoric (i.e., experiences a negative mood state) as a result of the stressors, and consequently enters a high-risk situation. Third the offender "lapses" (e.g. fantasises about having sex with a child), and in the final stage relapses (e.g. the offender assaults the child).

In adapting Marlatt's RP model to sex offenders, Pithers and his colleagues made a number of conceptual changes. In particular, Marlatt's definition of lapse and relapse were altered to accommodate the nature of the sexual offending domain. For Marlatt, a lapse was defined as an initial reoccurrence of the prohibited behaviour (e.g. puff of a cigarette or sip of alcohol). However, it is clearly unacceptable with sex offenders to define a lapse in these terms, that is, as the first instance of a sexually

abusive behaviour, and the victimisation of a woman or child. To remedy this problem, Pithers redefined a lapse as the intentional involvement in risky behaviour (e.g. deviant sexual fantasising, volunteering to baby-sit) and a relapse as the initial occurrence of any sexual offence (as opposed to frequent engagement in the prohibited behaviour, as specified by Marlatt).

In the Pithers model, the relapse process is described as an affective/cognitive/behavioural chain resulting in the recurrence of sexually deviant behaviour (Pithers et al., 1983). In his description and visual representation of the relapse process, Pithers identifies only one pathway to high-risk situations, the covert route, where apparently irrelevant decisions directly lead to a situation where the offender's control over his sexually abusive behaviour is threatened (see Pithers, Kashima, Cumming, & Beal, 1988). Pithers states that a high-risk situation is typically characterised by a negative emotional state, interpersonal conflict, or external conditions (e.g. baby-sitting) (Ward et al., 1996).

According to Pithers' model of the relapse process, the offender is initially in an abstinent state with high self-efficacy beliefs regarding the avoidance of sexual offending. However, with the advent of apparently irrelevant decisions, a high-risk situation emerges which, if not coped with effectively, results in a lapse. For example, the apparently irrelevant decision to accept a neighbour's request to baby-sit their child may result in a high-risk situation. Failure to cope effectively with this situation could potentially lead to a lapse (e.g., sexual fantasies about children).

Following the lapse, the offender experiences the AVE. According to Pithers definition of the AVE, there is conflict between a sex offender's self-image as reformed and the recent experience of a lapse (Ward et al., 1996). How this dissonance effect is resolved determines whether or not a lapse becomes a relapse. If

the AVE is attributed to treatment failure (i.e. the person views himself as an unreformed sexual offender, treatment has failed), then relapse will be expected and viewed as inevitable. In addition, Pithers argues that a key component of the AVE in sex offenders is the problem of immediate gratification, where an offender focuses on positive consequences of sexual assault and ignores the negative. This process serves to augment the intensity of the AVE and make it even more likely that relapse will occur (Ward et al., 1996). Note that for Pithers the PIG occurs as part of the AVE and facilitates the transition from a lapse to a relapse, whereas for Marlatt, it mediates the transition from a high-risk situation to a lapse.

Problems with Pithers' Relapse Prevention Model

Marlatt's and Pithers' model have both been extensively critiqued in detail elsewhere (see Ward et al., 1996) and we will only focus on the main problems here.

Because Pithers' model relies so heavily on the original RP theory developed by Marlatt, it is vulnerable to many of this theory's problems. We will briefly summarise these problems before considering criticisms specific to Pithers' own version of the relapse process in sexual offenders.

General criticisms

A first point is that Pithers, like Marlatt, postulates the existence of a number of mechanisms associated with the relapse process that appear to either conflict with each other, or are not clearly connected. Second, Pithers does not convincingly address the interactions between the major constructs such as high-risk situations, lapses, apparently irrelevant decisions, and so on. Contrary to what Pithers' model suggests, an offender frequently experiences a number of lapses before ultimately relapsing, as there are usually a number of feedback loops or interactions between the various components that eventually may lead to relapse (Hall, 1989; Kirkley &

Fisher, 1988; Saunders & Allsop, 1987). For example, an individual might move back and forth from lifestyle stresses to high-risk situations several times before finally relapsing. Third, Pithers also runs the risk of evoking unconscious decision making (by the way of apparently irrelevant decisions) without accounting for the mechanisms involved. Finally, Pithers over-emphasises the role of skill deficits in relapse compared to decision making (Rohsenow, Niaura, Childress, Abrams, & Monty, 1991).

Specific problems are as follows.

Negative affect as a high-risk situation

Pithers identifies negative affect as an example of a high-risk situation but neglects to clarify how this is so. Ward et al. (1996) have argued that negative emotional states are related to high-risk situations in two ways. First, such states might constitute high-risk situations on their own and lead to relapse if the offender fails to cope effectively with them. Second, such states could lead to high-risk situations via apparently irrelevant decisions, where negative affect is a risk factor possibly associated with lifestyle imbalance. Pithers does not acknowledge this and therefore overlooks the possibility that apparently irrelevant decisions may only be involved in the establishment of certain high-risk situations.

Another problem is the connection between apparently irrelevant decisions and negative affective states. In Pithers' model, covert planning (apparently irrelevant decisions) is the only pathway to high-risk situations. This inflexibility means that the model can only account for external high-risk situations (being with a potential victim) and not internal high-risk situations (e.g. negative affect),-as a negative emotional state is non-volitional. That is, it is not really plausible to argue that a person can intentionally plan to be in a negative emotional state in order to

provide a reason to lapse. Following on from this, we suggest that a distinction needs to be made between external high-risk situations and those situations that refer to internal, non-volitional states such as negative affect (Ward et al., 1996). The fact that it does not cover all the possible pathways involved in re-offending is perhaps the most serious weakness in Pithers' model.

The abstinence violation effect

Pithers' reliance on Marlatt's earlier (and less satisfactory) conceptualisation of the abstinence violation effect is a significant weakness of his model (Ward et al., 1996). Rather than comprising the AVE, it is possible that cognitive dissonance and the formulation of attributions can occur and function quite independently. That is, each set of processes can lead to relapse on their own and do not need to function as integrated components of the same process.

A further problem is that in the Pithers model, the AVE and the PIG function together to mediate the transition from a lapse to relapse. However, this is conceptually confusing and theoretically questionable. The two mechanisms act in opposition to each other: the AVE is associated with negative affect (guilt, feelings of failure and decreased self-efficacy beliefs etc.) and the PIG is comprised of positive emotions and appetitive process, for example, sexual arousal and positive views regarding abusive sex (Ward et al., 1996). The decision to link the PIG and AVE together in this way contrasts sharply with the Marlatt model where the PIG occurs prior to the AVE, and functions primarily to lead the offender from a high-risk situation to a lapse. In our view Pithers makes this error because of his prior decision to redefine lapse as risky behaviour reflecting the intention to commit a sexual offence. The problem is that at this point the offender is in a sexually aroused state and is unlikely to experience an AVE. In fact, consistent with this observation, Ward,

Hudson, and Marshall (1994) have found that child molesters tend to experience the AVE following a relapse rather than a lapse.

Lapse and relapse distinctions

Though Pithers makes the necessary distinction between a lapse and relapse, he neglects to draw a further distinction between the first instance of a sexual offence, and a return to pre-treatment levels of offending or increased severity of offending. There is an important difference between committing one offence and committing many or, as may be more common, increasing the severity of offending during a single assault (Ward et al., 1996). Perhaps it would be useful to create a further distinction based on the severity or frequency of offending. For example, a single instance of sexually aggressive behaviour could be labelled Relapse One, and multiple offences or increased severity, could be labelled Relapse Two (Marshall, Hudson, & Ward, 1992; Ward et al., 1996). It is a sensible and ethically appropriate strategy to continue to apply RP principles following the first sexual offence, though in therapy it is important to teach offenders to regard relapse as something to avoid (Ward et al., 1996).

Offender type

Pithers' RP approach has been found to be limited in its general scope regarding applicability to different offenders. In particular, sexual offenders who view adult-child sexual contact as legitimate and favourable are not easily accommodated within the model. Due to the positive regard these men have for sexual contact with children, they tend to experience higher levels of positive emotions throughout the offence cycle and take a more active pathway rather than the covert route described by Pithers (Ward, Loudon et al, 1995). Also, impulsive opportunism has been found by researchers to be a common precursor to sexual offending, particularly for rapists

(Knight & Prentky, 1990; Marshall & Serran, 2000). However, as these offenders may still be motivated to desist from sexually offending, it is likely that they will exhibit a relapse process that is representative of their characteristics, but inconsistent with Pithers' conception of the relapse process (Ward et al., 1996).

In closing, it should be highlighted that the adoption of the sex offender RP model from the substance abuse domain is problematic, as the extent to which sexual offending can be viewed as an addiction is, at best, controversial (Cooper, Scherer, Boies, & Gordon, 1999). In fact, research exists which indicates that the offence process of sexual offenders is not consistent with an addiction perspective (e.g. see Hudson, Ward, & McCormack, 1999).

A Self-Regulation Model of the Relapse Process

Unlike the above RP models that are merely theory based, the self-regulation model of relapse prevention (Ward & Hudson, 2000) has its foundations in both theoretical and empirical work. Using the written descriptions of offending obtained from 26 child molesters, Ward, Loudon et al. (1995) developed a descriptive model of sexual offending (i.e. the offence chain). This model was later tested and validated by Hudson, Ward and McCormack (1999), who furthered the understanding of offence pathways. By incorporating 86 offence descriptions into the descriptive model of child sexual offending, Hudson et al. (1999) identified eight distinct offence pathways of child molesters, with the majority of offenders falling into one of three (major) pathways. The three major pathways consisted of a positive affect pathway, a negative affect pathway and a mixed pathway. The positive affect pathway is characterised by a positive mood in the beginning, followed by direct and explicit offence planning. The offender perceives his relationship with the victim to be mutual in nature and therefore evaluates his sexually abusive behaviour positively. Consequently, there is

a commitment to continue offending in the future. These child sex offenders may refer to their relationship with their victim as follows, “we were partners” or “we were in love”. Conversely, the negative affect pathway features negative emotions throughout the entire offence process, with implicit planning featuring as the precursor to the sexual offence. Child sex offenders who follow this pathway may suggest, “I never thought of anything happening between her and I – it just happened”. Alternatively the mixed pathway begins with a negative affect and is followed by explicit distal planning. Later, proximal planning leads the offender to feel positive (“I enjoyed it—felt loved”) or negative effect (“I used my position of power to do to her what I wanted”). Post-offence evaluations are negative (fear of being caught or feelings of disgust and regret), and subsequently the offender does not intend to offend again.

Polaschek, Hudson, Ward and Siegert (2001) developed a similar model for rapists and again, found several common offence pathways for rape offenders. However the most recent development in this research programme is the development of the self-regulation model (Ward et al., 2000), which is a reformulation of the offence pathways research using self-regulation theory. It represents a theoretically coherent and empirically grounded model that is currently the focus of a number of research programs (e.g., Bickley & Beech, 2002).

The Self-Regulation model of Relapse Prevention for Sex Offenders

Self-regulation pertains to the use of internal and external process that enable individual's to engage in goal-directed behaviour; this can refer to either the achievement or the avoidance of desired goals (Baumeister & Heatherton, 1996; Karoly, 1993). Cochran and Tesser (1996) make the distinction between acquisitional

(approach) and inhibitory (avoidance) goals. Acquisitional goals concern the establishment of a skill or situation and involve approach behaviour whereas inhibitory goals relate to the decrease or complete suppression of a behaviour or situation and necessitate avoidance behaviour.

The self-regulation model of the relapse process builds upon ongoing research into the offence process and theoretical and empirical research on self-regulation (Ward et al., 2000). The model constitutes nine phases and four pathways organised around the nature of sexual offence goals (approach versus avoidant) and the types of strategies used to achieve those goals.

Ward and Hudson (1998; 2000) describe the phases of the model as follows:

Phase 1: Life event

An individual is attempting to remain offence-free when some kind of life event occurs (e.g. relationship stress or a problem at work.). The individual appraises this event according to existing beliefs and attitudes, his goals at that moment, and the context in which it is occurring. This then activates certain patterns of thoughts, emotions, and intentions. For example, the loss of a job may conjure up feelings of inadequacy and a desire to retaliate against the world.

Phase 2: Desire for deviant sex or activity

The life event and ensuing appraisal results in the emergence of a desire for offensive sex, and the presence of emotions associated with these desires. This may lead to the activation of an offence script (cognitive representations from the individual's long-term memory which contain information that guides offending behaviour) and covert rehearsal of the offence, which in turn lowers the individual's inhibitions against indulging in deviant fantasies. As offence scripts can be activated and executed without conscious intention, the individual may initially have minimal awareness of

the overall goal. The accompanying affective states may be happiness, sexual arousal, anxiety, and anger.

Phase 3: Offence related goals established

At this point the offender considers the acceptability of his maladaptive desire and decides what, if anything, he should do about it. As the desire for deviant sex is established, the resultant offence related goal is also identified. Here, there are two possible goals, avoidance or approach goals. Avoidance goals are associated with the desire to remain offence-free and are essentially negative in nature as the goal is not to achieve a particular state of affairs. The individual is therefore likely to experience a negative affective state as he will be fearful and anxious about the possibility of offending. In contrast, approach goals reflect the motivation to sexually offend. Individuals may experience either a positive or negative affective state depending on their aims. For example, if the aim is to be sexually gratified then the affect is likely to be positive, however if the aim is to punish or humiliate someone, then the affect is likely to be extremely negative.

Phase 4: Strategy Selected

Though not necessarily an explicit decision, the selection of strategies designed to achieve the goal occurs at this stage. Strategies can be selected automatically based on the activated offence script. There are four possible pathways; they are avoidant-passive, avoidant-active, approach-automatic and approach-explicit. Two pathways are associated with avoidance goals and two are associated with approach goals.

The *avoidant-passive* pathway contains both the desire not to offend but also the inability to prevent the offence from happening. As far as self-regulation goes, this is an under-regulation or disinhibition pathway as negative affective states function as either a disinhibitor or else lead to behaviours that result in a loss of control. These

individuals find it difficult to control their offending due to their lack of effective coping skills and ongoing problems with impulsivity; they also typically use covert planning.

In the *avoidant-active* pathway, individuals actively attempt to control deviant thoughts and fantasies but employ strategies that are ineffective or counterproductive. Consequently, this is a mis-regulation pathway as the strategies used to avoid offending, paradoxically, increase the likelihood of an offence occurring. For example, an offender may use alcohol to suppress the desire to offend but in reality, the use of alcohol decreases his inhibitions, which simply increases his chance of committing a sexually abusive act.

The *approach-automatic* pathway is also an under-regulation or disinhibition pathway. The individual has over-learned offence scripts that navigate the individual's behaviour toward sexually abusive behaviour and consequently, the associated strategies are unlikely to be under intentional control. Individuals may experience either a positive or negative affective state.

Lastly, the *approach-explicit* pathway constitutes conscious, explicit planning and involves finely tuned strategies aimed at sexual offending. This pathway represents an intact self-regulation pathway as the individuals' concerned possess good self-regulation skills. Rather, the problem relies in the nature of the underlying goals, which essentially support and encourage sexual abuse. The affective state experienced by the individual could again be either positive or negative depending on the goal. For example, if the goal is to establish an 'intimate relationship' with a child then the offender may experience strong positive affective states. In contrast, if the aim is to intimidate or punish someone (e.g. a woman) then strong negative states such as anger are likely to be present.

It is expected that for the two pathways associated with avoidance goals (i.e. not to offend), negative affective states will be predominant following the offence because of individuals' perception that they have 'failed'. Alternatively, those pathways associated with approach goals (i.e. to offend) will be likely to yield positive affective states following an offence because of the offender's perceived success.

Phase 5: High-risk situation

At this point, contact or the opportunity for contact, with a potential victim occurs as a result of the previous explicit or implicit planning or counterproductive strategies. The individual appraises the situation according to his goals. For those individuals whose strategies are to avoid offending, the high-risk situation signifies failure and negative affective states are almost certainly experienced. For those individuals taking an approach strategy, a positive affective state will likely be experienced because for them, the high-risk situation signifies success. Though it is possible for some offenders to be placed unexpectedly in a high-risk situation leading them to relapse at this phase, the type of goals held would still have some influence over how they interpret and respond to the high-risk situation.

Phase 6: Lapse

The lapse is the immediate precursor to the sexual offence, where the offender's intention is to engage in an offence. At this point, it is suggested that individuals following the avoidance pathways will temporarily switch from an avoidance goal to an approach goal. The avoidant-passive offender will give up his attempts of self-control whilst the avoidant-active offender will decide that he is unable to control his deviant sexual urges. The approach-automatic offenders are likely to be fully controlled by situational stimuli and therefore offend impulsively, whilst the

approach-explicit offender will demonstrate careful planning and management of the situation. Consequently, due to the increase in sexual arousal and/or the anticipation of pleasure, all offenders are hypothesised to experience positive affective states.

Phase 7: Sexual Offence

In a recent study, Ward et al., (1995) have identified three distinct models of the victim-offender relationship during the offence process. These models directly influence the amount of violence employed by the offender and the severity of the sexual offence itself. The first model is characterised by a self-focus where the offender's own needs (usually relief from heightened sexual arousal) are paramount. In the second model, there is a victim-focus where the offender regards the victim's needs as more important and sexual contact is viewed as occurring in the context of a 'caring relationship'. Offenders holding these set of beliefs are unlikely to behave in an overtly aggressive manner and often set out to please the victim; typically they (falsely) see themselves as nurturers. In the third model there is a mutual focus where the offender believes that both he and the victim desire sexual contact, and are involved in a "loving, reciprocal" relationship.

It is not clear in the self-regulation model whether particular pathways are associated with certain victim-offender relationship models. However, it is possible that individuals following avoidant pathways are likely to be self-focused, presumably because they are intent on fulfilling their own needs and succumbing to their desires. Those individuals following approach pathways may have varying foci depending on their goals. For instance, a goal to humiliate and punish the victim would suggest a self-focus, whilst a goal to please the victim may lead the offender to focus on the victim's needs.

Phase 8: Post offence evaluations

Following the offence, an evaluation of events is likely to occur. Avoidant pathway offenders are expected to evaluate themselves negatively in accordance with the abstinence violation effect, experiencing feelings of guilt shame and failure.

Conversely, it is anticipated that approach pathway offenders will experience positive emotional states because they have achieved their goals.

Phase 9: Attitude towards future offending

The final phase of the model concerns the impact of sexual offending on future intentions and expectations. Persons with avoidant goals may decide to either: (a) recommit to abstinence, attempt to regain control or continue mis-regulation, (b) continue offending because they feel they are unable to stop, or (c) openly choose offending as a positive option in their life and switch to an approach goal.

Alternatively, approach-automatic offenders are likely to have their offence scripts reinforced, ensuring future offending and approach-explicit offenders will learn from their experiences and develop and refine their offence strategies accordingly.

The self-regulation model of the sexual offence process is an ever-evolving model as it is heavily informed by emerging data. Consequently, new pathways or even sub-pathways may be identified in the future. Already, empirical research with an independent group of child sexual offenders has found support for the model's distinction between approach and avoidant goals and the classification of child sexual offenders according to such goals (Bickley & Beech 2002).

In his recent comprehensive review of relapse prevention, Laws (in press) identified the advantages of the self-regulation model as follows: It avoids the rigidity of the classical RP model whilst preserving many of its positive assessment and treatment features; it allows for the addition of more pathways and the incorporation

of new theoretical developments, and; it allows for multiple levels of detail where required. Furthermore, Laws describes the model's integration of goals and self-regulatory style as elegant and simple, without being too simplistic.

Practice Implications of the Self-Regulation Model of Relapse Prevention

The self- model conveys a richer understanding of the specific deficits and behaviours associated with sex offenders following certain pathways and as such provides an effective platform for treatment. This is to be contrasted with the traditional (Pithers) RP model which suggests that all offenders follow the same offence pathway (namely the covert route) and essentially display coping skill deficits. Indeed, some clinicians have previously viewed their task to be one of encouraging offenders to view their offences in terms of the single pathway presented in the classical RP model (Polaschek, 2002). The difficulty is that many offenders' offence processes do not fit within this framework.

From the perspective of the self-regulation model, major clinical tasks are to assess each sex offender's goal-type, self-regulation style, and to identify their specific deficits. This fine-grained analysis enables treatment providers to individualise treatment plans rather than adopt a 'one-size-fits-all' approach. For example, according to the self-regulation model, the avoidant-passive offender is likely to have particular skill deficits (e.g. poor coping skills and low awareness of his offence process), which are in need of direct modification. Therefore, for such offenders, explicitly addressing beliefs about personal agency and seeking to install skills for adequate self-management should take priority in therapeutic interventions (Hudson & Ward, 2000). Attention to self-management is of particular importance for these men, as the pathway they follow is one of under-regulation.

Alternatively, the avoidant-active offender follows a pathway representing mis-regulation (i.e. though there is a direct attempt to control deviant behaviour, counterproductive strategies are utilised, until he eventually switches to an approach goal). As the offence process is obvious to the offender, less work needs to be done on increasing his awareness of the process, rather there needs to be a focus on identifying the links in the offending process. In particular, helping him to understand that the strategies used to avoid offending, paradoxically, can result in sexually abusive behaviour (Hudson et al., 2000; Pithers, 1990).

For the approach-automatic offender, a major problem resides in his relative lack of awareness of the process of offending, in part due to the utilisation of over-learned offence scripts. A primary treatment goal would be assisting such individuals to understand his offence process followed by the teaching of appropriate self-regulation strategies and an awareness of goals. In contrast, the approach-explicit offender presents a very different clinical problem, possessing effective self-regulation skills and some degree of offence related “expertise”. The approach-explicit pathway is fundamentally about goals not skills. Core schema (self, intimacy, sexuality, sense of being wronged and blamed) should be the primary focus of the intervention, at least in the first instance. These men may also need reconditioning of their deviant sexual preferences. This client poses the most difficulty in treatment, as his pathway is the most dissimilar to what is communicated and understood in the traditional RP model (Hudson et al., 2000). Rather, intervention should focus on cognitive distortions, and disclosure of offence related thoughts, feelings and motivations, with the major therapeutic challenge being the changing of explicit goals (Hudson et al., 2000).

Conclusions

An adequate model of the relapse process in sex offenders should exhibit a sound understanding of the offence process, particularly capturing the diversity of pathways and processes. Pithers' RP model has provided clinicians and researchers with a basic understanding of this process and has contributed significantly to our present-day conceptualisation of sexual offending. However, there are a number of significant conceptual and empirical problems associated with this model which limit its clinical utility. We suggest that the self-regulation model presented in this chapter avoids these problems and is able to provide clinicians with a more comprehensive framework with which to guide assessment and treatment. Furthermore, the self-regulation model provides a broader understanding of the factors associated with relapse and subsequently enables clinicians to tailor treatment to the unique needs of specific types of offenders (Ward et al., 2000).

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