Dynamic Risk Factors and their Utilisation in Case Formulation: A New Conceptual Framework

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Abstract

The social pressure on policy makers and clinicians working with sexual offenders to reduce recidivism is extreme. A result of this pressure is the amount of research investigating risk-related features that has surged over the last few decades. Risk assessment has progressed from unstructured clinical judgement to development of risk factors that correlate with recidivism to predict levels of risk, and more recently, to forensic case formulation. This thesis concentrates on two key issues with forensic case formulation that has been largely neglected thus far. First, forensic case formulations rely heavily on the use of dynamic risk factors as causes of offending. The concern is that dynamic risk factors are composite constructs not causal mechanisms. Second, forensic case formulation models do not explain how to use an offender's information and their risk factors to hypothesise about the cause of their offending leading to issues of reliability. To address these issues, the RECFM consists of five phases that guides clinicians on how to appropriately use forensic case formulation. The Risk Etiology Case Formulation Model (RECFM) aims to incorporate a reconceptualised version of dynamic risk factors using an Agency Model to identify the interaction of agent and context that causes offending behaviour. By using the RECFM, treatment can be targeted to the individual and their specific causes of offending, which will lead to better results in reducing recidivism. The aim of this thesis is to provide a forensic case formulation model is comprehensible for clinicians and that targets the causes of offending.

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Introduction

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Sexual crimes are regarded by many as one of the most terrible crimes a person can commit against another. Society perceives sexual offenders as monstrous people who deserve long, tough sentences for their crimes. Sex offenders elicit fear and anxiety in the general public due to the belief they are highly likely to reoffend. However, offender research shows that a "get tough" stance on punishment simply does not work. Generally, most sex offenders have a relatively low rate of reoffending overall (14% after 5 years; Harris & Hanson, 2004), with the exception of high risk sex offenders who have a higher sexual recidivism rate of 22% after 5 years. There is also recent research to show that the recidivism rate declines significantly (4.2%) for those high risk offenders who remain offence-free in the community for 10 years (Hanson, Harris, Helmus, & Thornton, 2014). Nevertheless, public anxiety has led to policy changes and pressure on psychology professionals to reduce recidivism even more. Regardless of this social pressure, there has been insufficient acknowledgement of the fact that to effectively treat any disorder, you need to understand its causes. Thus, the sexual offending literature has posed the questions; what causes some individuals to sexually offend against children or adults? What has happened to these individuals that increases their likelihood of offending? And why is it that some individuals with the same characteristics do not sexually offend? These questions have informed sex offender research, leading to the development of risk assessments, risk factors, and individualised case formulations.

Case formulation is not a new method of practice but only recently has been the focus of research interest by researchers and clinicians in the forensic domain. The majority of case formulation research has concentrated on the reliability and the validity of formulations in mental health settings with mixed results. Unfortunately, there has not been the same amount

of attention centred on forensic case formulation, leaving a significant gap in the literature that needs to be addressed (Davies, Black, Bentley, & Nagi, 2013). Observing this literature gap, Hart (2011) has begun to identify the features necessary for a good forensic case formulation. Researchers have also started to construct guides and models derived from the risk literature to help practitioners identify the causes of offending in individual cases, and to use these hypothesised causes to guide treatment (Logan & Johnstone, 2010; Guy, Douglas, & Hart, 2015; Vess, Ward, & Collie, 2008). However, because these guides, models, and features of forensic case formulation are based upon an incorrect conceptualisation of dynamic risk factors, their validity and subsequent utility is questionable

Current conceptualisations of risk and dynamic risk factors are overly simplistic and focus mainly on the context of prediction (Mann, Hanson, & Thornton, 2010). Dynamic risk factors have been established as factors that are linked to recidivism outcomes but are frequently referred to as causal mechanisms without any theoretical explanation as to how this occurs. This is particularly problematic because forensic case formulation protocols use dynamic risk factors as core components of formulations to inform treatment, and typically view them as primary causes of offending (Ward & Beech, 2015). Arguably, what is needed is a comprehensive forensic case formulation model capable of incorporating (suitably reconceptualised) dynamic risk factors in conjunction with other relevant personal and social factors.

Chapter 1: Risk Assessment and Risk Factors

Risk Assessment

Based on strong empirical evidence over the last few decades that "get tough" or punishment oriented correctional policies (sanctions) do not reduce recidivism, there has been a revived focus on rehabilitative interventions (Caudy, Durso, & Taxman, 2013). In criminal proceedings, whether for a sexual offence or a violent offence, judges routinely order a pre-sentence report which contains a risk assessment conducted by professionals (psychologists, psychiatrists). These risk assessments are frequently vital to the sentence that the judge imposes and in Hart's view, "good sentencing requires good risk assessment" (Hart, 2009, p. 144). This means that risk assessments are significant in guiding the interventions that an offender receives, thus they have been heavily researched and have extensive consequences for the offender and for society. A risk assessment's main aim is to assess the likelihood of any further offending (Beech, Fisher, & Thornton, 2003) by focusing on the individual characteristics of the offender (Mann et al., 2010). Risk assessments proceed by gathering information about a person that is consistent with the best available scientific and practical research in order to understand the likelihood they will engage in sexual offending in the future,, and relatedly, to determine preventative measures to stop him from reoffending (Hart, 2009).

Beech et al. (2003) argue that a comprehensive risk assessment should include four broad categories: dispositional factors; historical factors; contextual antecedents; and clinical factors. Within these four general domains are risk factors, which are variables that increase the chance of an individual behaving in a harmful way (Ward & Maruna, 2007). Risk factors are typically split into static factors (historical in nature, which do not assess change over time) and dynamic factors (amenable to change; Beech & Craig, 2012). Risk factors will be

described in more detail later in the chapter. An important detail to note is that risk assessment does not predict changes in offending; rather it is the process of using risk factors to estimate the likelihood that an offender will reoffend (Ward & Beech, 2015).

First Generation Risk Assessment

Over the past 30 years the methods employed to assess offenders and predict recidivism have changed and the different phases of development can be described in terms of generations of risk assessment measures (Andrews & Bonta, 2010). The first generation of risk assessment is known as the Unstructured Clinical Judgement Approach (UCJ) (Hart, 2009) or professional judgement (Andrews & Bonta, 2010). The key features of the UCJ approach are clinician discretion and the absence of formal procedures or rules (Hart, Douglas, & Guy, 2015). Evaluator's exercise complete discretion regarding which risk factors they consider important and how they gather and integrate information during the risk assessment process (Guy et al., 2015).

In the UCJ approach, risk related information is gathered by the clinician in an unstructured clinical interview. Questions that are asked, tests that are administered, and files that are reviewed vary from one clinician to another (Andrews & Bonta, 2010). The underlying justification for using the UCJ was that violence risk assessment was too complex and thus best dealt with solely by an expert evaluator (Hart et al., 2015). Unfortunately for both offenders and communities, the disadvantages outweigh the benefits of the UCJ approach. While the UCJ is highly flexible and highly individualised to suit each offender's differing needs (Hart et al., 2015) it is not accurate in estimating levels of risk (Andrews & Bonta, 2010). Meta-analyses comparing generations of risk assessment research have consistently shown that the unstructured approach has weak predictive validity (Andrews, Bonta, & Wormith, 2006; Hanson & Morton-Bourgon, 2009), as well as a lack of transparency and low reliability (Hart et al., 2015).

Second Generation Risk Assessment

Due to the complexity of risk assessment and the perceived limited cognitive abilities of clinicians, the second generation of risk assessment (actuarial risk assessment) became the most common method of assessment (Hart et al., 2015). This approach is defined by its explicit rules guided by empirical research. Actuarial risk assessments rely on statistics and algorithms to categorise people according to levels of risk to estimate the probability of recidivism (Hart et al., 2015). Risk factors are identified and selected based on the strength of their association with sexual offending (Guy et al., 2015). Notably, the results derived from actuarial risk assessments only show that an individual shares the characteristics of a group that has a specified likelihood to reoffend (e.g. 40%) and does not mean that a specific individual within that group has the same likelihood of reoffending (Mills, Kroner, & Morgan, 2011). This is an important factor to consider when applying actuarial risk scores to an offender's case so that risk is not wrongly interpreted.

Actuarial risk assessment instruments (ARAIs) have dominated sexual offending risk assessments over the last few decades, with their use being written into legislation in the USA, UK, and Canada (Beech & Craig, 2012). ARAIs are typically made up of static risk factors (do not change over time). Researchers have reached a general consensus that actuarial measures are significantly more accurate in the prediction of both general and specific (violent or sexual) reoffending than clinical judgement alone (Hanson & Morton-Bourgon, 2009, Andrews & Bonta, 2010). ARAI's moderate to high levels of predictive validity and reliability as well as their high transparency and easy-to-follow categorisations of offenders mean that they have many benefits (Hart et al., 2015). However, Andrews and Bonta (2010) argue that most ARAIs lack a strong theoretical basis; by virtue of the fact that they neglect factors theoretically linked with recidivism thus limiting their utility. In addition, Hart et al. (2015) point out that relying on a single test to predict reoffending is questionable

and inflexible and recommend that multiple tests should be used as well as professional judgement.

Third Generation Risk Assessment

The third generation of risk assessment can be separated into two types of risk assessment; risk-need instruments which largely follow the Risk-Need-Responsivity principles, and the structured professional judgement approach, which is broader in its theoretical underpinnings. When risk-need instruments were first identified by Bonta in 1996, researchers began to incorporate dynamic (changeable) risk factors into these instruments in an attempt to overcome the limitations of ARAIs. (Beech et al., 2003). Risk-need assessments are empirically based and include items known as criminogenic needs, which are essentially dynamic risk factors (Andrews et al., 2006). The third generation risk assessments attend to changes in an offender's circumstances and functioning, and provide clinician's with information as to which of these identified criminogenic needs should be targeted in treatment (Bonta & Andrews, 2007).

The third generation approach also includes the structured professional judgement (SPJ) approach, which combines the clinical and actuarial approaches to produce a comprehensive clinical assessment (Guy et al., 2015). Decision-making in the SPJ approach is assisted by guidelines that are informed by scientific and professional literature, producing an evidence-based form of risk assessment that improves on the first and second generations of risk assessment (Hart & Logan, 2011). SPJ is more flexible and better generalizable across samples than actuarial assessments (Guy et al., 2015). However, it is limited in its assumption that clinicians will have some basic level of competence in risk assessment which is required to adequately and accurately utilise SPJ guidelines. Furthermore, it assumes that the procedural details and risk factors identified are optimal, when in fact knowledge about risk factors is being continuously researched and updated (Hart et al., 2015).

There are some differences between the risk-need instruments and SPJ third generation assessments in how risk factors are conceptualised. SPJ guidelines consider all information relevant to risk assessment to be risk factors whereas risk-need instruments distinguish between risk, need, and responsivity factors. The SPJ also defines risk more broadly than risk-need instruments does and focuses specifically on violence rather than general criminality (Hart et al., 2015). Nonetheless, empirical evidence shows SPJ approaches to have good to excellent reliability with actuarial results being slightly more reliable on average than SPJ procedures (Hart & Logan, 2011). Evidence also demonstrates moderate to good predictive validity with little to no difference between actuarial and SPJ procedures (Hart & Logan, 2011; Guy et al., 2015). Risk-need instruments have also been shown to have incremental predictive validity that exceeds actuarial methods (Andrews et al., 2006). Given the empirical evidence, it is clear that the third generation of risk assessment measures has surpassed the first generation ones in terms of their validity and reliability, and is equal, if not better, than the second generation.

Models of Risk Management (Rehabilitation)

Risk-Needs-Responsivity Model

The Risk-Needs-Responsivity (RNR) model developed by Andrews and Bonta emerged during the shift from second to third generation risk assessments and became the primary evidence-based framework for guiding offender assessment and linking those outcomes to treatment and rehabilitative services (Caudy et al., 2013). The RNR is based on a theory of criminal behaviour, the Psychology of Criminal Conduct (PCC), and consists of three *core* principles (Hart & Logan, 2011). First, the *risk principle* concerns who should be treated, suggesting that the level of services delivered should be proportional to individuals' level of risk. Thus, higher-risk offenders should receive more intensive services and lower-risk offenders should receive minimal intervention. The *need principle* concerns what to treat. Criminogenic needs are a subset of dynamic risk factors associated with a reduction in

recidivism when modified and it is suggested that they should be targeted in treatment (Ogloff & Davis, 2006). The *responsivity principle* is split into general and specific responsivity. General responsivity asserts that social learning and cognitive-behavioural strategies are the most effective in intervention. The specific responsivity principle argues that strategies in treatment should be adapted to suit the characteristics of the offender (Andrews & Bonta, 2010). More specifically, language skills, interpersonal skills, motivation, and anxiety are individual characteristics that should be matched with treatments (Ward & Maruna, 2007).

The *need principle* specifies which factors should be considered dynamic risk factors or criminogenic needs and according to the RNR, these factors are good predictors of reoffending (Ward, 2016). The RNR framework labels dynamic risk factors significantly linked to recidivism as the *central eight* (see Table 1). The central eight includes the "big four" which are factors directly linked to recidivism: history of antisocial behaviour; antisocial personality pattern; antisocial cognition; and antisocial associates (Caudy et al., 2013). The "moderate four" are moderately linked to recidivism: family/marital circumstance; low levels of educational/vocational/financial achievement; lack of pro-social leisure activities; and substance abuse (Caudy et al., 2013). However, the RNR recognises that there are some non-criminogenic factors that influence the individual such as emotional distress, mental disorders, social class, and physical health (Andrews & Bonta, 2010).

Table 1

The Central Eight Risk Factors and Required Interventions

Central Eight	Explanation	Example	Intervention
History of Antisocial Behaviour	Involvement in antisocial activities across a variety of settings from an early age.	Arrested at young age, variety of offences	Acquire noncriminal responses to high-risk situations
Antisocial Personality Pattern	Indicators of psychopathy or anger problems.	Antisocial behaviour early in life, criminal attitudes, generalized trouble	Gain skills in problem-solving, anger management, and self-control
Antisocial Cognition	Crime-supportive attitudes, values, and beliefs, criminal identity	Identifies with criminals, negative attitudes towards authority, justifies criminal behaviour	Reduce antisocial cognitions and learn prosocial ways of thinking
Antisocial Associates	Has criminal associates and less involvement with prosocial peers	Socially isolated, criminal peers	Increase relationships with prosocial peers
Family/Marital	Poor quality of interpersonal relationships and neutral expectations regarding crime	Poor relationships between child-parent or spouse-spouse	Reduce conflict, increase monitoring and supervision, build positive relationships
School/Work	Low levels of involvement and performance, low levels of rewards and satisfaction	Poor grades, poor performance and satisfaction at work/school	Increase levels of satisfaction and rewards, enhance performance

Leisure/Recreation	Low levels of involvement and satisfaction in prosocial activities	Does not enjoy recreational activities, or pursue leisure	Enhance involvement and satisfaction in prosocial activity
Substance Abuse	Abuse of alcohol or drugs. Current abuse indicates higher risk than past substance abuse.	Addiction or problems relating to alcohol or any other drugs	Treatment of substance abuse, increase use of alternatives

Table 1. The central eight risk factors and required interventions. Adapted from Andrews et al. (2006) and Andrews & Bonta (2010
Note. The first four risk factors identified in bold are labelled as the 'Big Four' as they are directly linked to recidivism.).

The RNR model has led to a wide range of research on risk assessment and influenced many treatment programmes. It is now considered the leading rehabilitative theory (Ward, Melser & Yates, 2007). Polaschek (2012) notes that the RNR demonstrates some significant strengths including strong external consistency, explanatory depth, and empirical validity. Support for the RNR comes from a meta-analysis of 23 studies, which found that treatment programmes that adhered to the RNR principles, in particular the need principle, showed the largest reductions in recidivism for both sexual and general offenders. However, the majority of the studies reviewed were classed as weak and these were the studies that showed the strongest effects (Hanson et al., 2009).

As with all theoretical models, the RNR has been subjected to plenty of criticism and has a few noteworthy weaknesses. Firstly, there is concern regarding the responsivity principle and motivation of offenders. The RNR focuses on individuals in terms of their individual risk factors rather than as an integrated whole and more importantly, as a human, which arguably adversely effects offenders' motivation in treatment and increases attrition rates (Ward & Stewart, 2003). Secondly, Ward and Gannon (2006) argue that the RNR lacks sufficient consideration of contextual and ecological variables, suggesting RNR treatment plans fail to acknowledge skills and resources required in specific environments. There is also

concern that the complexity and jargon in the RNR and its underlying theory, the PCC, has discouraged therapists and policy makers from fully understanding the model which leads to issues translating the principles into practice (Polaschek, 2012).

Crucially, Ward (2016) points out that the risk and responsivity principles rely on the need principle in order to function, assume the validity and applicability of the need principle and the concept of dynamic risk factors. What this means is that if there is a conceptual problem with the need principle, and dynamic risk factors in particular, then the RNR as a whole falls apart theoretically. A further argument against the RNR has focused on its theoretical basis, or lack thereof. It is argued the RNR is not a comprehensive theory but essentially a set of principles that are loosely related and does not adequately explain the relationship between the principles and their theoretical grounding (Ward & Maruna, 2007). Consequently, although the RNR has its strengths and changed the way risk assessment is viewed in corrections it should be viewed as a framework to guide assessment and treatment rather than an explanation of crime (Ward & Maruna, 2007).

The Good Lives Model (GLM)

The Good Lives Model (GLM) was developed by Ward and colleagues to address the theoretical and conceptual issues of the RNR and to provide a more positive and constructive approach to offender rehabilitation (Ward & Maruna, 2007). In essence, the GLM is a strengths-based approach to rehabilitation, which aims to "equip individuals with the capabilities to secure primary human goods in socially acceptable and personally meaningful ways" (Ward & Stewart, 2003, pg. 356). The GLM has mostly been applied to rehabilitation of sexual offenders, however, it was designed to apply to all types of criminal offending (Ward & Maruna, 2007). The key assumption of the GLM is that criminal actions arise when individuals lack the internal and external resources to achieve primary goods in pro-social ways, therefore, treatment should aim to provide these individuals with the resources to live good lives according to their personal preferences (Ward & Maruna, 2007).

Primary goods are activities, situations, or experiences that benefit individuals and increase their happiness and sense of fulfilment (Whitehead, Ward, & Collie, 2007). There are 11 classes of primary goods: life, knowledge, excellence in work, excellence in play, excellence in agency, inner peace, friendship, community, spirituality, happiness, and creativity (Ward & Gannon, 2006). Secondary goods are the means used to secure the primary goods (Whitehead et al., 2007). For instance, an individual may desire intimacy but use children to fulfil this need (Wilson & Yates, 2009). The GLM conceptualises criminogenic needs as barriers to achieving primary goods in pro-social ways. (Willis, Yates, Gannon, & Ward, 2012).

Both criminogenic and non-criminogenic needs exert influence on secondary goods and these should be targeted in effective sexual offender treatment. For example, poor emotional regulation (a dynamic risk factor) might block the achievement of inner peace (primary good) (Willis et al., 2012). However, attention in treatment should focus on the ultimate underlying motivating factors and what the individual is seeking when offending rather than the typically exclusive focus on what the individual is lacking or their psychosocial difficulties (Ward & Maruna, 2007). Within the GLM framework clinicians focus on reducing risk to re-offend and targeting criminogenic needs but also equally concentrate on enhancing the offender's capacity to improve their life (Wilson & Yates, 2009).

The GLM originally was criticised for its lack of a comprehensive, goal-oriented theory of etiology, such that it did not clearly specify how the problems in an offender's good lives plan caused their offending and was too general in its recommendations for treatment (Ward & Gannon, 2006). However, the GLM as it is known today is based on Ward and Beech's (2006) Integrated Theory of Sexual Offending (ITSO). This argues that biological factors (genetics, evolution), ecological niche factors (social, cultural, personal circumstances), and neuropsychological factors interact in a dynamic manner through distal

and proximal factors to produce sexual offending (Ward & Beech, 2006; for a detailed description of how the GLM is explained through the ITSO see Ward and Gannon 2006). The GLM also fits well with the self-regulation model (SRM) of offending (Wilson & Yates, 2009). With these theories behind the GLM, therapists are provided with a comprehensive package for treatment, policy formation, and risk analysis, meaning the GLM is a much stronger framework (Ward & Gannon, 2006).

Currently, there is limited empirical research that measures the success of the GLM as a rehabilitation model. However, a couple of studies have compared GLM-based rehabilitation programmes to standard Relapse Prevention programmes. Harkins, Flak, Beech, and Woodhams (2012) compared attrition rates and treatment change in the targeted areas but found no significant differences between a GLM derived programme (Better Lives module) and the Relapse Prevention programme which suggests they are equally successful in retaining members in treatment and changing their targeted behaviours. Yet, facilitators and offenders both felt more positively towards the Better Lives module than the Relapse Prevention (Harkins et al., 2012). In a more recent study, Barnett, Manderville-Norden, and Rakestrow (2014) found little to no difference in psychometric scores post-treatment between a Good Lives programme and a Relapse Prevention programme. However the results did suggest that participants attending the GLM group achieved more adaptive scores on measures of post treatment functioning (Barnett et al., 2014).

Due to the limited empirical support for the GLM (at this stage) and criticisms that the RNR is too focused on risk and the negatives of offending (Ward & Gannon, 2006), there is debate surrounding the integration of the GLM within the RNR. Wilson and Yates (2009) propose integrating the GLM and RNR models, as the GLM is still in its infancy, to maximise treatment gains and reduce recidivism. These authors suggest that to have the most effect on reducing recidivism, treatment should integrate the first two principles of the RNR (risk and need) with the responsivity principle that encompasses a good lives focus. For

example, Ogloff and Davis (2006) introduce the idea of two levels of responsivity, impediments and enhancements. Responsivity impediments are criminogenic needs or factors that prevent rehabilitation such as mental illness or lack of motivation. Responsivity enhancements are the factors or needs that enhance the offender's psychological wellbeing, as the GLM proposes. However, Ogloff and Davis (2006) support the continued use of the RNR with constant revisions until the GLM has a stronger empirical foundation.

Risk Factors

Static Risk Factors

As mentioned earlier in the chapter, risk factors are typically split into static and dynamic factors. Static risk factors do not change over time and are generally historical in nature (Beech & Craig, 2012). By definition, static risk factors raise the risk of reoffending but cannot be changed through deliberate intervention, for example, an offender's age or previous criminal history (Mann et al., 2010). Although, as pointed out by Mann et al. (2010) static risk factors can change however they are not suitable targets in the treatment of offenders. The most common measure of static risk factors is the Static-99 (Hart, 2009), designed to measure long-term risk potential of sexual offenders. As the Static-99 consists of static factors only (see Table 2 below), it cannot be used to select treatment targets, measure change, measure benefits of treatment, or predict sexual recidivism (Hanson & Thornton, 1999).

Table 2

Static-99 Risk Factors

Risk Factor Item	Definition
Young	Between the age of 18-25 years
Single	Ever lived with a partner in a romantic relationship for at least 2 years
Stranger Victims	Victims are unknown to the offender
Unrelated Victims	Victims are not related to the offender
Male Victims	Victims are male
Current Non-Sexual Violence	Current convictions for non-sexual violence
Prior Non-Sexual Violence	Prior convictions for non-sexual violence
Current Sexual Violence	Current convictions of sexual violence
Prior Sexual Violence	Prior convictions of sexual violence
Prior Sentencing	4+ prior sentencing dates

Table 2. Risk Factors of the Static-99. Adapted from Hanson & Thornton (2000) and Hart (2009).

Dynamic Risk Factors

Dynamic risk factors are typically split into two categories: *stable* dynamic factors are those that are amenable to change; and *acute* dynamic factors that signal an individual is highly likely to commit an offence in the near future (Beech et al., 2003). Stable dynamic factors are the major targets for treatment; they represent skill deficits, learned behaviours, and coping skills, and are frequently called criminogenic needs or psychologically meaningful risk factors (Harris & Hanson, 2010). Beech and Ward (2004) further discriminate between stable and acute dynamic factors; they describe stable dynamic risk factors as psychological traits that create vulnerabilities for sexual offending. The authors further explain acute dynamic risk factors as acute mental states that are caused by stable dynamic factors and are activated in specific contexts.

A number of assessment tools have been developed that incorporate dynamic risk factors as central components. Harris and Hanson developed the Sex Offender Need Assessment Rating (SONAR) to measure both acute and stable dynamic risk factors in 2000, which was updated and separated into STABLE-2007 and ACUTE-2007 (Beech & Craig, 2012). The STABLE-2007 contains 13 items across 6 dimensions: significant social influences, intimacy deficits, attitudes supportive of sexual assault, (non)co-operation with supervision, sexual self-regulation problems, and general self-regulation problems (Beech & Craig, 2012). Harris and Hanson conducted a study investigating probation officers conducting assessments on static (Static-99), stable (STABLE-2000), and acute (ACUTE-2000) factors with a 41-month follow-up. Three items were dropped from the STABLE-2000 to form the STABLE-2007 as they were not associated with recidivism. Once the Static-99 was controlled for, the STABLE-2007 provided incremental predictive validity for all types of recidivism (Harris & Hanson 2010). When controlling for the Static-99 and combined Static-99 and STABLE-2007 factors, ACUTE-2007 significantly added to the prediction of all recidivism (sexual, violent, and general; Harris & Hanson, 2010).

Mann, Hanson, and Thornton (2010) raise issues with the distinction between static and dynamic risk factors and the separation of acute and stable dynamic factors. These authors argue that based on Beech and Ward's (2004) suggestion that static risk factors can be predictive by acting as markers for dynamic risk factors that have operated in the past, the distinction loses meaning (Mann et al., 2010). Mann et al., (2010) propose that static and dynamic risk factors be reconceptualised as *psychologically meaningful risk factors*, which are individual propensities that manifest at any particular time. These propensities should be considered psychologically meaningful if they have the following features: are plausible causes of sexual offending, are theoretically supported, and are empirically supported as predictors of recidivism.

The psychologically meaningful risk factors that are empirically supported include sexual preoccupation, any deviant sexual interest (sexual interest in children, sexualised violence, multiple paraphilias), offence-supportive attitudes, emotional congruence with children, lack of emotionally intimate relationships with adults (never married, conflicts in intimate relationships), lifestyle impulsivity, general self-regulation problems (impulsivity, recklessness, employment instability), poor cognitive problem solving, resistance to rules and supervision (childhood behaviour problems, noncompliance with supervision, violation of conditional release), grievance/hostility, and negative social influences (Mann et al., 2010, p. 199). These factors have been shown to be predictive of sexual recidivism in three or more studies, with an average effect size of $d > 0.15$ (Mann et al., 2010).

Promising risk factors are empirically supported in at least one study. These are hostility towards women, Machiavellianism, callousness/lack of concern for others, and dysfunctional coping (sexualised coping, externalising; Mann et al., 2010, p. 199). Interestingly, Mann et al. (2010) found that depression, social skills deficits, poor victim empathy, and lack of motivation for treatment all fail to significantly predict recidivism suggesting they are not psychologically meaningful risk factors although they are commonly targeted in treatment. However, the supported and promising risk factor lists are not exhaustive and more importantly, are not established as causal. Thus, more research is needed to ascertain causal relationships but Mann et al. (2010) believe the causal factors will be similar to the variables they have identified. Recently, Thornton (2013) has summarised the psychologically meaningful risk factors and organised them into four domains of risk which can be a useful way of identifying risk factors for an individual. Mann et al's (2010) risk factors and Thornton's (2013) separation into domains and subdomains are shown in table 3.

Table 3

Four Domains of Dynamic Risk Factors

Psychologically Meaningful Risk Factors	Domain	Subdomain
Sexual Preoccupation Any Deviant Sexual Interest	Sexual Interests	Sexual Preoccupation • Impersonal sexual interests • Sexual coping • Diverse sexual outlets Offence-Related Sexual Interests • Sexual interest in prepubescent and pubescent children • Interest in sexual violence
Offense-Supportive Attitudes	Distorted Attitudes	Victim Schema • Pro-offending attitudes • Pro-child molestation attitudes • Pro-rape attitudes • General sexual offending attitudes Excessive sense of entitlement Machiavellianism Violent world schema
Emotional Congruence with Children Lack of Emotionally Intimate Relationships with Adults	Relational Style	Inadequate Relational Style • Emotional congruence with children • Dysfunctional self-esteem Lack of Emotionally Intimate Relationships with Adults • Lack of marital type relationships • Relationships involving violence Aggressive Relational Style

		• Grievance thinking • Callousness
Lifestyle Impulsivity General Self-Regulation Problems Poor Cognitive Problem Solving Resistance to Rules and Supervision Hostility	Self-Management	Social Deviance • Early onset of resistance to rules and supervision • Lifestyle impulsiveness Dysfunctional Coping in Response to Stress/Problems • Poor problem-solving • Poor emotional control

Table 1. Four Domains of Risk Factors identified by Thornton (2013) based on Mann et al.'s (2010) psychologically meaningful risk factors.

The sexual interests domain contains offence-related sexual interests and sexual preoccupation. Offence-related sexual interests are sexual interests in children or the sexualisation of violence which typically has been treated with behaviour therapy but with little evidence it works (Thornton, 2013). Sexual preoccupation involves intense involvement in impersonal sex, sexualised coping, and involvement in diverse unusual sexual activities (multiple paraphilias) which can be managed with medication. The second domain, distorted cognitions, is less clear-cut on what factors should be involved. Researchers agree that pro-offending attitudes are related to recidivism especially for child molesters and when the attitudes are consistent with prior victim choice, such as pro-rape attitudes being a better predictor for rapists (Thornton, 2013).

The relational style domain includes inadequate relational styles such as a lack of emotionally intimate relationships with adults and low self-esteem. Offenders displaying these characteristics satisfy their emotional intimacy needs by connecting emotionally with children, which is a risk factor for offenders with a history of molesting children but irrelevant for adult rapists. A more general risk factor in this domain involves difficulty forming emotionally intimate relationships with adults, evidenced by a lack of sustained

relationships or violent relationships (Thornton, 2013). Within this domain is also an aggressive relational style risk factor, where the offender acts in a callous or hostile manner towards others. However, this is to be distinguished from acting in a hostile way towards people the offender has sexually assaulted. A general display of hostility and callousness towards others is considered a risk factor. Whereas, displaying a lack of remorse or empathy towards victims has consistently failed to predict recidivism and therefore, is not a risk factor (Thornton, 2013). The two main risk factors within the self-management domain are oppositional reactions to rules and supervision, and lifestyle impulsiveness. These are characterised by childhood behaviour problems, juvenile delinquency, non-sexual crimes, supervision violations, impulsive decision making, poor lifestyle choices, and lack of long-term plans (Thornton, 2013).

Conceptual Problems with the Construct of Dynamic Risk Factors

The four domains provide a classification system for organising and identifying dynamic risk factors. The issue with this is that Thornton is just re-describing previously established dynamic risk factors without adding any insight to their conceptualisation or theoretical grounding. Thornton (2013) does not provide any explanation concerning how each domain functions in relation to the causal mechanisms of each group of dynamic risk factors. Unfortunately, this problem is not specific to Thornton (2013) and is a problem that is evident in all dynamic risk factor research. The need to understand how dynamic risk factors function and directly cause offending behaviour is crucial for forensic research, and it is startling how often it is overlooked and current dynamic risk factors are taken at face value.

Only very recently have researchers begun to criticise the way dynamic risk factors are conceptualised (Ward, 2016). As discussed above, Mann et al. (2010) dispute the current distinctions between static and dynamic risk factors as mentioned above and have used the category of psychologically meaningful risk factors instead. However, Mann et al. (2010) have fallen into the same trap as other risk researchers by neglecting to theoretically explain

the nature and function of the psychologically meaningful risk factors (Ward, 2016; Ward & Beech, 2015). As with Andrews and Bonta, who created the concept of dynamic risk factors or criminogenic needs in the RNR model, and subsequent literature (Beech et al., 2003; Ward & Beech, 2006) there has been a consistent failure to understand the underlying mechanisms of these dynamic factors. For example, sexual interest in children is accepted as a cause of sexual offending, but this is a rather vague assertion. What causes the sexual interest in children in the first place? Only by understanding how dynamic risk factors occur and operate can you fully grasp how best to treat them.

Ward and Beech (2015, p. 101) argue that dynamic risk factors should be conceptualised as "clusters of clinical features or 'symptoms' generated by underlying causal mechanisms". Therefore, they are not directly causal mechanisms as current practice assumes. Rather, dynamic risk factors are *composite constructs* composed of multiple variables that were designed to predict risk (Ward, 2016). Ward and Beech propose separating dynamic risk factors into two parts. First, researchers need to regard dynamic risk factors as exemplars (a representation of the typical course and symptoms) and reliably identify the exemplars evident in sexual offenders. These symptoms or clinical attributes can be linked to currently established dynamic risk factors, for example the clinical attribute of distorted thinking is linked to the dynamic risk factor of pro-offending attitudes (Ward & Beech, 2015). Variations in trajectory or offence course such as subgroups or victim preference need to be identified which may create additional exemplars and the temporal course of an exemplar.

Once the exemplars have been described, Ward and Beech (2015) suggest creating an explanatory model based on psychological, social, and biological constructs and guided by integrative pluralism and the abductive theory of method (Haig, 2014). The authors hope that constructing sex offending exemplars and using methodological guidelines to create explanatory models will increase the understanding of the causal mechanisms underlying the

clinical features of the offender which will, in turn, benefit risk and case formulations. However, until these exemplars of sexual offending can be identified, which will take a lot of hard work, new research should be careful not to assume that dynamic factors are causal processes and should aim to have a more etiological focus in order to better understand how to intervene and reduce recidivism. Ward (2016) argues that in their current form as composite constructs, dynamic risk factors are conceptually unable to be used in an explanatory way and should not be used in case formulations.

Protective Factors

Items representing risk factors that predict recidivism have dominated the majority of risk literature and risk assessment tools with offender's strengths and positive factors being often ignored altogether. However, there is a growing consensus that protective factors could have an important role to play in the prediction of recidivism and possibly treatment (de Vries Robbé, de Vogel, Koster, & Bogaerts, 2015). De Vries Robbé, Mann, Maruna, and Thornton (2015) define protective factors as those that lower the risk of reoffending; these are psychological, behavioural, social, interpersonal and environmental features of an individual's life. However, the concept of protective factors is ambiguous and researchers are yet to reach a consensus of what protective factors really are. Some researchers interpret protective factors as the *absence* of risk factors. Others argue they are the opposites of a risk factor (de Vogel, de Vries Robbé, Ruiter, & Bouman, 2011). Yet there is also evidence that protective factors can exist without a corresponding risk factor. For example, a negative relationship has been established between religiosity and delinquency but the absence of religion is not a risk factor (de Vries Robbé & de Vogel, 2013, p.294). Arguably, protective factors can be differentiated in the same way as dynamic risk factors, into static (unchangeable) and dynamic (changeable) protective factors. Furthermore, protective factors can also be differentiated into an underlying propensity and manifestations of that propensity

(de Vries Robbé et al., 2015). Additionally, there are two types of protective factors; those with a direct influence on desistance from offending irrespective of risk level, and those that moderate the impact of risk factors (de Vries Robbé et al., 2015). However, the literature on the definition and conceptualisation of protective factors is very limited and requires refining to become clearer.

The Structured Assessment of Protective Factors for violence risk (SAPROF) was developed by de Vogel et al. (2011) to provide guidelines for the inclusion of protective factors within risk assessments. The SAPROF contains internal items (personal characteristics), motivational items, and external items. Internal protective factors consist of intelligence, secure attachment in childhood, empathy, coping, and self-control. Motivational items are work, leisure activities, financial management, motivation for treatment, attitudes towards authority, life goals, and medication. External protective items include social network, intimate relationships, professional care, living circumstances, and external control (de Vogel et al., 2011). The SAPROF shows good reliability and good predictive validity for short to medium term prediction of non-recidivism (de Vries Robbé, de Vogel, & de Spa, 2011). Further research has also shown the SAPROF to show good predictive validity of future violence and sexual violence from 3 years to 15 years follow-up, even when controlling for the predictive validity of the HCR-20 and SVR-20 (de Vries Robbé et al., 2015).

Due to the relative infancy of protective factor research, it is no surprise that some researchers are critical of their conceptualisation. Durrant and Ward (2015) argue that the broadening of the definition of protective factors makes it harder to distinguish whether the reduction in reoffending is due to protective factors, maturation, therapy-induced change, or desistance. Ward and MacDonald (in press) have issues with de Vries Robbé's et al. (2015) idea that protective factors can be the opposite of dynamic risk factors concurrently and alter the nature of dynamic risk factors. The authors argue this is illogical, as one cannot possess a

characteristic yet lack it at the same time. Rather, Ward and MacDonald (in press) reinterpret the reduction of reoffending as a shift from the risk factor to its opposite protective factor over time due to therapy. Also, because the current definition of protective factors is based on the conceptualisation of dynamic risk factors which is theoretically flawed in itself, protective factors are a problematic concept. Therefore, dynamic risk factors and protective factors require a lot more theoretical attention and empirical research. Arguably they need to be reconceptualised as causal mechanisms of offending to have any value in the explanation of crime and intervention (Ward & MacDonald, in press).

Treatment

Current sexual offender treatment programmes are based (at least loosely) on the RNR principles and cognitive-behavioural approaches to treatment (Ward et al., 2011). In the 2000's, the typical sexual offender treatment tasks involved eliciting accounts of past deviancy/offending, challenging denial and self-serving cognitive distortions, developing empathy for victims, analysing past offences to identify precursors to offending, developing a relapse prevention plan, and rehearsing skills to put this plan into action (Thornton, 2013). However, as research has developed, it has been found that many of these treatment targets are not as beneficial as previously thought. More recently, models of self-regulation and self-management have been incorporated into treatment (Yates, 2003). Sexual offender treatment is constantly evolving over the years as new models are developed, modified, and refined based on empirical studies (Yates, 2013).

Current best practice involves applying cognitive-behavioural interventions targeting risk and adhering to principles of effective correctional intervention, i.e. the RNR model (Yates, 2013). CBT interventions are the most widely accepted and effective in the treatment of sexual offenders (Yates, 2003). CBT components frequently used in sex offender intervention include general and sexual self-regulation, addressing intimacy deficits, challenging cognitive distortions, explaining the offence process and precursors to offending,

and more recently aiming to change cognitive schemas that produce cognitive distortions, such as sexual entitlement (Yates, 2013). The RNR is the second main approach to sex offender treatment (Yates & Ward, 2008) and is popular in Canada, UK, New Zealand, and Australia (Looman & Abracen, 2013).

In a review of the RNR approach to treatment, Hanson et al. (2009) coded 23 treatment studies comparing recidivism rates of treated sex offenders with a comparison group of sex offenders, according to their adherence to the RNR principles. Adherence to the principles meant that the studies used high risk sex offenders, targeted criminogenic needs (dynamic risk factors), and matched the learning style of the offender. Treatments that followed the RNR showed greater reductions in recidivism compared to treatments that did not adhere to the principles (Hanson et al., 2009). They also found a linear relationship between the number of principles adhered to in treatment and the recidivism rate (Looman & Abracen, 2013).

However, Looman and Abracen (2013) argue the RNR is not a treatment model and researchers recommend its use in conjunction with the GLM and Self-Regulation Model (Yates & Ward, 2008). Yates and Ward (2008) suggest that an integrated risk assessment should result in a treatment plan that contains both risk management elements (that address static and dynamic risk factors), and good lives elements (to help the offender obtain the goods he values in non-criminal ways). These authors believe that treatment as it currently stands is insufficient; teaching the offender containment strategies and management strategies is inadequate unless they are also taught and provided with ways to attain the values that they seek (Yates & Ward, 2008). These risk and good lives elements that are specific to the offender and used in treatment are identified through case formulation, described in the next chapter.

It is essential to remember when reading about current treatment practices, that treatment is centred on and directly targets the concept of dynamic risk factors. As mentioned

above, the problem is that the processes referred to by these constructs do not (i.e., cannot) directly cause offending. Since they are arguably summary or composite constructs they do not refer to any particular casual processes; at least, in an unambiguous way (Ward, 2016). Unfortunately, this means treatment may be missing the true causes of offending and not reaching its full potential. The detrimental effects of this may be that offenders graduate from their treatment programmes with the causes of offending still unaltered, resulting in reoffending.

Chapter 2: Case Formulation

Clinical Case Formulation

A clinical case formulation is a "hypothesis about the causes, precipitants, and maintaining influences on a person's psychological, interpersonal, and behavioural problems" (Eells, 2007a, p. 4). A case formulation also provides structure for organizing information, particularly information that is contradictory, and is used to guide treatment (Eells, 2007a). Formulation is considered an essential skill for therapists and is viewed by a number of professional bodies as a core component of evidence-based mental health and forensic practice (Davies et al., 2013). Many clinicians believe that treatment should be tailored to the individual rather than using standardised treatment protocols as human beings are immensely complex and understanding them requires individualisation (Ghaderi, 2011).

Case formulation is fundamental to mental health and forensic services for several reasons (Eells & Lombart, 2011). Firstly, formulation integrates theory and empirical knowledge to inform practitioners' understanding and subsequent treatment of a client. Secondly, current nosologies are symptom-focused and descriptive and neglect to explain why a person may have these symptoms. Whereas a case formulation aims to explain the causal mechanisms generating symptoms, a crucial feature that separates formulation from risk assessment. Thirdly, diagnosis on its own is inadequate in guiding treatment selection. Lastly, formulation tailors treatment to the specific individual by integrating information about an individual's circumstances, allowing for the treatment of multiple issues that may be neglected in standardised protocols (Eells & Lombart, 2011). In particular, case formulation is most beneficial when the individual has multiple problems, experiences a breach in the therapeutic relationship, no empirically validated treatment currently exists, or has failed to respond to standard interventions (Ward, Nathan, Drake, Lee, & Pathe, 2000).

Case formulation arose during the paradigm shift from the medical model in psychiatry to the concept of evidence-based practice, which established the idea of applying

psychological knowledge to clinical problems according to scientific methodology and convention (Tarrier & Johnson, 2016). This led to the development of empirically-based treatment and research as well as the adoption of a psychological understanding of clinical problems to guide intervention (Tarrier & Johnson, 2016). Kanfer and Saslow introduced the idea of case formulation within this paradigm shift from the medical model to the behavioural-analytic approach in their classic 1965 paper (Westmeyer, 2003). They began to explain and understand an individual's problems in terms of environmental stimuli and response contingencies rather than by reference to psychiatric diagnosis (Tarrier & Calam, 2002). It became apparent to these authors and others that a taxonomic classification system of diagnosis did not adequately consider the variability of an individual's circumstances, thus they concluded a case formulation should be individualised and analyse multiple areas of the individual's life (Tarrier & Johnson, 2016).

Various methods of case formulation have been developed based on different psychological theories such as psychodynamic theory, cognitive-behavioural therapy (CBT), and humanistic theory. Yet they share the same basic steps in constructing a formulation: observe and describe clinical information; infer, interpret, or organise the observed information; and apply the formulation to the case, and revise as needed (Eells, 2007b). Initial models of case formulation were structured and systematic. Formulations were structured by identifying information based on predetermined categories and involved relatively low levels of inference. Importantly, therapists were trained in the method of formulation they were to use (Eells & Lombart, 2011).

These methods of formulation included the Core Conflictual Relationship Theme (CCRT) based on psychodynamic theory, which assumes that early interpersonal experiences predict later interpersonal relationships. In therapy, the clinician identifies the client's most common interpersonal wishes, how they expect others to respond to those wishes, and how they respond to others expected responses (Eells & Lombart, 2011). Another method that

clinicians use for formulation is The Plan Formulation Method based on control mastery theory, which assumes psychopathology comes from pathogenic beliefs derived from childhood trauma. Using this method, the formulation seeks to identify those traumas and resulting pathogenic beliefs and aim to help the patient achieve their goals (Eells & Lombart, 2011). However, as cognitive-behavioural (CBT) therapies are most often prescribed in treatments of sexual offenders and general offenders (Ward, Gannon, & Yates, 2008), CBT case formulations will be described in more detail.

Cognitive-behavioural formulation. A comprehensive case formulation (see Figure 1) includes the following information: a patient's problems, symptoms, and disorders; the psychological mechanisms that are hypothesised to cause and maintain the problems; origins of the mechanisms; precipitants that activate the mechanisms; and environmental factors that will impact on treatment (Persons & Hong, 2016). The CBT formulation emphasises hypotheses testing (Eells & Lombart, 2011) so as to be scientifically accountable and make further testable predictions through assessment and treatment (Tarrier & Calam, 2002). CBT-guided formulations involve three steps. Firstly, the clinician gathers all the information mentioned above to construct the formulation of the case. Second, the clinician uses the formulation to select an intervention and other treatment options, such as areas that require specific focus before beginning intervention. Thirdly, s/he implements the treatment and gathers feedback through the patient's response to treatment. The clinician tests the formulation (hypothesis-testing) and if necessary, revises both formulation and treatment accordingly to increase the patient's response (Persons & Hong, 2016). CBT case formulations are used to inform assessment and treatment of all the major DSM diagnoses, including but not limited to, depression, anxiety, eating disorders, personality disorders, and psychosis (Sturmey, 2009).

Eells and Lombart (2011) constructed a general case formulation framework to address the difficult choice of deciding between the many different approaches to

formulation. These authors recommend considering several models of formulation rather than rejecting all of those which do not fit with the clinician's theoretical orientation. Thus, the general case formulation model is embedded in a general therapy model and contains four major components. The third step, developing an explanatory hypothesis, is the step Eells and Lombart (2011) consider most crucial. The authors suggest the hypotheses contain precipitants, origins of the proposed mechanism, the individual's resources and strengths, and potential obstacles blocking successful treatment. A hypothesis containing these four components will be more comprehensive, complex, and coherent.

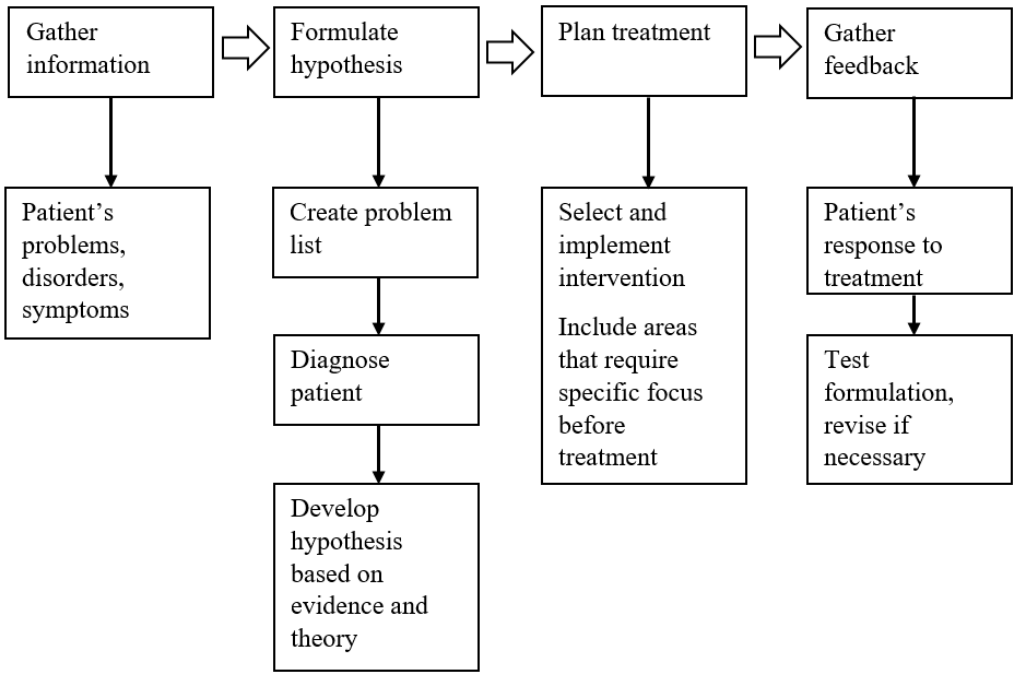

Figure 1. A Typical Case Formulation Model (Eells & Lombart, 2011; Persons & Hong, 2016).

Evidence and issues. One of the most important aspects of any clinical case formulation is its reliability and validity. The method most commonly used by researchers to test reliability of a formulation is to have clinical judges rate the similarity of two independent formulations based on the same set of clinical problems (Eells, 2007). In studies that have tested the reliability of the CCRT, clinical judges have demonstrated moderate to good agreement and when systematically used by well-trained clinicians treatment outcomes can be improved (Beiling & Kuyken, 2003). Persons, Mooney, and Padesky (1995) measured

interrater reliability on two aspects of a CBT case formulation, the problem list and the underlying mechanisms. The results showed that clinicians showed moderate agreement in identifying the overt problems but poor agreement on the underlying mechanisms. However, in a group of 5 judges, interrater reliability for underlying mechanisms was good (Persons et al., 1995), with similar results found in a further study by Persons and Bertagnolli (1999).

Studies such as these demonstrate the moderate to good reliability for the descriptive elements of a case formulation but poorer reliability for the inferential aspects of a case (Beiling & Kuyken, 2003). It is not clear whether these difficulties in inferential aspects are due to methodological issues or the formulation process (Kuyken, Fothergill, Musa, & Chadwick, 2005). However, there is a lack of studies focusing on the treatment utility of case formulation, with the few studies available showing limited treatment improvement (Beiling & Kuyken, 2003). Within the existing literature, studies show a mixture of negative, positive, and null findings, have a lack of power, and contain methodological issues (Ghaderi, 2011).

Forensic Case Formulation

Literature on forensic case formulation is scarce but increasing as the field recognises it's potential as an important component of offender assessment. As with clinical case formulation, individualised assessments through formulations became increasingly required as actuarial methods failed to account for differences in specific individuals. Scotland's Risk Management Authority (RMA) published guidelines that concluded actuarial tools for risk assessment were only permissible when used as part of a structured professional assessment that identifies risk and protective factors specific to the individual and formulates risk analytically (RMA, 2007, as cited in Guy et al., 2015). A formulation is preferred to the use of static actuarial measures as they do not provide a comprehensive risk assessment on the specific contingencies and risk factors in each individual case nor can they determine when and under which circumstances re-offending may occur (Vess, et al., 2008). Thus, current

risk assessment involves frameworks such as the RNR, which combines static and dynamic risk factors to determine risk (Andrews & Bonta, 2010).

As discussed in the first chapter, there are conceptual problems with current risk assessment procedures for sexual offenders, stemming from the use of dynamic risk factors. These issues, along with the growing desire for more individualised treatment of offenders has led to the development and use of case formulation in forensic practice (Ward & Beech, 2004). Vess and Ward (2011) argue that risk assessments of offenders should conclude with a case formulation depicting the etiology of dynamic risk factors present for the specific individual. Essentially, the forensic case formulation follows the same principles as a clinical case formulation except the individual's problems and underlying mechanisms represent their criminality, for example dysfunctional core beliefs or behavioural deficits (Ward et al., 2000).

The forensic case formulation culminates in a conceptual model in which the offenders problems, hypothesised underlying mechanisms, and their interrelationships are represented (Vess & Ward, 2011). The result is a testable (mini) theory specifying how the offender's problems are generated by psychological mechanisms (Ward et al., 2000), which provides a rational basis for treatment tailored to the individual with the aim to achieve optimal outcomes (Collie, Ward & Vess, 2008). The forensic case formulation is informed by current theory and research with established reliability and validity throughout the assessment procedure from gathering information to selecting target problems and selecting treatment programmes (Collie et al., 2008).

Hart, Sturmey, Logan, and McMurran (2011) acknowledge that currently within forensic and mental health practice, there is no agreement concerning how the case formulation process should be conducted or evaluated. These authors have identified a number of general features that they argue all case formulations ought to contain. Formulations are *inferential*, which means going beyond mere description to explain key offending features and facilitates the making of predictions. They are *action-oriented* and

theory-driven. Clinicians are guided by the theoretical approach that they choose, however, each theoretical approach considers different behaviours, variables, and treatments as legitimate and valid as causal explanations. As a result, formulations may differ depending on the theory chosen by the clinician. Formulations are *individualised*, that is they are informed by each individual's data as well as current theory. Hart et al. (2011) also consider formulations as *narratives* requiring narrative cognition that is inherently qualitative rather than quantitative. What this means is that formulations should contain the critical information and a 'plot' that structures the information. Therefore, a formulation is told as a story featuring key elements (descriptions of important events in the individual's past, key motivations at present, and possible futures; Hart et al., 2011), making the formulation *diachronic* (spans time). The final feature of a formulation is that the explanatory hypothesis is *testable* and overall *ampliative*, that is, it produces new information (Hart et al., 2011).

Further research by Hart (2011) suggests that there a ten important features to consider when reconceptualising and evaluating risk assessment: does the framework work?; gather information concerning multiple domains of the individual's functioning; the use of multiple methods to gather information, gather information from multiple sources; gather information concerning static and dynamic risk factors; evaluate the accuracy of the information; evaluate changes in risk over time; be comprehensive; be comprehensible to consumers (judges, police, etc.); professionals can be trained to use the procedure consistently; and results in the reduction of offending. A forensic case formulation framework, if properly conducted, addresses all of the above aspects and is considered to be appropriate and comprehensive (Hart, 2011).

Ward et al. (2000) has also researched the utility of forensic case formulation and identified and provided examples of four key circumstances in which formulation is particularly beneficial. These four situations are; complex offenders, unusual presentations, treatment failure, and threats to therapeutic relationship (Ward et al., 2000). Complex

offenders are those who exhibit multiple, distinct clusters of problems which makes it difficult for the clinician to decide on the primary treatment target. For example, a combination of paedophilia, schizophrenia, and medical issues, which are independent conditions, leads to the requirement of an individualised case formulation and treatment plan (Ward et al., 2000). Unusual presentations represent the individuals who are not easily categorised and treated, their offender types are poorly understood and require more individualised treatment plans. For example, female offenders who exhibit deviant sexual interests, and child molesters who present without typical levels of deviant sexual arousal (Ward et al., 2000). In addition, some sexual offenders may not respond to standardised treatment programmes as expected, and might benefit from a case formulation which identifies vital information that was overlooked thus providing a better basis for treatment. When some offenders struggle with aspects of treatment, or display signs of lack of motivation or denial, this can lead them to leave the programme or frustrate the therapist straining the relationship. In this situation, forensic case formulation can identify the causes of these difficulties and suggest a plan to remove the difficulties (Ward et al., 2000).

Methods of Formulation.

While forensic case formulations share central characteristics and objectives, there are different techniques and approaches to formulating a case. Hart et al. (2015) describes two different techniques; atheoretical and theoretical, each possessing different strengths and weaknesses. Atheoretical techniques allow the causal mechanisms to emerge from the analysis of the case, using conceptual clusters or Root Cause Analysis to trace proximal causes to distal causes (Hart et al., 2015). Whereas atheoretical formulations are more liberating they can be inefficient and difficult to construct, the opposite is true with theoretical techniques which are straightforward but more restrictive. Theoretical techniques formulate cases using a particular conceptual model or theory such as the SPJ approach, or GLM (Hart et al., 2015). For example, decision theory guides forensic case formulation of

violence risk by viewing risk factors as influencing decision making, by motivating, disinhibiting, and destabilizing decisions to engage in violence (Hart & Logan, 2011). As forensic case formulation is increasingly utilised, different approaches have been developed to formulate a case.

Logan (2014) has established two different methods for organizing the information gathered from risk assessment tools, the 5Ps or the 3Ds. The 5Ps contains the problem (risk of what?), predisposing factors (vulnerabilities), precipitating factors (triggers), perpetuating factors (maintenance), and protective factors (Logan, 2014). The other method is similar, drivers (motivators), destabilisers (precipitating factors), and disinhibitors (predisposing factors). Drivers increase the perceived rewards of the offence, destabilisers disturb the offender's ability to control their decision making, and disinhibitors decrease the perceived costs of offending (Hart & Logan, 2011). Logan (2014) considers risk information organised in such a way allows the clinician to prepare the formulation to better understand why the individual has chosen to offend and under what circumstances they might do it again, which is the purpose of the following phases. Yet these methods are flawed in that they assume causal relationships between the risk factors and offending. However, by using the Agency Model of Risk's visual structure (this model is discussed later in this chapter), any information gathered can be organised by agency and context, therefore the Agency model can be integrated into a case formulation model.

Abductive Method. The abductive method was developed by Ward and Haig (1997) and has since been elaborated on and applied to forensic case formulation practice. Vertue and Haig (2008) argue that the abductive method of theory (ATOM) provides a coherent, systematic way for clinical psychologists to use clinical reasoning in diagnosis and formulation of a person's psychological problems. Traditional scientific methods, inductive and hypo-deductive, fail to be appropriate as general models for systematically structuring clinical assessment from gathering data to evaluation of the formulation (Ward, Vertue, &

Haig, 1999). The hypo-deductive method is most commonly associated with case formulation as it emphasises hypothesis testing. From the perspective of this method, case formulation begins with identifying the individual's problems and finishes with a well-supported hypothesis that provides an explanatory account of the data. Hypotheses are often generated before the clinician meets the individual and further obtained data is then used to confirm or disconfirm these hypotheses (Ward & Haig, 1997). The hypo-deductive method is considered a weak method as it is used without prior relevant knowledge (Vertue & Haig, 2008). Further arguments against the hypo-deductive method of case formulation centre on its over-emphasis on hypothesis testing and neglect of the importance of the epistemic values of explanatory depth, coherence, and simplicity (Ward & Haig, 1997).

The abductive method is a form of clinical reasoning that begins by detecting phenomena through data pattern analysis. Hypotheses are then developed about the potential explanations for those phenomena. These hypotheses can in turn be used to make predictions. (Hart et al., 2011). Phenomena are "general and stable features of the world that we seek to explain" (Ward et al., 1999, p. 50), that includes objects, states, processes, events, and other features that are generally unobservable and difficult to classify, for example, low self-esteem, or aggression. Data, on the other hand, are reports and recordings that are perceptually accessible, observable, and open to the public. Data serves as evidence for phenomena, for example personality test scores (Ward et al., 1999). Abductive reasoning is directed at patterns in the data, or phenomena, to produce plausible explanations of those phenomena (Vertue & Haig, 2008).

The abductive method of case formulation contains five phases. The first phase is the detection of phenomena through data collection and data analysis, for example patterns of sexual offending (Collie et al., 2008). Data is collected from clinical interviews, the referral question (why they are seeking help), and salient cues or flags that arise during data exploration (Vertue & Haig, 2008). When formulating a forensic case, several categories of

factors are required to be examined; historical (past offences and treatment), developmental (adverse events, family relationships), cognitive (intelligence, cognitive distortions, beliefs), personality (psychopathy, traits), and clinical (psychiatric diagnosis, substance abuse; Vess et al., 2008), these provide a comprehensive set of data in which phenomena can reliably be inferred (Vertue & Haig, 2008).

Assessment involves more than collecting information about the offender; the information must be evaluated and integrated into a clear understanding of the person's difficulties and the causes of those difficulties (Collie et al., 2008). Thus, the second phase is concerned with inferring causal mechanisms of the phenomena detected in the first phase. Vertue and Haig (2008) refer to these as vulnerability factors that are triggered by internal or external events to cause the phenomena. Vulnerability factors that cause phenomena are typically known as stable dynamic risk factors such as offense supportive beliefs, sexual interests, and self-regulation (Collie et al., 2008). Vertue and Haig (2008) recommend listing the phenomena and identifying clusters of well-established symptoms before thinking abductively about their causes, and visually displaying how different factors contribute to the phenomena (distal, proximal, psychological, environmental, and maintaining factors) using different frameworks for structure.

In the third phase, a causal model is developed from the plausible explanatory hypotheses generated in phase two, to establish the relationships between the causal mechanisms. The causal model is guided by the clinician's experience, psychopathological theories, and empirical research (Vertue & Haig, 2008). During the fourth phase, the causal model is evaluated according to a number of epistemic criteria including explanatory breadth, simplicity, and analogy. The case formulation needs to account for the empirical findings, provide more explanatory breadth than other models, display simplicity (make few untested assumptions), and it should be analogous to a successful earlier model (Ward et al., 1999). Finally in the fifth phase, the information from phases 2-4 is integrated into a comprehensive

narrative containing the phenomenology, etiology, maintaining factors, prognosis, and treatment recommendations (Vertue & Haig, 2008).

SPJ Method. Hart and colleagues have developed their own approach to risk assessment, the structured professional judgement approach and use this within clinical case formulation. The SPJ approach and the administration of an SPJ instrument, the Historical-Clinical-Risk-Management-20 version 3 (HCR-20^{v3}) are the basis for the seven steps in conducting a comprehensive risk assessment involving case formulation for violent risk (Guy et al., 2015). The HCR-20^{v3} contains 20 items consisting of historical factors, clinical factors, and risk management factors that are rated as present and relevant (Logan, 2014). There are three categories within the seven steps of comprehensive clinical assessment; identifying facts, making meaning of the facts, and taking action (Guy et al., 2015).

Category one. The first category is identifying facts and contains two steps; first basic case information is gathered and documented. Guy et al. (2015) strongly recommend thorough, relentless, and persistent fact checking of all information gathered as well as gathering information from multiple sources. Importantly, clinicians must balance comprehensiveness with efficiency as not all information will be relevant to the case, and what is considered relevant must be reliable. Step two involves identifying the presence of a core set of defined factors and additional case-specific factors, those determined by risk assessment instruments such as the HCR-20^{v3}, which have established validity and reliability. Judging whether a risk factor is present is designed to show that the clinician has considered all evidence in order to make informed decisions regarding the person's problems related to each risk factor and how this can facilitate any decisions made to manage that risk (Guy et al., 2015). A core set of risk factors, typically the list of dynamic risk factors that the majority of risk assessment tools use, prevents clinicians from focusing on risk factors with little validity and conversely, neglecting those with established validity (Guy et al., 2015).

However, Guy et al. (2015) acknowledge that the list of dynamic risk factors is not exhaustive and case-specific risk factors need to be investigated.

Category two. Once the facts of the case have been identified, the clinician assesses the relevance of each risk factor in step three. A risk factor is considered relevant if it was a key factor in past violence, is likely to influence the decision to engage in future offending, or is critical for the risk management plan (Guy et al., 2015). The fourth step consists of integrating the risk factors into a conceptually meaningful framework to explain the individual's violence or offending through case formulation (Guy et al., 2015). The SPJ approach to case formulation is guided by decision theory which can be considered a version of the psychology of criminal conduct theory but specific to violence. Violence is viewed as a choice, or as behaviour that aims to achieve goals (Hart & Logan, 2011). According to this view, risk factors influence decision making and risk assessment aims to understand how and why people decide to engage in offending (Hart & Logan, 2011).

The case formulation, therefore, considers the extent to which these risk factors motivate, disinhibit, or destabilise an individual. Clinicians can formulate by creating a hierarchy of risk factors based on relevance, or create clusters of risk factors that may have a common root cause (Guy et al., 2015). In the fifth step, future offending scenarios are created (based on the formulation of risk factors) that speculate on the most likely scenarios in which the individual will engage in future offending (Guy et al., 2015). The scenarios provide a detailed description of the nature, severity, imminence, duration, frequency and likelihood of future offending and will be used to guide risk management plans (Guy et al., 2015).

Category three. Steps six and seven form the taking action category of the comprehensive clinical assessment. In step six, risk management strategies are recommended that are directly related to the above steps, this means basing strategies on the scenarios that were constructed based on the individual's risk factors. Risk management plans are guided by the RNR model (as research has shown this to reduce recidivism) and focus on four kinds of

strategies; monitoring/surveillance, supervision/control, treatment/assessment, and victim safety planning (Guy et al., 2015). Within each type of strategy, specific strategies are identified for the individual and turned into detailed risk management plans. In the final step, step 7, the clinician rates the offender's level of risk as low, moderate, or high, which reflects the intervention required for that individual (Guy et al., 2015).

Empirical Evidence and Issues.

Evidence. The majority of research on forensic case formulation has so far been theoretical in nature with case studies used as examples on how the formulation should operate. There is a massive evidence gap in the forensic literature as there are no studies on the validity or reliability of forensic case formulations, and no studies on training clinicians to conduct a forensic case formulation. Sturmey and McMurran (2011) recommend that research should determine what constitutes an adequate forensic formulation, reveal whether clinicians can write an adequate formulation, and establish the validity and reliability of forensic case formulations. However, breaking down the formulation into stages can be useful when establishing empirical evidence until more research investigating forensic case formulation as a whole is completed. Vess and Ward (2011) point out that forensic formulations typically begin with initial estimates of risk based on empirically validated static and dynamic risk measures such as the Static-99, STABLE-2007, and ACUTE-2007. In the beginning steps of formulation, risk factors are identified using actuarial and dynamic risk measures which have provided moderate to high effect sizes. Actuarial measures such as the Static-99 designed to predict sexual recidivism show the highest predictive accuracy (*d.* = 0.78) compared to other methods (Hanson & Morton-Bourgon, 2009). While the identification of these established risk factors may be empirically validated and considered reliable, the identification of other case relevant risk factors specific to the individual should also be based on empirical evidence. Furthermore, given that current models of forensic case formulation are closely modelled on clinical case formulation, this suggests that there is

likely to be little accuracy and interrater reliability for the steps involving clinical judgement beyond pre-set risk factors. However, there is no research as of yet that measures how accurate clinicians are in identifying these case specific risk factors.

Issues. A common theme throughout all current forensic case formulations is the view that forensic case formulation is essential for risk assessment and management as the predictor variables in a formulation are dynamic risk factors (Sturmey & McMurran, 2011). Yet, a difficulty is that dynamic risk factors are problematic constructs themselves, as discussed in chapter 1 of this thesis. Dynamic risk factors arguably do not refer directly to specific causal mechanisms underlying criminal behaviour; rather they are composite constructs that are summaries of possible causes, contextual factors and mental state variables (Ward, 2016; Ward & Beech, 2015). Current risk assessment literature treats dynamic risk factors as causal without providing any theoretical basis concerning how they are structured and function. Furthermore, there is little attempt to understand how these factors interact with each other to form causal mechanisms (Ward & Beech, 2015).

Hart and colleagues set out to integrate the SPJ method of risk assessment with formulation to improve practice (Hart & Logan, 2011). The issue with both the abductive method and Hart's SPJ method of forensic case formulation is that they simply take a list of dynamic risk factors from previously established measures and assume they are causal without explaining why and how this is the case. It is noteworthy that Hart and colleagues have renewed interest and discussion around forensic case formulation but their SPJ guidelines are confusing formulating a case with managing risk, which are similar but not the same tasks. Formulation aims to *explain why* individuals offend and is used to guide treatment (Eells, 2007a), whereas risk assessment and management aims *to predict* levels of risk and identify treatments that will reduce the level of risk an individual poses (Hart, 2009).

Hart's case formulation model aims to integrate risk factors but is cumbersome because the risk factors do not refer to anything substantial; they are composite constructs

(Ward, 2016). By using dynamic risk factors in their current form without trying to understand their etiological function, Hart has provided a model that merely re-describes a case and does not add any value for both the offender and therapist (Ward & Beech, 2015).

The problems arise in step four where the task is to integrate risk factors into a "psychologically meaningful framework" to explain offending. Firstly, there is no guidance on what constitutes a "psychologically meaningful framework" or how one should use this to explain offending. An effective model of forensic case formulation needs to be explicit in describing how the interacting factors should be organised in order to be explanatory whether this is a written narrative or in the form of a visual model. Secondly, in current methods of formulation the risk factors that are integrated to explain offending are not factors that directly cause offending and it is dangerous to assume they do. If dynamic risk factors continued to be conceptualised as causal mechanisms, then forensic case formulations relying on them will not work. Guy and colleagues' (2015) model does not address the problem with dynamic risk factors but continues to focus on individual risk factors as the main drivers of offending rather than the psychological features of an individual and the context interacting to cause offending. In order to effectively guide treatment, dynamic risk factors need to be reconceptualised and utilised in a new way and combined with contextual factors to create an explanatory framework used in forensic case formulation. In the next chapter I will attempt to do this by developing the Risk Etiology Case Formulation Model.

Chapter 3: Risk Etiology Case Formulation Model

In the previous chapter, current approaches to case formulation were introduced. Specifically, the SPJ model described by Hart and colleagues which aims to integrate risk assessments listing dynamic risk factors (viewed as causal mechanisms) with clinical judgement in order to have a less rigidly structured case formulation. However, in doing so, Hart and colleagues have managed to produce a cumbersome model that ignores the etiology of offending. The fundamental part of their model, which they describe as "integrating individual risk factors into a conceptually meaningful framework to explain offending" (Guy et al., 2015, p. 60), is merely a description of what needs to be done rather than an explanatory case model. Dynamic risk factors are theoretically problematic when used to explain offending and current forensic case formulation models do not take this into account. Therefore, this chapter aims to develop an etiological model that integrates dynamic risk factors into case formulation based on the theoretical model created by Heffernan and Ward (2015), the Agency Model of Risk (AMR).

Ward and colleagues argue that although dynamic risk factors do not refer to real psychological mechanisms, they are useful in risk prediction (Heffernan & Ward, 2015; Ward, 2016). Case formulations incorporate dynamic risk factors in their current, unmodified form for both risk prediction and the explanation of offending. The problem is that existing dynamic risk factors should not be used in case formulations without reworking them conceptually; but due to there being no viable alternative clinicians have little choice. I suggest that by refocusing conceptual attention to components of human agency, dynamic risk factors can be utilised in a more theoretically coherent and practice useful way (Durrant & Ward, 2015; Heffernan & Ward, 2015). Agency refers to an individuals' capacity to effectively manage multiple and competing goals in ways that enable them to sustain their

functioning, repair damage, avoid harm, and implement plans that are cohesive and responsive to any relevant contexts (Durrant & Ward, 2015, p.192).

The Agency Model of Risk

Theoretical Assumptions

The Agency Model of Risk (AMR) draws on a wide range of theories and is based on three major theoretical assumptions; emergent materialism, pervasiveness of normativeness, and the important role of psychological processes in offending (Heffernan & Ward, 2015). The idea that psychological capacities such as agency are crucial to the survival of humans forms the basis of e*mergent materialism*. The theory of emergent materialism argues that to sustain human functioning there are distinct levels of analysis which correspond to the different systems comprising human beings. The ontological perspective within emergent materialism claims that each system has its own unique constituent processes but each systems also impacts on other systems to contribute to the overall functioning of a person. The epistemological perspective argues that knowledge concerning these processes provides a significant understanding of human functioning. Therefore, agency level explanations of human behaviour provide an explanatory perspective that is distinctive and complex. For researchers developing theories of behaviour (normative or dysfunctional) it is essential that individuals' experiences, values, beliefs, and contexts are taken into consideration (Durrant & Ward, 2015).

The second assumption, *pervasiveness of normativeness* in human culture, suggests that norms are influenced by values, which govern the functioning of action sequences. Norms are also evident in human's goals. Individuals select strategies to further their goals supported by these norms and their associated values in a dynamic manner. In changing environmental contingencies, humans adjust their goal-directed strategies and plans accordingly, within their cognitive capacity and availability of resources (Heffernan & Ward, 2015).

Thirdly, *internal psychological processes* (emotions, cognitions, drives, needs) support the development of goals and influence subsequent action. Contextual cues lead to the activation or selection of goals, whether they are external (e.g. presence of threat) or internal (e.g. sexual desire, anger). In order for humans to construct plans to guide their actions, they require the capability to balance multiple goals simultaneously. This juggling of multiple goals enables humans to predict environmental outcomes. If there are any discrepancies between the predicted outcome and the norms associated with their goals, then persons can correct their actions. Adaptations such as social learning aid the activation of goals and plans and create external contexts that support the procurement of new, complex skills (Heffernan & Ward, 2015).

The Agency Model of Risk (AMR)

The AMR contains two major sources of causal influence, the agent and the context within which actions occur, which have a bidirectional relationship (see Figure 2). The three levels of agency in the AMR are each associated with a specific set of behavioural and psychological processes that occur in response to specific internal and external cues. (Heffernan & Ward, 2015). The first level is that of *personal identity* or self-conception, which involves formulating a good life plan that is heavily influenced by an individual's beliefs, values, and priorities. Secondly, the *social role* level concerns the self in relation to others. Social roles incorporate social and professional responsibilities, and their associated skills and capacities. The *systems*-level is comprised of the physical or biological needs that are present and salient to the offender, such as sexual arousal or altered consciousness, which influence offending. When each level of agency is activated, their associated values are translated into goals that direct subsequent actions (Durrant & Ward, 2015).

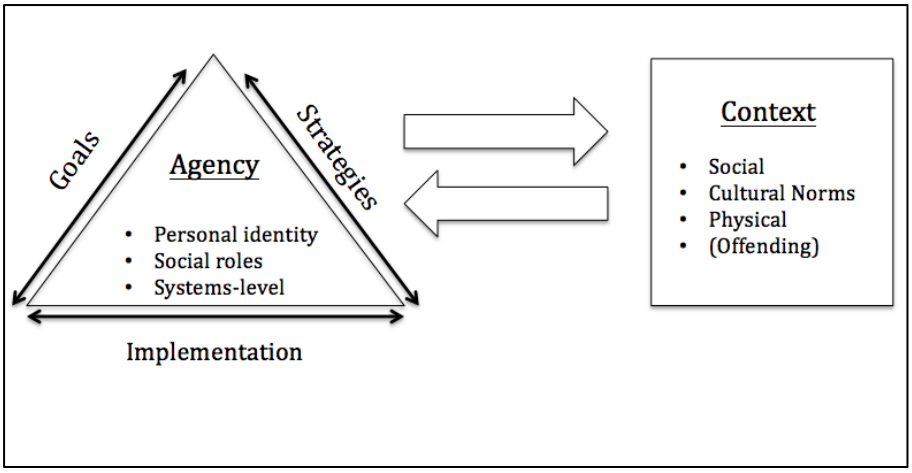

Figure 2. The Agency Model of RIsk. Heffernan and Ward (2015)

Goals. Goals are guided by values and beliefs, which determine action sequences, consisting of predicted outcomes that the individual believes will lead to the achievement of a desired value. Sexual offending is motivated by goals informed by an individual's core beliefs, interpersonal functioning, personal identity, and sexual needs; once an offender establishes a goal he deliberates how best to achieve it within the current context (Heffernan & Ward, 2015).

Strategies. Planning involves deciding what actions to take in order to successfully achieve a goal, and skills such as interpersonal capacities become relevant. This aspect of agency is informed by beliefs and expectations. Success depends upon knowledge and skills, such as theory of mind, cognitive skills, counterfactual thinking, and the use of scripts and action templates. Over time, these skills become deeply embedded in long-term memory and offending action-sequences become frequently automatic and part of an offender's typical behavioural pattern, especially when proven to be successful in obtaining a valued outcome (Heffernan & Ward, 2015).

Implementation. This phase consists of the actual offending, subsequent outcomes and evaluations. An offender reviews the success of his actions and ascertains whether a more effective strategy is needed to achieve his goals. Implementation is reliant on strategies formed prior to offending. New goals may be formed during this phase or in the strategy

phase above and unsuccessful phases can be abandoned or modified (Heffernan & Ward, 2015). Implementation is also influenced by triggers such as contextual variables and emotional state. Effective action-sequences are repeated and form cognitive and behavioural scripts, guiding future actions depending on existing internal and external conditions (known as acute dynamic risk factors). After the initial implementation of an offence, other values may be implicated in the following sequence of offending action, therefore, the same strategies are used to reach different values and associated goals (Heffernan & Ward, 2015).

Context. Consideration of context is fundamental in the explanation of sexual offending and its relationship with dynamic risk factors. The environment is instrumental in meeting goals but can also fail to produce the resources required for their successful completion. For example, restricted access to appropriate sexual partners may lead sex offenders to regard children as possible substitutes. People pursue contexts that align with their priorities and preferences, such as a child sexual offenders seeking out communities where their offending is supported. But, individuals are also heavily influenced by those contexts, meaning that these environments can trigger underlying motivations or in some instances, cause them directly. Thus, the relationship between agency and context is reciprocal. Both the agent and the context must support offending and neither on their own is sufficient to cause sexual offending (Heffernan & Ward, 2015). Successful agency involves the integration of goals, strategies, and norms within a coherent action sequence (Durrant & Ward, 2015). Thus, the AMR views sexual offending as relational and dependent upon individual's vulnerabilities and the social contexts in which they are embedded and views risk factors as the psychological and social processes (associated with goals, strategies, and implementation) that impair normal functioning (Heffernan & Ward, 2015).

The Risk Etiology Case Formulation Model

The Risk Etiology Case Formulation Model (RECFM) aims to integrate reconceptualised dynamic risk factors into case formulations drawing from theoretical

models; the Agency Model of Risk, depicted above (Heffernan & Ward, 2015), the Good Lives Model (Ward & Gannon, 2006), and the Risk-Needs-Responsivity Model (see chapter 1, Andrews & Bonta, 2010). The RECFM also builds upon the case formulation models described in the previous chapter (Vess et al., 2008; Guy et al., 2015). However, some significant changes have been made to the steps provided in previous case formulation models developed by Guy et al. (2015) and Logan and Johnstone (2010) to create a new framework, the RECFM.

The RECFM condenses the seven steps from Guy et al. (2015) into five, more comprehensive, steps. A comprehensive set of steps allows for clinician's to utilise the framework in any forensic case formulation easily. The RECFM has altered Guy et al.'s (2015) steps 2 and 3; identifying risk factors as present and assessing the relevance of risk factors. I believe that it is unnecessary to have a step dedicated to simply listing dynamic risk factors that are present and then create another step where these dynamic risk factors are labelled by relevance in terms of high, medium, or low. Risk factors that are present but not relevant do not need to be targeted to reduce offending. Therefore, the RECFM includes a step that identifies dynamic risk factors that are relevant and includes other psychological features that also impact on offending. In doing so, the step becomes more comprehensible and beneficial for case formulation as a tool for understanding the causes behind offending.

The RECFM's five steps are related to previous models such as Logan and Johnstone's (2010) seven stages of clinical case formulation development and Guy et al.'s (2015) seven steps, which were explained in the previous chapter. Steps one to two are similar to the RECFM, where the presenting problems are described and relevant factors that contribute to the problem are identified. However, while some of the following steps are still useful for forensic case formulation, the RECFM deviates from Logan and Johnstone (2010) and Guy et al. (2015) by using the AMR developed by Heffernan and Ward (2015). The use of the AMR to develop the next steps of the RECFM provides a way to integrate

reconceptualised dynamic risk factors into the formulation in an attempt to work out the actual causal mechanisms of offending for each particular individual.

The fourth step in Guy et al. (2015) involves integrating case information through formulation "into a conceptually meaningful framework". However, there is no guidance on how to incorporate risk factors into an explanatory hypothesis of offending so the RECFM uses the AMR to construct dynamic risk factors into causal factors. Furthermore, the last step identified by Guy et al. (2015) is removed as there is no need for an evaluation of risk in terms of high, medium or low as this is made clear during the case formulation using the AMR.

The key purpose in developing the RECFM is to provide clinician's with a framework for coherently incorporating dynamic risk factors into a case formulation to explain sexual offending. It is hoped that the new model will enable dynamic risk factors to be utilised correctly in formulating cases and move away from treating them as direct causes of offending. The RECFM comprises of five phases which can be thought of as conceptual steps illustrated in Table 4.

Table 4

Risk Etiology Case Formulation Model

Phase				
Identifying Facts	Identify DRFs, PFs, and Relevant Features	Identification and Integration of Causal Factors through AMR	Future Offending Scenarios	Intervention Plan
Identify facts of the case: • Gather and document basic case information from multiple sources • Determine key people involved, what happened, why it happened, where and when it occurred, and offender's reactions	Identify relevant Dynamic Risk Factors: • Use multiple risk factor scales • Clinical observation • Case specific risk factors Integrate information with psychological vulnerabilities and contextual variables • Personality • Psychopathy • Intimacy Deficits Protective Factors	Locate relevant causal factors using the AMR Template • Goals, values • Strategies • Contextual Factors • Interrelationships • Emphasise prominent causal factors (hierarchy) • Use visual model as a structure	• Describe the most likely scenarios of future sexual offending • Speculation based on information from phases 2-3 • Not a prediction • Guide intervention	Create a treatment plan based on the AMR model for individuals. • Set out in steps • Based on information from phases 2-4 • Use RNR and GLM principles • Considers environment and resources specific to the offender as well as offender characteristics

Table 4. The Risk Etiology Case Formulation Model.

Phase 1: Identifying Facts

When an offender has been referred to a clinician for assessment and the task is to develop a case formulation to generate a treatment plan, s/he must first establish the facts of the case. Case formulations, while driven by theory, are also driven by each offender's data which leads to highly individualised formulations and treatment plans (Hart et al., 2011). Therefore, it is essential to understand the details of the offence; what happened, who was involved, who were the victims, where and when the offence occurred, what the offender was aiming to achieve (motivations, intentions), and the offender's reactions (before, during, and after). It is important that the clinician review the above information as the reliability and validity of the formulation is linked to the quantity and quantity of this information (Guy et al., 2015). Hence, information must be gathered from multiple sources, including the offender themselves, the victim(s), witnesses, criminal history, mental health and medical history, family and friends, and education and employment records. Guy et al., (2015) suggest that it is beneficial to create a timeline of previous offences, if there are any, to determine any patterns in the offence process. For all offenders, case information is typically gathered through interviews.

Phase 2: Identify DRFs, PFs, and Relevant Features

Dynamic risk factors, as currently conceptualised, are not very useful in the explanation of offending, but they are important in the prediction of future offending. However, if dynamic risk factors are reconceptualised as psychological and social processes (i.e., possible causes, contextual factors, and mental state variables) that impair normal functioning (Heffernan & Ward, 2015), then they can be used to understand why and how sexual offending occurs. Therefore, as it is likely dynamic risk factors are markers for some of the causal process underlying offending, they can play a crucial role in case formulation (Durrant & Ward, 2015).

Firstly, the clinician needs to determine which dynamic risk factors are present and relevant for the individual offender. There are an abundance of risk assessment tools that measure risk factors present in an individual such as: the HCR-20^{v3} which has specific guidelines for violence case formulation (Logan, 2014), the Risk for Sexual Violence Protocol (RSVP; Hart, 2009), the Sex Offender Need Assessment Rating (SONAR; Hanson & Harris, 2001), the Risk Matrix 2000 (Thornton, 2007), the Violence Risk Appraisal Guide (VRAG; Quinsey, Harris, Rice, & Cormier, 1998), Static-99 (Hart, 2009) and the LSI-R (Andrews & Bonta, 2010). However, as there is no measure that is considered the "best" or one that contains a comprehensive set of factors that cause sexual offending, clinicians have to rely on their judgement when considering which measures to use and how to interpret the results (Hanson & Morton-Bourgon, 2006). Essentially, the clinician can choose which measures they prefer to use, provided they have been shown to be reliable and valid.

The dynamic risk factors that are considered as relevant are those that played a key contribution to past offences, are likely to influence the offender's decision to offend in the future, likely to impair the offender's capacity to use non-deviant approaches to problem solving or interpersonal relations, or thought to be critical in the risk management plan (Guy et al., 2015). For example, an offender who has a history of cocaine dependence, is likely to have the substance abuse risk factor present. However, if his cocaine dependence did not feature in his past offending and he was never under the influence during an offence, the risk factor is irrelevant to future risk of offending (Logan, 2014). While this offender's substance abuse is a problem that needs further attention, it is not a problem that should be the central focus in the case formulation. Substance abuse may not be directly causing offending but be related to other causes. Dynamic risk factors determine risk state (intra-individual risk level) and variations of risk over time are influenced by these dynamic risk factors which is crucial to understand for effective risk management (Vess et al., 2008). It is important to keep in

mind that the dynamic risk factors may be relevant and play a part as markers of causal processes in offending but they are not causing an individual to sexually offend because they do not directly refer to causal processes; they are composite constructs (Durrant & Ward, 2015).

It is also critical to consider factors other than dynamic risk factors. Protective factors reduce the likelihood of offending occurring and are important to take into account when constructing a formulation and treatment plan (Heffernan & Ward, 2015). A popular criticism of risk assessments is that they are extremely one-sided by focusing exclusively on risk factors (de Vries Robbé, et al., 2011), which can lead to over-prediction of risk and poor treatment planning (de Vries Robbé, et al., 2014). Firstly, by incorporating protective factors into forensic case formulation, this criticism can be avoided. Secondly, protective factors add incremental predictive validity over risk factors alone (de Vries Robbé et al., 2014). Protective factors include moderate intensity sex drive, supportive attitudes of appropriate sexual relationships, sexual preferences for consenting adults, preference for emotional intimacy with adults, self-control, problem solving skills, and functional coping (de Vries Robbé et al., 2014). This list is by no means exhaustive but highlights the nature of protective factors as polar opposites to empirically supported risk factors. While research on protective factors is scarce, forensic case formulation will benefit from considering them in the intervention plan.

Other psychological features and contextual features can be relevant for a complete forensic case formulation. Ward and Beech (2006) consider dispositional factors or dynamic risk factors and clinical factors such as emotional and social difficulties, as the most important types of risk factors for therapeutic purposes. However, a forensic case formulation should take into account an offender's psychopathic or antisocial personality, developmental factors, deviant social networks, psychiatric diagnoses, poor level of functioning, and

substance abuse (Beech et al., 2003). As the literature indicates, dynamic risk factors are those that have been empirically validated as reducing recidivism when targeted in treatment and these should be included in formulations as markers for potential causes. Yet there are other factors that Mann et al., (2010) identified as promising risk factors and unsupported with interesting exceptions that may be worth investigating if the individual displays these characteristics. These characteristics include but are not limited to hostile beliefs towards women, sexualized coping, denial, low self-esteem, major mental illness, and loneliness (for more details see chapter 1). Therefore, these factors may be important in indicating underlying causes of sexual offending for a particular offender and need further attention in their individual case formulation. Research also suggests that attention should be paid to signs and symptoms of personality disorders as they are highly prevalent in offenders in general, including psychopathy in sexual offenders in particular (Logan & Johnstone, 2010), which may be useful to include in the formulation to guide treatment.

Phase 3: Identification and Integration of Causal Factors through AMR

This phase involves taking the dynamic, protective, and other risk factors identified in the above step and integrating them with the AMR to develop hypotheses about the causes of the individuals offending. Heffernan and Ward (2015, p.257) provide an example of a child sex offender's risk factors in the visual representation of the AMR which is easily comprehensible. Therefore, it is recommended that the clinician uses the AMR as a visual model to explain offending to aid clinicians in understanding the underlying processes that are interacting in causing offending for each individual.

Firstly, for all individuals their levels of agency should be identified. For personal identity, the clinician needs to work with the offender to find out how he views himself and his life. This means interviewing the offender with the purpose to discovering his beliefs and values, as well as his personal priorities. The social role of agency involves understanding

individual's roles in society including their occupation and responsibilities, skills and capacities they possess, and family roles such as parent or uncle. The systems level identifies which biological or physical needs are salient at the time of offending, such as arousal or intoxication. Some of these may have already been established as dynamic risk factors or protective factors in the previous phase but they are reconceptualised as vulnerabilities that influence goals and values which in turn influences behaviour (Heffernan & Ward, 2015).

Thus, an offender's goals and strategies need to be examined and explained. The Good Lives Model (Ward & Gannon, 2006) is useful here and assumes that humans seek goals that reflect their core values and which are supported by their beliefs. In the case formulation process, by understanding and uncovering the offender's levels of agency (personal identity, social roles, systems level), beliefs and values, and the contexts specific to them, the clinician will be able to comprehend the offender's goals were in offending. What were they aiming to achieve? What did they want to get from sexually offending? How did they believe they would best achieve these goals? Once the goals and motivations for offending are clear, the clinician can work with the individual to identify his strategies to achieve his goals. For example, any planning involved, actions perceived to be successful, and behavioural scripts that may have been formed over time. This also involves identifying the contexts in which the individual is likely to offend and contexts in which they will not offend, such as the presence or absence of other adults. It is important to ascertain which contexts in the individual's life supports offending and triggers motivations to offend.

Implementation refers to the offending and evaluations of outcomes (Heffernan & Ward, 2015). The clinician should establish how the offending occurred and how the offender evaluated his success in offending and whether he thought his strategies should be refined. This indicates the offender's thoughts and feelings towards his offending and provides insight into possible future offending scenarios. Through the use of the AMR, the offender's

dynamic risk factors are conceptualised as the psychological and contextual vulnerabilities that influence their goals and strategies to offend. Thus, the clinician has a causal model specific to the offender that results in a hypothesis as to why the offending occurred.

Phase 4: Future Offending Scenarios

A scenario of future offending is basically a narrative about sexual offending that an individual might perpetrate, informed by the causal mechanisms determined throughout phases 2 and 3. Rather than focusing on prediction of reoffending, the scenarios speculate about what reasonably could happen given the clinician's knowledge and experience combined with the specifics of the case at hand (Guy et al., 2015). Scenarios are "short narratives designed to simplify complex forecasts in a way that facilitates planning" (Hart & Boer, 2010, p. 276). There are countless scenarios that a clinician could come up with for each individual offender, however, these must be "pruned" to include only a few scenarios that are reasonable, credible, and consistent with fact and theory (Hart & Logan, 2011). For example, an offender who may repeat his violent offences may experience stress in his relationships that leads to feelings of anger and insecurity. Motivated by his desire to regain mastery coupled with negative attitudes towards women, denial, and substance abuse, he uses coercion to have sex. The victims are likely to be female adults, that he perceives as denying him sexual gratification which he is entitled to, causing psychological harm and moderate to severe physical harm to his victims. The offender displays chronic risk of sexual violence (Hart & Logan, 2011).

Hart and colleagues suggest consideration of four broad scenarios of violence, which can also be used for sexual offending. The first is a *repeat, flat trajectory, linear projection, or point projection* scenario that reflects the offender's current or most recent sexual offence in which the offender commits a similar act. This repeat scenario asks the question "what would have to happen for the offender to decide to commit this type of sexual offence

again?" The second scenario is the *best case* or *optimistic* scenario. The clinician contemplates scenarios where the trajectory of sexual offending decreases or becomes less serious or severe in nature. The ultimate best case scenario considers the circumstances that would lead to the offender to desist offending altogether. A third scenario, the *worst case* or *doom* scenario considers the possibility in which the trajectory of offending increases and the offender commits a more serious act, such as going from sexual grooming to sexual assault. Lastly, in a *twist* or *sideways trajectory* scenario, the clinician should consider future events in which the nature of the offence changes or evolves. This change in offending can involve the motivation behind the offence, the manner of victim selection, or the type of coercion used. Typically, three to five general scenarios are sufficient in capturing the range of plausible outcomes for a case and these are used to guide the development of intervention plans (Hart & Logan, 2011; Guy et al., 2015).

The RECFM proposes that Hart's approach to scenarios be incorporated with the AMR as the causes of the individual's offending will be better understood during phase 3 of the RECFM compared to previous models of case formulation. The AMR future offending scenarios would speculate on the individual's three levels of agency that influences their goals and strategies in the future. The clinician would further hypothesise on the contexts that interact with agency to suggest the implementation of a future offence whether this is similar to their past offences, an escalation in the type of offence, a different type of offence, or a less severe offence. The scenarios will be based on the facts of the case, the agency model, and existing research and will be used in the next phase to guide implementation.

Phase 5: Intervention Plan

Based on the formulation using the above phases and current sexual offender treatment, the clinician can construct an informed intervention plan. The case formulation provides the basis for determining the offender's treatment needs which are used to

individualise interventions with the aim of achieving optimal outcomes, including reducing reoffending (Vess & Ward, 2011). The offender only receives the treatment necessary to remove his specific problems rather than receiving all the possible interventions that are currently used in a corrections cognitive-behavioural treatment programme (Ward et al., 2000). Guy et al. (2015) recommend the intervention plan adhere to the RNR principles, however, I believe that this is not enough. The intervention plan should integrate the RNR with the GLM and Self-Regulation Model, as suggested by Yates and Ward (2008). Rather than targeting criminogenic needs, or dynamic risk factors in the typical way of identifying them and aiming to reduce or eliminate them, therapists should use the RECFM to guide treatment.

The AMR prioritises building internal and external resources and skills that assist pro-social agency (Heffernan & Ward, 2015). The AMR also identifies the offender's goals and strategies providing an excellent starting point for treatment targets. Therefore the RECFM suggests incorporating offenders' levels of agency and context into their intervention plans. This can be done by working with the offender to realise that the antisocial strategies they employ to achieve their goals are inappropriate and work to find pro-social goals and strategies that work for the individual, taking into account their environment and resources. Offenders should also receive treatment for problems in their life that inhibit their ability to achieve pro-social goals, such as substance abuse and emotional issues, using the knowledge from their identified levels of agency in step 3 of the case formulation.

Consistent with the GLM, it is important when constructing the case formulation and working on a treatment plan with the individual that the clinician regards the offender as an autonomous agent and works *with them* to create a good life plan (Purvis, Ward, & Willis, 2011). The RECFM recommends that clinicians should use the above five steps to develop a detailed treatment plan with GLM elements. The first two steps of the case formulation

provide the necessary information on the social, psychological, and environmental aspects of offending at the time the offence occurred and in the past. This should be combined with the information from the third step of the formulation regarding the offender's behaviours, goals, and strategies identified through the AMR to understand how the offender achieves their primary human goods and their secondary goods. The treatment plan should be set out in specific steps based upon the goals and values specific to the offender (Purvis et al., 2011). In developing the intervention plan, the resources and environment that the offender will have upon release needs to be considered. Thus, to reduce reoffending, offenders need to acquire the necessary skills, attributes, and environments to allow them to pursue their goals in a pro-social and personally meaningful way (Purvis et al., 2011).

Summary

The RECFM provides a step-by-step framework to formulate a case based on the Agency Model of Risk (Heffernan & Ward, 2015), the Good Lives Model (Ward & Gannon, 2006) and previous models of case formulation (Hart et al., 2011). The model's five phases add value to existing case formulation approaches by providing clinicians with a clear guide to formulating a case in a systematic but individualised manner. Each case is analysed using the facts of the case and the relevant risk factors and features for that individual. These factors are integrated with the Agency Model of Risk to produce a visual and narrative model of offending that demonstrates how agency and context interact to inform goals and strategies that eventually lead to the implementation of an offence. Once the potential causes for the offending are identified, the clinician can use the model and case facts to tailor treatment to the individual.

Chapter 4: Case Example: Kevin

The following case example is fictitious and is used solely as an example of how the RECFM could be ideally used in forensic and correctional practice. The case example is designed to enable the reader to understand the RECFM in a more concrete manner and to better grasp its utility in clinical practice.

Developmental History

Kevin's father abandoned him and his mother when he was 6 years old. He was subsequently bought up by his mother who, used alcohol as a coping mechanism and became an alcoholic. Kevin recalls his mother frequently telling him that he was the reason his father left, typically after she had been drinking heavily. Kevin's mother began a new relationship with a man when Kevin was 14. His step-father had two daughters from a previous marriage aged 3 and 5. Kevin's step-father was frequently away for weeks at a time for work and on his return was frequently aggressive towards the family. Both Kevin's mother and step-father became increasingly hostile and abusive towards Kevin, who regularly felt rejected and jealous of his step-sisters who received less abuse. His parents became more neglectful and abusive towards all three children as their alcohol abuse became more severe.

As the neglect by his mother and her partner continued, Kevin became rebellious and disruptive throughout his teenage years, getting into physical fights with other students. Kevin's grades slipped and he did not have many friends. Kevin was frequently in trouble at school because of his violence and aggression but his mother and stepfather did not seem to care. Around age 13, Kevin described his first sexual attraction to girls of his age. However, he did not attempt to engage in any form of intimate relationships with the girls at school as he believed he was 'a loser' and they would reject him. Kevin felt as though the girls in his classes were laughing at him and teased him behind his back. Instead, he learned about sex

and sexuality through the pornographic magazines his step-father owned, and as he got older, he turned to the internet to obtain pornography.

At age 15, Kevin made friends with a group of older boys at school who introduced him to smoking and drinking. Kevin would frequently stay over at one of their houses to avoid going home. At home, Kevin and his half-sisters were subjected to psychological and physical abuse from his mother and step-father. Due to the abuse and failing grades, Kevin felt miserable at home and at school, his only form of enjoyment came from his antisocial peer group. He felt like he finally had some friends who would look out for him even though they encouraged delinquency. Kevin reports that he and his friends would steal from shops and planned to rob houses in the neighbourhood to get items to sell for cash. During an attempted robbery at age 16, he and his friends were caught by police and dealt with by the Youth Court who ordered restitution and 150 hours of community work.

Throughout his teenage years, Kevin's interest in pornography grew and he started using the internet for pornography more frequently. He found that he spent a lot of his time surfing the web for pornographic material and sexually explicit chat sites. Kevin eventually grew bored with "normal" pornography and developed an interest in, and arousal for, violent pornography. He recalls feeling more excited than he had before when he first came across violent sexual material online.

Adult Life Prior to and Leading up to Offending

When Kevin was 17, he became employed at his local McDonalds and helped to pay for food and bills at home. At 18 he moved out of home into a rental with one of his friends from work. During his late teens, Kevin had a few intimate relationships with females and reports feeling frustrated and unhappy during this time. These relationships ended quickly and made Kevin feel inadequate and angry. He frequently found himself getting into drunken fights on nights out with his friends. Kevin would go out on the weekend drinking or had

parties at his flat where he would drink and smoke marijuana. Sometimes, he would get drunk and attempt to engage in sexual activity with an intoxicated girl at these parties. These sexual attempts would typically end in rejection, which increased Kevin's aggression and hostility towards women. Kevin was often angry and depressed about his loneliness. Due to these failures with women in real life, he would resort to using pornography for sexual satisfaction.

At age 21, Kevin became an apprentice in building and construction and moved into a small flat on his own. However, due to his drinking he was always in trouble at work for being late. Yet his boss frequently gave Kevin second chances and said he saw potential in Kevin to become a great builder. Kevin liked his boss and reports feeling supported, believing that if he ever needed help with something, his boss would be there for him. Determined to get his life on track, Kevin stopped drinking for a little while. During this time he met Holly at a work function. Like Kevin, Holly had grown up within an abusive family and experienced a lonely childhood. They married when Kevin was 24 and she was 23. Kevin described their relationship as happy in the beginning. He became a qualified builder and started his own business, while Holly trained as a teacher. They had two children together several years after getting married.

However, after several more years Kevin's business was not doing well, putting significant financial strain on the family. Kevin and Holly's relationship became volatile as they frequently argued over money and work. Kevin began drinking again and reported feeling like he was destined to fail. He said that although he loved Holly, he was sick of her acting like it was all his fault that they were in trouble. Kevin recalled that they rarely had sex anymore and when they did it was "boring" and he wasn't satisfied. He knew she was only having sex out of obligation, which made him feel angry and rejected. He began having recurrent sexual thoughts about violent sex with women that he would see in the streets.

Holly became increasingly distant and went out a lot with her friends leaving Kevin at home to look after the children. Kevin remembers that during these nights, he would put the kids to bed and drink heavily, feeling sorry for himself and thinking that Holly was having an affair. At age 30, Kevin decided he had had enough. After a night of drinking he accused Holly of cheating on him. She admitted that she was in a relationship with another teacher from the school she worked at. She told Kevin that she felt he didn't care for her anymore and he wasn't interested in her sexually and that she needed more from life. Kevin stated that he was extremely angry and felt like a complete failure.

Kevin felt overwhelmed with how much his life had gone downhill. He described himself as feeling constantly angry and let down by the world. He felt he deserved more than a failing business and a cheating wife as he had worked so hard.

The Offence

Kevin explained his offending as his way of regaining some control in his life while also looking for sex and intimacy. He had not had sex with his wife for a long time and was angry that his wife had cheated on him. When Kevin first offended he had been drinking. He had been thinking about sex with another woman for a couple of weeks since learning about his wife's affair. In these couple of weeks Kevin had returned to watching violent pornography and fantasised about acting these scenes out. Kevin met a woman at the pub that he had seen there on a number of occasions and who he found attractive. Kevin began flirting with her and arranged to meet up on a date. After the date he offered to walk her home which she accepted. As she was opening her door, Kevin pushed her inside and violently raped her. He threatened to come back and kill her if she ever told anyone. Kevin recalled being extremely excited during the offence and feeling in control and powerful. He stated that he thought the woman was flirting with him and really wanted to have sex with him. Although he said that he knew what he did was wrong, he wanted to do it again. A couple of weeks

later, Kevin went back to her house and said if she did not let him in, he would break in and kill her. She agreed and he attempted to rape her again. However, a neighbour heard her scream and phoned the police who subsequently arrested Kevin.

Case Analysis of Risk Etiology Case Formulation

Phase 1: Identifying Facts

Kevin's only previous convicted offence was attempted robbery when he was 16. However, Kevin reported also stealing items from local shops for fun. The recent sexual offences were the rape of a woman that Kevin had only known for a few weeks. The rape and attempted rape were violent and highly traumatic for the victim. The victim was a 25 year old female who lived alone. The sexual abuse only ended due to Kevin's arrest, he indicated that he would not have stopped otherwise. Kevin was convicted of sexual violation and assault with intent to commit sexual violation.

Phase 2: Identify DRFs, PFs, and Relevant Features

Static Factors. In this phase, features and risk factors that are present and relevant to the offender are described. According to the Static-99, which measures long-term risk potential using static (unchangeable) factors (Hart, 2009), Kevin displays the following risk factors; unrelated victim and stranger victim. He has a total score of 2 out of 12, which gives him the risk potential of moderate-low. However, static factors are not the only factors to consider.

Dynamic Factors. Using the STABLE-2007, Kevin displays a number of dynamic risk factors: significant negative social influences, intimacy deficits, attitudes supportive of sexual assault, general self-regulation problems, and sexual self-regulation problems. Kevin's significant social influences include his mother and stepfather. They were physically abusive towards him and his sisters during his childhood which taught Kevin that violence was normal and an appropriate way to control situations. This lead to him using violence in his

own life, evidenced by the fights he was involved in as a teenager and his preference for violent pornography. His mother and stepfather modelled pro-criminal attitudes and activities through their abusive behaviours and substance abuse. As Kevin grew up, his peer group were negative social influences who supported antisocial behaviours and criminal activities. On the other hand, Kevin's wife Holly was a positive social influence in his life, despite the affair. She promoted pro-social values and discouraged Kevin's alcohol abuse and violent outbursts. She encouraged and supported Kevin to succeed in his business and regarded him as a good father. Through her teaching role, Holly provided material support such as finances, food, and shelter for the family. She is aware of Kevin's sexual offences and is willing to work with probation officers and Kevin to help him in treatment.

Kevin also displays the dynamic risk factor of intimacy deficits. Kevin's abuse, rejection, and lack of support from his parents in childhood lead to an insecure attachment style causing Kevin to experience emotional loneliness and difficulties in relating to other people. Due to his problems forming relationships, Kevin was heavily influenced by the violent pornography he watched growing up, which encouraged inappropriate intimate behaviours. Although Kevin had a long-term relationship with his partner, they often argued with each other. Both partners have said that they truly care about each other but they did not know how to show it. Kevin recalls that he and his wife were unhappy but refused to talk about their problems, which made him feel lonely and rejected. He also exhibits signs of hostility towards women. He believes that women are not to be trusted and lie to get men to do what they want. He displays sexist attitudes towards women believing that they are sexual objects for men's satisfaction. Overall, Kevin is lonely, he doesn't have many friends and he isn't intimately close with his wife. He feels like the world is against him and it is not his fault.

Kevin has minor general self-regulation problems such as low levels of impulsivity. His impulsive behaviour is evident in his substance abuse of alcohol and tendency to start fights. He displays negative emotionality, feeling everyone is against him, and that he cannot cope. He does not deal with stress appropriately and tends to overreact, sometimes aggressively. Kevin also shows signs that he has problems with sexual self-regulation. He spends large amounts of time surfing the web for pornography and uses the internet primarily to access sexually explicit websites and chat rooms. He frequently fantasises about sex with other women, often with a violent component. Sometimes he found these thoughts to be disturbing as he knew they were not considered normal. He used his sexual offences as a way to cope with the humiliation and anger he felt that his wife had been cheating on him. Kevin also reports that when he was particularly stressed over work or money he would increase the amount of pornography he viewed or manipulate his wife into sex. His deviant sexual interests involve non-consenting adults and sexualised violence.

In line with Mann et al.'s (2010) list of empirically supported risk factors, Kevin also exhibits offense supportive attitudes. He believes that women are sexual objects and enjoy being forced into sex. In particular, he believes that his victim seduced him by flirting and accepting the date. Kevin also reports that he felt he deserved to have sex with somebody after his wife had sex with another man. Furthermore, he shows signs of dysfunctional coping by managing his negative emotions (loneliness, anger, stress, rejection) through heavy drinking. This risk factor overlaps with the substance abuse sub-domain of self-regulation deficits.

Protective Factors. Using de Vogel et al.'s (2011) protective factors measure SAPROF, Kevin displays elements of both internal and external protective factors. The internal protective factors Kevin possesses include his intelligence. He is an intelligent person who is capable of learning new skills, which may provide him with the ability to succeed in

turning his life around. His motivational protective factors include his work, life goals, attitudes towards authority, and motivation for treatment. He is motivated and dedicated to fixing his failing business, his life goals are to become a successful builder who can provide for his children. Kevin has demonstrated motivation for treatment, reporting that he wants to change and work with therapists to get better.

Phase 3: Identification and Integration of Causal Factors through AMR

The RECFM's third step involves describing Kevin's levels of agency to identify the causes of his sexual offending. The level of personal identity comprises of Kevin's values, beliefs, and his priorities in life. Kevin had a difficult childhood in which he was abused by his mother and step-father and abandoned by his father which led to difficulties in attachment. He feels rejected, emasculated, and misunderstood. Constant rejection by his parents and women his own age has caused Kevin to feel isolated, lonely, and unhappy. Therefore, Kevin displays intimacy deficits that hinder his relationship with his wife causing a breakdown in the marriage and his wife's affair. He believes women should be faithful to their men and his wife cheating on him threatened his masculinity. Kevin values success and his failing business has resulted in him feeling like he is a disappointment. He prioritises having control of his life and desires sex and intimacy. Thus, Kevin's personal identity contributes to the causes of his offending through his values and beliefs about women and masculinity, and his goals of sex and intimacy.

Kevin's social roles level of agency includes his role as father to two young girls and husband. He is perceived as being a good family man which he uses to his advantage as others view him as respectable and approachable. He is also a business owner which provides him with the responsibility and skills he needs to be financially successful and respected by others. The final level of agency, systems-level, is Kevin's arousal by sexualised violence and coercive sex. At the time of the first offence, Kevin was intoxicated which reduced his self-

regulation capacity to not offend. However, arousal alone became a strong motivator to experience sexual satisfaction and offend against the victim a second time.

As it is clear that Kevin highly values sexual satisfaction and intimacy and displays the distorted belief that women want sex and like being forced into sex, it is now possible to understand Kevin's goals and motivations behind his offending. Kevin's ultimate goal is to experience sexual pleasure and intimacy with a partner. Kevin wants someone who won't reject him and wants to have sex with him as well. He wanted to have sex with young women as he is sexually attracted to them and believed that they would enjoy it. He also wanted to experience control and power over a woman as he felt humiliated by his wife. Kevin thought that the best way to achieve this was by having sex with a woman he did not know.

Kevin's strategy to obtain his goal of sex with a woman was planned in advance and influenced by his deviant sexual interests. The implementation of the offences occurred at the victim's house which Kevin forcibly entered. However, Kevin's strategy of befriending a woman changed during the second sexual offence as he had to resort to threats to gain access to the victim. Kevin's levels of agency and context are reciprocal. He was influenced by the context of rejection by his wife, trying to date again, and being around women who are under the influence of alcohol. Yet due to Kevin feeling lonely, rejected, and entitled to sex plus being aroused by women, he directly seeks out these contexts so that he can implement his goals of sex and control. Kevin's dynamic risk factors that were identified in the first phase can be reconceptualised as aspects of his agency that impair his normal functioning. His intimacy deficits indicates his problems in achieving interpersonal goods (Heffernan & Ward, 2015) and contributes to his personal identity. He feels lonely, rejected, and entitled to sex. His loneliness and humiliation is caused by the interpersonal conflicts and rejection by his wife which has produced the goals of sex with women. The hostility he feels towards women

leads him to believe they are manipulative and get whatever they want which results in his goal of exerting control and power over women.

Kevin's self-regulation problems make it difficult for him to achieve primary goods such as excellence in agency and inner peace, as well as excellence in work and play. He acts impulsively using alcohol as a coping method. His sexual self-regulation problems are evident in his obsession with violent pornography which has resulted in thoughts about violently raping a woman in real life. Therefore, his offences are planned explicitly to achieve his goals. Kevin's offence-supportive beliefs conflict with society's norms and are maladaptive. He believes he is misunderstood and entitled to sex as women are sexual objects for men's pleasure. He also believes the world is a bad place and that people are "out to get" him. These beliefs influence the goals and strategies he uses, such as pornography, to arouse himself and prepare for his offending. Kevin's personal identity issues surrounding his beliefs, values and goals, social roles of respectable family man, and systems level of deviant sexual arousal individually are not enough to cause his offending. However, when these elements combine in conjunction with the contextual factors outlined above, we can see how the information gathered in this formulation is operating to cause his offending (see Figure 3.).

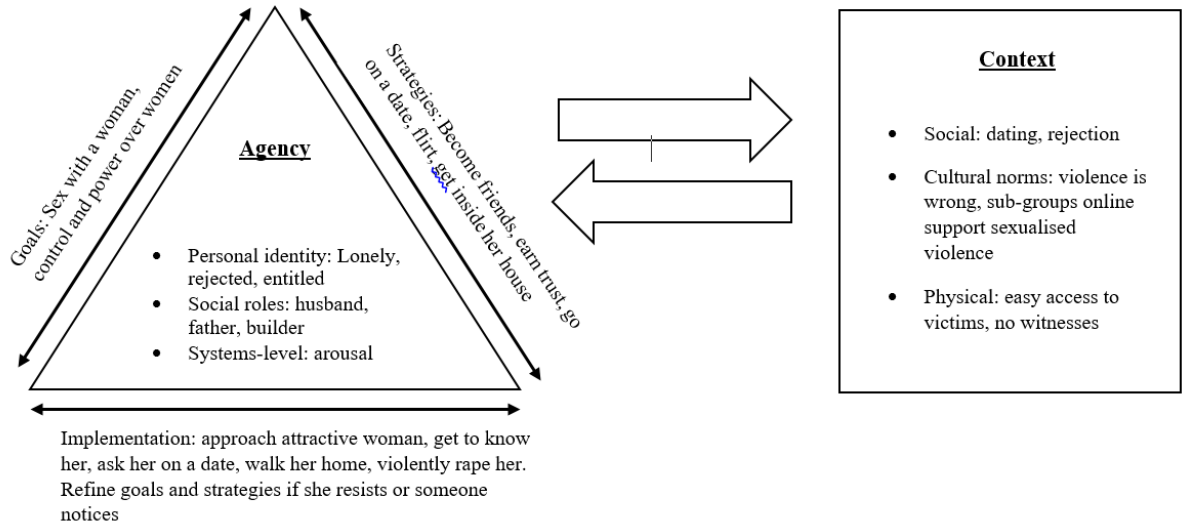

Figure 3. The AMR for Case Example: Kevin

Phase 4: Future Offending Scenarios

In a *repeat future offending scenario* the offender commits a similar sexual offence that reflects the offender's most recent offence. In this case, Kevin's personal identity would be the same, he would continue to feel emotional loneliness and entitlement and still believe that he is a failure. He would not have many friends and stay isolated and lonely. His social roles would also remain the same, he would come into contact with another woman that he found attractive and have the same disturbing sexual thoughts. He would be motivated by his goals for sex and control and his inability to form an appropriate sexual relationship. In a similar situation, Kevin would try to form a relationship with a woman where he is trusted and work his way into their house where he can offend again.

In a future scenario where Kevin's crimes *escalate in severity*, it would be possible that he hurts the victim so severely that she is hospitalised. He could even kill his victim. Kevin's strategies would change from forming a trusting relationship with the victim in order to get into their house to breaking into women's houses to rape them. In this situation, Kevin's goals of sex and control are the same but the outcome is more severe. Alternatively, Kevin's sexual offending could escalate in terms of higher numbers of victims. He may

become confident that he will be able to manipulate women into having sex with him and attempt this with more victims. Therefore his goals may shift to sex with multiple partners and his strategies would involve the selection of more women rather than focusing on one. The implementation of the offences would remain the same.

In *a best case scenario*, Kevin would have undergone treatment for his sexual offending and alcohol abuse. He would have learnt prosocial skills to enable him to form relationships with adults, both friendships and intimate relationships. Kevin would be able to control his violent sexual urges and distorted cognitions about women as sexual objects and desist from offending altogether. Kevin would also feel less lonely and less inclined to think that "the world is against" him leading him to want better things from life. His goals would no longer focus on sex and control of women but rather intimacy with a partner. He would learn new strategies to appropriately form intimate relationships and successfully implement these without the need for offending.

Phase 5: Intervention Plan

Kevin's treatment plan is based on the above case formulation using the AMR and the GLM to develop a good life plan. First of all, Kevin's treatment should adhere to the principles of the RNR but with the GLM and AMR guiding the application of these principles. Kevin's treatment plan should reflect his level of risk. His treatment should target his range of "criminogenic needs", reflecting the factors identified in phase 2 and their integration with the AMR in phase 3 of the formulation. Also, the treatment strategies should match his characteristics; these treatment strategies will follow the responsivity principle as the case formulation is specific to Kevin as an individual.

In the first step of developing a treatment plan for Kevin, the beginning phases of his case formulation provides the vital information on his social, psychological and environmental factors that influence his offending behaviours. The social factors include his

role as a father, his relationship with his parents and wife, and any friendships. His psychological factors involve his substance abuse, intimacy deficits, self-regulation problems, (general and sexual), and his attitudes supportive of offending. The environmental factors consist of the context in which the offending occurred, also his employment status and financial status. In combination, these influence his offending actions, which are driven by his goals, values, and pursuit of his primary human goods. The next step involves identifying the functions of Kevin's offence-related actions by using his individualised AMR. The purpose of Kevin's offending is to achieve his goals of intimacy and sex with a female and to exert control over a female. These goals correspond with the primary human goods of excellence in agency, relatedness, and states of happiness and pleasure. However, Kevin lacks the capacity and the means to achieve these goals which leads to the sexual offending strategies identified in phase 3 of the formulation.

In developing a good life plan for Kevin, his resources and environment upon release needs to be considered. He will need to be in an environment that discourages alcohol and receive treatment for his substance abuse. He will also need to work towards being financially stable and restarting his career. First of all, Kevin should receive help in developing pro-social goals such as learning to experience intimacy in an appropriate manner. His treatment should also focus on learning to manage his hostility and desire to control women and form meaningful relationships. Treatment should use CBT techniques to help Kevin develop the skills and attributes that are necessary to achieving his prosocial goals.

Chapter 5: Evaluation, Future Directions, and Conclusions

The first chapter in this thesis argued that the conceptualisation of risk, risk assessment, and case formulation is problematic because it is based on a flawed theoretical notion of dynamic risk factors. Throughout the subsequent chapters, dynamic risk factors were reconceptualised using the AMR to create a contemporary case formulation framework. A case example was provided to demonstrate how the RECFM can be applied in a real world situation. In this final chapter, I will evaluate the implications of the RECFM as a theoretical framework and as a guide to practice. Two major points will be addressed; how the RECFM can contribute to the risk-related sexual offending theories, and how the RECFM can be used to benefit clinical practice. Firstly, I will consider the theoretical significance of the RECFM to the offending literature. I will also discuss the model's strengths and weaknesses as a theoretical framework. Furthermore, I will evaluate the potential practical implications that the RECFM will have in the treatment of offenders for both the offender and the clinician. I will also suggest future research before providing an overall conclusion on the addition of the RECFM to the offending literature.

Theoretical Implications:

First, the RECFM is a novel framework that explicitly explains how to formulate a case based on the recently developed AMR and the well-established Good Lives Model. The RECFM aims to provide clinicians with a much needed guide as many researchers and clinicians view formulation as fundamental to forensic services and an essential skill for therapists (Eells and Lombart, 2011; Davies et al., 2013). Despite this widely held view, research on formulation has not been a major focus until very recently. The key aim of the RECFM is to integrate a reconceptualised version of dynamic risk factors into a case formulation model. The RECFM contains the basic ideas of early models of case formulation;

namely that a case formulation should be individualised and be used to inform intervention. As with other case formulation models, the RECFM begins with observing and describing basic factual information and then inferring underlying causes and any relevant contextual factors. Ultimately, a case formulation should provide a model of the causes of offending. Thus, the RECFM is built on the aspects of case formulation models that are accepted as being reliable and valid.

Previous models of forensic (and correctional) case formulation have assumed that dynamic risk factors are actual causes of offending which, as discussed in the previous chapters, is a flawed conception. Dynamic risk factors are *composite c*onstructs, meaning that each dynamic risk factor is constituted by multiple variables, which while useful as a means of predicting risk are unable to explain offending and its associated problems (Ward, 2016). Thus, the RECFM uses the relatively novel reconceptualization of dynamic risk factors as markers of vulnerabilities, mental states, and contextual features rather than as direct causes. A strength of the RECFM is its sound theoretical foundations; the AMR and the GLM, which argues that agency and context are necessary components for offending. According to these theories, an individual's values, beliefs, and goals, as well as context, influences behaviour. Dynamic risk factors can be broken down into elements that effect a person's agency or context but do not directly cause offending on their own, instead they can be thought of as markers for the psychological and social causes of offending (Ward, 2016). The use of the RECFM is arguably more likely to identify relevant causal mechanisms by virtue of its focus on individuals' cognitive, affective, and behavioural processes; which interact with contextual factors to result in offending.

As the RECFM is a new theoretical framework based on other theoretical works, it lacks empirical evidence of its utility. The AMR is also a recent theory that has not been directly tested. Also, the GLM has not received the same degree of research as other theories

such as the RNR. However, developing the RECFM is only the first stage in the advancement of case formulation and risk factor research. Future research can, and no doubt will, expand and alter aspects of the RECFM as knowledge in this area develops. It will be necessary for research to establish that the RECFM can be applied to all types of sexual offending; but still in an individualised manner, therefore case studies are essential to evaluating the model. Research can begin to test the model for differences between case studies using traditional case formulation methods, a RNR-based risk assessment, and the RECFM. This will allow researchers to discover whether using the RECFM can produce a deeper understanding of the causal mechanisms generating an individual's offending in comparison to other forms of assessment.

Practical Implications

Early models of case formulation were vague in stating how best to conduct a formulation, which lead to difficulties in clinicians reliably and validly identifying target behaviours. Clinicians also found it difficult to infer the underlying mechanisms generating symptoms and problems (Beiling & Kuyken, 2003); which may have been due to ambiguous formulation guides (Kuyken et al., 2005). Recently, formulation researchers developed features and guides that describe the elements considered fundamental to the process of case formulation (Hart, 2011; Guy et al., 2015). The aim was to benefit clinicians by reducing the ambiguity in the formulation process and improve outcomes. However, these guides still led to mixed results (Davies et al., 2013). Due to the guides focusing on risk prediction rather than understanding the causal mechanisms of offending, modern case formulation models are cumbersome and inefficient when applied to the forensic psychology area.

In the dynamic risk and case formulation literature, the failure to recognize that there is a conceptual difference between prediction and explanation is common (Ward, 2016). This failure has led to dynamic risk factors being accepted as causal mechanisms which has

produced tools such as case formulation that fail to refer to the actual causes of offending and thus, do not adequately respond to offenders rehabilitation needs.

Hence a key aim in developing the RECFM is to provide clinicians with a guide how to conduct a formulation rather than a list of *what* needs to be included, an aspect that previous models have lacked. Hart et al's model focuses on features of a formulation, what the clinician needs to include and merely states what each step involves. Whereas a strength of the RECFM is that it explicitly states how each step should be conducted and stipulates how to utilise dynamic risk factors when formulating a case and constructing a treatment plan. Therefore, by developing the RECFM, I am seeking to increase the reliability and validity of case formulations by reducing the clinician's uncertainty in formulating the inferential part of the case.

The RECFM adds value to existing case formulation research as the five phases are explicit in including the causes of offending for each individual by utilising reconceptualised dynamic risk factors and the AMR. Previous models have used dynamic risk factors as putative causal mechanisms on their own, which is an inherent problem in the risk literature. Dynamic risk factors are reconceptualised as suggested by Ward (2016) Heffernan and Ward (2015), and Ward and Durrant (2015) as markers for causal processes. By incorporating the AMR into the RECFM, clinicians are provided with a template to work from without removing the individuality that formulation requires. Using this framework, the clinician can tailor the formulation to the individual and use the knowledge of how the offender's life history, behaviours, and risk factors inform their goals, values, and beliefs regarding their offending.

Importantly, the framework recommends that clinicians use the RECFM and AMR during phase 3 as a visual model when formulating a case. The significance of using a visual model for case formulation will hopefully benefit the clinician by providing them with the

means to organise and understand the offender's information. The result of this is that the clinician will arrive at a well-formed, theory-based causal hypothesis of offending. A further strength of the RECFM is its value in aiding the clinician to find the appropriate treatment needs for the specific individual by using the information gathered throughout the five phases and by relying on current theoretical and empirical evidence. This will enable offenders to receive the treatment likely to benefit them the most, and ideally, reduce their recidivism. In gaining a full understanding of an offender's history, their risk factors, their agency and the context in which they offend, clinicians are better equipped to confidently and accurately hypothesise on the causes of offending for an individual and implement treatments that will be more effective.

Future Directions

The RECFM is a new framework based on both contemporary theories; the AMR, the RNR, and the GLM. This novel framework provides the opportunity for more research in the case formulation area, something that is urgently needed to benefit both clinicians and offenders. The RECFM is the one of the first frameworks to use the AMR as a key component of a theoretical model with the purpose of being applied to clinical practice. Both the RECFM and AMR provide a new way of thinking about dynamic risk factors in case formulation and traditional risk assessment. The RECFM is also the first case formulation model to utilise dynamic risk factors in their reconceptualised form. It is important to capitalise on this theoretical work and for future research to assess the utility of the RECFM and the AMR. For example, future research can ask the question "does the reconceptualization of dynamic risk factors and the application of the AMR contribute to the outcome of the case formulation?" Also, it would be essential for future research to identify the reliability and validity of the RECFM compared to other forensic case formulation models by having trained clinicians apply each method to case examples.

Concluding Remarks

The literature on risk assessment and risk factors has evolved substantially over the last few decades, from professional judgement to actuarial risk assessment to a combination of the two. The result has been the development of a number of excellent risk assessment instruments and methods that have increased the reliability and predictive validity of assessment compared to professional judgement alone (Hart & Logan, 2011). However, our understanding of the nature of dynamic risk factors and their theoretical elaboration has not kept up with this technical progress. In fact, only recently has it been argued that researchers have made conceptual mistakes (a) in assuming they directly refer to the causes of offending and (b) by conflating the contexts of prediction and explanation (Ward, 2016; Ward & Durrant, 2015). The development of case formulation models in the forensic and correctional areas is a good idea, but we need to make sure that in our haste to come up with better assessment frameworks we do not -theoretically speaking- jump from the frying pan into the fire. There is a real danger that if the problems dynamic risk factors face of poor specificity, incoherence, and lack of reference are not sufficiently appreciated by researchers and practitioners, then interventions with offenders will not be as effective as they could be. I argue that theory formation and development should guide assessment and not be an afterthought. To formulate a case well we need to be clear about what is going on and be able to infer the causes of crime and its problems in ways that goes beyond risk prediction and management. My hope is that case formulation frameworks such as the RECFM will help in this journey.

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