

# Case Formulation in the Treatment of a Man With a History of Sexual Offenses: A Network Approach

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## Abstract

Prevention of sexual reoffending is the primary goal of forensic treatment for individuals with a history of sexual offenses. Risk assessment and case formulation form the foundation of cognitive behavioral therapy informed forensic treatment. Integrating both into practice, however, is not always straightforward. This case study explores how risk assessment and case formulation can be integrated using the network-based model of risk of sexual reoffending (NBM-RSR, hereafter referred to as the NBM-RSR case formulation). Peter's NBM-RSR case formulation illustrates the contribution of his own experience of sexual abuse to the development of dynamic risk factors. The interconnections between these factors provide insight into their role in his risk of sexual reoffending. Peter's risk of reoffending appears to emerge from two clusters of dynamic risk factors: one involving emotional loneliness, feelings of shame and guilt, and the other consisting of exhibitionistic fantasies, sex as a coping mechanism, and contact with unknown women and girls. The need for validation and the use of sex as a coping mechanism form the link between these two networks. This case study demonstrates that the NBM-RSR case formulation provides an explanatory model for the onset and maintenance of sexual offending. It provides practical guidance for forensic treatment and helps formulate and prioritize treatment goals through analyzing how dynamic risk factors interconnect.

## Keywords

forensic case formulation, sexual reoffending, dynamic risk factors, risk assessment



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## Highlights

### ***NBM-RSR case formulation:***

- maps dynamic risk factors in a causal network to tailor reoffending risk.
- integrates risk assessment and case conceptualization.
- supports structured and transparent treatment prioritization.
- strengthens clinical decision-making in forensic practice.

*Peter, a twenty-seven-year-old man with no reported significant somatic medical conditions, was referred by his probation officer for forensic outpatient treatment in the eastern part of The Netherlands. He shared unsolicited nude photos and videos of himself with both adult women and underage girls through social media. The images showed him masturbating. He was also suspected of grooming underage girls. Peter first encountered the justice system at the age of 15, when he was reported to the police for repeated incidents of indecent exposure. Specifically, he exposed his genitals to unknown girls and adult women in public settings, which resulted in a referral for forensic outpatient treatment. At approximately 22 years of age, he was again subject to a police investigation, this time as a suspect in an alleged sexual offense involving a minor. Peter denied the allegations, and the case did not lead to prosecution.*

*Peter attended the admission session accompanied by his current partner, with whom he was cohabiting at the time. He had previously lived with a different partner, and in all cases – including his current relationship – he had never lived with a partner for longer than two years. He had multiple periods of romantic involvement and engaged in casual sex. Peter appeared quiet, hesitant, and visibly ashamed. He openly acknowledged having no understanding of how to prevent sexual offending in the future.*

General practitioners or probation services refer clients like Peter for forensic treatment with the primary goal of preventing future sexual offending. Treatment providers use risk assessment instruments to evaluate the likelihood of these offenses at the start of the treatment. Based on the outcomes of these instruments, treatment duration and intensity are determined (Bonta & Andrews, 2023; Hanson et al., 2009). Additionally, they collaborate with the client to explore how his sexual offending developed and was maintained by his learning history. This process is called case formulation (Craig & Rettenberger, 2022). Both risk assessment instruments and case formulation identify risk

factors for future sexual offending and inform the development of the treatment plan. Despite this shared goal, integrating the two approaches remains challenging.

This case study introduces the recently developed network-based model of risk of sexual reoffending (NBM-RSR; van den Berg et al., 2024). This model conceptualizes the risk of sexual reoffending as a network of causally connected dynamic risk factors. Recognizing how these factors interrelate in an individual helps prioritize treatment goals (van den Berg et al., 2022). The study describes how Peter and his therapist work together on an NBM-RSR case formulation (referred to as the NBM-RSR case formulation). The study will begin by examining risk assessment instruments and their current role in treatment.

## Risk Assessment Instruments

In the Netherlands and Flanders, the STATIC-99R, STABLE-2007, and ACUTE-2007 are used to assess the risk of reoffending in men with a history of sexual offenses (respectively: Phenix et al., 2017; Fernandez et al., 2017; Fernandez et al., 2014). These instruments contain items (i.e., risk factors) that have been scientifically linked to future sexual offenses. Such risk factors can be categorized as static or dynamic (Hanson & Harris, 2000). Static risk factors do not change through treatment. These factors can be scored using demographic data, information from criminal records, and information about victims. They include the current age, whether the person has cohabited with someone, the number and types of previous offenses, the relationship to the victims, and the victims' gender. The STATIC-99R is an example of a risk assessment instrument that contains only static risk factors. Dynamic risk factors, however, are subject to change. Changes in these factors lead to changes in the risk of sexual reoffending (Babchishin & Hanson, 2020; Bonta & Andrews, 2023; Mann et al., 2010; Olver & Stockdale, 2020; van den Berg et al., 2018). Dynamic risk factors can be further divided into stable and acute dynamic risk factors (Hanson & Harris, 2000). Stable dynamic risk factors are relatively resistant to change and require significant effort from both the client and therapist. These factors include personality traits, learned behaviors, and skill deficits (Uzieblo et al., 2024). Examples of stable dynamic risk factors include patterns of impulsive behavior, inadequate problem-solving skills, a pervasive sense of social rejection and/or loneliness, sexual motivation/preoccupation, and deviant sexual preferences or interests (e.g., a fetish or sexual attraction to prepubescent children). Acute dynamic risk factors can change rapidly and may lie beyond the client's sphere of influence (Uzieblo et al., 2024). Examples of such factors include access to victims, substance abuse, emotional breakdown, or the loss of social support. The STABLE-2007 and ACUTE-2007 risk assessment instruments designed to assess respectively stable and acute dynamic risk.

Risk assessment instruments play a crucial role not only in estimating the risk of reoffending but also in determining treatment duration and intensity, setting treatment goals, and evaluating treatment effectiveness.

## Treatment Duration and Intensity

The risk of recidivism for men with a history of sexual offenses can for example be assessed using the total scores from the STATIC-99R and STABLE-2007 in The Netherlands and Flanders. For men whose STATIC-99R/STABLE-2007 combination falls within the lowest risk category, the likelihood of future sexual offending is comparable to that of individuals previously convicted of non-sexual offenses (Hanson et al., 2017). Over follow-up periods of 1, 3, and 5 years, approximately 0%, 3%, and 3% of men in this category reoffended with a new sexual offense, respectively (Brankley et al., 2017). Due to their relatively low risk of reoffending, forensic treatment aimed at preventing future sexual offending offers little added value for clients whose total scores fall within the lowest risk category. Men whose scores fall within the two highest risk categories, however, are approximately two to four times more likely to commit a new sexual offense than the average man previously charged or convicted of such offenses. Over follow-up periods of 1, 3, and 5 years, approximately 4%, 12%, and 14% of men in category IVa, and 15%, 22%, and 27% of men in category IVb, respectively, were charged with or convicted of a new sexual offense (Brankley et al., 2017). In such cases, in accordance with the risk-need-responsivity (RNR) principles, more intensive and longer-lasting therapy is indicated to reduce their risk (Bonta & Andrews, 2023; Gannon et al., 2019; Hanson et al., 2009; Holper et al., 2024; Schmucker & Lösel, 2017). According to the RNR model, not only should the intensity of intervention correspond to the individual's level of risk (risk principle), but treatment should also target dynamic risk factors (need principle). In addition, interventions should be tailored to individual characteristics, such as cognitive abilities, motivation, and learning style, in order to maximize treatment effectiveness (responsivity principle; Bonta & Andrews, 2023).

*During Peter's admission session, the STATIC-99R and STABLE-2007 were administered to assess the risk of sexual reoffending. For the STATIC-99R, data were derived from official records, including criminal history, pre-sentencing and probation reports, and prior treatment records. For the STABLE-2007, a semi-structured interview was conducted according to the instrument's guidelines, gathering information from both Peter and his partner, with whom he was cohabiting at the time. Additional clinical data were obtained after the admission session through self-reports and observations during therapy sessions, whereas information from involved family members was collected at a subsequent stage (e.g., Peter's parents and brothers). Peter had a*

*total score of 4 on the STATIC-99R. This score reflected his age (at the time of conviction), his conviction for a non-contact sexual offense, as well as offenses involving unknown victims and victims outside the immediate family. On the STABLE-2007, Peter scored a total of 9. The stable dynamic risk factors contributing to his score included significant social contacts, the capacity for relationship stability, social rejection/loneliness, sexual motivation/preoccupation, using sex as a coping mechanism, and deviant sexual preferences or interests. The STATIC-99R/STABLE-2007 combination resulted in a category IVa classification, representing the second-highest risk level.*

*Following a review of the information obtained during the admission session and the risk assessment, the multidisciplinary team recommended that Peter participate in the multi-day outpatient treatment program for individuals who had committed sexual offenses. This recommendation was communicated to Peter, who agreed to participate. The treatment program was structured and adopted an integrative approach, incorporating principles from cognitive-behavioral therapy, schema therapy, and client-centered therapy. Each day began with a session in which participants reported progress on their personal goals and concluded with a daily reflection, including adjustment of learning goals if necessary. These goals targeted dynamic risk factors as well as aspects contributing to overall well-being and fulfillment. Core components included integrative psychotherapy addressing personal vulnerabilities and internal processes related to offending behavior, structured offense prevention with analysis of the individual offense chain and development of a personalized relapse prevention plan, psychosomatic care monitoring physical complaints and medication effects, sexual health counseling to promote healthy sexuality and relationships, and experiential therapies, such as drama and art therapy, to enhance emotional awareness and behavioral skills through action-based work.*

## Formulating and Evaluating Treatment Goals

Once treatment is indicated, the next question is which specific areas it should target to effectively minimize the risk of reoffending. The results of the STABLE-2007 and ACUTE-2007 are used to answer this question. After all, these instruments identify risk factors that can be addressed through treatment or risk management, and changes in these factors directly impact the likelihood of reoffending. Additionally, these tools are used during treatment evaluations to objectively measure progress. For example, if a

treatment goal is set to learn alternative ways of coping with loneliness besides using sex, one would expect a decrease in the item sex as coping.

Cognitive behavioral therapy is the treatment of choice for individuals with a history of sexual offenses (Gannon et al., 2019; Hanson et al., 2009; Schmucker & Lösel, 2017). This approach begins with the client and therapist collaboratively forming an explanatory model for the onset and maintenance of offending behavior, known as the case formulation (Craig & Rettenberger, 2022). Based on this formulation, they develop a treatment plan and prioritize treatment goals, which is especially important for clients whose scores fall within the highest-risk categories. These clients often present multiple dynamic risk factors, making it difficult to address them all within one treatment phase. Current risk assessment tools, however, do not explain the onset and maintenance of sexual offending, nor do they offer the ability to specify which dynamic risk factors should be addressed first. The recently developed NBM-RSR offers a method for integrating the case formulation with the outcomes of risk assessment instruments. This enables both the development of an explanatory model for the onset and maintenance of sexual offending and the identification and prioritization of treatment goals (van den Berg et al., 2024; van den Berg & Smid, 2026).

## NBM-RSR Case Formulation

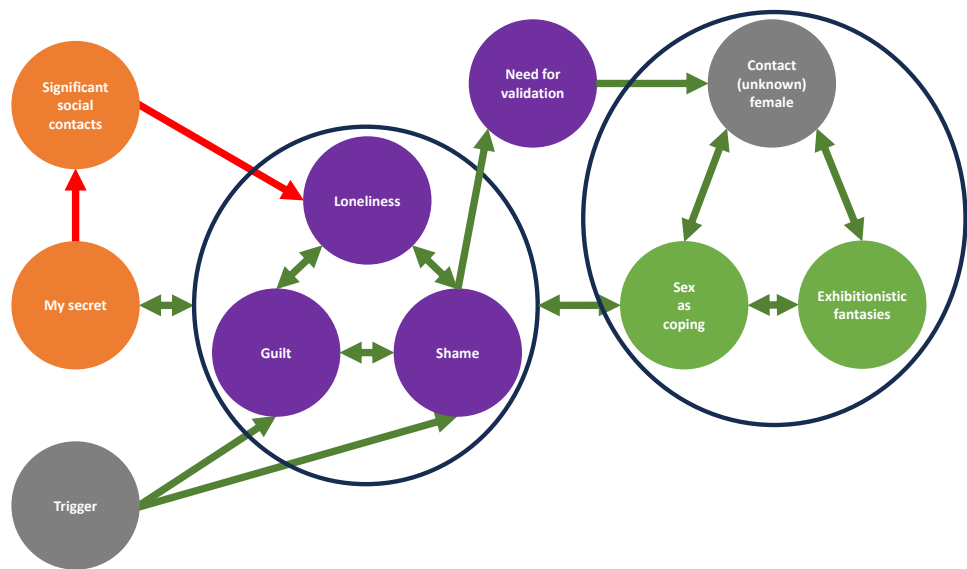
The NBM-RSR posits that dynamic risk factors are causally interconnected, meaning that they influence each other. For instance, feelings of loneliness may lead to using sex as a coping mechanism. Conversely, the act of using sex as a coping mechanism intensifies feelings of loneliness. The way dynamic risk factors interconnect varies from person to person. For example, one individual may use sex as a coping mechanism for emotional loneliness stemming from social rejection. Another person, however, might experience anger and frustration in response to social rejection. Expressing these emotions may, in turn, increase the likelihood of further social rejection. When causal connections between dynamic risk factors become strong enough, a self-sustaining network will emerge. An example of a self-sustaining subnetwork, also referred to as a cluster, can be seen in Peter's pattern of emotional loneliness, shame, and guilt (Figure 1).

*During the admission session, Peter shared that he grew up with his father, mother, and three brothers. He described his family as happy and supportive. However, when he was around 13 years old, everything changed dramatically. Peter was sexually abused by an unknown adult man during a vacation. Feeling ashamed and not wanting to make his parents feel guilty, he did not tell his parents or anyone else about the abuse. In response, Peter created a 'mask' to conceal the trauma. He distanced himself emotionally from others and always acted cheer-*

*ful when asked how he was doing. This helped him keep his secret hidden and protected himself from feelings of guilt and shame. The downside, however, was that nobody truly knew him, which led to a sense of emotional isolation and intensified his feelings of shame. Peter developed a self-sustaining network of loneliness, shame, and guilt (see Figure 1). This pattern corresponded directly to several STABLE-2007 items: by distancing himself emotionally, Peter's **significant social contacts** lacked meaning and support, his **capacity for relationship stability** was limited, and he experienced **social rejection and loneliness**. Peter discovered that sexual fantasies and masturbation temporarily reduced his negative emotions (**sex as coping**). However, these feelings returned more intensely after fantasizing and masturbating. As a result, Peter frequently used this coping strategy (**sexual motivation/preoccupation**), and developed more sexual fantasies, including those involving exhibitionism (**deviant sexual preferences or interests**). In these fantasies, girls and women responded positively to him, which gave him the impression that he was a likable and attractive young man. This led to the development of a second network of dynamic risk factors, consisting of sexual fantasies and behaviors.*

*Peter's causal network of dynamic risk factors also related to ACUTE-2007 items. He was especially vulnerable to (online) sexual offending when he was alone, had access to his mobile phone (**victim access**), and experienced strong negative emotions—such as guilt, shame, or anxiety about losing contact with significant others (**emotional collapse, changes in social support**).*

**Figure 1**  
*Peter's Network of Dynamic Risk Factors*



*Note.* Dynamic risk factors are represented by colored circles. The colors indicate the domains to which the risk factors belong: orange – significant social influences, purple – intimacy deficits, green – sexual self-regulation, and gray – situational and contextual factors. Green arrows represent a positive and red arrows a negative causal relation. Dynamic risk factors within the black-outlined circle form a self-sustaining subnetwork. Peter's (external) triggers primarily include flashbacks and social exclusion.

## Relevance of Dynamic Risk Factor Network Structure

How dynamic risk factors form a causally interconnected network is important for treatment. For example, two clients with identical dynamic risk factors may require different treatment priorities. For one client, emotional loneliness may play a central role in his network of dynamic risk factors, while for the other, this factor may be less significant in maintaining his risk of sexual reoffending. Through an NBM-RSR case formulation, the client and therapist gain insight into how these dynamic risk factors interconnect. With this understanding, they can identify which factors have the greatest influence and should therefore be prioritized in the upcoming treatment period. The relative influence of each factor is determined by its centrality within the network and whether it serves a bridging function.

### Centrality

Peter's network of dynamic risk factors (Figure 1) illustrates how dynamic risk factors differ in the number of causal connections they have. For instance, significant social

contacts influence loneliness, while shame contributes to an increase in loneliness, guilt, and the need for validation. In the network approach, this difference in influence is referred to as centrality. A dynamic risk factor's centrality increases with the number and strength of its causal connections within the network. According to this approach, effectively treating a dynamic risk factor with high centrality leads to a reduction in relatively many other dynamic risk factors (van den Berg et al., 2024; van den Berg & Smid, 2026). This results in a more significant decrease in risk of sexual reoffending compared to treating factors with lower centrality. Consequently, Peter and his therapist will initially prioritize addressing his feelings of shame rather than his lack of meaning and support from significant social contacts, because shame occupies a more central position in his network of dynamic risk factors. However, centrality is not the only method for determining the relative influence of dynamic risk factors on risk of reoffending.

### Bridge Function

A dynamic risk factor also gains relatively more influence on the risk of sexual reoffending when it serves a bridging function within the network. This occurs when a dynamic risk factor connects two self-sustaining subnetworks of dynamic risk factors, referred to as clusters. In Peter's case, this applies, for example, to his need for validation. This need creates a connection between the cluster of guilt, shame, and loneliness, and the cluster consisting of exhibitionistic fantasies, sex as coping and contact with unknown women and girls. Through treatment, as Peter's need for validation from others decreases, the causal influence of the cluster of guilt, shame, and loneliness on the cluster of exhibitionistic fantasies, sex as coping, and contact with unknown women and girls will weaken. At that point, the influence will persist only through sex as a coping mechanism. In other words, according to the NBM-RSR, eliminating Peter's need for validation results in a relatively stronger reduction in recidivism risk, as the influence of guilt, shame, and loneliness on the cluster of exhibitionistic fantasies, sex as coping, and contact with unknown women and girls becomes less pronounced.

*Peter's feelings of guilt and shame seemed to hinder his participation in group treatment. He remained quiet and withdrawn, unwilling to discuss relevant matters. He also responded minimally to invitations from group members and therapists, and as a result, no one truly got to know him. During an individual conversation with his lead clinician, Peter shared that he experienced flashbacks related to his history of abuse. These flashbacks intensified his feelings of guilt and shame. Trauma-focused treatment was initiated, and Peter soon noticed a reduction in these feelings. He reported that the trauma-focused treatment had helped him to view himself differently. He no longer saw the abuse as his fault, but as something that was done to him as a child. Peter became increasingly open with the group, therapists, and his*

*family members. Everyone showed understanding and support when he shared his feelings, fears, and past experiences of abuse.*

*Once his feelings of guilt and shame had decreased, he shared that he still experienced sexual arousal at the idea of unsolicited sharing nude photos and videos of himself with both adult women and under-age girls. He agreed with the therapy group to place his phone in another room whenever his girlfriend was at work on the weekend or when he experienced heightened feelings of guilt, shame, or emotional loneliness. At the beginning of treatment, as part of risk management, he had already removed social media apps from his phone. Additionally, he opened up to his parents and brothers about his ongoing need for exhibitionism. He agreed to call one of them whenever he felt distressed or when the urge for exhibitionism arose. Throughout the treatment, Peter actively re-engaged in old hobbies. He also learned to tolerate negative emotions and the need for exhibitionism, telling himself, "It will pass." As a result, Peter developed stronger and more effective sexual and emotional self-regulation. He no longer avoided emotional intimacy during sexual contact and realized that this increases his satisfaction. His desire for exhibitionism had decreased so much that it almost never occurred. Even though when the urge did arise, it was brief and much less intense.*

*The STABLE-2007 was administered again after a year of treatment. Peter's positive progress in treatment was confirmed by the STABLE-2007, which showed a clear decrease in dynamic risk factors, including significant social contacts, social rejection and loneliness, sexual motivation/preoccupation, and using sex as a coping.*

## Concluding Remarks

This case study explores how the case formulation and risk assessment of a man with a history of sexual offending are integrated into an NBM-RSR case formulation. This explanatory model offers a structured and clinically viable approach to understand the onset and maintenance of sexual offending. It assists in the prioritization of treatment goals by targeting dynamic risk factors with relatively high influence within the causal network. However, while dynamic risk factors centrality and bridge function provide important information about a factor's relative influence, practitioners should also consider the client's readiness and motivation to address each factor. The NBM-RSR case formulation does not prescribe a fixed order; rather, prioritization is determined on a case-by-case basis, balancing the structural position of dynamic risk factors in the network with the client's engagement and capacity to work on them effectively.

Creating an NBM-RSR case formulation can be combined with keeping an (electronic) diary. In this diary, the client rates the presence of their risk factors at multiple fixed times throughout the day or week. Previous research indicates that combining the NBM-RSR case formulation with monitoring risk-related factors through an electronic diary enhances clients' awareness of their dynamic risk factors (van den Berg et al., 2025). Furthermore, clients gained a deeper understanding of how these interconnected factors contribute to their risk of sexual reoffending.

In summary, insights gained from an NBM-RSR case formulation help both the client and therapist prioritize treatment goals. This approach ideally leads to more effective treatment, resulting in a faster and stronger reduction in the risk of reoffending among men with a history of sexual offenses. However, the effectiveness of NBM-RSR case formulation depends on therapists' familiarity with and proficiency in applying the model. It also relies on clients' cognitive capacities and engagement. Clients with cognitive impairments (e.g., neurological disorders, intellectual disability), severe psychopathology (e.g., paranoid or psychotic disorders), or low insight states (such as dissociative presentations) may struggle to grasp abstract causal relations (Vogel et al., 2025). By contrast, clients with limited treatment motivation or low engagement may understand these relations but have difficulty acknowledging or acting upon them in the context of risk reduction. Moreover, retrospective and recall biases may compromise the validity of perceived causal links. Additionally, the case formulation captures relationships at a single time point and perceived causality does not necessarily reflect actual mechanisms. Consequently, while NBM-RSR case formulation is a promising tool for personalized treatment, clinicians should be aware of these limitations and consider complementary strategies to support comprehension, engagement, and longitudinal monitoring of dynamic risk factors.

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**Ethics Statement:** Informed consent for publication of anonymized clinical details was obtained from Peter prior to submission. The name "Peter" is a pseudonym used to protect the participant's identity.

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**Data Availability:** No research data were collected or analyzed for this case study.

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