Part 4:
Treatment Engagement and Special Needs Clients

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Welcome!

Safer Society FOUNDATION

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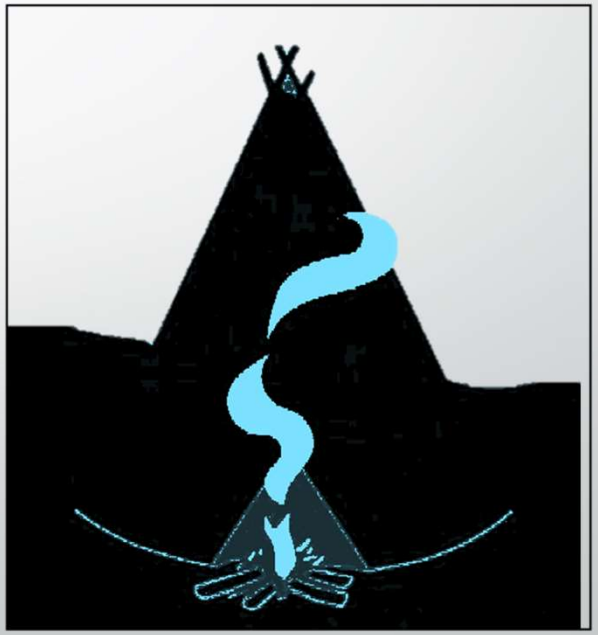
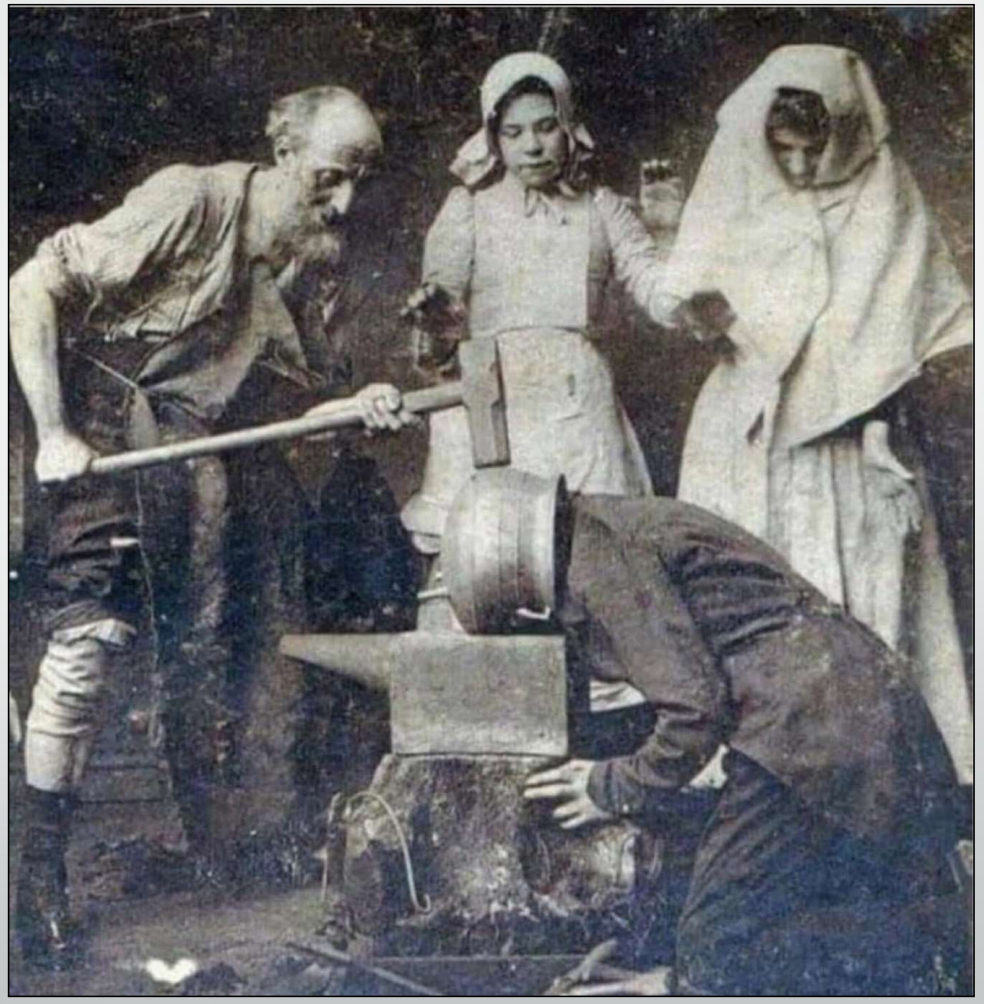
- *Healthy lives, Safe communities*



Background Information

Overview

- 1895-1985



1979: Edward S. Bordin

- Therapeutic alliance:
  - Agreement on relationship
  - Agreement on goals
  - Agreement on tasks
  - (Norcross, 2002, would add client preferences)

  - Over 1,100 studies have emphasized the importance of the alliance in psychotherapy since (Orlinsky, 1994)

Ideally

Ultimately

By the most rigorous/conservative standards:

1. Punishment doesn't reduce risk
   - Punishment = punishment
2. Treatment can work
3. Treatment can be better with the right community supervision

Take-Away Message

- People change
  - We have proof
- Punishment does not reduce recidivism
  - We have proof
- When all else fails, get back to the basics
  - Effective treatment gets people to change the way they think and gets others to support those changes

Ambivalence

Ambivalence

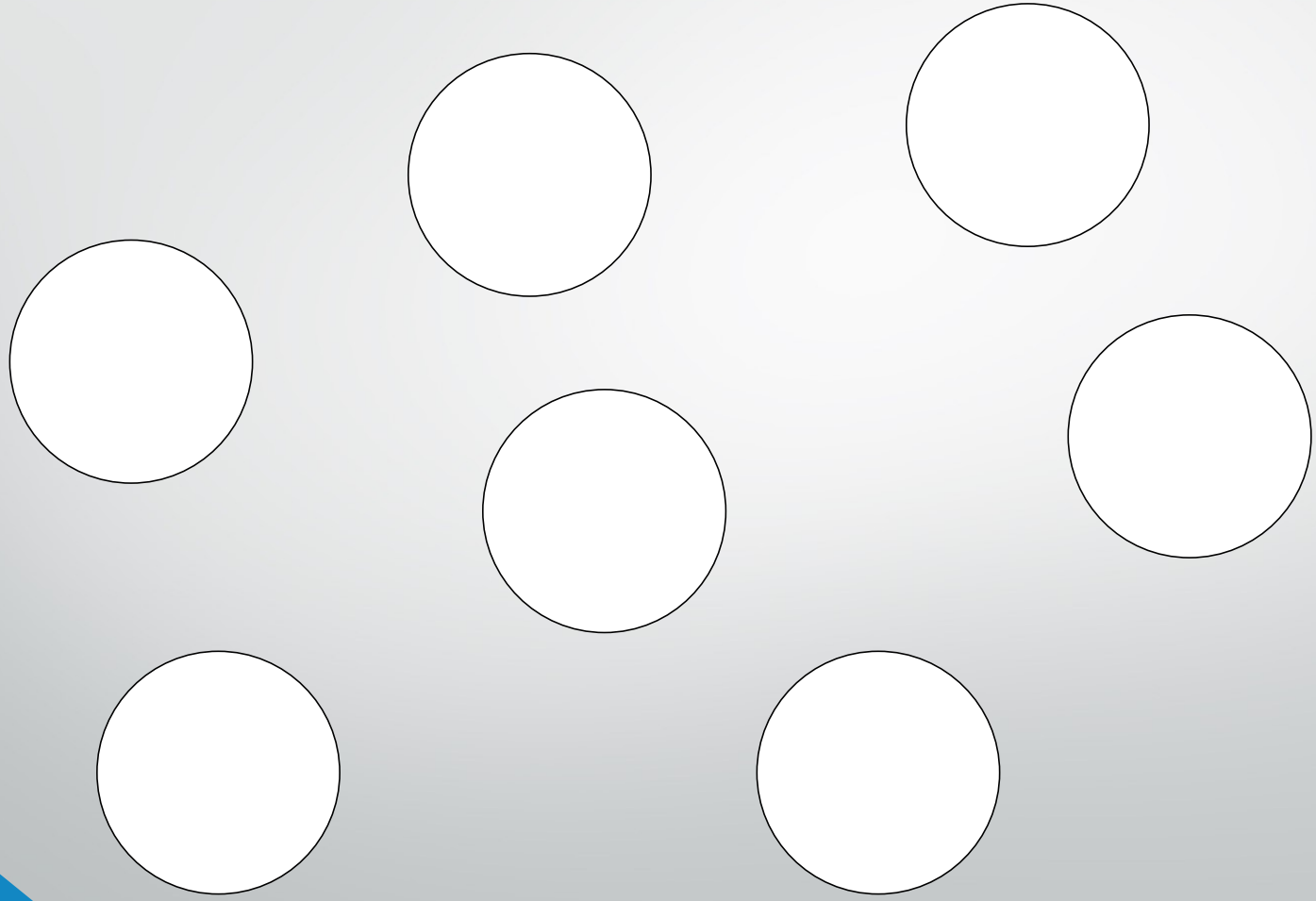
- I want to talk with you and I don't want any more trouble
- I want to work with you, and I don't want to look like a fool
- I want to tell the truth and I want my family to still love me
- I want to change, and I want to be respected
- I want to be in treatment, and I don't want to be in a one-down position
- I want to look at myself, and I don't want to feel less manly
- etc. etc. etc. etc. etc.

"I'm all good. I can take care of myself. There's nothing I need help to change."

- Go upstream (can use goals presented later in this workshop)
- Still, small voice exercise
- What does this young person think about when s/he can't sleep?
- Given that s/he is in trouble for sexual behavior, there is almost always a difference between where the client is and where they want to be in their life.

Where do your clients experience ambivalence?

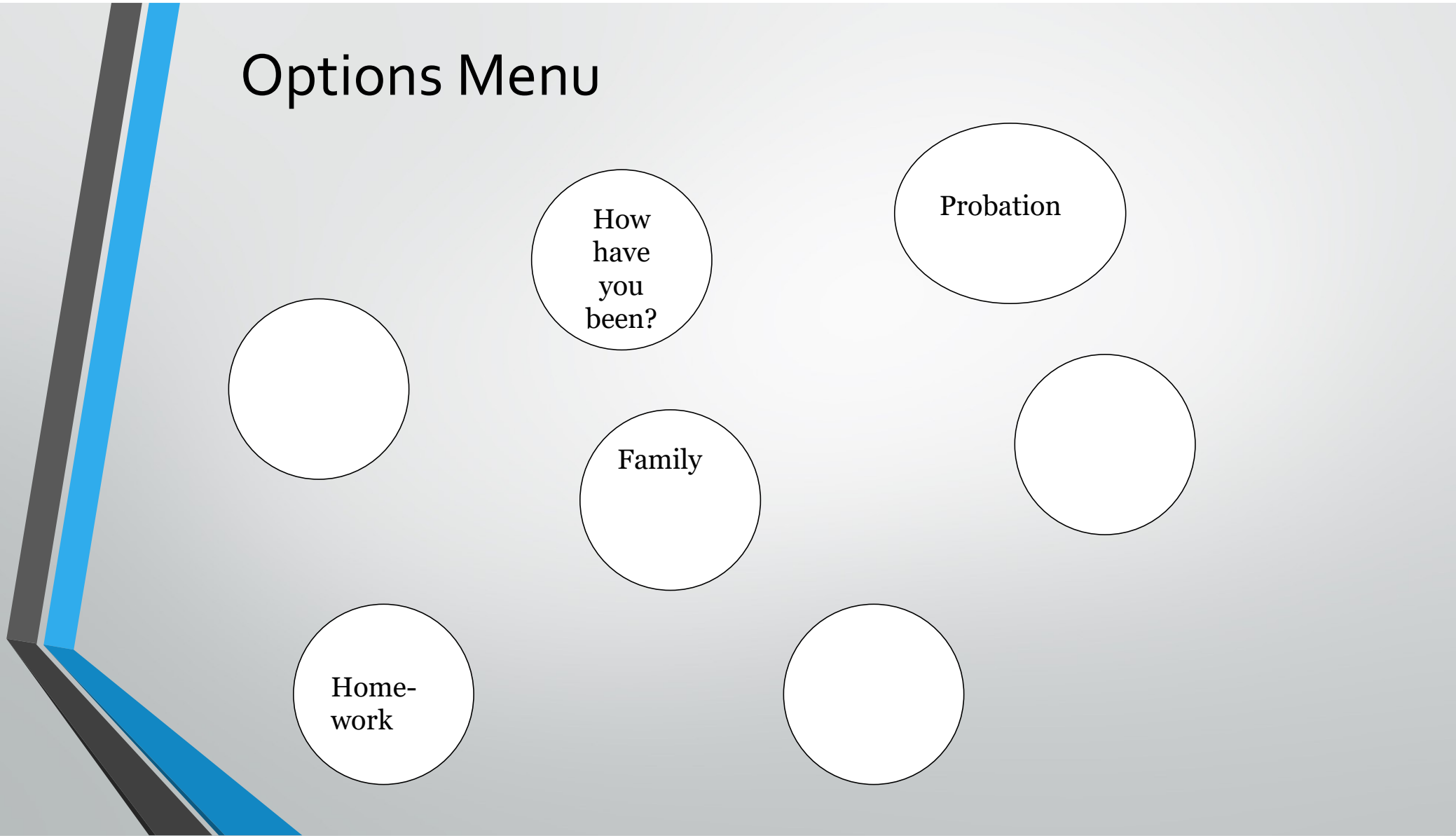
Options Menu



A Good Options Menu

- Focuses the direction
- Respects client autonomy

Options Menu



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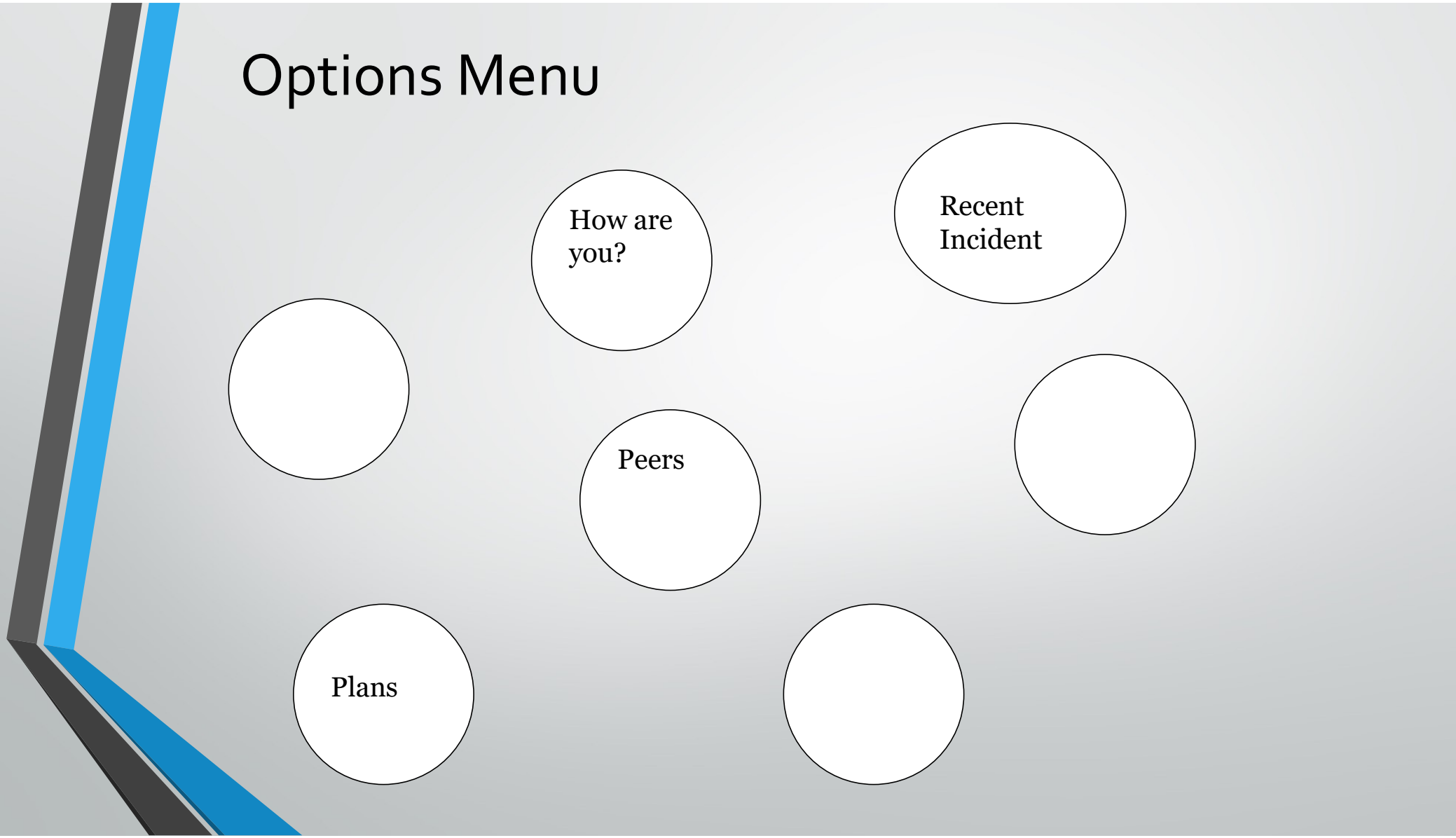

Conversation Flow

- Connect
- Offer
- Explore

- Connect
- Offer
- Explore

Are We Ready?

0 1 2 3 4 5 6 7 8 9 10

Motivation = Importance + Confidence

Good Teachers

What are they like?

Self-study exercises

- Recall a time when someone was <u>really</u> listening to you
  - What did they look like?
- Recall a time when someone really understood you.
  - What did they do?

2013 Practitioner's definition

Motivational interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change.

2013 Technical definition

Motivational interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.

The Spirit of Motivational Interviewing

- Partnership
- Acceptance
- Compassion
- Evocation

Four Processes

- Engaging
- Focusing
- Evoking
- Planning

Talk

Sustain Change Commit

There is no such thing as “resistance”

There is discord and sustain talk

“I’m not gonna; you can’t make me.”

- Sustain talk AND discord

Change Talk

- Desire "*I want to…*"
- Ability "*I can…*"
- Reason "*There are good reasons to…*"
- Need "*I need to*"

Responding to change talk

- ***When you hear change talk, don't just stand there!***
  - Elaborate (tell me more)
  - Affirm
  - Reflect
  - Summarize

Getting Moving: OARS

- Open questions
  - (hint: notice your closed questions and practice opening them up)
- Affirmations
  - (hint: Keep them real, especially with teens)
- Reflections
- Summaries
  - (Hint: think of the vase full of flowers)

Reflective Listening

- Simple Reflection
  - Exact words
  - Closely related words
- Complex Reflection
  - Continuing the paragraph
  - Reflecting emotions

Advanced Skill

- When using complex reflections, try to reflect back more than the client said but not more than they meant
  - (hat tip to Allan Zuckoff)

Telling "The Hard Truth"

- Feedback Sandwich
  - Affirm => Feedback => Affirm
- Elicit => Provide => Elicit
  - Ask permission to give feedback, give the feedback, then elicit the client's thoughts about your feedback
- Motivational approaches are not necessarily warm and fuzzy

Good Life Goals

(Prescott, 2018; Print, 2013)

- Having fun
- Being an achiever
- Being my own person
- Being connected to other people
- Having a purpose in life
- Meeting my emotional needs
- Meeting my sexual needs
- Being physically healthy

GLM vs. Andrews & Bonta Big 8

(possible comparison)

- Having fun
- Being an achiever
- Being my own person
- Being connected to other people
- Having a purpose in life
- Meeting my emotional needs
- Meeting my sexual needs
- Being physically healthy

- Substance abuse and other pleasure seeking
- Poor performance in school or work
- Impulsivity/self-regulation deficits
- Antisocial peer group/social isolation/family problems
- Antisocial history
- Aggression/irritability
- Attitudes and beliefs supportive of sexual violence
- Alcohol/drugs, reckless, dangerous behavior

Thinking on these goals

- What will progress in this look like to me and others?
- What can I do to make positive changes in this?
- What problems might happen as I try to improve?
- How would I know when things aren't working?
- How would others know when things aren't working?
- What can I and others do when things start to go wrong?
- How can I and others acknowledge progress when it happens?

Thinking Further on These Goals

- How have traumatic and otherwise adverse experiences affected this person's ability to get this goal?
- How have the same experiences affected how he looks at the world?
- Where are all the places that this person may experience ambivalence about this goal?
- How can we elicit the client's internal motivation(s) regarding attaining this goal without harming others?


Start with
Strengths

CASES

From the Front Lines

#1

- Client has difficulty respecting others space. Staff provided the example of walking down the hallway and brushing against women's body parts. Staff added he does this towards peers and adults. Client has masturbated and wiped the ejaculate on staff. Client slaps staff on the butt. There have been two incidents where Client has engaged in sexual activity with a male peer. Sexual behaviors have decreased. Staff also reported physical aggression toward others.
- Client's mother reported physical aggression in her home. Client will often get into arguments and physical fights with his brother. Client's mom physically tries to stop the fight. Client's mother was informed of an incident that recently occurred in the car. Client was upset and threw his headphones at the windshield as she was driving. Both staff and client's mom reported verbal aggression from client. Client has said things similar to "I'm going to hit you". Physical aggression is observed every weekend.


WHEN HULK FLIES INTO A VIOLENT RAGE, HE'S "INCREDIBLE"
WHEN I DO IT, I END UP IN PLACEMENTS

#1

Risk

- Interpersonal competence
- Impulsivity
- Poor cognitive problem-solving
- Focusing on emotions instead of solutions

Good Lives Goals implicated

- Independence/autonomy
- Relatedness
- Excellence
- Peace of mind
- Happiness/pleasure
- Meaning and purpose(?)

#1

- GLM Obstacles
- Conflict between goals
  - Independence is clashing with everything else
- Internal capacity
  - Lack of skills to achieve these goals
  - Lack of clarity around what he actually wants
  - Suspect trauma as responsivity factor

- Teaching boundaries
  - What's in it for him?
  - Protected but connected
  - Remember that it took years for him to get into this situation
  - Psycho-ed: 2-second rule, space bubble, quiet voices, etc.

Family

- Family good life plan versus individual GLP
- Values clarification
  - Not just what they are, but why
- Focus on what he *can* do more than on what he can't
- Set the standards for behavior prior to leaving the house
- Assess for trauma in the family and how that might lead to everyone triggering each other

#2

- Foster Mother has stated that a recent sexualized behavior incident occurred involving client. She stated she is waiting for the detective to speak with her. Her family doesn't know what transpired and is therefore unable to discuss it. Foster Mother stated something happened at school, and Child Welfare approached the family pending the completion of the investigation. Foster Mother stated going forward client may not be able to be in a home with other children. She stated client has been in temporary respite care for a year. Foster Mother further stated that the client has a history of aggressive behaviors. She stated the client still has meltdowns when something changes in his schedule. These meltdowns were frequent for a long time; now when they happen, they actually seem much better. Foster Mother stated client has meltdowns 1x weekly now, which is minute compared to what his behaviors used to be.

#2

- She stated that the behaviors improved overnight when medication was started. Foster Mother stated client truly knew he couldn't control those behaviors; he is aware of this and apologized to foster family. He is aware of how he is feeling now and how he felt without proper medication. Foster Mother stated client has trauma of seeing his sister overdose and has enacted physically how she seized. Foster Mother stated she has been worried about getting trauma therapy for him, and he has been diagnosed with PTSD. She stated the client is also recently getting a relationship started with his biological father. He had no real relationship with him until now, and his father only just proved his paternity. Foster Mother stated it's hard to find triggers with client, and that he often seems to have random fits.

Comments

- Remember: **Safety first** always
  - Pending investigation obviously an issue
  - Note the commitment and alliance with foster mother
- Don't overlook psychiatric interventions
  - (Medication noncompliance can be a risk factor of its own)
  - Be careful about over-reliance on meds
- No one has "random" fits
  - We just don't understand the patterns yet
- There is a real question of understanding problematic sexual behavior outside of medication context
- Focus on developing skills for keeping peaceful and calm at all times.

Recommendations

- Honor thy foster mother!
- Outside consult to ensure safety in the home
  - Don't assume that supervision is always working, but don't assume that it's not.
- Listen with a goal of understanding in order to better identify triggers.
- Treatment should have a strong skills focus and involve foster mother.
  - Goal is being a bigger, stronger young man who can live a balanced, self-determined lifestyle.

#2

Risk

- Interpersonal competence
- Impulsivity
- Poor cognitive problem-solving
- Focusing on emotions instead of solutions

- **Good Lives Goals implicated**
- Independence/autonomy
- Relatedness
- Excellence
- Peace of mind
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- Meaning and purpose(?)

#2

- GLM Obstacles
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- Teaching boundaries
  - What's in it for him?
  - Protected but connected
  - Remember that it took years for him to get into this situation
  - Psycho-ed: 2-second rule, space bubble, quiet voices, etc.

#3

- Grandmother shared that client is needing to process the loss of her father. Client will become very emotional when talking about her father. Group Home Manager also shared that Client is also having issues at the program with personal boundaries and is having inappropriate behaviors. Client will touch her own private area and smell it, and there was a recent incident in which client put her hands down another peer's underwear and touched her vaginal area, kissed her, and touched her breast. Client's response was "I wanted to see what it was to be a lesbian." Client did share that the other individual told her to stop but that client kept touching her. The incident was reported to the treatment team and police. Personal boundaries is what the Group Home Manager would like for client to work on and ways to deal with her urges to explore.

#3

- Grief counseling!
- Assess for trauma treatment
- Beware of "counterfeit deviance"
- Risk factor: Self-regulation
- GLM goals:
  - Relationships
  - Peace of Mind
  - Happiness/Pleasure
- Strong Message: You deserve to be in control of your own boundaries, body, and future.
  - Don't listen to the trauma whisper from the past!

#3

- Family
  - Listen long to grief and loss
  - Consider how trauma is playing out in their interactions
  - Emphasize that this is now a safe home
  - Listen long to hopes, dreams, and aspirations
- GLM goals for family and individual:
  - Relationships
  - Peace of Mind
  - Happiness/Pleasure
  - Meaning and purpose
  - Meeting my emotional needs
  - Meeting my sexual needs

#4

- Client is “addicted” to porn. Had a psychotic episode at 9 years old, when they found him naked on the ground under the family’s RV. They have caught him naked outside on other occasions, sometimes masturbating. He has a foot fetish. He was taking the iPad secretly; Mother had taken phone away but has since found him making a porn video of himself. Mother “doesn't know what goes on behind closed doors.” He would hide the porn videos on his phone. Mother reports that it has gotten better and does it in private. Mom cannot really know for sure what he is up to but is skeptical of him.

#4

- Comments
  - Move upstream from porn addiction
  - Happiness and pleasure
  - Peace of mind
  - Lack of internal capacity to achieve these
  - Question:
    - What kind of sexual person does he want to be?
    - What has he learned about men and sexuality from viewing porn?
  - Setting aside the porn, there is a concern about his willingness to break rules
    - What other rules is he willing to break?

#5

- Mom would like to focus on boundaries, especially with sexuality. Female client has viewed pornography. Prior to that, mom mentioned that she would limit things being watched (meaning there have been rules in place all along). Mom mentioned that counselor at the local community center asked mother to have “the talk” with client due to the client “hugging up" with another child. Mom has spoken to counselor. Client tends to look clueless when this topic comes up. Client would allow for others to see her areas when she was younger, "sort of like flashing". Client was not recognizing that she wasn’t supposed to expose herself. Mom mentioned that she constantly has to talk to her about not walking around without clothes. Mom mentioned that previous therapist spoke with mom about boundaries with dad, spends too much time hugging up on dad, dad's new wife expressed concerns upon that. Mom wants to reiterate to client what is okay and not okay.

#5

- I'm not convinced there are universal rule on how much hugging is too much with family members, especially after bad experiences.
- Clueless look may simply mean that direction and limits have been vague.
  - "Don't be inappropriate" versus specific directions on how to hug.
- Strong Message: You deserve to be in control of your own boundaries, body, and future.
  - Don't listen to the trauma whisper from the past!

A trend emerges…

Challenges to a GLM plan often follow a path like:

- Client lacks skills in key areas AND
- Client lacks opportunities to develop skills =>
- Client therefore tries to attain goods in problematic ways =>
- Client has narrow scope; pursues some primary goods and not others =>
- Client's goals come into conflict with one another.

#6

- Group Home Manager stated client is on verge of disruption in her placement. Group Home Manager stated client has sexualized behaviors and she is under investigation with school for several incidents of inappropriate touching of students. Group Home Manager stated school filed a report and has 90 days to investigate before decision is made. Group Home Manager stated in the home they are a co-ed house, and the client expresses that she likes both boys and girls so there are concerns of her being inappropriate around other youth. Group Home Manager stated the client kept grabbing a female peer, tickling her, and she wouldn't stop when asked. Group Home Manager stated client was also caught in boys' rooms and she knows she is not permitted to be in any other peer's room. Group Home Manager stated these behaviors are a constant issue. Group Home Manager stated the client is mean and aggressive towards her younger brother. She is often hitting him and is verbally aggressive with him.

#6

- Group Home Manager stated client is defiant and disrespectful with staff and they struggle with her not listening or following directions. Group Home Manager stated client has been causing disruptions in the middle of night, damaging property and bxs continue even after several sit downs with her to support her. Group Home Manager stated team talked about looking for higher level of care for client and it was discussed during a treatment team meeting that she would be separated from brother, which her father was against. Group Home Manager stated it may be in best interest of her and her continuing behaviors. Group Home Manager stated she called dad to explain behaviors and he explained that the siblings are all each other has, and if it comes down to it they could be separated. Group Home Manager stated client took heed to it, but at the same time there were further reports over the weekend of her bxs. Group Home Manager stated client often has unsafe behaviors, such as opening windows to throw/dump things off 2nd story and she took screen off her bedroom window and damaged it.

#6

Reflections:

- Need to stop and slow down
- Termination increases risk
- Assess to see if a common dynamic is at play: When the staffing is weak, the clients run the program
  - Safety, supervision, attention to routines, clarity of expectations
- Assess for trauma/trauma-informed care
- Consider DBT skills

#7

- Mother would like for client to have therapy to help adjust to new living environment. Mother wants to have client learn healthy ways to express her emotions. Mother also had a situation seven months ago where client touched another student in his private area. When school called police, client told the officers that someone had touched her, but due to limited information it was left unknown who had done this, and the case was closed. It was suggested for mother to place client in counseling.

#7

- Trauma assessment
  - Where does safety lie for this youth and others?
  - Treatment must be collaborative; not simply "do EMDR"
- Risk:
  - Self-regulation
  - Interpersonal competence
- GLM goals/goods:
  - Meeting my emotional needs/peace of mind
  - Knowledge (about trauma and school)
  - Relationships
- Consider DBT skills

#8

- Mother stated male client needs support with understanding personal boundaries/space. Mom stated client has been exhibiting some sexualized behaviors and he doesn't understand boundaries with others. Mom stated he doesn't like clothes due to sensory issues and he strips his clothes off after school and gets naked. Mom stated client has finally been keeping his underwear on after family worked hard with him on it. Mom stated client would try to take his clothes off in public, which has decreased. Mom stated client has been asking questions about sex. Mom stated she's honest with him and they use proper terminology in their house. Mom stated client needs support with learning appropriate language.

#8

- Mother stated she's unsure how much he was touched by his brother; he won't talk about it if approached. Mom stated client will try to sniff peoples' butts because he thinks it's funny and he will stop if asked. Mom stated client asked her what makes something not appropriate and she's unsure how to build on his understanding of appropriateness. Mom stated client struggles with following directions and respecting others' bubbles of personal space. Mom stated client has Pica and he likes to chew on plastic straws. Mom stated family worked hard to get him to only use straws because he used to chew on all sorts of things.

#8

- "Appropriate" is an unhelpful word. Need to unpack this
- Social Stories!
- Use of imagery – pictures to highlight what is and isn't expected
- Consider frequent use of reinforcers
  - Money, time spent with preferred people, etc.

#9

- Foster mother is seeking specialized treatment for a client to work on appropriate boundaries. Client has disclosed that he was a victim of sexual abuse and thought it was normal, and he would touch his younger sister in her private parts. Foster mother shared that client is a well-behaved boy, and she has client and sister in separate rooms.

#9

- Specialized assessment
  - Trauma
  - Sexual behavior
- Risk is probably low
- Consider steps needed for clarification

Treatment Considerations for Special Needs Clients

Research on Special Needs and Problem Sexual Behaviors (PSB)

- Few studies
- Small sample sizes
- Varying cognitive abilities among samples
- Diagnostic tools not always great
  - For example, Autism traits vs diagnosis
- Offending vs nonoffending articles have dichotomous tones

ASD Symptom Vulnerabilities

- Difficulty understanding social cues
- Sensory sensitivities
- Specialized interests can be obsessive
- Poor Theory of Mind: Struggle to understand that other people have their own thoughts and feelings
- New experiences and transitions can be challenging
- Cognitive rigidity: difficulty being flexible to environmental and others' needs/perceptions
- Use of fantasy

Developmental Considerations

- May not have received sexual education
- Less likely to have same opportunities for dating and relationships as same aged peers
- Less likely to utilize friends/peers for social learning

Comorbidities

- Anxiety
- ADHD
- Trauma
- Depression
- Gender Dysphoria
- OCD
- Psychosis vs Active Fantasy
- Intellectual/Developmental Disabilities

Counterfeit Deviance

- Known topic in ID/DD world
- Deviance may develop from residing in a system where appropriate sexual knowledge, relationships, and opportunities for healthy sexual experiences aren't supported and/or provided
  - Is a behavior truly deviant?

Commonly Reported Behaviors

- Public exposure
- Masturbating with unusual objects (objects related to specialized interest)
- Touching children inappropriately
- Indiscreet discussion of sexually inappropriate topics
- Aversion to penetration
- Cross dressing/Costume dressing
- Refusing to touch one's own penis while urinating
- Peeking behaviors (e.g. looking down tops)

Commonly Reported Behaviors

- Unaware of physical boundaries (groping, bumping into)
- Tactile stimulation/aversion (e.g. furries)
- Limited social awareness (e.g., stalking)
- Sexual themes overlap with specialized interest (e.g., Minnie Mouse)
- Sexual interest in nonhuman like objects (e.g., cartoon characters, anime, Thomas the train)
- Less partner-oriented sex
- Higher prevalence of same-sex feelings

Treatment Challenges

- Group vs. Individual
- Direct/Blunt nature
- Cognitively focused
  - Can be rule driven/based
- Therapist language changes
  - Direct communication
  - Accepting of direct feedback
  - Abstract, inferences, and sarcasm can be difficult
- May need to account for Developmental/Intellectual Disabilities

Adaptation OF GLM

(Young Men's Group)

- 8 Good Life Goals
- Content digestible/ directed- identify/build on strengths ; getting needs met- will this "help or hurt me?" , "does this hurt or help?"
- Rules for Group / Structure of Group / Review of Group Materials (Rule governed: need and like rules)
- Use of ORS/SRS (Feedback-Informed Treatment) to help stay on track and make sure no-one gets lost along the way
- Group setting enables social interaction and sharing experiences. Promotes participants' self-acceptance by allowing them to gain insight into both the obstacles and the strengths that characterize they possess, and to recognize that others share similar challenges.

Adaptation of GLM

- Extra work on relationship concerns
  - Can be hard for them to see beyond what they want from a given person to the person themselves.
  - Theory of mind, understanding, empathy, etc.
  - Can be better at picking apart others' issues in treatment than their own
- Vision Boxes in GLM workbook are particularly difficult.

Additional Tips

- Depending on where they with their needs, be patient and repeat X3.
- Have the individual truly explore what "their good life means" and make it concrete. For example, XY loves to go into the community with his mom, "love my mom". Things that get in way – "obstacles" – include negative behavior.. aggression and property damage.
- Another example, YX wanted a job the Team Lead worked with him on what they would be and how to accomplish that.

Additional Tips

- Don't be afraid to review the incidents from the week and how they got in the way of that individuals good life plan.
- Work within the program: Can include putting up signs on the mirror for clients: “Good Choices, Good Person, Good Life." He reads this on the morning after ADLs or at time when he is getting agitated.

Cases

Case Study A

- 19-year-old male who is "okay with some spontaneity but I don't really care for it."
- Currently unemployed.
- Resides in 24 hour supervised group home with four house-mates.
- Placement is 3 years old and constitutes first time living outside of family home.
- Primary Dx: ASD, OCD, ADHD, Pedophilic DO- non exclusive type, Borderline Intellectual Functioning. Also has diagnosis of Diabetes.
- PSB- contact / non-contact offending behavior reported from age 14.
- No judicial involvement.
- History of self harm, psychiatric hospitalizations.
- Poor social interactions / feeling lonely/ questioning own sexuality-Anxiety, depression, low self-regard.

Case Study A Good Lives Plan

- Would like to be more independent move to shared living arrangement, close to family and continue to visit them. Would also like to continue with therapy and be a better person and stay healthy.
- Being connected to other people
  - Attending coffee shop open mic night, UU church
- Meeting my emotional needs
  - Staying in contact with family
- Being my own person
  - Working on progressive independence activities
- Having a purpose in life
  - Applying to college / volunteering /some work experience

Case Study A Good Lives Plan

- Meeting my emotional needs
  - Managing PSB, skill building, GLTBQ group
- Being physically healthy
  - Managing medication/ support group
- Being an achiever
  - Would like to have a career involving art (graphic animation) and earn money.
  - Bus pass, learning timetables
  - "I don't want to drive, so I should probably figure out buses."

Case Study B

- 22-year-old male, currently unemployed. “My thoughts torture me.”
- Resides in 24-hour supervised group home with four house-mates.
- Lived in current home for 1 year, first treatment placement following 3-month psychiatric hospitalization. Attended outpatient services. Lived in mother’s home.
- Currently estranged from family, except mother.
- Primary Diagnosis: Mood Disorder, Autism Spectrum Disorder (ASD), Pedophilic Disorder, sexually attracted to females, Non-exclusive Type ,Fetishistic Disorder R/O, Personality disorder traits suggestive of Anti-Social Personality DO.
- Has Associates Degree in Liberal Arts and some work history.
- PSB- contact and non-contact offending behavior reported from age 12. No judicial involvement.

Case Study B Good Lives Plan

- Would like to pay off student loans. Would like to figure out where he will live in the future.
- Being my own person
  - Working on progressive independence activities
- Being an achiever
  - Managing budget and resources.
- Being connected to other people
  - Establishing connections to available family members. Show family he can be a better man.
  - Researching adult language classes; going to see music bands.

Case Study B Good Lives Plan *(cont'd)*

- Meeting my emotional needs
  - Currently participating in individual and group treatment.
  - Using techniques to manage thoughts that torture him
  - Would like to talk to people without "freaking them out."
- Meeting my sexual needs
  - Understanding PSB impacts and strengthening healthy sexual identity.
- Having a purpose in life
  - Looking for employment, considering a trade in order to support self. Working on medication management.

Case Study C

- 28-year-old male, currently unemployed.
- Resided in current area 5 years in 24-hour supervised group home, currently with four house-mates.
- Primary diagnosis: Autism Spectrum Disorder, Pedophilic Disorder, ADD, Mild ID
- Has lived in residential placements from 16 years following increase in aggression in family home.
- Removed from biological family at 3 (abuse and neglect), adopted aged 6
- Has high school diploma, minimal work experience
- PSB- contact and non-contact offending behavior reported from age 12

Case Study C Good Lives Plan

- "I want to leave this program, but I still need help."
- Meeting my emotional needs
  - Attending to mental health and management of PSB: attending therapy/psychiatry.
- Being physically healthy
  - Managing medications / attending medical appointments to maintain health- rock gym/cycling/working in the yard.
- Being an achiever/ having fun
  - Completed reiki classes, returned to karate classes
- Having a purpose in life
  - Obtained drivers permit + starting road lessons, volunteering / considering job & or training to be able to support self. Seeking opportunities to develop independent activities.

Case Study C Good Lives Plan

- Would like to maintain contact with parents/family & continue to visit them.
- Being Connected to other people
  - Recently vacationed with mother to visit grandparents across country. Strengthening family bonds during visit by following expectations and safety planning.
- Being my Own Person
  - Working on progressive independence activities. Recognizing bodily changes in response to stimuli and managing self to promote safety. (Meditation/Body Scan)
  - working on ADLs/progressive independence activities/ looking for job.

Reflections

- The Good Lives goals can /do overlap but it's helpful for the individual to choose a "Headliner" goal and as they go along they can see the interplay of goals.
- Helps individuals create a tangible road map for their own treatment trajectories and a point of reference.
- Aim for a busy balanced schedule. Visuals schedules /Planners are magic!
- Helps boost autonomy within the treatment process.
- Assists individuals live a fulfilled and meaningful life without the need to offend.

Questions?

Comments?

Thank you!