Draft of a chapter from Ward, T., Willis, G. M., Prescott, D. S., Vandevelde, S., Barnao, M., & Wanzeele, W. (2025). *The Good Lives Model of Correctional Rehabilitation: Integrating Theory, Research, and Practice*. Springer Nature.

Chapter 4

Designing and Implementing Interventions

As a practice framework, the GLM is applied differently to individual clients and populations depending on their setting and individual needs. Implementing the GLM with fidelity therefore is not nearly as simple as ensuring that everyone gets the same treatment experience. Designing interventions and putting them into practice requires several layers of consideration—including the core values, knowledge-related principles, and practice guidelines—to understanding how each client's primary human goods were (and weren't) implicated in their harmful behaviors. This chapter reviews the fundamentals of GLM design and offers ideas for implementation that include client culture, history of adversity, and specific risks and protective factors.

4.1 Introduction

This chapter examines how to (and how not to) apply GLM treatment interventions. In line with the description of evidence-based practices in Chapter 1, it builds on clinical experience from implementation projects around the world, reviews research-based best practice in program implementation, and offers guidance on matching treatment services to client characteristics, preferences, and cultural considerations (effective GLM intervention requires that the latter be considered in both assessment and treatment). While Chapter 1 includes a more comprehensive overview of

the theoretical underpinnings and discussion of the three levels of the GLM, this chapter explores their application in practice settings.

In brief, GLM interventions center on a personally meaningful good life plan, containing all primary goods to varying degrees (chosen by the individual), and the secondary goods (goals and strategies) required to attain these without harming others (Willis & Ward, 2024). This can be linked with risk reduction by identification of the goods sought via offending (either directly or indirectly) in the past, and the barriers or problems (i.e., criminogenic needs as motivational signals) evident within the strategies used to attain these goods. For example, sexual offending is sometimes used to achieve relatedness or pleasure because of problems differentiating between appropriate partners (i.e., children are preferred as sexual partners because individuals feel emotionally safer with them). A treatment good life plan could incorporate relatedness and pleasure via the goal of seeking an intimate relationship with an age-appropriate consenting partner. Treatment strategies may include attending social activities, creating an online dating profile, engaging in conversation, physical intimacy, vulnerable disclosure, conflict resolution, and so on. Treatment can target risk factors, such as emotional congruence with children, through the development or strengthening of internal and external capacities and resources. For example, developing healthy beliefs about the self, others, and relationships (e.g., “others are trustworthy”, “I am safe”), communication and negotiation skills, emotion-management, perspective-taking, and so on. The availability of external resources (e.g., opportunity, finances, freedom) can support or obstruct PHG attainment and should also be included in a good life plan.

Essentially, GLM-guided treatment should identify the most heavily weighted goods (which are linked to a person’s practical identity and sense of meaning) and those

sought via offending, use these to construct a comprehensive good life plan, and then develop or strengthen the internal and external resources required to live a good life without reoffending. The GLM proposes a dual focus on promoting goods and overcoming internal and external barriers. It does this in collaboration with the individual to build on strengths and focus on meaningful personal goals, rather than simply avoiding reoffending.

The GLM has been used in a wide variety of ways in diverse settings on virtually every continent with very different populations. These settings include prisons, psychiatric hospitals, special commitment centers, intensive residential programs, group homes, and community-based treatment programs. While this provides testimony to the adaptability of the GLM, it also means that there are misunderstandings about what the GLM actually is and how it should be applied (Willis et al., 2014).

4.2 What the GLM Is and What It Is Not

Since its introduction, many programs and practitioners have implemented the GLM in diverse ways, sometimes more successfully than others. Chapter 1 describes three interwoven levels of the GLM: core values, knowledge-related assumptions, and practice guidelines. It is worthwhile for practitioners to bear in mind these levels when considering individual clients or implementation of the GLM in a program or constellation of programs. Using the three levels as a backdrop, it is critical that before applying the GLM, programs and practitioners should:

- Be grounded in mission of building internal and external capacities for clients.

- Pay equal attention to risk variables.
- Keep in mind that the overall focus of the GLM is to help clients achieve wellbeing and a life worth living as well as in managing risk.
- Consider that client successes often stem from the interactive nature of this dual emphasis. Clients who are seeking to live a better life often find managing risk easier to accomplish than if their sole focus is on avoiding re-offending.
- Approach each client as a fellow human being in the world rather than little more than the sum of their risk factors. Each client has fundamental human rights and is worthy of dignity and respect.
- Strive to remain strengths-based in every area of intervention. Programs and practitioners that do not have a strengths-based perspective will not be successful with the GLM.
- Understand that human beings are goal-directed and autonomous, and their behavior is meaningful and with purpose.

The points above are worth emphasizing because programs can often lose sight of them. Programs have sometimes relegated pieces of the GLM to psychoeducational module, as if saying, "Here is a list of goals (referring to the primary human goods [PHGs]) you might accomplish once you are done taking responsibility for your actions and are managing your risk factors." Having a firm foundation in the three interwoven levels can prevent misapplication of the model further.

As programs seek to implement the GLM, it can be useful to begin by reviewing their goals. Programs commonly have a mission statement that is explicitly written in policy and often reflected in the culture of the program. For example, many programs in

the USA have a mission statement along the lines of, “no more victims.” While this is a laudable goal on its face and no professional in this work wishes for people to be victimized, it does not align with the foundation of the GLM. In some cases, programs with a no-more-victims mission have explicitly or inadvertently veered away from the evidence for what works in preventing further offending. These programs have focused so much on risk management that they have forgotten the other side of the equation: that people who work to lead better lives are more likely to be successful in leading fulfilled, offense-free lives. In part this is because individuals who commit offences are motivated by a set of fundamental human desires (PHG) and therefore seek to achieve goals such as intimacy, a sense of control, or social acceptance rather than simply an offense. In these cases, a mission along the lines of, “preventing further victimization by ensuring that clients build lives that are incompatible with offending” might be more useful.

Over time, several misconceptions about the GLM have become apparent during GLM training and consultation efforts, which are useful to address early on:

- The GLM is a practice framework and not a specific treatment protocol (see Chapter 1). Many programs and practitioners have come to assume that the GLM must be like the empirically supported protocols (ESTs) that they have learned in other settings and that are emphasized in contemporary public discourse. Dialectical behavior therapy (Linehan, 2014), for example, requires very strict adherence to a set of methods. Those using motivational interviewing are often trained to use certain behavior counts, such as maintaining a ratio of two reflective statements for every open-ended question asked. Other ESTs are

modularized in a specific sequence. These approaches often have an excellent research base and are worthy of the term EST. There are good reasons to employ each of these methods and models; indeed, many of their techniques blend well with the GLM. However, the emphasis on ESTs in various locations around the world has often meant that the flexibility of the GLM practice framework requires a fresh perspective on how treatment works.

- Keeping the above in mind, the GLM is not time limited. Program administrators interested in learning about the model frequently ask how long or how many sessions it takes. The duration of treatment will depend on the individual and the nature of ancillary treatment needs (for example, see the case example of Linda in Chapter 8. In her case, treating her substance abuse disorder would be a major component of her treatment.) While programs will wish to be familiar with available literature on treatment dosage, the course of GLM treatment should be determined by the individual's risks and needs).
- The GLM is not designed to be implemented in any one specific or inflexible way. However, some elements are essential in any successful implementation, and these are described below.
- Further, there is no official certification of GLM practitioners or programs. There are many reasons for this, including the absence of a research base showing that certification efforts improve outcomes for clients. Rather, the authors recommend that programs and practitioners adhere to the findings of implementation studies (e.g., Fixsen et al., 2005). This includes reading the extant literature, attending training, receiving consultation, using the fidelity

monitoring tool mentioned later in this chapter, and establishing deliberate practice plans (Prescott et al., 2017) to ensure that their skills are improving.

- Properly applied, the GLM is not a way of telling clients what is wrong or missing from their lives. Some practitioners have taken a reductionistic view the GLM and have expressed the view that, at its core, the GLM is simply a way of reminding clients what's wrong with them. This view reflects a deep misunderstanding of the GLM as an overarching practice framework. Therapists should not view themselves as normative police officers, always searching for value violations and correcting clients. Practitioners reminding clients of what is wrong or missing from their lives are not practicing the GLM.
- Properly applied, the GLM is not patronizing or paternalistic. While some have rightly warned against this in the literature (Glaser, 2011), its focus is on viewing the client as a fellow traveler and relies heavily on the therapist characteristics described below. Care must be taken to elicit honest feedback from the client on what is and isn't working in therapy, and what they need more or less of. Goals related to well-being should never be imposed on a client but should result from clinical discussion.
- The GLM is not "done to" a client. The GLM is inherently collaborative.

In summary, the GLM applied properly is delivered in a collaborative manner, builds on client strengths, and depends on understanding and responding to clients' personal and cultural values alongside their histories of adverse experiences.

4.3 A Note on Coercive Approaches and Treatment Experience.

It is worth noting that research has consistently found that the greater the level of coercion experienced in treatment, the less likely these services are to be effective at reducing recidivism (Parhar et al., 2008). In some corners of the world, intrusive and invasive methods such as aversion therapy using noxious smells, the penile plethysmograph, and polygraph examinations have often played a role in assessment and treatment. Each of these has been controversial in the literature for many reasons, and a full accounting is well beyond the scope of this book.

Historically, writings on the GLM have been silent regarding these methods. While some jurisdictions have required the use of the polygraph as a condition of probation, but when used against the client's wishes, these methods are antithetical to the core values of the GLM.I It may be useful to clarify this with clients in the service of the therapeutic relationship. Nevertheless, many practitioners using the GLM have found themselves with no choice (for example, a probation department requires a polygraph examination if the client wants to live freely in the community as opposed to in an institution). Under these circumstances, practitioners should regard these methods as outside the core values and scope of the GLM practice framework, and special care may be needed to reduce any harm that may result.

4.4 Therapist Characteristics

Attention to therapist characteristics is essential in the GLM framework; this section offers ideas to help operationalize them. Empirical attention to therapist characteristics and treatment process variables has emerged since the 1990s (Drapeau, 2005; Marshall, 2005; Miller & Rollnick, 2024). To summarize, Marshall (2005) reviewed the available research, including in forensic treatment programs, and outlined that the most effective therapists were those who are:

- Warm
- Empathic
- Rewarding
- Directive

"Directive" in this case means having a clear sense of direction and moving treatment forward accordingly. Together these characteristics form the acronym WERD, which helps people newer to the field to remember them. It is important to recognize that no one is always at their best at displaying these features in every personal and professional setting, and so each of these can be the focus of ongoing "deliberate practice" efforts (Chow, 2017).

Along similar lines, a large body of motivational interviewing research (Miller & Rollnick 2023) has illustrated the importance of the "spirit" of motivational interviewing (sometimes also thought of as its mindset and heart set). This involves interacting with each client in a spirit of:

- Partnership

- Acceptance
- Compassion
- Empowerment

To accomplish this, Miller and Rollnick (2023) emphasize the importance of approaching each client with humility; the practitioner may be an expert in the forensic arena, but only the client is the ultimate expert on their life. These central values form the acronym PACE, which can also be a useful acronym to help newer practitioners stay grounded.

Attention to each of these variables and the core values, knowledge assumptions, and practice guidelines form the foundation of the GLM. Sadly, research has found that therapists can overestimate their effectiveness with clients (Beech & Fordham, 1997; Levenson et al., 2024; Walfish et al., 2012). For this reason, it is vital that practitioners get ongoing feedback from their clients on what is and isn't working for them (Prescott et al., 2022). Together, the above characteristics provide a firm foundation for therapists working with the GLM.

4.5 Approach versus Avoidance Goals

Approach and avoidance goals are introduced in Chapter 1. These types of goals have to do with whether a person is approaching a goal that they can achieve, attain, or acquire, or that they otherwise aspire to as opposed to something they are simply trying to avoid. Examples of approach goals from daily life include developing healthier eating habits, improving relationships, or spending more time feeling at peace. Examples of

avoidance goals might be to not eat unhealthy foods, stay away from friends who aren't good for them, and feeling less stressed out. The way that people frame their goals can help determine whether they are successful. Approaching better physical health can be a more appealing goal than quitting smoking.

The practitioner's work involves managing the delicate balance between the approach goal of promoting the individual's goods and the avoidance goal of reducing risk. For the purposes of treatment planning and practices, it is important to bear in mind that the PHGs and development of a good life plan rely in large part on the use of approach goals. This can be a difficult challenge for newer practitioners who are often used to thinking in terms of reducing symptoms, solving problems, fixing that which is broken, or making others stop their harmful behaviors.

Professionals occasionally raise the concern that approach goals might not be a good fit with a particular client. For example, they may ask whether the client who says, "My only goal at present is to avoid further offending" shouldn't be allowed to retain this as a goal. This question typically arises as a hypothetical, and the authors have never heard of a case in which avoiding offending was in fact the only aspiration that the client had. In these cases, the therapist or evaluator might:

- Simply have a conversation with the client to see what other aspirations arise and how they might connect to their good life plan at the time of their offending or in their future. This could involve asking clients why they want to avoid offending, what's stopping them from having and doing what they want in their lives, and what they would gain if they did put an end to harmful behaviors. This might help to elucidate other goals.

- Begin treatment with the central goal being to avoid offending and using sessions to understand what the client's good life plan was at the time of their harmful behavior. As therapy proceeds, the client may come to view their life as a mix of approach and avoidance goals, then work to reorganize their plans accordingly. Remember, offending provides a window into clients prioritized PHGs and associated practical identities (see Chapters 1 and 2).

What programs and practitioners should never do is tell them that an avoidance-based goal is not allowed or insist that the client must fit themselves into the GLM before they are ready. As a colleague once asked in a training about empirically supported protocols, "Are we personalizing our manuals or are we trying to manualize persons?" These are all reasons why the GLM is a practice framework and not a specific protocol.

4.6 Getting the Context Right

Some additional considerations for getting started with the GLM include:

- The therapist's grounding in the agent-action-context schema mentioned in Chapter 1. This can help therapists keep focused on the many components involved in problematic behaviors and not just the actions or characteristics of the agent.
- Taking client concerns seriously and listening for evidence of the PHGs behind the concern. For example, the client who doubts whether a program or

practitioner can help them is likely expressing concerns about internal and external capacities involving the PHG of relatedness.

- Likewise, listening for evidence of early life adversity when clients are expressing concerns can help to foment an understanding.
- For clients residing in a secure setting or under intensive community monitoring for more than a year into the future, it may be helpful to consider developing intervention plans both for while the client is residing in the high-intensity setting and again as they are approaching a return to greater freedom in the community.
- In inpatient settings, it is helpful to have the paraprofessional and/or security staff trained to have familiarity with the model so that they can provide support to clients (also see Chapter10). In some non-forensic inpatient settings, such as group homes (see the case of Linda in Chapter 8), there may be activities or psychoeducational groups that the paraprofessional staff can provide.
- Consider the language used. This book and virtually all the other GLM literature uses the term "primary human goods," which many clients will find difficult to understand. Many GLM resources (e.g., Prescott & Pflugradt, 2024) use the term "good life goal" in its place (see Chapter 3). This kind of adaptation is not made lightly. It is vital to the integrity of the GLM that the PHGs be thought of by the practitioner as actions, experiences, and states of being that one seeks to attain for their own sake. This means that they are more than simply goals. However, when applying the model in forensic settings and other agencies, it can be helpful to operationalize the PHGs as goals. Likewise, it is worthwhile to remember that some words may have different connotations in various areas of the world.

"Agency," for example, may need to be restated as "personal choice and independence" in some settings. Likewise, relatedness may be restated as "to love and be loved."[1]

4.7 Getting Started

Once the formal assessment is complete (and the therapist and client understand the results, case conceptualization, and intervention plan), an excellent place to start when speaking with the client is to consider the components of the therapeutic alliance (Ross, Polaschek, & Ward, 2008). While many therapists confuse this term with having a positive relationship with a client, the therapeutic alliance, as defined by Bordin (1979) and reconsidered more recently by Norcross (2010) is more comprehensive. As applied to the GLM, practitioners can ask:

- Do the client and I agree on the goals of therapy?
- Do the client and I agree on the nature of our relationship and how I fit into their life?
- Do the client and I agree on the approaches used in treatment?
- Are the client and I working in accordance with their cultural values and strongly held beliefs?

[1] See appendix F for suggestions for translating primary human goods into good life goals

These questions, and the resulting feedback from clients, can yield insights into how and when clients may not move forward in treatment. As good as any assessment process may be, the final report may not fully convey the intricacies of a client's daily life, and therapists may not always see PHG-related content in sessions. For example:

Therapist (T): "Welcome, Chris! It's great to see you here today."

Client (C): "Well, it's not so great to see you today. They scheduled this session at the same time as I was supposed to work over in the machine shop, at the other end of this hellhole of a prison. No offense, but you're just about the last person I want to talk to right now."

For some therapists, this brief exchange might appear as resistance, and they may feel compelled to respond accordingly. After all, job opportunities can be plentiful, while therapy sessions need to be scheduled when they can. These therapists might be tempted to remind the client about the realities of treatment within a prison setting, such as scheduling challenges and the importance of treatment completion to establishing release dates. Some therapists might assume that the client is manipulating the therapist and trying to avoid treatment intervention. Still other therapists, seeking to be helpful, may start by attempting to resolve the scheduling conflict (which is an excellent idea, but may only offset a deeper and more compassionate response within the GLM framework).

Seen through the lens of the therapeutic alliance, several opportunities present themselves for a helpful intervention. Starting with the questions above:

Do the client and I agree on the goals of treatment? In this case, the client is providing a lesson about what is meaningful and important to them. First, the overall

presentation reflects the client's concerns about agency. By all appearances, he wants to be in charge of how his life is balanced with respect to such elements as therapy and mastery experiences. He is angry at the impositions on his independence and autonomy in this situation. While the client's presentation may be rude, the compassionate therapist can see that this person is seeking out the very same agency that the staff of the prison take for granted. Further, in explicitly saying that the therapist is the last person that they want to see at that moment, the client is demonstrating that relatedness has a place in his life and that there is discord and possible rupture within the therapeutic relationship, whether either of them asked for it or not. Finally, the client is explicitly emphasizing the importance of mastery at work.

Do the client and I agree on the nature of our relationship? In the few words exchanged above are many possibilities for reflection. Does the client view the therapist as an agent of the police power of the state? As a tool of a cruel and unjust system? Are they simply another person in their life who wields undue influence over them? Or as someone who might help if only they really understood the client? Do they view the therapist as a source of shame or of support and validation? These may all be possible, and other more subtle differences may be present. Does the client think therapy is a place where they must express emotions all the time? Do they confuse the relationship they have with that of their mother, father, potential lover, etc.? This will be very important to clarify, since the PHG of relatedness is so often central to clients' good life plans.

Do the client and I agree on the approaches used in treatment? In this instance, the client may be the therapist's best teacher. Through this brief exchange, the client is offering information as to what will and won't work. Treatment that honors the client's

sense of agency and mastery at work will likely be the most successful. While the impulse to rush towards problem-solving is not misguided, it may overlook an opportunity for a broader discussion of how they can work together in the future.

Are the client and I working in accordance with their cultural values and strongly held beliefs? While there is no information about cultural values in the vignette above, the client is letting the therapist know about his strongly held values (mastery at work and agency). It seems that these PHGs are central to his *practical identity*, described in Chapters 1 and 8. Proceeding with respect for this practical identity will serve the client and therapist well. It will help to prevent the client from developing a bleak outlook on his future and sense of meaning and purpose, which is connected to the PHG of spirituality. When programs introduce challenges to mastery at work for people to whom this is part of their practical identity, they have the rehabilitative process backwards. When programs work to produce balance in change efforts and other activities, they are modeling the core values of the GLM.

Instead of responding with an immediate attempt to solve the problem or provide guidance on the role of the client, a better way forward would be:

T: "You're missing out on work right now and it's got you angry."

C: "Yes. It was in that assessment they did that work is important to me. Every hour matters. I need skills and I need to get out of here someday."

T: "We're about to figure out the best way forward. But first, can I just ask: Am I correct that it's not just about the hours and the pay and the skills. This is about

who you are as a working man, and every roadblock is a potential threat to your autonomy and eventual independence, and even a bit about how you plan to live and survive?" (all PHGs).

C (pausing and thinking):" Yes. Now let me ask you. What are you going to do about it?"

T: "The first thing I'm going to do is to get with your employer to work out our scheduling. Nothing's ever perfect when it comes to scheduling, but we will work something out. Anything I should know first, like are you a morning or a night person?"

C: "That part doesn't matter so much."

T: "Okay, I'll make a phone call in a moment, and you're invited to be part of it. First can I ask: We both know you're in prison and I'm a therapist. We both know this is my job and I go home at night. What I don't know is what you expect and what you hope for in working with me. What are your thoughts about how we work together? What else is important for me to know? What are your thoughts about how all this works?"

C: "That's a lot of questions."

T: 'How about this: How do you see me fitting into your life?"

C: “I don’t know if I do see you fitting into my life.”

T: “You’re not sure you can trust any of this.”

C: “No.”

T: “So, you’ll hear me out and take me at my word and then wait to see if I’m true to it all, correct?”

C: “Yes.”

T: “Thanks. I’ll keep working on it. Shall we call over to your work about that schedule?”

By listening reflectively, and with each of these components of the therapeutic alliance understood, the therapist has gained additional insights into how best to work with this client.

4.8 What Does the End of Treatment Look Like?

The GLM mapping tool and intervention plan referenced in Chapter 3 are excellent resources for assessment, understanding, and treatment. This section explores how they fit into the broader context of a treatment program. In real-world settings, it is

often difficult for clients and practitioners alike to know what the expectations of treatment actually are, especially when programs are working within broader agencies of mental health or corrections and the legal systems beyond.

Understanding what is expected within the GLM framework is an important aspect of getting treatment started. Put another way, what does the end of treatment look like for the program and for the client? The answers often depend on the systems in which treatment occurs and are, therefore, all the more important to clarify. Clients who don't clearly understand the endpoint and what's expected of them often find themselves having difficulty moving forward in treatment programs and with their lives more generally.

Different settings will have different expectations and policies regarding expectations in treatment. Many inpatient settings require a comprehensive risk assessment to examine overall risk and potential next steps for a client. For clients residing in the community, treatment completion may be inextricably linked with decisions made by a case manager or probation officer. In some cases, a court hearing may be required so that a judge can lift a treatment requirement.

Some treatment programs follow a structure of three to four phases. The first phase focuses on addressing whatever aspects of the client's life might interfere with treatment. The second phase explores the client's past good life plan and helps them to develop internal and external capacities to begin working on a new good life plan. Subsequent work can explore how a client can build more horizontal and vertical coherence in their good life plan with a focus on their practical identity/identities. A third phase focuses on the implementation and refinement of the good life plan, while the fourth and final phase may represent a sort of aftercare situation, reviewing the ups

and downs of the client's good life plan in daily life. In one instance, an inpatient program was clever and made clear in their policies that the aftercare phase, by definition, was to take place in the community. This ensured that the judges overseeing cases knew that leaving them in the institution was not an option. It also ensured that clients got the services they needed once they were out in the community.

In several sources (e.g., Prescott & Pflugradt, 2024), a series of questions can be useful for each PHG. These questions are intended for deep exploration and discussion for treatment planning, not simple answers:

4.9 Past

- What are all the ways that the client attempted to achieve this PHG in the past?
- What internal and external strengths and resources did they have to achieve this PHG?
- What worked and/or didn't work for them?
- How did the processes underlying risk play a role in this PHG?
- What challenges did they face?
- How did adverse and otherwise traumatic events act as roadblocks on the way to achieving this PHG?
- Looking back, did they overemphasize this PHG at the expense of others? Or did they neglect this PHG?
- What did they notice about their efforts when things were going well in attaining this PHG?

- What did others (close friends, family, or acquaintances) notice when things were going well for the client in attaining this PHG?
- Did they notice when things weren't working or were getting worse? If so, what did they notice?
- Did others notice when things weren't working? If so, what did they notice and how did they let the client know?
- Were there other sources of feedback, things that people said or did, that acted as warning signs when things were getting worse with respect to this PHG?
- How did they acknowledge progress or lack of progress in achieving this PHG? Did they ever celebrate this progress? If so, how?

4.10 Present

- What are all the ways that the client is currently attempting to achieve this PHG?
- What internal and external strengths and resources do they have to achieve this PHG?
- What's working and what's not working for them?
- How are the processes underlying risk playing a role in their current efforts to achieve this PHG?
- What challenges are they facing now?
- How are past adverse experiences and otherwise traumatic events continuing to act as roadblocks on the way to achieving this PHG?

- Are they overemphasizing this PHG at the expense of others? Or might they be neglecting it? How can they best ensure vertical and horizontal coherence?
- What do they notice about their efforts when things are going well in attaining this PHG?
- What do others notice when things are going well for this client in attaining this PHG?
- Does the client notice when things aren't working or are getting worse? If so, what do they notice?
- Do others in their life (close friends, family, or acquaintances) notice when things aren't working? If so, what do they notice and how did they let the client know?
- Are there other sources of feedback that act as warning signs that things are getting worse with respect to this PHG?
- How does the client acknowledge progress or lack of progress in achieving this PHG? Do they celebrate this progress? If so, how?

4.11 Future

- How does the client plan to achieve this PHG in the future?
- What internal and external strengths and resources will they have to achieve this PHG?
- What internal and external strengths and resources do they still need to develop to achieve this PHG?

- How might the processes underlying risk play a role in their future efforts to achieve this PHG?
- What challenges do they anticipate facing?
- How might the client's past adverse experiences and otherwise traumatic events act as roadblocks on the way to achieving this PHG and what would need to happen to prevent this?
- Are there ways that they might overemphasize this PHG at the expense of others? Or might they neglect it while focusing on other PHGs? What can they do to maintain vertical and horizontal coherence in their GLP going forward?
- What will they notice about their efforts when things are going well in attaining this PHG?
- What will others notice when things are going well for this client in attaining this PHG?
- What will the client notice when things aren't working or are getting worse? What ways will be available to them to take stock of what's working?
- What will others in their life (close friends, family, or acquaintances) notice when things aren't working? How can they let the client know?
- Are there other sources of feedback that will act as warning signs that things are getting worse with respect to this PHG?
- How will the client acknowledge progress or lack of progress in achieving this PHG? Do they celebrate this progress? If so, how?

Negotiating present and future good life plans can also involve discussions about how skills, circumstances, and vertical and horizontal coherence may change when someone is off intensive supervision in the community or leaves a high-security setting.

4.12 Understanding the Role of Trauma and Early Life Adversity

There has been a surge of research and practical interest in trauma-informed care in recent years (Levenson et al., 2017; Levenson & Willis, 2019). While a full description is beyond the scope of this chapter, a few points can be helpful for evaluators and therapists using the GLM.

First, it is important to distinguish trauma-specific treatment protocols (for example, eye movement desensitization and reprocessing; Shapiro, 2018) from trauma-informed care, which is best thought of as a set of principles that include understanding the impact that traumatic events have had on people's lives. Chapter 8 includes two cases of clients who have each been affected by trauma and adversity. The case example of Linda shows how a specific empirically supported protocol was used to address a long history of trauma and adversity. On the other hand, the case of Tommy includes discussion of how adversity was related to his practical identity and the PHGs implicated in his offense. Together, the cases illustrate how the effects of trauma can vary dramatically from one client to the next and that, just as in every aspect of the GLM, one size never fits all.

Second, the impact of complex trauma and its aftereffects can influence internal and external capacity for achieving PHGs. The effects of trauma and adversity often fall into three overarching domains: attachments and relationships, cognitions and core

beliefs about the world, and self-regulation (Levenson et al., 2017). Looking at each, one can imagine many ways how each of these domains are affected:

Attachments and relationships. Problems in this area can prevent internal (and potentially external) capacity development in:

- Relatedness
- Community
- Living and surviving (through viewing relationships as a potential existential threat)
- Knowledge (via difficulties working with and trusting teachers and similar professionals)
- Mastery at play (through not being able to engage in activities with others)
- Mastery at work (by not being able to form collaborative relationships with colleagues)

Cognitions and core beliefs about the world. When the world is viewed as a dangerous or out-of-control place, where might makes right and authorities can't be trusted, it is no surprise that these kinds of cognitions could interfere with reaching one's full potential with respect to all of the PHGs. Related conditions might include two challenges to executive functioning often seen in people with long histories of problematic or harmful behaviors: Cognitive rigidity and an external locus of control (Morgan & Lilienfeld, 2000). Most directly, these might affect internal (and potentially external) capacity development in:

- Knowledge (For example, cognitive rigidity presents a barrier to learning, which involves thinking differently about subjects.)
- Relatedness (For example, an external locus of control can prevent taking effective action on one's responsibilities within a relationship.)
- Community (For example, rigidly believing that a community should exist within a particular structure and that other structures would be wrong. It might also include not seeing oneself as a participant in a community due to seeing only the community's impact on the client.)
- Inner peace (For example a person may not believe that they can have peace unless their external circumstances change.)
- Creativity (For example, creativity often requires cognitive flexibility.)
- Agency (For example, not seeing oneself as capable of autonomy or independence due to an internal locus of control or rigid beliefs about one's circumstances.)
- Mastery at work (For example, rigidly believing that because one is subject to the whims of external circumstances, they cannot attain this PHG.)

Self-regulation. Clearly, it is difficult to be successful with any good life plan when one has problems with self-regulation. Without self-regulatory abilities, it is entirely possible that all PHGs can be directly affected, with some of the most pronounced effects occurring in:

- Life
- Mastery at work
- Mastery at play
- Agency

- Relatedness
- Community
- States of happiness and pleasure
- Inner peace

Ultimately, an awareness of the impact of trauma and adversity on PHG acquisition is fundamental to GLM practice.

A final note on multidisciplinary efforts in implementing the GLM with people who have histories of trauma and adversity is in order. The effects of early adversity on clients can touch every aspect of their lives. Implications for GLM practice include understanding that change for some clients may come slowly. After all, given the rates of issues with cognitive skills, such as rigid thinking and an external locus of control, no program or practitioner should expect that clients will be able to reassemble and improve their lives in a short period of time. A common message heard in inpatient programs using the GLM is the need for patience and understanding with clients.

4.13 The Role of Culture

The GLM cannot be properly implemented without respect for cultural differences between clients (Ward & Dickie, in press). While cultural awareness has been at the center of societal debates for centuries, a few points may be useful for GLM practice.

Practitioners should always keep in mind that culture can have a very different impact on clients. Therapists using the GLM may be viewed as state agents participating

in systems of oppression. Even the ways that communities talk about culture can vary around the world; in some languages, the word “race” is not used because it is assumed that all people belong only to the human race.

PHGs are prioritized more in some cultures than others, and the impact of racism can present severe restrictions on external capacity (for example, through stigma, discrimination, and the lingering effects of colonization) and internal capacity (when racist beliefs become internalized). The question isn’t whether the GLM works with clients of a given background, but rather, how the various cultures (including race, ethnicity, gender, sexuality, nationality, and religious background) in this person’s life may have influenced their good life plan and how these can best be addressed within the GLM.

In some cases, applying the GLM will require knowledge of broad cultural aspects. As one example, the relationship of indigenous people to those descended from colonists can vary from one part of the world to another, requiring broad knowledge of the history in that region. In some instances, practitioners will have to focus on a more individualized basis (e.g., “our client came from an Eastern European country and is now here in our city. We are trying to learn from him what is important for us to know as we start GLM practice.”). In one case, a conversation went along the lines of:

Client: “I’ve heard about the GLM. It won’t work for me.”

Therapist:” Why not?”

C: “I’m Asian. The GLM is for white people.”

T: “I’m not sure I follow.”

C: “I’ve talked to the other guys here in the program. They keep talking about how their pursuit of ’agency’ was all wrong and got them into trouble. They’re out of the old cowboy movies! Everything they talk about has something to do with freedom and independence and autonomy and making their own decisions. I’m from an entirely different culture. For us, family is everything. Where I’m from if you ask me how I’m doing, I’d tell you about my family. If you ask me how I’m doing individually, I won’t be able to answer as easily as those guys do.”

T: “Yes, those are some big differences. You’re making some important points. Can I ask a couple of questions to see if I understand?”

C: “Sure.”

T: “When you lived with your family, were there ever times you wanted to eat something different for dinner than what your mother was making?”

C: “Yes, of course.”

T: “Did you ever dream of doing something for a living that might have been outside your family’s plans for you?”

C: “Definitely. I’m here, aren’t I?”

T: “Very true. Did you ever try to influence your family to do something that you wanted to do?”

C: “Of course. What’s your point?”

T: “That developing agency can look very different in different cultures. Your family relationships really are important to you, yet they may not be everything. You may not be a lot like the others in the program, but you share a lot of things in common below the surface. What’s different isn’t your goals in life, but how important they are and how you go about making them happen. Does that make sense?”

C: “Okay, I got it. And if I’d thought more about how those things work off each other, like making decisions about my actions, I might have prevented some big mistakes.”

T (smiling): “You’ve really been thinking about your life. Great work. It’s not easy to put in that kind of effort.”

With an understanding of the central themes in treatment and the role of seemingly thorny issues such as trauma, culture, and the role of the therapist, the rest of

the chapter can focus on other practical considerations, including modalities, fidelity monitoring, and barriers to implementation.

4.14 GLM with Adolescents

It is worth noting here that the GLM is routinely adapted for use with adolescents (Fortune, 2018; Prescott, 2025; Print, 2013). It is noted throughout the available texts that applying the GLM to adolescents should never be a simple downward extension of methods for treating adults. Rather, much like approaches such as motivational interviewing (Miller & Rollnick, 2023), using the GLM with adolescents involves tailoring it to the unique characteristics of the client (see Chapter 5 for further discussion on emerging adults). The following overarching considerations are important:

- Professionals must understand the developmental aspects of the adolescent. Adolescents are typically in a state of constant change. Aspects such as decision-making, emotions, risk-taking, and sexuality are all typically still very much in development, requiring developmentally sensitive methods and approaches by adults.
- Professionals must also consider the environment in which the young person exists. Adolescents are, by definition, dependent upon the nature and quality of the contexts in which they find themselves.
- Professionals will need to keep in mind that the nature of internal and external capacities will change across adolescence, as will the other obstacles mentioned above. Further, their PHGs will also change, both with respect to importance (for

example, seeing a stronger drive towards agency) and the means by which the young person seeks to attain them.

Finally, it is important to note that adolescents will naturally have less capacity to account fully for their actions, whether in the eyes of the law or in their therapists' offices. Readers are referred to the other extant literature for applying the GLM to this age group.

4.15 GLM Modalities

As an overarching practice framework, the GLM lends itself to several modalities. It has been applied in case management (Purvis et al., 2013) as well as to therapeutic programs. It can be used in individual or group therapy.

Individual therapy. As a framework designed to be individualized, the GLM lends itself to individual therapy in a straightforward fashion. Elsewhere in this volume, the GLM mapping tool and intervention plan can help to guide treatment. Individual therapy also lends itself to more extensive conversations on topics that a client may be reluctant to bring up in group.

Group therapy. There is a rich literature on group therapy in forensic contexts (e.g., Sawyer & Jennings, 2016) leaving no doubt as to its potential for helping clients to build better lives for themselves. Depending on circumstances, group therapists might consider conducting groups in an open fashion, with each client discussing various aspects of the GLM that they are working on and getting feedback from others. Those who are further along in treatment can ask questions and provide support to those who

are newer, and all members can review their efforts at developing skills and other forms of capacities. Another option can be for the therapist(s) to develop exercises based on GLM principles, such as how clients are working to develop capacities with respect to a good life goal. There are many possibilities (for example, the use of music in Chapter 6).

One option for group therapy can be to use a workbook exercise as the start of a discussion topic for the session (e.g., Prescott, 2025; Prescott & Dent, 2016; Prescott & Pflugradt, 2024; Prescott, Pflugradt, & Allen, 2023).I In some settings, the clients may begin group by quickly reviewing an exercise in the workbook that they completed on their own time, reading their answers out loud to the group, after which the facilitator starts a discussion and clients offer feedback to one another. This approach has been helpful in settings with clients whose special needs may make group participation challenging (and who presumably are also receiving individual therapy). Under no conditions should the workbook be mistaken for a prescribed curriculum, but rather as a tool for clinical discussion.

In some high-intensity inpatient programs, the therapist may give the paraprofessional staff exercises to use with clients that focus on PHG acquisition. These non-clinical topics might involve skills for getting and maintaining a job (mastery at work); independent living skills (life); relaxation (inner peace); skills for community activities to prevent awkward, uncomfortable, or even illegal interactions with others (community); and the like. Some programs display artwork on the walls with GLM themes that can help with these discussions. One program had the clients paint one wall of their common area with a picture of a tree; each branch was named after a PHG.

The one caution in any application of the GLM practice framework is ensuring that a clinical specialist with the appropriate degree and license/registration oversees

the activities to ensure that the style, spirit, vision, and technical aspects of the GLM are followed correctly.

4.16 Fidelity Monitoring

Helping programs and practitioners to maintain fidelity to the GLM has been a major focus of recent efforts and resulted in a tool that is widely available in English, French, and Dutch (Prescott et al., 2022; Prescott & Willis, 2021a; Ward et al., 2024). It covers three areas: Fundamental considerations and processes, GLM-specific considerations and processes, and client-focused GLM considerations. The tool has scoring instructions and ideas for its best use, primarily as a tool for consultation, supervision, and self-reflection.

Fundamental considerations and processes. This section includes a focus on the qualities of the therapist as perceived by the client and others, a review of the underlying spirit of treatment delivery, how the therapist prioritizes clinical skills that promote change, and actively and explicitly seeking client feedback.

GLM-specific considerations and processes. This examines the extent to which the therapist focuses on the PHGs generally and those PHGs implicated in harmful behaviors, conceptualizes risk factors, and focuses on activities that ameliorate the obstacles to one's good life plan.

Client-focused GLM considerations. This consists of ten questions exploring therapists' progress developing a GLM-grounded case conceptualization and therapy plan for individual clients.

Even the best of therapists can sometimes drift off course or develop habits and practices that do not entirely comport with the GLM. With the proliferation of programs seeking to implement the GLM comes the need to consider many perspectives on its successful application. At a minimum, the GLM Fidelity Monitoring Tool enables users to examine their alignment with broader elements of the GLM as well as the processes within it (Prescott et al., 2022).

4.17 GLM Implementation

The GLM has been implemented in diverse settings and circumstances in many areas around the world. Over time, research has emerged to guide programs in how to implement new programs and what challenges one might expect (Brattland et al., 2018; Fixsen et al., 2005). In our experience, there are several beliefs held by programs and practitioners that can impede meaningful implementation (Prescott & Willis, 2021b). These include:

Lack of support by leadership. Applying the GLM requires that programs and practitioners possess certain attributes and engage in processes often referred to as a program's "culture." As with any workplace or educational setting, if the people who oversee the program are not invested in the GLM, it is less likely to be implemented well. When considering GLM implementation, ensuring leadership buy-in is often the most important first task.

The belief that "we already do this." It can be easy for those who first encounter the GLM to form premature judgements about it. Often this takes the form of seeing its commonalities to other forms of psychotherapy (for example, the importance of the

therapeutic alliance) and assuming that it must be like those methods with which the practitioner is already familiar. In some cases, this belief can result in confirmation bias, whereby the individual disregards aspects of the GLM with which they are not familiar or believe that since they have the general idea, they have enough information to stop their learning. As described elsewhere (Prescott & Willis, 2021b), questions for new GLM practitioners to consider include:

- Is the practitioner using the actual PHGs described in the GLM?
- Is the practitioner using the PHGs as they are defined? The PHGs as constructed have an empirical foundation described in the foundational writings (e.g., Ward & Stewart, 2003; Yates et al., 2010).
- Can the practitioner identify which PHGs are important to this client?
- Has the practitioner explored the client's practical identity?
- Can the practitioner describe how the PHGs were implicated (or not implicated) in the client's problematic behaviors?
- Does the practitioner have a solid understanding of how PHGs interact with causal processes implicated in the client's offending?
- Has the practitioner conducted a solid assessment of the client's strengths (as they relate to prosocial acquisition of PHGs) and accounted for how the client can apply them to treatment and to his or her life beyond treatment more effectively?
- Has the practitioner explored the vertical and horizontal coherence of the client's good life plan?
- Can the practitioner identify the obstacles in the client's good life plan?

- Can the practitioner identify how the client has sought to implement a good life plan in the past, in the present, and how they plan to implement in the future?
- Have the practitioner and client arrived at the answers to questions such as how the client and others around them will know that they are attaining a good effectively or ineffectively?

The belief that "this is easy." Learning portions of the GLM or learning about it is not the same as developing deep practice expertise. High-quality implementation takes time, effort, and practice; this fact is in line with the findings of implementation research with many models. Ultimately, study, training, and supervision/consultation are all vital in putting the GLM into practice.

Simplifying the GLM. The authors have been aware of occasional attempts to simplify the GLM, often by removing PHGs and related goals that the therapist, administration, or researcher deems to be superfluous, such as spirituality or states of happiness and pleasure. Often these decisions have been made without consultation with the clients they serve. Such simplifications can become reductionistic and contrary to the holistic underpinnings of the GLM. Similar simplification can occur when personal opinions interfere with implementation. One colleague who was unfamiliar with the GLM stated that, "It's time we go beyond the GLM and use mindfulness as the centerpiece of our program." This person had been unaware of the PHGs of inner peace and spirituality at the time. Different clients will need shorter and longer lengths of treatment but altering the GLM to speed up treatment or slow it down will not improve outcomes in the long run.

4.18 Conclusion

Applying the GLM in therapy and treatment programs requires patience and commitment, but its holistic nature typically means a more impactful experience for the client. Its nature as a practice framework is often a new experience for those who have been trained primarily in specific protocols. Its implementation across programs often involves training, supervision, consultation, and practitioner self-reflection. The case examples included in Chapter 8 may contribute to a sense of how best to apply the model in different circumstances.

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